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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	07/14/20
BUSINESS UNIT	BUYER
25710178	JULIE SCHILTZ (AS)

CONTRACT NUMBER
71165 O4

VENDOR NUMBER: 2266837

VENDOR ADDRESS:

NEBRASKA TOTAL CARE INC
7700 FORSYTH BLVD STE 800
SAINT LOUIS MO 63105-1837

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: Amanda Brown
Phone: 531-329-8583
E-Mail: amanda.r.brown@nebraskatotalcare.com

(djo 04/12/16)

AMENDMENT ONE AS ATTACHED. (11/30/16 sc)

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

AMENDMENT THREE AS ATTACHED. (11/28/17 sc)

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

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

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

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

AMENDMENT EIGHT 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)

DocuSigned by:
Jeremy Brunssen
42A61D4FE4D94B5...

DHHS DIVISION DIRECTOR

BUYER

7/28/2020

MATERIEL ADMINISTRATOR

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STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

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CONTRACT NUMBER
71165 O4

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

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**

JS
BUYER INITIALS

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AMENDMENT ELEVEN
Contract 71165 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and Nebraska Total Care, Inc.

The State of Nebraska and Nebraska Total Care, Inc. make this Amendment (the Amendment") to Contract 71165 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

(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 Cotton

Title: Materiel Administrator

Date: 7/28/2020

Nebraska Total Care, Inc.

By: _____

Printed Name: Heath Phillips

Title: CEO

Date: 7/6/2020

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

By: DocuSigned by: Jeremy Brunssen 42A61D4FE4D9465...

Name: Jeremy Brunssen

Title: Interim Director

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

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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Attachment 38 – Revised Reporting Requirements

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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Status: Completed
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Division: MLTC
Envelope Type: Contract
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Document Pages: 72
Signatures: 18
Certificate Pages: 5
Initials: 0
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Time Zone: (UTC-06:00) Central Time (US & Canada)

Envelope Originator:
Keith Roland
301 Centennial Mall S
Lincoln, NE 68508-2529
keith.roland@nebraska.gov
IP Address: 164.119.6.37

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Jeremy Brunssen Jeremy.Brunssen@nebraska.gov Deputy Director, Finance and Program Integrity Division of Medicaid and Long-Term Care Department of Health And Human Services Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Accepted: 2/4/2020 5:56:12 AM ID: 443d0eb8-802b-40d7-abd6-39d96b9e9921	DocuSigned by: Jeremy Brunssen 42A61D4FE4D94B5... Signature Adoption: Pre-selected Style Using IP Address: 164.119.5.143	Sent: 7/22/2020 1:39:10 PM Viewed: 7/22/2020 1:40:43 PM Signed: 7/22/2020 1:41:23 PM
In Person Signer Events	**Signature**	**Timestamp**
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Intermediary Delivery Events	**Status**	**Timestamp**
Certified Delivery Events	**Status**	**Timestamp**
Carbon Copy Events	**Status**	**Timestamp**
Kristine Radke Kristine.Radke@nebraska.gov Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Not Offered via DocuSign	COPIED	Sent: 7/22/2020 1:39:10 PM
Nancy Keller nancy.keller@nebraska.gov Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Not Offered via DocuSign	COPIED	Sent: 7/22/2020 1:39:10 PM

Carbon Copy Events	Status	Timestamp
Julie Schiltz Julie.Schiltz@nebraska.gov Security Level: Email, Account Authentication (None)	COPIED	Sent: 7/22/2020 1:41:27 PM Viewed: 7/22/2020 3:31:12 PM

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Witness Events	Signature	Timestamp

Notary Events	Signature	Timestamp

Envelope Summary Events	Status	Timestamps
Envelope Sent	Hashed/Encrypted	7/22/2020 1:41:27 PM
Certified Delivered	Security Checked	7/22/2020 1:41:27 PM
Signing Complete	Security Checked	7/22/2020 1:41:27 PM
Completed	Security Checked	7/22/2020 1:41:27 PM

Payment Events	Status	Timestamps

Electronic Record and Signature Disclosure

CONSUMER DISCLOSURE

From time to time, Nebraska Department of Health & Human Services (we, us or Company) may be required by law to provide to you certain written notices or disclosures. Described below are the terms and conditions for providing to you such notices and disclosures electronically through the DocuSign, Inc. (DocuSign) electronic signing system. Please read the information below carefully and thoroughly, and if you can access this information electronically to your satisfaction and agree to these terms and conditions, please confirm your agreement by clicking the 'I agree' button at the bottom of this document.

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Withdrawing your consent

If you decide to receive notices and disclosures from us electronically, you may at any time change your mind and tell us that thereafter you want to receive required notices and disclosures only in paper format. How you must inform us of your decision to receive future notices and disclosure in paper format and withdraw your consent to receive notices and disclosures electronically is described below.

Consequences of changing your mind

If you elect to receive required notices and disclosures only in paper format, it will slow the speed at which we can complete certain steps in transactions with you and delivering services to you because we will need first to send the required notices or disclosures to you in paper format, and then wait until we receive back from you your acknowledgment of your receipt of such paper notices or disclosures. To indicate to us that you are changing your mind, you must withdraw your consent using the DocuSign 'Withdraw Consent' form on the signing page of a DocuSign envelope instead of signing it. This will indicate to us that you have withdrawn your consent to receive required notices and disclosures electronically from us and you will no longer be able to use the DocuSign system to receive required notices and consents electronically from us or to sign electronically documents from us.

All notices and disclosures will be sent to you electronically

Unless you tell us otherwise in accordance with the procedures described herein, we will provide electronically to you through the DocuSign system all required notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to you during the course of our relationship with you. To reduce the chance of you inadvertently not receiving any notice or disclosure, we prefer to provide all of the required notices and disclosures to you by the same method and to the same address that you have given us. Thus, you can receive all the disclosures and notices electronically or in paper format through the paper mail delivery system. If you do not agree with this process, please let us know as described below. Please also see the paragraph immediately above that describes the consequences of your electing not to receive delivery of the notices and disclosures electronically from us.

How to contact Nebraska Department of Health & Human Services:

You may contact us to let us know of your changes as to how we may contact you electronically, to request paper copies of certain information from us, and to withdraw your prior consent to receive notices and disclosures electronically as follows:
To contact us by email send messages to: john.canfield@nebraska.gov

To advise Nebraska Department of Health & Human Services of your new e-mail address

To let us know of a change in your e-mail address where we should send notices and disclosures electronically to you, you must send an email message to us at john.canfield@nebraska.gov and in the body of such request you must state: your previous e-mail address, your new e-mail address. We do not require any other information from you to change your email address..

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To request delivery from us of paper copies of the notices and disclosures previously provided by us to you electronically, you must send us an e-mail to john.canfield@nebraska.gov and in the body of such request you must state your e-mail address, full name, US Postal address, and telephone number. We will bill you for any fees at that time, if any.
To withdraw your consent with Nebraska Department of Health & Human Services

To inform us that you no longer want to receive future notices and disclosures in electronic format you may:

i. decline to sign a document from within your DocuSign session, and on the subsequent page, select the check-box indicating you wish to withdraw your consent, or you may;

ii. send us an e-mail to john.canfield@nebraska.gov and in the body of such request you must state your e-mail, full name, US Postal Address, and telephone number. We do not need any other information from you to withdraw consent.. The consequences of your withdrawing consent for online documents will be that transactions may take a longer time to process..

Required hardware and software

Operating Systems:	Windows® 2000, Windows® XP, Windows Vista®; Mac OS® X
Browsers:	Final release versions of Internet Explorer® 6.0 or above (Windows only); Mozilla Firefox 2.0 or above (Windows and Mac); Safari™ 3.0 or above (Mac only)
PDF Reader:	Acrobat® or similar software may be required to view and print PDF files
Screen Resolution:	800 x 600 minimum

Enabled Security Settings:	Allow per session cookies

** These minimum requirements are subject to change. If these requirements change, you will be asked to re-accept the disclosure. Pre-release (e.g. beta) versions of operating systems and browsers are not supported.

Acknowledging your access and consent to receive materials electronically

To confirm to us that you can access this information electronically, which will be similar to other electronic notices and disclosures that we will provide to you, please verify that you were able to read this electronic disclosure and that you also were able to print on paper or electronically save this page for your future reference and access or that you were able to e-mail this disclosure and consent to an address where you will be able to print on paper or save it for your future reference and access. Further, if you consent to receiving notices and disclosures exclusively in electronic format on the terms and conditions described above, please let us know by clicking the 'I agree' button below.

By checking the 'I agree' box, I confirm that:

- I can access and read this Electronic CONSENT TO ELECTRONIC RECEIPT OF ELECTRONIC CONSUMER DISCLOSURES document; and
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- Until or unless I notify Nebraska Department of Health & Human Services as described above, I consent to receive from exclusively through electronic means all notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to me by Nebraska Department of Health & Human Services during the course of my relationship with you.

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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	07/14/20
BUSINESS UNIT	BUYER
25710178	JULIE SCHILTZ (AS)

CONTRACT NUMBER
71165 O4

VENDOR NUMBER: 2266837

VENDOR ADDRESS:

NEBRASKA TOTAL CARE INC
7700 FORSYTH BLVD STE 800
SAINT LOUIS MO 63105-1837

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: Amanda Brown
Phone: 531-329-8583
E-Mail: amanda.r.brown@nebraskatotalcare.com

(djo 04/12/16)

AMENDMENT ONE AS ATTACHED. (11/30/16 sc)

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

AMENDMENT THREE AS ATTACHED. (11/28/17 sc)

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

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

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

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

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

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

AMENDMENT TEN (10) 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

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25710178	JULIE SCHILTZ (AS)
VENDOR NUMBER: 2266837	

CONTRACT NUMBER
71165 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**

JS
BUYER INITIALS

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AMENDMENT TEN
Contract 71165 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and Nebraska Total Care, Inc.

The State of Nebraska and Nebraska Total Care, Inc. make this Amendment (the Amendment") to Contract 71165 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: _____

Printed Name: Douglas D Carlson

Title: Materiel Administrator

Date: 7/26/2020

Nebraska Total Care, Inc

By: _____

Printed Name: Heath Phillips

Title: CEO

Date: 7/6/2020

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

By: Jeremy Brunssen
DocuSigned by:
42A61D4FE4D94B5...

Name: Jeremy Brunssen

Title: Interim Director

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

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Nebraska Total Care – 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	$1,728.10	$25.03	$1,753.13
AABD 21+ M&F	$2,048.74	$20.44	$2,069.18
AABD 21+ M&F-WWC	$5,362.59	$40.04	$5,402.63
CHIP M&F	$226.59	$3.50	$230.09
Family Under 1 M&F	$856.07	$18.89	$874.96
Family 01-05 M&F	$200.34	$3.72	$204.06
Family 06-20 F	$234.66	$3.20	$237.86
Family 06-20 M	$259.20	$2.98	$262.18
Family 21+ M&F	$621.97	$5.36	$627.33
Foster Care M&F	$697.84	$7.00	$704.84
Healthy Dual	$339.41	$0.00	$339.41
Dual LTC	$203.18	$0.00	$203.18
Non-Dual LTC	$4,285.88	$28.76	$4,314.64
Dual Waiver	$331.51	$0.00	$331.51
Non-Dual Waiver	$1,996.65	$15.22	$2,011.87
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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Nebraska Total Care – 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	$1,663.73	$29.13	$1,692.86
AABD 21+ M&F	$2,224.93	$8.68	$2,233.61
AABD 21+ M&F-WWC	$6,536.79	$88.80	$6,625.59
CHIP M&F	$238.59	$1.29	$239.88
Family Under 1 M&F	$836.62	$10.81	$847.43
Family 01-05 M&F	$206.57	$1.15	$207.72
Family 06-20 F	$259.17	$0.78	$259.95
Family 06-20 M	$257.60	$0.72	$258.32
Family 21+ M&F	$732.18	$1.36	$733.54
Foster Care M&F	$600.49	$1.85	$602.34
Healthy Dual	$307.26	$0.00	$307.26
Dual LTC	$197.24	$0.00	$197.24
Non-Dual LTC	$2,000.03	$3.56	$2,003.59
Dual Waiver	$348.85	$0.00	$348.85
Non-Dual Waiver	$2,142.24	$10.16	$2,152.40
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

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Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	07/14/20
BUSINESS UNIT	BUYER
25710178	JULIE SCHILTZ (AS)

VENDOR NUMBER: 2266837

VENDOR ADDRESS:

NEBRASKA TOTAL CARE INC
7700 FORSYTH BLVD STE 800
SAINT LOUIS MO 63105-1837

CONTRACT NUMBER
71165 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: Amanda Brown
Phone: 531-329-8583
E-Mail: amanda.r.brown@nebraskatotalcare.com

(djo 04/12/16)

AMENDMENT ONE AS ATTACHED. (11/30/16 sc)

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

AMENDMENT THREE AS ATTACHED. (11/28/17 sc)

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

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

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

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

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

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

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

BUYER
MATERIEL ADMINISTRATOR
7/28/2020

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

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2 of 2	07/14/20
BUSINESS UNIT	BUYER
25710178	JULIE SCHILTZ (AS)
VENDOR NUMBER: 2266837	

CONTRACT NUMBER
71165 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**

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

AMENDMENT NINE
Contract 71165 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and Nebraska Total Care, Inc.

The State of Nebraska and Nebraska Total Care, Inc. make this Amendment (the Amendment") to Contract 71165 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.l -

l. 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: .

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

Nebraska Total Care, Inc.

By: _____

Printed Name: Heath Phillips

Title: CEO

Date: 7/6/2020

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

CONTRACT NUMBER
71165 O4

VENDOR NUMBER: 2266837

VENDOR ADDRESS:

NEBRASKA TOTAL CARE INC
7700 FORSYTH BLVD STE 800
SAINT LOUIS MO 63105-1837

THE CONTRACT PERIOD IS:

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Original/Bid Document 5151 Z1

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Phone: 531-329-8583
E-Mail: amanda.r.brown@nebraskatotalcare.com

(djo 04/12/16)

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

3/4/20 3-4-20
BUYER

3-4-2020
MATERIEL ADMINISTRATOR

DHHS DIVISION DIRECTOR

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25710178	JULIE SCHILTZ (AS)
VENDOR NUMBER: 2266837	

CONTRACT NUMBER
71165 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**

BUYER INITIALS

AMENDMENT EIGHT
Contract 71165 04
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and Nebraska Total Care, Inc.

The State of Nebraska and Nebraska Total Care, Inc. make this Amendment (the Amendment") to Contract 71165 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.

III. Vendor Contact:

VENDOR CONTACT: Amanda Brown
PHONE: 531-329-8593
E-MAIL: Amanda.R.Brown@NebraskaTotalCare.com

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

Nebraska Total Care, Inc

By: _____

Printed Name: [illegible]

Title: [illegible]

Date: 2/19/2020

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

By: _____

Name: Matthew Van Patton

Title: Director

Date: ~~Feb~~ March 4, 2020

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%
Childhood Immunization Status (CIS): Percentage of children two (2) years of age who had four (4) diphtheria, tetanus and acellular pertussis (DtaP); three (3) polio (IPV); one (1) measles, mumps and rubella (MMR); three (3) haemophilus influenza type B (HiB); three (3) hepatitis B (HepB), one (1) chicken pox (VZV); four (4) pneumococcal conjugate (PCV); one (1) hepatitis A (HepA); two (2) or three (3) rotavirus (RV); and two (2) influenza (flu) vaccines by their second birthday. Measure calculates a rate for each vaccine and nine separate combination rates.	Combination #2 34% Combination #10 23%	Combination #2 - 5% Combination #10 - 5%
Immunization for Adolescents (IMA): Percentage of adolescents 13 years of age who had one (1) dose of meningococcal vaccine, one (1) tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. Measure calculates a rate for each vaccine and two (2) combination rates.	Combo #1 – 84% HPV- 25%	Combo #1 – 7% HPV—3%
Follow-up After Hospitalization for Mental Illness (FUH): Percentage of discharges for members six (6) years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: 1. Percentage of discharges for which the member received follow-up within 30 days after discharge. Percentage of discharges for which the member received follow-up within 7 days after discharge.	30 day – 65% 7 day – 45%	30 day 5% 7 day 5%
MEASURE AMB-CH: AMBULATORY CARE: EMERGENCY DEPARTMENTY (ED) VISITS Rate of Emergency Department (ED) visits per 1,000 beneficiary months among children up to age 19.	43	5%
Follow-Up Care for Children Prescribed ADHD Medication (ADD): Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three (3) follow-up visits within a 10 month period,	Monitoring Metric Only Note: State pharmacy file format change may impact validation	NA

one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported: • *Initiation Phase.* Percentage 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.		
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

Nebraska Total Care – HH Rates – 1.1.2020

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	$1,551.83	$25.03	$1,576.86
AABD 21+ M&F	$1,839.77	$20.44	$1,860.21
AABD 21+ M&F-WWC	$4,815.60	$40.04	$4,855.64
CHIP M&F	$203.48	$3.50	$206.98
Family Under 1 M&F	$768.75	$18.89	$787.64
Family 01-05 M&F	$179.90	$3.72	$183.62
Family 06-20 F	$210.73	$3.20	$213.93
Family 06-20 M	$232.76	$2.98	$235.74
Family 21+ M&F	$558.53	$5.36	$563.89
Foster Care M&F	$626.66	$7.00	$633.66
Healthy Dual	$304.79	$0.00	$304.79
Dual LTC	$182.46	$0.00	$182.46
Non-Dual LTC	$3,848.72	$28.76	$3,877.48
Dual Waiver	$297.69	$0.00	$297.69
Non-Dual Waiver	$1,792.99	$15.22	$1,808.21
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	$1,494.03	$29.13	$1,523.16
AABD 21+ M&F	$1,997.99	$8.68	$2,006.67
AABD 21+ M&F-WWC	$5,870.04	$88.80	$5,958.84
CHIP M&F	$214.26	$1.29	$215.55
Family Under 1 M&F	$751.28	$10.81	$762.09
Family 01-05 M&F	$185.50	$1.15	$186.65
Family 06-20 F	$232.73	$0.78	$233.51
Family 06-20 M	$231.33	$0.72	$232.05
Family 21+ M&F	$657.50	$1.36	$658.86
Foster Care M&F	$539.24	$1.85	$541.09
Healthy Dual	$275.92	$0.00	$275.92
Dual LTC	$177.12	$0.00	$177.12
Non-Dual LTC	$1,796.02	$3.56	$1,799.58
Dual Waiver	$313.27	$0.00	$313.27
Non-Dual Waiver	$1,923.73	$10.16	$1,933.89
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 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%.

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)

VENDOR NUMBER: 2266837

VENDOR ADDRESS:

NEBRASKA TOTAL CARE INC
7700 FORSYTH BLVD STE 800
SAINT LOUIS MO 63105-1837

CONTRACT NUMBER
71165 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: Nancy A. Mundy
Phone: 531-329-8584
E-Mail: nancy.a.mundy@nebraskatotalcare.com

(djo 04/12/16)

AMENDMENT ONE (1) AS ATTACHED. (11/30/16 sc)

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

AMENDMENT THREE (3) AS ATTACHED. (11/28/17 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 INITIAL CONTRACT TERM YEAR 1	392,451,761.0000	$	1.0000	392,451,761.00

DHHS DIVISION DIRECTOR

7/26/19 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

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25710178	JULIE SCHILTZ (AS)

VENDOR NUMBER: 2266837

CONTRACT NUMBER
71165 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 SEVEN
Contract 71165 04
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and Nebraska Total Care, Inc.

The State of Nebraska and Nebraska Total Care, Inc. make this Amendment (the Amendment") to Contract 71165 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 Cobb

Title: Materiel Administrator

Date: 7-29-19

Nebraska Total Care, Inc

By: _____

Printed Name: Sherry Husa

Title: President & CEO

Date: 7/17/19

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	$1,381.49	$26.78	$1,408.27
AABD 21+ M&F	$1,825.30	$26.14	$1,851.44
AABD 21+ M&F-WWC	$3,385.08	$153.92	$3,539.01
CHIP M&F	$194.06	$2.04	$196.10
Family Under 1 M&F	$758.35	$12.03	$770.38
Family 01-05 M&F	$166.19	$2.45	$168.63
Family 06-20 F	$198.05	$2.41	$200.45
Family 06-20 M	$225.96	$2.09	$228.05
Family 21+ M&F	$516.61	$8.37	$524.98
Foster Care M&F	$693.73	$6.25	$699.98
Healthy Dual	$308.26	$2.60	$310.87
Dual LTC	$259.02	$0.53	$259.55
Non-Dual LTC	$3,373.90	$32.44	$3,406.34
Dual Waiver	$337.35	$1.25	$338.61
Non-Dual Waiver	$1,728.63	$16.11	$1,744.74
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	$1,491.14	$7.52	$1,498.67
AABD 21+ M&F	$1,972.88	$8.96	$1,981.84
AABD 21+ M&F-WWC	$3,588.88	$61.20	$3,650.08
CHIP M&F	$195.17	$0.92	$196.08
Family Under 1 M&F	$747.73	$7.69	$755.42
Family 01-05 M&F	$167.53	$0.74	$168.27
Family 06-20 F	$229.36	$0.75	$230.11
Family 06-20 M	$233.15	$0.55	$233.70
Family 21+ M&F	$619.32	$2.64	$621.95
Foster Care M&F	$614.68	$2.59	$617.28
Healthy Dual	$254.53	$0.33	$254.87
Dual LTC	$203.90	$0.09	$203.99
Non-Dual LTC	$2,075.10	$1.40	$2,076.50
Dual Waiver	$320.28	$0.12	$320.40
Non-Dual Waiver	$1,557.69	$5.10	$1,562.79
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	$5,100.73	$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
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25710178	JULIE SCHILTZ (AS)

CONTRACT NUMBER
71165 O4

VENDOR NUMBER: 2266837

VENDOR ADDRESS:

NEBRASKA TOTAL CARE INC
7700 FORSYTH BLVD STE 800
SAINT LOUIS MO 63105-1837

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2021

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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.

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Original/Bid Document 5151 Z1

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Vendor Contact: Nancy A. Mundy
Phone: 531-329-8584
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(djo 04/12/16)

AMENDMENT ONE AS ATTACHED. (11/30/16 sc)

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

AMENDMENT THREE AS ATTACHED. (11/28/17 sc)

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

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

AMENDMENT SIX 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
2	MEDICAID MANAGED CARE	409,151,871.0000	$	1.0000	409,151,871.00

DHHS DIVISION DIRECTOR

2/26/19 PK 2-25-19
BUYER
2/26/19
MATERIEL ADMINISTRATOR

R43500|NIS|0003|NISH0003 20150901

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

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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 SIX
Contract 71165 04
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and Nebraska Total Care, Inc.

The State of Nebraska and Nebraska Total Care, Inc. make this Amendment (the Amendment") to Contract 71165 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

<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)** 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 Cahn

Title: Materiel Administrator

Date: 2/26/19

Nebraska Total Care, Inc

By: _____

Printed Name: Michael Heifetz

Title: Plan President + CEO

Date: 02-14-19

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	$ 1,361.19	$ 26.78	$ 1,387.98
AABD 21+ M&F	$ 1,784.62	$ 26.14	$ 1,810.75
AABD 21+ M&F-WWC	$ 3,332.07	$ 153.92	$ 3,485.99
CHIP M&F	$ 191.89	$ 2.04	$ 193.93
Family Under 1 M&F	$ 746.83	$ 12.03	$ 758.86
Family 01-05 M&F	$ 164.23	$ 2.45	$ 166.68
Family 06-20 F	$ 195.42	$ 2.41	$ 197.83
Family 06-20 M	$ 222.91	$ 2.09	$ 224.99
Family 21+ M&F	$ 511.05	$ 8.37	$ 519.42
Foster Care M&F	$ 681.32	$ 6.25	$ 687.56
Healthy Dual	$ 279.77	$ 2.60	$ 282.37
Dual LTC	$ 253.67	$ 0.53	$ 254.20
Non-Dual LTC	$ 3,330.52	$ 32.44	$ 3,362.96
Dual Waiver	$ 312.25	$ 1.25	$ 313.50
Non-Dual Waiver	$ 1,702.96	$ 16.11	$ 1,719.06
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	$ 1,473.64	$ 7.52	$ 1,481.16
AABD 21+ M&F	$ 1,936.61	$ 8.96	$ 1,945.57
AABD 21+ M&F-WWC	$ 3,539.94	$ 61.20	$ 3,601.15
CHIP M&F	$ 193.19	$ 0.92	$ 194.11
Family Under 1 M&F	$ 736.76	$ 7.69	$ 744.45
Family 01-05 M&F	$ 165.97	$ 0.74	$ 166.71
Family 06-20 F	$ 226.66	$ 0.75	$ 227.40
Family 06-20 M	$ 230.41	$ 0.55	$ 230.97
Family 21+ M&F	$ 613.39	$ 2.64	$ 616.02
Foster Care M&F	$ 605.47	$ 2.59	$ 608.06
Healthy Dual	$ 237.79	$ 0.33	$ 238.12
Dual LTC	$ 200.78	$ 0.09	$ 200.86
Non-Dual LTC	$ 2,057.60	$ 1.40	$ 2,059.00
Dual Waiver	$ 295.47	$ 0.12	$ 295.59
Non-Dual Waiver	$ 1,535.48	$ 5.10	$ 1,540.58
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: 2266837

VENDOR ADDRESS:

NEBRASKA TOTAL CARE INC
7700 FORSYTH BLVD STE 800
SAINT LOUIS MO 63105-1837

CONTRACT NUMBER
71165 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: Nancy A. Mundy
Phone: 531-329-8584
E-Mail: nancy.a.mundy@nebraskatotalcare.com

(djo 04/12/16)

AMENDMENT ONE AS ATTACHED. (11/30/16 sc)

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

AMENDMENT THREE AS ATTACHED. (11/28/17 sc)

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

AMENDMENT FIVE 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 INITIAL CONTRACT TERM YEAR 2	409,151,871.0000	$	1.0000	409,151,871.00

DHHS DIVISION DIRECTOR

11/9/18

BUYER

11/6/18

MATERIEL ADMINISTRATOR

11/9/18

R43500|NISH0003|NIS10003 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: 2266837

CONTRACT NUMBER
71165 O4

Line	Description	Estimated 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**

BUYER INITIALS

AMENDMENT FIVE
Contract 71165 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and Nebraska Total Care, Inc.

The State of Nebraska and Nebraska Total Care, Inc. make this Amendment (the "amendment") to Contract 71165 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: 11/9/18

Nebraska Total Care, Inc

By: _____

Printed Name: Michael Heifetz

Title: Plan President + CEO

Date: 10-22-18

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

By: _____

Name: Matthew VanPatton

Title: Director

Date: 11/8/18

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
71165 O4

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

VENDOR NUMBER: 2266837

VENDOR ADDRESS:

NEBRASKA TOTAL CARE INC
7700 FORSYTH BLVD STE 800
SAINT LOUIS MO 63105-1837

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: Nancy A. Mundy
Phone: 531-329-8584
E-Mail: nancy.a.mundy@nebraskatotalcare.com

(djo 04/12/16)

AMENDMENT ONE AS ATTACHED. (11/30/16 sc)

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

AMENDMENT THREE AS ATTACHED. (11/28/17 sc)

AMENDMENT FOUR 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
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

3/29/18

BUYER

8/24/18

MATERIEL ADMINISTRATOR

AMENDMENT FOUR
Contract 71165 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and Nebraska Total Care, Inc.

The State of Nebraska and Nebraska Total Care, Inc. make this Amendment (the "amendment") to Contract 71165 04 (the "contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

Effective immediately, the vendor contact information is hereby superseded and replaced by:

Vendor Contact: Nancy A. Mundy
Phone: 531-329-8584
Email: Nancy.A.Mundy@NebraskaTotalCare.com

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: 8/29/18

Nebraska Total Care, Inc.

By: _____

Printed Name: Michael Heifetz

Title: Plan President + CEO

Date: 07-26-18

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

By: _____

Name: Matthew VanPatton

Title: Director

Date: 21st August 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	$1,334.74	$14.69	$1,349.43
AABD 21+ M&F	$1,866.43	$16.49	$1,882.92
AABD 21+ M&F-WWC	$3,473.31	$49.60	$3,522.91
CHIP M&F	$199.99	$1.06	$201.05
Family Under 1 M&F	$758.82	$14.40	$773.22
Family 01-05 M&F	$182.41	$1.24	$183.65
Family 06-20 F	$194.76	$1.02	$195.78
Family 06-20 M	$221.94	$0.83	$222.76
Family 21+ M&F	$452.13	$3.44	$455.57
Foster Care M&F	$531.52	$3.83	$535.34
Healthy Dual	$276.93	$4.04	$280.97
Dual LTC	$233.02	$2.86	$235.88
Non-Dual LTC	$3,594.54	$52.66	$3,647.20
Dual Waiver	$284.65	$3.71	$288.36
Non-Dual Waiver	$1,752.38	$28.48	$1,780.85
Katie Beckett 00-18 M&F	$13,942.18	$13.55	$13,955.73
599 CHIP - Cohort	$418.31	$10.35	$428.65
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	$1,351.04	$10.17	$1,361.21
AABD 21+ M&F	$1,981.23	$6.63	$1,987.86
AABD 21+ M&F-WWC	$4,508.09	$3.61	$4,511.71
CHIP M&F	$201.64	$0.76	$202.40
Family Under 1 M&F	$691.00	$12.22	$703.22
Family 01-05 M&F	$167.66	$0.54	$168.20
Family 06-20 F	$202.68	$0.61	$203.29
Family 06-20 M	$236.47	$0.50	$236.97
Family 21+ M&F	$527.33	$1.28	$528.61
Foster Care M&F	$536.29	$1.59	$537.89
Healthy Dual	$230.44	$1.75	$232.19
Dual LTC	$195.61	$1.04	$196.64
Non-Dual LTC	$2,265.47	$11.94	$2,277.41
Dual Waiver	$253.69	$1.85	$255.55
Non-Dual Waiver	$1,623.28	$12.76	$1,636.04
Katie Beckett 00-18 M&F	$13,942.18	$13.55	$13,955.73
599 CHIP - Cohort	$418.31	$10.35	$428.65
599 CHIP - Supplemental	$4,714.41	$74.83	$4,789.24
Maternity	$8,119.13	$19.62	$8,138.76

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
71165 O4

PAGE	ORDER DATE
1 of 2	11/28/17
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

VENDOR NUMBER: 2266837

VENDOR ADDRESS:

NEBRASKA TOTAL CARE INC
7700 FORSYTH BLVD STE 800
SAINT LOUIS MO 63105-1837

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: Brent Layton
Phone: 770-241-9066
Cellular: 770-241-9066
E-Mail: BLAYTON@CENTENE.COM

(djo 04/12/16)

AMENDMENT ONE AS ATTACHED. (11/30/16 sc)

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

AMENDMENT THREE AS ATTACHED. (11/28/17 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

12/5/17 Michelle Thompson 12-1-17
BUYER
MATERIEL ADMINISTRATOR 5 DEC 17

R43500|NISH0003|NISH0003 20150901

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

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PAGE	ORDER DATE
2 of 2	11/28/17
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)
VENDOR NUMBER: 2266837	

CONTRACT NUMBER
71165 O4

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

MT 12.1.17
BUYER INITIALS

AMENDMENT THREE
Contract 71165 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and Nebraska Total Care, Inc.

The State of Nebraska and Nebraska Total Care, Inc. make this Amendment (the Amendment") to Contract 71165 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: Douglas Wilken

Printed Name: Douglas Wilken

Title: Materiel Administrator

Date: 5 DEC 17

Nebraska Total Care

By: [signature]

Printed Name: Ryan R Sadler

Title: CEO

Date: 11/16/17

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

By: [signature]

Name: Thomas "Rocky" Thompson

Title: Interim Director

Date: 11/29/2017

NTC – 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	$ 1,219.58	$ 20.77	$ 1,240.35
AABD 21+ M&F	$ 1,763.72	$ 23.32	$ 1,787.04
AABD 21+ M&F-WWC	$ 3,311.18	$ 70.12	$ 3,381.30
CHIP M&F	$ 186.05	$ 1.50	$ 187.55
Family Under 1 M&F	$ 718.19	$ 20.36	$ 738.55
Family 01-05 M&F	$ 170.78	$ 1.75	$ 172.53
Family 06-20 F	$ 180.65	$ 1.44	$ 182.09
Family 06-20 M	$ 204.48	$ 1.17	$ 205.65
Family 21+ M&F	$ 430.24	$ 4.86	$ 435.10
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	$ 1,249.55	$ 14.37	$ 1,263.92
AABD 21+ M&F	$ 1,857.69	$ 9.37	$ 1,867.06
AABD 21+ M&F-WWC	$ 4,304.25	$ 5.11	$ 4,309.36
CHIP M&F	$ 190.11	$ 1.08	$ 191.19
Family Under 1 M&F	$ 654.31	$ 17.28	$ 671.59
Family 01-05 M&F	$ 158.48	$ 0.77	$ 159.25
Family 06-20 F	$ 188.35	$ 0.86	$ 189.21
Family 06-20 M	$ 220.86	$ 0.71	$ 221.57
Family 21+ M&F	$ 499.24	$ 1.81	$ 501.05
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.

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
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Lincoln, Nebraska 68508

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PAGE	ORDER DATE
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25710178	MICHELLE THOMPSON (AS)

VENDOR NUMBER: 2266837

VENDOR ADDRESS:

NEBRASKA TOTAL CARE INC
7700 FORSYTH BLVD STE 800
SAINT LOUIS MO 63105-1837

CONTRACT NUMBER
71165 O4

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JANUARY 01, 2017 THROUGH DECEMBER 31, 2022

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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

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Vendor Contact: Brent Layton
Phone: 770-241-9066
Cellular: 770-241-9066
E-Mail: BLAYTON@CENTENE.COM

(djo 04/12/16)

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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**

DHHS Division Director

7/3/17 Michelle Thompson 7.3.17
BUYER
MATERIEL ADMINISTRATOR

R43500|NISH0003|NISH0003 20150901

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

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71165 O4

PAGE	ORDER DATE
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25710178	MICHELLE THOMPSON (AS)
VENDOR NUMBER: 2266837	

MT 7.3.17
BUYER INITIALS

AMENDMENT TWO
Contract 71165 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services
for the State of Nebraska
Between the State of Nebraska and Nebraska Total Care Inc

The State of Nebraska and Nebraska Total Care Inc make this Amendment (the Amendment") to Contract 71165 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.

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.~~
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 Wilken

Name: ~~Bo Botelho~~ Doug Wilken

Title: Materiel Administrator

Date: 16 June 17

Nebraska Total Care Inc

By: Ryan R Sadler, CEO

Name: Ryan R Sadler

Title: CEO

Date: 6/15/17

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

By:

Name: Thomas W 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 Stete-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
71165 O4

PAGE	ORDER DATE
1 of 1	11/30/16
BUSINESS UNIT	BUYER
25710176	MICHELLE THOMPSON (AS)

VENDOR NUMBER: 2266837

VENDOR ADDRESS:

NEBRASKA TOTAL CARE INC
7700 FORSYTH BLVD STE 800
SAINT LOUIS MO 63105-1837

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: Brent Layton
Phone: 770-241-9066
Cellular: 770-241-9066
E-Mail: BLAYTON@CENTENE.COM

(djo 04/12/16)

AMENDMENT ONE AS ATTACHED. (11/30/16 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

12/2/16 Michelle Thompson 12-1-16
BUYER
12/2/16
MATERIEL ADMINISTRATOR

R43500|NISH0003|NISH0003 20150901

AMENDMENT ONE
Contract 71165 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services
for the State of Nebraska
Between
The State of Nebraska and Nebraska Total Care, Inc.

This Amendment (the "Amendment") is made by the State of Nebraska and Nebraska Total Care, Inc. parties to Contract 71165 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.

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: 12/5/16

Nebraska Total Care, Inc.

By: _____

Name: Ryan R Sadler

Title: CEO

Date: 11/2/16

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

By: _____

Name: Calder Lynch

Title: Director

Date: 11/30/16

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

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

VENDOR NUMBER: 2266837

VENDOR ADDRESS:

NEBRASKA TOTAL CARE INC
7700 FORSYTH BLVD STE 800
SAINT LOUIS MO 63105-1837

CONTRACT NUMBER
71165 O4

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: Brent Layton
Phone: 770-241-9066
Cellular: 770-241-9066
E-Mail: BLAYTON@CENTENE.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 — BUYER 4-14-16

MATERIEL ADMINISTRATOR 4/14/16

R43500|NISK0002|NISK0002 20150901

For public information purposes only; not part of contract.

Request for Proposal Number 5151 Z1
Contract Number 71165 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.

Nebraska Total Care, Inc.

1. Section i. Summary of Bidders Proposed Personnel…Resumes, Proposed Personnel Resumes, Page 39
2. IV.D Staffing Requirements, Question 15, Staffing, Organizational Charts, Attachments Section
3. Question 23, Value Adds, Pages 117-146
4. IV.E. Attachments, Attachment 26, US Script Work Plan, 12 pages
5. Question 31, Content Overview of NTC Secure Member Portal, Page 172
6. Question 31, MyNTC Mobile Application Table, Page 173-174
7. Question 49, Real-time Editing & Pricing (RTEP), Page 240
8. Question 49, Efficiently and Effectively Scheduling Member Care, Page 240
9. IV.K Subcontracting Requirements, Question 56, Organizational Charts, Attachment
10. Question 101, Enhanced CRM Technology to Rapidly Adapt to Service Changes and Ensure Service Excellence, Page 442-443
11. Question 101, New Functionality for Members, Page 447
12. Question 104, Innovative Database Technology, Page 458

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.

Nebraska Total Care, Inc.

1. Attachment Q.24. LA Health Report Card
2. Attachment 35.1_NTC_Sample_Benefit book
3. Attachment 35.2 LHC Fall Sample Newsletter
4. Attachment 35.3 IHC Sample Newsletter
5. Attachment 35.4 PSHP Sample Newsletter
6. Attachment 35.5 BCHP Sample Newsletter
7. *Adventures from Sugarland!*
8. *Quas-eye, Blink-eye & Vill-eye The Gunky Bacteria Brothers*
9. *Off the Chain – Real Answers Real Issues*
10. *Off the Chain – It's All About Diabetes*
11. *A Foster Care Journey*
12. *Smokey Yuckpak Parents Guide*
13. *Smokey Yuckpak*
14. *My Care Planner*

15. *My Route to Health Road Map*
16. *The FAQs of HIV*
17. *Listening to Your Heart Matters*
18. *Living Well with Sickle Cell*
19. *A Fresh View on Your Diabetes*
20. *Start Smart Your Pregnancy Booklet*
21. *Start Smart Journey Book*
22. *Start Smart Welcome Letter*
23. *Prenatal Depression Scale*
24. *Start Smart Depression Flyer*
25. *Emergency Room Brochure*
26. *NurseWise Brochure*
27. *Start Smart Newborn Welcome Letter*
28. *Start Smart Recovery Bouncing Book*
29. *Start Smart for Your Baby Brochure*
30. *Start Smart Guide to your Baby's Care*
31. *Start Smart Newborn Journey Book*
32. *Lead Poison Brochure*
33. *Vaccines are not just for babies!*
34. Attachment 50.B Quick Reference Guide
35. Attachment 50.C Prior Authorization
36. Attachment 115.C_2013-2014 PIP Report

TECHNICAL PROPOSAL

Response to the Request for Proposal (RFP) No. 5151 Z1 for Medicaid Integrated Managed Care Program for the State of Nebraska

Submitted To:

State Purchasing Bureau
Attn: Michelle Thompson / Teresa Fleming
AS Materiel State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Opening Date:

January 5, 2016 at 2:00 p.m. Central Time

nebraska total care™

Table of Contents

FORM A BIDDER CONTACT SHEET

ADDENDA

REFERENCES

1. REQUEST FOR PROPOSAL FORM

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM 1

III. TERMS AND CONDITIONS 2

2. CORPORATE OVERVIEW .....

a. BIDDER IDENTIFICATION AND INFORMATION 4

b. FINANCIAL STATEMENTS 5

c. CHANGE OF OWNERSHIP 10

d. OFFICE LOCATION 11

e. RELATIONSHIPS WITH THE STATE 12

f. BIDDER'S EMPLOYEE RELATIONS TO STATE 13

g. CONTRACT PERFORMANCE 14

h. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE 17

i. SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH 24

j. SUB-CONTRACTORS 40

3. TECHNICAL APPROACH

a. Understanding of the project requirements 44

b. Response to proposal statements and questions in Attachment 19 – Proposal Statements and Questions 47

III.G. Insurance Requirements 74

IV.B Eligibility and Enrollment 75

IV.C Business Requirements 90

IV.D Staffing Requirements 96

IV.E. Covered Services and Benefits 115

IV.F Member Services and Education 159

IV.H Grievances and Appeals 194
IV.I Provider Network Requirements 199
IV.J Provider Services 229
IV.K Subcontracting Requirements 259
IV.L Care Management 278
IV.M Quality Management 335
IV.N Utilization Management 375
IV.O Program Integrity 416
IV.Q Provider Reimbursement 427
IV.R Systems and Technical Requirements 441
IV.S Claims Management 466
IV.T Reporting and Deliverables 485
IV.X Transition and Implementation 501
IV.Z FFS Claims Management and Processing 506

c. Proposal deliverables as listed in Attachment 5 – Policies, Procedures, and Plans

Provider Contract Template 542
Network Development Plan 561
Key Staff Resumes 571
Preliminary Implementation Plan 572
Draft Member Handbook 579

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:	Nebraska Total Care, Inc.
Bidder Address:	1299 Farnam Street, Ste. 300 Omaha, NE 68102
Contact Person & Title:	Brent Layton, Chief Business Development Officer
E-mail Address:	BLAYTON@CENTENE.COM
Telephone Number (Office):	770-241-9066
Telephone Number (Cellular):	770-241-9066
Fax Number:	na

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:	Nebraska Total Care, Inc.
Bidder Address:	1299 Farnam Street, Ste. 300 Omaha, NE 68102
Contact Person & Title:	Brent Layton, Chief Business Development Officer
E-mail Address:	BLAYTON@CENTENE.COM
Telephone Number (Office):	770-241-9066
Telephone Number (Cellular):	770-241-9066
Fax Number:	na

nebraska total care

Confidential and Proprietary

The information enclosed has been submitted in confidence and contain trade secrets and/or privileged or confidential information that if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)).

Section or Question	Heading	Page	Rationale
Section i. Summary of Bidders Proposed Personnel…Resumes	Proposed Personnel Resumes	Page 39	Nebraska Total Care and Centene Corporation believe that our employees and our organization of our staff represent some of strongest assets and therefore believe this information should be protected from competitors.
IV.D Staffing Requirements, Question 15	Staffing, Organizational Charts	Attachments Section	Nebraska Total Care and Centene Corporation believe that our employees and our organization of our staff represent some of strongest assets and therefore believe this information should be protected from competitors.
Question 23	Value Adds	Pages 117-146	Competitive differentiator
Question 31	Content Overview of NTC Secure Member Portal	Page 172	Competitive differentiator
Question 31	MyNTC Mobile Application Table	Page 173-174	Competitive differentiator
Question 49	Real-time Editing & Pricing (RTEP)	Page 240	Competitive differentiator
Question 49	Efficiently and Effectively Scheduling	Page 240	Competitive differentiator

	Member Care		
IV.K Subcontracting Requirements, Question 56	Organizational Charts	Attachment	Nebraska Total Care and Centene Corporation believe that our employees and our organization of our staff represent some of strongest assets and therefore believe this information should be protected from competitors.
Question 101	Enhanced CRM Technology to Rapidly Adapt to Service Changes and Ensure Service Excellence	Page 442-443	Competitive differentiator
Question 101	New Functionality for Members	Page 447	Competitive differentiator
Question 104	Innovative Database Technology	Page 458	Competitive differentiator

nebraska total care™

ADDENDA

RFP ADDENDA

The Bidder may provide references within the proposal response. References may be in a separate identified tab within the proposal response. (per Addendum 7 Q&A)

Nebraska Total Care, Inc. acknowledges and has provided copies of all addenda 1-12 to RFP No. 5151Z1. Please see the following pages for all addenda regarding this RFP.

NEBRASKA
AdministrativeServices

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.

NEBRASKA
Administrative Services

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.

(Intentionally left blank)

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
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 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
AS 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
Administrative Services

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 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.

NEBRASKA
dministrativeServices

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.

AdministrativeServices

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 entire contract period." 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.

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

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.

NEBRASKA
AdministrativeServices

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.

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REFERENCES

REFERENCES

The Bidder may provide references within the proposal response. References may be in a separate identified tab within the proposal response. (per Addendum 7 Q&A)

Nebraska Total Care, Inc. has listed three (3) relevant corporate contract references, from our parent company, Centene Corporation in the tables below.

Reference #1:	
1. Name of Contract	**Florida Agency for Healthcare Administration**
2. Contracting Officer's Contact Information	Jennifer E. Courtney, FCCM Plan Management Operations 2727 Mahan Drive, Bldg. #3, M.S. 50 Tallahassee, Florida 32308 (850) 412-4067

Reference #2:	
1. Name of Contract	**Kansas Department of Health and Environment**
2. Contracting Officer's Contact Information	Susan Mosier, MD Secretary of Medicaid Services 900 SW Jackson, Suite 900N Topeka, Kansas 66612-1220 (785) 296-0461

Reference #3:	
1. Name of Contract	**Louisiana Department of Health & Hospitals Bureau of Health Services Financing**
2. Contracting Officer's Contact Information	Ruth Kennedy Medicaid Director - Bayou Health 628 N. 4th Street, Bienville Building, 7th floor Baton Rouge La. 70802 (225) 241-1437

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1. REQUEST FOR PROPOSAL FORM

1. REQUEST FOR PROPOSAL FORM

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES 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.

Please see following pages for the 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: Nebraska Total Care, Inc.

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

TELEPHONE NUMBER: 314-236-8343 FAX NUMBER: 877-401-8179

SIGNATURE: Steve White DATE: 12/19/15

TYPED NAME & TITLE OF SIGNER: Steve White, President and CEO

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TERMS AND CONDITIONS

SECTION III. TERMS AND CONDITIONS

Further, Section III. Terms and Conditions must be returned with the proposal response.

Please see following pages for Terms and Conditions submitted by Nebraska Total Care, Inc.

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:
dw			

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:
dw			

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:
KW.			

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:
LW.			

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:
LW			

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:
LW			

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:
R.W.			

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:
R.W.			

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:
RW.			

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:
RW			

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:
RW.			

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:
RW.			

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:
RW			

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:
RW			

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:
RW			

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:
RW			

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:
RM			

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:
RM			

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:
RM			

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:
RM			

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:
LOW			

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:
LOW			

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:
LOW			

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:
RM.			

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:
RM.			

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:
RM.			

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:
RM			

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:
RM			

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:
LM			

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:
LM			

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:
LM			

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:
LM			

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:
RR			

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:
LM			

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:
LM			

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:
LM			

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:
LM			

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:
LD.			

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:
RM			

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:
RM.			

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:
RM.			

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:
RM.			

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:
RM.			

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:
RM.			

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.

STATE OF NEBRASKA

United States of America, } ss.
State of Nebraska }

Secretary of State
State Capitol
Lincoln, Nebraska

I, John A. Gale, Secretary of State of the State of Nebraska, do hereby certify that

NEBRASKA TOTAL CARE, INC.

incorporated on September 16, 2015 and is duly incorporated under the law of Nebraska;

that no occupation taxes due from and assessable against the Corporation are unpaid and have become delinquent;

that no annual or biennial report required to be forwarded by the Corporation to the Secretary of State has become delinquent;

that Articles of Dissolution have not been filed.

This certificate is not to be construed as an endorsement, recommendation, or notice of approval of the entity's financial condition or business activities and practices.

In Testimony Whereof,

I have hereunto set my hand and affixed the Great Seal of the State of Nebraska on this date of

December 29, 2015

John A. Gale

Secretary of State

Verification ID 76cb490 has been assigned to this document. Go to ne.gov/go/validate to validate authenticity for up to 12 months.

CERTIFICATE OF LIABILITY INSURANCE

DATE(MM/DD/YYYY) 12/29/2015

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Aon Risk Services Central, Inc. St. Louis MO Office 8182 Maryland Avenue St Louis MO 63105 USA	CONTACT NAME: PHONE (A/C, No, Ext): (866) 283-7122 FAX (A/C, No.): (800) 363-0105 E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A:	Zurich American Ins Co	16535
INSURER B:	XL Specialty Insurance Co	37885
INSURER C:	Illinois Union Insurance Company	27960
INSURER D:		
INSURER E:		
INSURER F:		

INSURED
Nebraska Total Care
1299 Farnam Street
Suite 300
Omaha NE 68102 USA

COVERAGES **CERTIFICATE NUMBER:** 570060722860 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS. Limits shown are as requested

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY			GLA 9826749-04	11/01/2015	11/01/2016	EACH OCCURRENCE	$1,000,000
	CLAIMS-MADE X OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$1,000,000
							MED EXP (Any one person)	$10,000
							PERSONAL & ADV INJURY	$1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$2,000,000
	X POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$2,000,000
	OTHER:							
	AUTOMOBILE LIABILITY			GLA 9826749-04	11/01/2015	11/01/2016	COMBINED SINGLE LIMIT (Ea accident)	$1,000,000
	X ANY AUTO						BODILY INJURY (Per person)	
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	
	X HIRED AUTOS / X NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	
B	X UMBRELLA LIAB X OCCUR			US00068524LI15A	11/01/2015	11/01/2016	EACH OCCURRENCE	$5,000,000
	EXCESS LIAB CLAIMS-MADE			SIR applies per policy terms & conditions			AGGREGATE	$5,000,000
	DED X RETENTION						Deductible or Retent	$10,000
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR / PARTNER / EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: Y If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		WC647833301	11/01/2015	11/01/2016	X PER STATUTE / OTH-ER	
							E.L. EACH ACCIDENT	$1,000,000
							E.L. DISEASE-EA EMPLOYEE	$1,000,000
							E.L. DISEASE-POLICY LIMIT	$1,000,000
C	ManageCare Liab			MSPG27099567003 SIR applies per policy terms & conditions	11/01/2015	11/01/2016	Aggregate Retention	$10,000,000 $2,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

The State of Nebraska, certificate holder, is an additionally insured, primary & noncontributory on the General Liability where required by written contract. Waiver of Subrogation on the Worker's Compensation in favor of the State of Nebraska in accordance with the policy provisions.

CERTIFICATE HOLDER

State of Nebraska
Administrative Services
State Purchasing Board Bureau
1526 K Street, Suite 130
Lincoln NE 68508 USA

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Aon Risk Services Central, Inc.

Holder Identifier :

Certificate No : 570060722860

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CERTIFICATE OF LIABILITY INSURANCE

DATE(MM/DD/YYYY) 12/29/2015

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Aon Risk Services Central, Inc. St. Louis MO Office 8182 Maryland Avenue St Louis MO 63105 USA	CONTACT NAME: PHONE (A/C. No. Ext): (866) 283-7122 FAX (A/C. No.): (800) 363-0105 E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
INSURED Nebraska Total Care 1299 Farnam Street Suite 300 Omaha NE 68102 USA	INSURER A: Indian Harbor Insurance Company	36940
	INSURER B:	
	INSURER C:	
	INSURER D:	
	INSURER E:	
	INSURER F:	

COVERAGES **CERTIFICATE NUMBER:** 570060722857 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS. **Limits shown are as requested**

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	
							MED EXP (Any one person)	
							PERSONAL & ADV INJURY	
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	
	OTHER:							
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	
	☐ ANY AUTO						BODILY INJURY (Per person)	
	☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	
	☐ HIRED AUTOS ☐ NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	
	☐ DED ☐ RETENTION							
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR / PARTNER / EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ N/A						E.L. EACH ACCIDENT	
	(Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE-EA EMPLOYEE	
							E.L. DISEASE-POLICY LIMIT	
A	Cyber Liability			MTP903149901 Claims Made SIR applies per policy terms & conditions	10/02/2015	11/01/2016	Limit SIR	$10,000,000 $2,500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

State of Nebraska
Administrative Services
State Purchasing Board Bureau
1526 K Street, Suite 130
Lincoln NE 68508 USA

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Aon Risk Services Central, Inc.

Holder Identifier :

Certificate No : 570060722857

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Ownership and Disclosures

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.

Ownership and Disclosures Statement

Nebraska Total Care is a wholly-owned subsidiary of Centene Corporation, of which Centene Corporation has 100% ownership, management, and control.

nebraska total care

Confidential and Proprietary

The information enclosed has been submitted in confidence and contain trade secrets and/or privileged or confidential information that if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)).

Section or Question	Heading	Page	Rationale
Section i. Summary of Bidders Proposed Personnel…Resumes	Proposed Personnel Resumes	Page 39	Nebraska Total Care and Centene Corporation believe that our employees and our organization of our staff represent some of strongest assets and therefore believe this information should be protected from competitors.
IV.D Staffing Requirements, Question 15	Staffing, Organizational Charts	Attachments Section	Nebraska Total Care and Centene Corporation believe that our employees and our organization of our staff represent some of strongest assets and therefore believe this information should be protected from competitors.
Question 31	Content Overview of NTC Secure Member Portal	Page 172	Competitive differentiator
Question 31	MyNTC Mobile Application Table	Page 173-174	Competitive differentiator
Question 49	Real-time Editing & Pricing (RTEP)	Page 240	Competitive differentiator
Question 49	Efficiently and Effectively Scheduling Member Care	Page 240	Competitive differentiator

IV.K Subcontracting Requirements, Question 56	Organizational Charts	Attachment	Nebraska Total Care and Centene Corporation believe that our employees and our organization of our staff represent some of strongest assets and therefore believe this information should be protected from competitors.
Question 101	Enhanced CRM Technology to Rapidly Adapt to Service Changes and Ensure Service Excellence	Page 442-443	Competitive differentiator
Question 101	New Functionality for Members	Page 447	Competitive differentiator
Question 104	Innovative Database Technology	Page 458	Competitive differentiator

nebraska total care™

2. CORPORATE OVERVIEW

nebraska total care™

A.BIDDER IDENTIFICATION AND INFORMATION

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,

Nebraska Total Care, Inc.

address of the company's headquarters,

1299 Farnam Street
Suite 300
Omaha, NE 68102

entity organization (corporation, partnership, proprietorship),

Corporation

state in which the bidder is incorporated or otherwise organized to do business,

Nebraska

year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized.

Nebraska Total Care, Inc. was organized in 2015 and there have been no changes to the name or form of organization since first organized.

nebraska total care™

B. FINANCIAL STATEMENTS

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. 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.

Audited Financial Statements

Nebraska Total Care (NTC) is a newly formed entity, and therefore does not have audited financial statements. We are providing financial statements from our parent company, Centene. The independently audited financial statements use Generally Accepted Accounting Principles (GAAP) to comply with Nebraska requirements. ***The following financial statements are located at the end of this Financial Statements section:***

- ***Attachment 3.b.1_2015 Centene 10Q 3rd Quarter***
- ***Attachment 3.b.2 _2015 Centene 10Q 2nd Quarter***
- ***Attachment 3.b.3_2015 Centene 10Q 1st Quarter***
- ***Attachment 3.b.4 _2014 Centene 10K***
- ***Attachment 3.b.5_2013 Centene 10K***
- ***Attachment 3.b.6_2012 Centene 10K***

AM Best Ratings

In September 2013, A.M. Best Co. affirmed the issuer credit rating (ICR) of "bb" and debt rating of "bb" on $425 million 5.75% senior unsecured notes, due 2017 of the parent, Centene Corporation. The outlook for all ratings was stable. Concurrently, A.M. Best withdrew the ratings for all Centene entities as the company had requested to no longer participate in A.M. Best's interactive rating process.

Provided in the table below are current debt ratings as well as ratings for each of the past three years from Moody's Investor Service.

Company Name	Current	2014	2013	2012
Centene Corporation	Ba2 senior debt rating	Ba2 senior debt rating	Ba2 senior debt rating	Ba2 senior debt rating

No Bankruptcy or Insolvency Proceedings

In our corporate history, Centene Corporation has not filed any bankruptcy or insolvency proceedings. Because Centene is a publicly held corporation please see the previously mentioned audited financial statements for 2012-2014.

Positive Financial Institution Business Relationship

Please also see the following page for a statement from our fiscally responsible representative financial or banking organization US Bank, which has supplied a letter, illustrating that NTC's business relationship with the financial institution is in positive standing.

The name, address, and telephone number of the fiscally responsible representative of our financial Institution from US Bank is provided below:

Name:	John Snider, Vice President, Treasury Management Corporate For-Profit Healthcare, U.S. Bank
Address:	505 N 7th St, St Louis, MO 63101
Telephone Number:	(314) 418-2923

nebraska total care.

usbank.

All of us serving you.

November 25, 2015

Attn: Byron L. Diamond
Director of Administrative Services, State of Nebraska

To Whom It May Concern:

This letter indicates that the Centene Corporation has a Proposer's business relationship with US Bank and we have listed the Corporation in positive standing. We continue to build a strong partnership and we look forward to future opportunities that we can help provide additional banking services.

Please let me know if you have further questions, I can be reached at 314-418-2923.

Cordially,

John M. Snider
U.S.Bank
Vice President – Treasury Management
Corporate For-Profit Healthcare

Disclosure of Judgments and Litigation

NTC has no judgments or litigation, which might materially affect the viability or stability of the organization. Bidder and its affiliates are routinely subject to legal proceedings in the normal course of business. While the ultimate resolution of such matters is uncertain, it is not expected that the results of any of these matters, individually, or in the aggregate, will have a significant impact on this contract. NTC is a subsidiary of Centene Corporation ("Centene"), a fortune 500 public company. Set forth below is a litigation matter referenced in Centene's Securities and Exchange Commission filing that does not involve NTC but rather involves another Centene subsidiary and an affiliate of NTC:

Kentucky Spirit Health Plan Inc. v. Commonwealth of Kentucky Finance and Administration Cabinet et.al; Commonwealth of Kentucky Franklin Circuit Court, Division 1, Civil Action No. 12-CI-01373. On July 5, 2013, the Company's subsidiary, Kentucky Spirit Health Plan, Inc. (Kentucky Spirit), terminated its contract with the Commonwealth of Kentucky (the Commonwealth). Kentucky Spirit believes it had a contractual right to terminate the contract and filed a lawsuit in Franklin Circuit Court seeking a declaration of this right. The Commonwealth has alleged that Kentucky Spirit's exit constitutes a material breach of contract. The Commonwealth seeks to recover substantial damages and to enforce its rights under Kentucky Spirit's $25 million performance bond. The Commonwealth's attorneys have asserted that the Commonwealth's expenditures due to Kentucky Spirit's departure range from $28 million to $40 million plus interest, and that the associated CMS expenditures range from $92 million to $134 million. Kentucky Spirit disputes the Commonwealth's alleged damages and is pursuing its own litigation claims for damages against the Commonwealth.

On February 6, 2015, the Kentucky Court of Appeals affirmed a Franklin Circuit Court ruling that Kentucky Spirit does not have a contractual right to terminate the contract early. The Court of Appeals also found that the contract's liquidated damages provision "is applicable in the event of a premature termination of the Contract term." On September 8, 2015, Kentucky Spirit filed a motion for discretionary review seeking Kentucky Supreme Court review of the finding that Kentucky Spirit's departure constituted a breach of contract. On October 9, 2015, the Commonwealth filed a response opposing discretionary review.

Kentucky Spirit also filed a lawsuit in April 2013, amended in October 2014, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches. On December 9, 2014, the Franklin Circuit Court denied the Commonwealth's motion for partial summary judgment on Kentucky Spirit's damages claims. On March 15, 2015, the Franklin Circuit Court denied the Commonwealth's motion to stay discovery and ordered that discovery proceed on those claims.

On May 26, 2015, the Commonwealth issued a demand for indemnification to its actuarial firm for "all defense costs, and any resultant monetary awards in favor of Kentucky Spirit, arising from or related to Kentucky Spirit's claims which are predicated upon the alleged omissions and errors in the Data Book and the certified actuarially sound rates." On August 19, 2015, the actuarial firm moved to intervene in the litigation. The Franklin Circuit Court granted the actuarial firm's motion on September 8, 2015 and ordered a forty-five day stay of all pretrial proceedings in order for the firm to review the record. Also, on August 19, 2015, the actuarial firm filed a petition seeking a declaratory judgment that it is not liable to the Commonwealth for indemnification related to the claims asserted by Kentucky Spirit against the Commonwealth. On October 5, 2015, the Commonwealth filed an answer to the actuarial firm's petition and asserted counterclaims/cross-claims against the firm.

On March 9, 2015, the Secretary of the Kentucky Cabinet for Health and Family Services (CHFS) issued a determination letter finding that Kentucky Spirit owed the Commonwealth $40 million in actual damages plus prejudgment interest at 8 percent. On March 18, 2015, in a letter to the Kentucky Finance and Administration Cabinet (FAC), Kentucky Spirit contested CHFS' jurisdiction to make such a determination. The FAC did not issue a decision within the required 120 days. On August 13, 2015, Kentucky Spirit filed a declaratory judgment action against the Commonwealth in Franklin Circuit Court. The judgment seeks a declaration that the Commonwealth may not purport to issue a decision against Kentucky Spirit awarding damages to itself when the matter is already before the Kentucky courts, and that the Commonwealth has waived its claims against Kentucky Spirit for damages arising out of the contract.

The resolution of the Kentucky litigation matters may result in a range of possible outcomes. If Kentucky Spirit prevails on its claims, it would be entitled to damages. If the Commonwealth prevails, a liability to the Commonwealth could be recorded. Centene Corporation is unable to estimate the ultimate outcome resulting from the Kentucky litigation. As a result, Centene Corporation has not recorded any receivable or any liability for potential damages under the contract as of September 30, 2015.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-Q

(Mark One)

[X] **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended September 30, 2015

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: 001-31826

CENTENE CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**42-1406317**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification Number)*
7700 Forsyth Boulevard **St. Louis, Missouri** *(Address of principal executive offices)*	**63105** *(Zip Code)*

Registrant's telephone number, including area code:

(314) 725-4477

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 Web site, 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 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 "small reporting company" in Rule 12b-2 of the Exchange Act. 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 ☒

As of October 16, 2015, the registrant had 119,202,788 shares of common stock outstanding.

CENTENE CORPORATION
QUARTERLY REPORT ON FORM 10-Q
TABLE OF CONTENTS

		PAGE
	Part I	
	Financial Information	
Item 1.	Financial Statements	1
	Consolidated Balance Sheets as of September 30, 2015 and December 31, 2014 (unaudited)	1
	Consolidated Statements of Operations for the Three and Nine Months Ended September 30, 2015 and 2014 (unaudited)	2
	Consolidated Statements of Comprehensive Earnings for the Three and Nine Months Ended September 30, 2015 and 2014 (unaudited)	3
	Consolidated Statement of Stockholders' Equity for the Nine Months Ended September 30, 2015 (unaudited)	4
	Consolidated Statements of Cash Flows for the Nine Months Ended September 30, 2015 and 2014 (unaudited)	5
	Notes to the Consolidated Financial Statements (unaudited)	6
Item 2.	Management's Discussion and Analysis of Financial Condition and Results of Operations	17
Item 3.	Quantitative and Qualitative Disclosures About Market Risk	30
Item 4.	Controls and Procedures	30
	Part II	
	Other Information	
Item 1.	Legal Proceedings	31
Item 1A.	Risk Factors	32
Item 2.	Unregistered Sales of Equity Securities and Use of Proceeds	44
Item 6.	Exhibits	45
Signatures		46
Certifications		47

CAUTIONARY STATEMENT ON FORWARD-LOOKING STATEMENTS

All statements, other than statements of current or historical fact, contained in this filing are forward-looking statements. We have attempted to identify these statements by terminology including "believe," "anticipate," "plan," "expect," "estimate," "intend," "seek," "target," "goal," "may," "will," "would," "could," "should," "can," "continue" and other similar words or expressions in connection with, among other things, any discussion of future operating or financial performance. In particular, these statements include statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions, including our proposed merger with Health Net, Inc. (Health Net) (Proposed Merger), investments and the adequacy of our available cash resources. These statements may be found in the various sections of this filing, including those entitled "Management's Discussion and Analysis of Financial Condition and Results of Operations," Part II, Item 1A. "Risk Factors," and Part II, Item 1 "Legal Proceedings." Readers are cautioned that matters subject to forward-looking statements involve known and unknown risks and uncertainties, including economic, regulatory, competitive and other factors that may cause our or our industry's actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

All forward-looking statements included in this filing are based on information available to us on the date of this filing and we undertake no obligation to update or revise the forward-looking statements included in this filing, whether as a result of new information, future events or otherwise, after the date of this filing. Actual results may differ from projections or estimates due to a variety of important factors applicable to both us and Health Net, including but not limited to:

- our ability to accurately predict and effectively manage health benefits and other operating expenses and reserves;
- competition;
- membership and revenue projections;
- timing of regulatory contract approval;
- changes in healthcare practices;
- changes in federal or state laws or regulations, including the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act and any regulations enacted thereunder;
- changes in expected contract start dates;
- changes in expected closing dates, estimated purchase price and accretion for acquisitions;
- inflation;
- foreign currency fluctuations;
- provider and state contract changes;
- new technologies;
- advances in medicine;
- reduction in provider payments by governmental payors;
- major epidemics;
- disasters and numerous other factors affecting the delivery and cost of healthcare;
- the expiration, cancellation or suspension of our or Health Net's managed care contracts by federal or state governments (including but not limited to Medicare and Medicaid);
- the outcome of our or Health Net's pending legal proceedings;
- availability of debt and equity financing, on terms that are favorable to us;
- changes in economic, political and market conditions;
- the ultimate closing date of the Proposed Merger;
- the possibility that the expected synergies and value creation from the Proposed Merger will not be realized, or will not be realized within the expected time period;
- the risk that acquired businesses will not be integrated successfully;
- disruption from the Proposed Merger making it more difficult to maintain business and operational relationships;
- the risk that unexpected costs related to the Proposed Merger will be incurred;
- the possibility that the Proposed Merger does not close, including, but not limited to, due to the failure to satisfy the closing conditions thereto; and
- the risk that financing for the Proposed Merger may not be available on favorable terms.

This list of important factors is not intended to be exhaustive. We discuss certain of these matters more fully, as well as certain risk factors that may affect our business operations, financial condition and results of operations, in our filings with the Securities and Exchange Commission, including our annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K.

Other Information

The discussion in Part I, Item 2. "Management's Discussion and Analysis of Financial Condition and Results of Operations" under the heading "Results of Operations" contains financial information for new and existing businesses. Existing businesses are primarily state markets, significant geographic expansion in an existing state or product that we have managed for four complete quarters. New businesses are primarily new state markets, significant geographic expansion in an existing state or product that conversely, we have not managed for four complete quarters.

Item 1A "Risk Factors" of Part II of this filing contains a further discussion of these and other important factors that could cause actual results to differ from expectations. We disclaim any current intention or obligation to update or revise any forward-looking statements, whether as a result of new information, future events or otherwise. Due to these important factors and risks, we cannot give assurances with respect to our future premium levels or our ability to control our future medical costs.

Non-GAAP Financial Presentation

The Company is providing certain non-GAAP financial measures in this report as the Company believes that these figures are helpful in allowing individuals to more accurately assess the ongoing nature of the Company's operations and measure the Company's performance more consistently. The Company uses the presented non-GAAP financial measures internally to allow management to focus on period-to-period changes in the Company's core business operations. Therefore, the Company believes that this information is meaningful in addition to the information contained in the GAAP presentation of financial information. The presentation of this additional non-GAAP financial information is not intended to be considered in isolation or as a substitute for the financial information prepared and presented in accordance with GAAP.

PART I
FINANCIAL INFORMATION

ITEM 1. ***Financial Statements.***

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
(In millions, except share data)
(Unaudited)

	September 30, 2015	December 31, 2014
ASSETS		
Current assets:		
Cash and cash equivalents	$ 1,665	$ 1,610
Premium and related receivables	1,281	912
Short term investments	162	177
Other current assets	488	335
Total current assets	3,596	3,034
Long term investments	1,992	1,280
Restricted deposits	106	100
Property, software and equipment, net	488	445
Goodwill	849	754
Intangible assets, net	161	120
Other long term assets	130	91
Total assets	$ 7,322	$ 5,824
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$ 2,144	$ 1,723
Accounts payable and accrued expenses	1,035	768
Return of premium payable	313	236
Unearned revenue	66	168
Current portion of long term debt	5	5
Total current liabilities	3,563	2,900
Long term debt	1,276	874
Other long term liabilities	274	159
Total liabilities	5,113	3,933
Commitments and contingencies		
Redeemable noncontrolling interests	156	148
Stockholders' equity:		
Preferred stock, $0.001 par value; authorized 10,000,000 shares; no shares issued or outstanding at September 30, 2015 and December 31, 2014	—	—
Common stock, $.001 par value; authorized 200,000,000 shares; 124,940,103 issued and 119,201,560 outstanding at September 30, 2015, and 124,274,864 issued and 118,433,416 outstanding at December 31, 2014	—	—
Additional paid-in capital	909	840
Accumulated other comprehensive loss	(2)	(1)
Retained earnings	1,247	1,003
Treasury stock, at cost (5,738,543 and 5,841,448 shares, respectively)	(103)	(98)
Total Centene stockholders' equity	2,051	1,744
Noncontrolling interest	2	(1)
Total stockholders' equity	2,053	1,743
Total liabilities and stockholders' equity	$ 7,322	$ 5,824

The accompanying notes to the consolidated financial statements are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF OPERATIONS
(In millions, except share data)
(Unaudited)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2015	2014	2015	2014
Revenues:				
Premium	$ 4,983	$ 3,780	$ 13,974	$ 10,182
Service	480	379	1,434	1,070
Premium and service revenues	5,463	4,159	15,408	11,252
Premium tax and health insurer fee	358	193	1,050	584
Total revenues	5,821	4,352	16,458	11,836
Expenses:				
Medical costs	4,433	3,390	12,475	9,093
Cost of services	413	327	1,234	935
General and administrative expenses	464	334	1,309	951
Premium tax expense	274	161	794	492
Health insurer fee expense	54	32	161	94
Total operating expenses	5,638	4,244	15,973	11,565
Earnings from operations	183	108	485	271
Other income (expense):				
Investment and other income	8	6	27	18
Interest expense	(11)	(9)	(32)	(25)
Earnings from continuing operations, before income tax expense	180	105	480	264
Income tax expense	87	27	234	107
Earnings from continuing operations, net of income tax expense	93	78	246	157
Discontinued operations, net of income tax expense of $0, $0, $0, and $1, respectively	1	1	—	2
Net earnings	94	79	246	159
(Earnings) loss attributable to noncontrolling interests	(1)	3	(2)	5
Net earnings attributable to Centene Corporation	$ 93	$ 82	$ 244	$ 164
Amounts attributable to Centene Corporation common shareholders:				
Earnings from continuing operations, net of income tax expense	$ 92	$ 81	$ 244	$ 162
Discontinued operations, net of income tax expense	1	1	—	2
Net earnings	$ 93	$ 82	$ 244	$ 164
Net earnings per common share attributable to Centene Corporation:				
Basic:				
Continuing operations	$ 0.77	$ 0.69	$ 2.05	$ 1.40
Discontinued operations	0.01	0.01	—	0.01
Basic earnings per common share	$ 0.78	$ 0.70	$ 2.05	$ 1.41
Diluted:				
Continuing operations	$ 0.75	$ 0.67	$ 1.99	$ 1.35
Discontinued operations	0.01	0.01	—	0.02
Diluted earnings per common share	$ 0.76	$ 0.68	$ 1.99	$ 1.37
Weighted average number of common shares outstanding:				
Basic	119,121,524	117,226,968	118,970,853	115,912,304
Diluted	123,131,810	121,363,750	122,904,476	119,873,398

The accompanying notes to the consolidated financial statements are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENT OF COMPREHENSIVE EARNINGS
(In millions)
(Unaudited)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2015	2014	2015	2014
Net earnings	$ 94	$ 79	$ 246	$ 159
Reclassification adjustment, net of tax	—	—	—	—
Change in unrealized gain on investments, net of tax	2	(3)	3	2
Foreign currency translation adjustments	—	—	(4)	—
Other comprehensive earnings	2	(3)	(1)	2
Comprehensive earnings	96	76	245	161
Comprehensive (earnings) loss attributable to noncontrolling interests	(1)	3	(2)	5
Comprehensive earnings attributable to Centene Corporation	$ 95	$ 79	$ 243	$ 166

The accompanying notes to the consolidated financial statements are an integral part of this statement.

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENT OF STOCKHOLDERS' EQUITY
(In millions, except share data)
(Unaudited)

Nine Months Ended September 30, 2015

	Centene Stockholders' Equity								
	Common Stock					Treasury Stock			
	$.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	$.001 Par Value Shares	Amt	Non controlling Interest	Total
Balance, December 31, 2014	124,274,864	$ —	$ 840	$ (1)	$ 1,003	5,841,448	$ (98)	$ (1)	$ 1,743
Comprehensive Earnings:									
Net earnings	—	—	—	—	244	—	—	—	244
Change in unrealized gain on investments, net of $1 tax	—	—	—	3	—	—	—	—	3
Foreign currency translation	—	—	—	(4)	—	—	—	—	(4)
Total comprehensive earnings									243
Common stock issued for acquisition		—	8	—	—	(247,580)	4	—	12
Common stock issued for employee benefit plans	665,239	—	6	—	—	—	—	—	6
Common stock repurchases	—	—	—	—	—	144,675	(9)	—	(9)
Stock compensation expense	—	—	48	—	—	—	—	—	48
Excess tax benefits from stock compensation	—	—	7	—	—	—	—	—	7
Contribution from noncontrolling interest	—	—	—	—	—	—	—	2	2
Reclassification to redeemable noncontrolling interest	—	—	—	—	—	—	—	1	1
Balance, September 30, 2015	124,940,103	$ —	$ 909	$ (2)	$ 1,247	5,738,543	$ (103)	$ 2	$ 2,053

The accompanying notes to the consolidated financial statements are an integral part of this statement.

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
(In millions)
(Unaudited)

	Nine Months Ended September 30,	
	2015	**2014**
Cash flows from operating activities:		
Net earnings	$ 246	$ 159
Adjustments to reconcile net earnings to net cash provided by operating activities		
Depreciation and amortization	82	65
Stock compensation expense	48	35
Deferred income taxes	(14)	(65)
Gain on settlement of contingent consideration	(37)	—
Goodwill and intangible adjustment	28	—
Changes in assets and liabilities		
Premium and related receivables	(360)	(243)
Other current assets	(103)	(25)
Other assets	(40)	(51)
Medical claims liabilities	394	476
Unearned revenue	(104)	54
Accounts payable and accrued expenses	209	427
Other long term liabilities	101	17
Other operating activities	7	4
Net cash provided by operating activities	457	853
Cash flows from investing activities:		
Capital expenditures	(101)	(69)
Purchases of investments	(1,077)	(738)
Sales and maturities of investments	418	320
Proceeds from asset sale	7	—
Investments in acquisitions, net of cash acquired	(16)	(94)
Net cash used in investing activities	(769)	(581)
Cash flows from financing activities:		
Proceeds from exercise of stock options	5	6
Proceeds from borrowings	1,305	1,385
Payment of long term debt	(910)	(1,118)
Excess tax benefits from stock compensation	7	7
Common stock repurchases	(9)	(6)
Contribution from noncontrolling interest	2	5
Debt issue costs	(4)	(6)
Payment of contingent consideration obligation	(29)	—
Net cash provided by financing activities	367	273
Net increase in cash and cash equivalents	55	545
Cash and cash equivalents, beginning of period	1,610	1,038
Cash and cash equivalents, end of period	$ 1,665	$ 1,583
Supplemental disclosures of cash flow information:		
Interest paid	$ 28	$ 18
Health insurer fee paid	$ 213	$ 126
Income taxes paid	$ 229	$ 167
Equity issued in connection with acquisitions	$ 12	$ 190

The accompanying notes to the consolidated financial statements are an integral part of these statements.

1. Basis of Presentation

Basis of Presentation

The accompanying interim financial statements have been prepared under the presumption that users of the interim financial information have either read or have access to the audited financial statements included in the Form 10-K for the fiscal year ended December 31, 2014. The unaudited interim financial statements herein have been prepared pursuant to the rules and regulations of the Securities and Exchange Commission. Accordingly, footnote disclosures which would substantially duplicate the disclosures contained in the December 31, 2014 audited financial statements have been omitted from these interim financial statements where appropriate. In the opinion of management, these financial statements reflect all adjustments, consisting only of normal recurring adjustments, which are necessary for a fair presentation of the results of the interim periods presented.

Certain 2014 amounts in the notes to the consolidated financial statements have been reclassified to conform to the 2015 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

On February 2, 2015, the Board of Directors declared a two-for-one split of Centene's common stock in the form of a 100% stock dividend distributed February 19, 2015 to stockholders of record on February 12, 2015. All share and per share information presented in this Form 10-Q has been adjusted for the two-for-one stock split.

Recent Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board (FASB) issued an Accounting Standards Update (ASU) which supersedes existing revenue recognition standards with a single model unless those contracts are within the scope of other standards (e.g., an insurance entity's insurance contracts). Under the new standard, recognition of revenue occurs when a customer obtains control of promised goods or services in an amount that reflects the consideration which the entity expects to receive in exchange for those goods or services. In addition, the standard requires disclosure of the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers. In August 2015, the FASB issued an ASU which deferred the effective date of the new revenue standard by one year. The new effective date is for annual and interim periods beginning after December 15, 2017. Early adoption is permitted. The Company is currently evaluating the effect of the new revenue recognition guidance.

In April 2015, the FASB issued an ASU which changes the presentation of debt issuance costs in financial statements. Under the new standard, debt issuance costs are presented in the balance sheet as a direct deduction of the related debt liability rather than as an asset. Amortization of the cost is reported as interest expense. The new standard is effective for annual and interim periods beginning after December 15, 2015 and early adoption is permitted. The Company elected to adopt this guidance beginning in the first quarter of 2015 and has applied the new standard retrospectively to all prior periods. The reclassification of debt issuance costs impacted the Consolidated Balance Sheets by decreasing both Other Long Term Assets and Long Term Debt by $14 million at December 31, 2014 and $15 million at September 30, 2015. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

In May 2015, the FASB issued an ASU which expands the disclosure requirements for insurance companies that issue short-duration contracts. The new standard will increase the level of disclosure around the Company's Medical Claims Liability to include the following: claims development by year; claim frequency; a rollforward of the claims liability; and a description of methods and assumptions used for determining the liability. It is effective for annual periods beginning after December 15, 2015 and interim periods beginning after December 15, 2016. Early adoption is permitted. The Company is currently evaluating the effect of the new disclosure requirements.

In September 2015, the FASB issued an ASU which simplifies the accounting for measurement-period adjustments in business combinations. Under the new standard, an acquirer must recognize adjustments to provisional amounts that are identified during the measurement period in the reporting period in which the adjustment amounts are determined. Additionally, the acquirer must present separately on the face of the income statement, or disclose in the notes, the portion of the amount recorded in the current-period earnings by line item that would have been recorded in previous reporting periods if the adjustment to the provisional amounts had been recognized as of the acquisition date. It is effective for annual and interim

periods beginning after December 15, 2016. Early adoption is permitted. The Company elected to adopt this guidance in the current fiscal quarter.

2. Health Net, Inc. Merger

On July 2, 2015, the Company announced that the Company and two direct, newly formed subsidiaries of the Company had entered into a definitive merger agreement with Health Net, Inc. (Health Net) under which the Company will acquire all of the issued and outstanding shares of Health Net. Under the terms of the agreement, at the closing of the transaction, Health Net stockholders (with limited exceptions) would receive 0.622 of a validly issued, fully paid, non-assessable share of Centene common stock and $28.25 in cash for each share of Health Net common stock. The transaction is valued at approximately $6.8 billion (based on the Centene closing stock price on July 1, 2015), including the assumption of debt.

The transaction is expected to close in early 2016 and is subject to approvals by relevant state insurance and healthcare regulators and other customary closing conditions. In August 2015, the Company announced the early termination of the waiting period required under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended. In October 2015, the Company and Health Net announced the transaction was approved by both the Centene and Health Net stockholders. The Company expects to fund the cash portion of the acquisition through a combination of existing cash on hand and debt financing.

3. Acquisitions and Redeemable Noncontrolling Interest

Acquisitions

Community Health Solutions of America, Inc.

In July 2014, the Company completed a transaction whereby Community Health Solutions of America, Inc. assigned its contract with the Louisiana Department of Health and Hospitals under the Bayou Health Shared Savings Program to the Company's subsidiary, Louisiana Healthcare Connections (LHC). The fair value of consideration transferred included the present value of the estimated contingent consideration, subject to membership retained by LHC in the first quarter of 2015. The fair value of contingent consideration was $18 million at December 31, 2014. During the first quarter of 2015, the Company determined the amount of the actual contingent consideration to be $8 million. A gain of $10 million related to the settlement of the obligation was recorded in General and Administrative expense.

LiveHealthier, Inc.

In January 2015, the Company acquired the remaining 79% of LiveHealthier, Inc. (LiveHealthier) for $28 million, bringing its total ownership to 100%. LiveHealthier is a provider of technology and service-based health management solutions. The fair value of consideration of $28 million consists of cash paid of $11 million, Centene common stock issued at closing of $13 million, and the fair value of estimated contingent consideration of $4 million to be paid in cash over a three year period. The contingent consideration will not exceed $9 million.

The Company's allocation of fair value resulted in goodwill of $26 million and other identifiable intangible assets of $15 million. The goodwill is not deductible for income tax purposes. The acquisition is recorded in the Managed Care segment.

Fidelis SecureCare of Michigan, Inc.

In May 2015, the Company acquired 100% of Fidelis SecureCare of Michigan, Inc. (Fidelis) a subsidiary of Concerto Healthcare, for $57 million. Fidelis was previously selected by the Michigan Department of Community Health to provide integrated healthcare services to members who are dually eligible for Medicare and Medicaid in Macomb and Wayne counties. The fair value of consideration of $57 million consists of initial cash consideration of $7 million and the fair value of estimated contingent consideration of $50 million. The contingent consideration is based on duals membership and revenue per member during the first year of the contract (July 2015 - June 2016), including reconciliation payments settled over a two year period. The contingent consideration fair value is estimated based on expected membership during the first year of the contract as well as estimated revenue per member reflecting both member mix and risk adjustment. The Company's allocation of fair value resulted in goodwill of $29 million and other identifiable intangible assets of $23 million. 100% of the goodwill is deductible for income tax purposes. The acquisition is recorded in the Managed Care segment.

During the third quarter of 2015, the Company experienced higher than anticipated opt-out rates and member attrition in the dual demonstration program, resulting in lower than expected membership and lower blended premium rates. As a result, the fair value of estimated contingent consideration was reduced to $23 million, and the Company recorded a gain of $27 million in general and administrative expenses. In connection with the lower membership and revenue outlook, the Company conducted an impairment analysis of the identifiable intangible assets and goodwill, resulting in a reduction of goodwill and intangible assets of $28 million which was recorded in general and administrative expenses. At September 30, 2015, the Company had goodwill of $15 million and other identifiable intangible assets of $7 million remaining on the balance sheet.

Agate Resources, Inc.

In September 2015, the Company completed the acquisition of Agate Resources, Inc. (Agate) for $120 million. Agate is a diversified holding company that offers primarily Medicaid and other healthcare products and services to Oregon residents. The fair value of consideration of $120 million consists of initial cash consideration of $93 million, the present value of future cash payments of $18 million to be paid out over a three year period, and the fair value of estimated contingent consideration of $9 million. A portion of the contingent consideration is based on the achievement of underwriting targets and will be paid in cash over a three year period; the remainder is based on the receipt of a retrospective rate adjustment and is expected to be settled in cash in the fourth quarter of 2015.

The Company's preliminary allocation of fair value resulted in goodwill of $51 million and other identifiable intangible assets of $34 million. The Company has not finalized the allocation of the fair value of assets and liabilities. The goodwill is not deductible for income tax purposes. The acquisition is recorded in the Managed Care segment.

Redeemable Noncontrolling Interest

In January 2015, the Company sold 25% of its ownership in Celtic Insurance Company for $7 million. No gain or loss was recognized on the sale of the ownership interest. Celtic Insurance Company is included in the Managed Care segment. In connection with the sale of the ownership interest, the Company entered into a put agreement with the noncontrolling interest holder, allowing the noncontrolling interest holder to put its interest back to the Company beginning in 2022. As a result of put option agreements, the noncontrolling interest is considered redeemable and is classified in the Redeemable Noncontrolling Interest section of the consolidated balance sheets.

A reconciliation of the changes in the Redeemable Noncontrolling Interests is as follows ($ in millions):

Balance, December 31, 2014	$	148
Fair value of redeemable noncontrolling interest sold		7
Reclassification to redeemable noncontrolling interest		(1)
Net earnings attributable to redeemable noncontrolling interests		2
Balance, September 30, 2015	$	156

4. Short term and Long term Investments, Restricted Deposits

Short term and long term investments and restricted deposits by investment type consist of the following ($ in millions):

	September 30, 2015				December 31, 2014			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 468	$ 2	$ —	$ 470	$ 393	$ 1	$ (2)	$ 392
Corporate securities	837	4	(4)	837	556	2	(2)	556
Restricted certificates of deposit	9	—	—	9	6	—	—	6
Restricted cash equivalents	78	—	—	78	79	—	—	79
Municipal securities	489	2	(2)	489	174	1	—	175
Asset-backed securities	186	—	—	186	180	—	—	180
Residential mortgage-backed securities	75	2	—	77	84	1	—	85
Commercial mortgage-backed securities	26	—	—	26	—	—	—	—
Cost and equity method investments	72	—	—	72	68	—	—	68
Life insurance contracts	16	—	—	16	16	—	—	16
Total	$ 2,256	$ 10	$ (6)	$2,260	$ 1,556	$ 5	$ (4)	$1,557

The Company's investments are classified as available-for-sale with the exception of life insurance contracts and certain cost and equity method investments. The Company's investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets with the focus on high credit quality securities. The Company limits the size of investment in any single issuer other than U.S. treasury securities and obligations of U.S. government corporations and agencies. As of September 30, 2015, 38% of the Company's investments in securities recorded at fair value that carry a rating by S&P or Moody's were rated AAA/Aaa, 62% were rated AA-/Aa3 or higher, and 88% were rated A-/A3 or higher. At September 30, 2015, the Company held certificates of deposit, life insurance contracts and cost and equity method investments which did not carry a credit rating.

The Company's residential mortgage-backed securities are all issued by the Federal National Mortgage Association, Government National Mortgage Association or Federal Home Loan Mortgage Corporation, which carry implicit or explicit guarantees of the U.S. government. The Company's commercial mortgage-backed securities are primarily senior tranches with a weighted average rating of AA+ and a weighted average duration of 2.0 years at September 30, 2015.

The fair value of available-for-sale investments with gross unrealized losses by investment type and length of time that individual securities have been in a continuous unrealized loss position were as follows ($ in millions):

	September 30, 2015				December 31, 2014			
	Less Than 12 Months		12 Months or More		Less Than 12 Months		12 Months or More	
	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ —	$ 68	$ —	$ 16	$ —	$ 72	$ (2)	$ 180
Corporate securities	(3)	317	(1)	41	(2)	311	—	1
Municipal securities	(1)	120	(1)	5	—	20	—	7
Asset-backed securities	—	68	—	13	—	70	—	10
Residential mortgage-backed securities	—	—	—	—	—	18	—	—
Total	$ (4)	$ 573	$ (2)	$ 75	$ (2)	$ 491	$ (2)	$ 198

As of September 30, 2015, the gross unrealized losses were generated from 202 positions out of a total of 680 positions. The change in fair value of fixed income securities is a result of movement in interest rates subsequent to the purchase of the security.

For each security in an unrealized loss position, the Company assesses whether it intends to sell the security or if it is more likely than not the Company will be required to sell the security before recovery of the amortized cost basis for reasons such as liquidity, contractual or regulatory purposes. If the security meets this criterion, the decline in fair value is other-than-temporary and is recorded in earnings. The Company does not intend to sell these securities prior to maturity and it is not likely that the Company will be required to sell these securities prior to maturity; therefore, there is no indication of other-than-temporary impairment for these securities.

During the nine months ended September 30, 2015, the Company recognized $8 million of income from equity method investments.

The contractual maturities of short term and long term investments and restricted deposits are as follows ($ in millions):

	September 30, 2015				December 31, 2014			
	Investments		Restricted Deposits		Investments		Restricted Deposits	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value
One year or less	$ 162	$ 162	$ 95	$ 95	$ 176	$ 177	$ 92	$ 92
One year through five years	1,613	1,616	11	11	1,121	1,121	8	8
Five years through ten years	268	268	—	—	121	120	—	—
Greater than ten years	107	108	—	—	38	39	—	—
Total	$ 2,150	$ 2,154	$ 106	$ 106	$ 1,456	$ 1,457	$ 100	$ 100

Actual maturities may differ from contractual maturities due to call or prepayment options. Asset-backed and mortgage-backed securities are included in the one year through five years category, while cost and equity method investments and life insurance contracts are included in the five years through ten years category. The Company has an option to redeem at amortized cost substantially all of the securities included in the greater than ten years category listed above.

The Company continuously monitors investments for other-than-temporary impairment. Certain investments have experienced a decline in fair value due to changes in credit quality, market interest rates and/or general economic conditions. The Company recognizes an impairment loss for cost and equity method investments when evidence demonstrates that it is other-than-temporarily impaired. Evidence of a loss in value that is other-than-temporary may include the absence of an ability to recover the carrying amount of the investment or the inability of the investee to sustain a level of earnings that would justify the carrying amount of the investment.

5. Fair Value Measurements

Assets and liabilities recorded at fair value in the consolidated balance sheets are categorized based upon observable or unobservable inputs used to estimate fair value. Level inputs are as follows:

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

The following table summarizes fair value measurements by level at September 30, 2015, for assets and liabilities measured at fair value on a recurring basis ($ in millions):

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$ 1,665	$ —	$ —	$ 1,665
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 437	$ 14	$ —	$ 451
Corporate securities	—	837	—	837
Municipal securities	—	489	—	489
Asset-backed securities	—	186	—	186
Residential mortgage-backed securities	—	77	—	77
Commercial mortgage-backed securities	—	26	—	26
Total investments	$ 437	$ 1,629	$ —	$ 2,066
Restricted deposits available for sale:				
Cash and cash equivalents	$ 78	$ —	$ —	$ 78
Certificates of deposit	9	—	—	9
U.S. Treasury securities and obligations of U.S. government corporations and agencies	19	—	—	19
Total restricted deposits	$ 106	$ —	$ —	$ 106
Other long term assets:				
Interest rate swap agreements	$ —	$ 18	$ —	$ 18
Total assets at fair value	$ 2,208	$ 1,647	$ —	$ 3,855

The following table summarizes fair value measurements by level at December 31, 2014, for assets and liabilities measured at fair value on a recurring basis ($ in millions):

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$ 1,610	$ —	$ —	$ 1,610
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 360	$ 17	$ —	$ 377
Corporate securities	—	556	—	556
Municipal securities	—	175	—	175
Asset-backed securities	—	180	—	180
Residential mortgage-backed securities	—	85	—	85
Commercial mortgage-backed securities	—	—	—	—
Total investments	$ 360	$ 1,013	$ —	$ 1,373
Restricted deposits available for sale:				
Cash and cash equivalents	$ 79	$ —	$ —	$ 79
Certificates of deposit	6	—	—	6
U.S. Treasury securities and obligations of U.S. government corporations and agencies	15	—	—	15
Total restricted deposits	$ 100	$ —	$ —	$ 100
Other long term assets:				
Interest rate swap agreements	$ —	$ 11	$ —	$ 11
Total assets at fair value	$ 2,070	$ 1,024	$ —	$ 3,094

The Company periodically transfers U.S. Treasury securities and obligations of U.S. government corporations and agencies between Level I and Level II fair value measurements dependent upon the level of trading activity for the specific securities at the measurement date. The Company's policy regarding the timing of transfers between Level I and Level II is to measure and record the transfers at the end of the reporting period. At September 30, 2015, there were less than $1 million of transfers from Level I to Level II and $2 million of transfers from Level II to Level I. The Company utilizes matrix pricing services to estimate fair value for securities which are not actively traded on the measurement date. The Company designates these securities as Level II fair value measurements. The aggregate carrying amount of the Company's life insurance contracts and other non-majority owned investments, which approximates fair value, was $88 million and $84 million as of September 30, 2015 and December 31, 2014, respectively.

6. Health Insurance Marketplace

The Affordable Care Act (ACA) established risk spreading premium stabilization programs effective January 1, 2014 for the Health Insurance Marketplace product. These programs, commonly referred to as the "three Rs," include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. Additionally, the ACA established a minimum annual medical loss ratio for the Health Insurance Marketplace. Each of the three R programs are taken into consideration to determine if the Company's estimated annual medical costs are less than the minimum loss ratio and require an adjustment to Premium revenue to meet the minimum medical loss ratio.

In June 2015, CMS released final results on reinsurance and risk-adjustment for the 2014 plan year. These final results had an insignificant impact to the Company for the 2014 plan year.

The Company's receivables (payables) for each of these programs are as follows ($ in millions):

	September 30, 2015	December 31, 2014
Risk adjustment	$ (77)	$ (44)
Reinsurance	14	11
Risk corridor	(31)	(9)
Minimum medical loss ratio	(14)	(6)

7. Debt

Debt consists of the following ($ in millions):

	September 30, 2015	December 31, 2014
$425 million 5.75% Senior notes, due June 1, 2017	$ 428	$ 429
$500 million 4.75% Senior notes, due May 15, 2022	500	300
Fair value of interest rate swap agreements	18	11
Senior notes	946	740
Revolving credit agreement	275	75
Mortgage notes payable	68	70
Capital leases	7	8
Debt issuance costs	(15)	(14)
Total debt	1,281	879
Less current portion	(5)	(5)
Long term debt	$ 1,276	$ 874

Senior Notes

In January 2015, the Company issued an additional $200 million of 4.75% Senior Notes ($200 Million Add-on Notes) at par. The $200 Million Add-on Notes were offered as additional debt securities under the indenture governing the $300 million of 4.75% Senior Notes issued in April 2014. In connection with the January 2015 issuance, the Company entered into interest rate swap agreements for a notional amount of $200 million at a floating rate of interest based on the three month LIBOR plus 2.88%. Gains and losses due to changes in the fair value of the interest rate swap completely offset changes in the fair value of the hedged portion of the underlying debt and are recorded as an adjustment to the $200 Million Add-on Notes.

The indentures governing both the $425 million notes due 2017 and the $500 million notes due 2022 contain non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio.

Interest Rate Swaps

The Company uses interest rate swap agreements to convert a portion of its interest rate exposure from fixed rates to floating rates to more closely align interest expense with interest income received on its cash equivalent and variable rate investment balances. The Company has $750 million of notional amount of interest rate swap agreements consisting of $250 million which are scheduled to expire on June 1, 2017 and $500 million that are scheduled to expire May 15, 2022. Under the Swap Agreements, the Company receives a fixed rate of interest and pays an average variable rate of the three month LIBOR plus 2.85% adjusted quarterly. At September 30, 2015, the weighted average rate was 3.16%.

The Swap Agreements are formally designated and qualify as fair value hedges and are recorded at fair value in the Consolidated Balance Sheet in other assets or other liabilities. Gains and losses due to changes in fair value of the interest rate swap agreements completely offset changes in the fair value of the hedged portion of the underlying debt. Therefore, no gain or loss has been recognized due to hedge ineffectiveness. Offsetting changes in fair value of both the interest rate swaps and the hedged portion of the underlying debt both were recognized in interest expense in the Consolidated Statement of Operations. The Company does not hold or issue any derivative instrument for trading or speculative purposes.

Revolving Credit Agreement

The Company has an unsecured $500 million revolving credit facility. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. The agreement has a maturity date of June 1, 2018, provided it will mature 90 days prior to the maturity date of the Company's 5.75% Senior Notes due 2017 if such notes are not refinanced (or extended), certain financial conditions are not met, or the Company does not carry $100 million of unrestricted cash. As of September 30, 2015, the Company had $275 million of borrowings outstanding under the agreement with a weighted average interest rate of 3.01%.

The agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt-to-EBITDA ratios and minimum tangible net worth. The Company is required to not exceed a maximum debt-to-EBITDA ratio of 3.0 to 1.0. As of September 30, 2015, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

Letters of Credit & Surety Bonds

The Company had outstanding letters of credit of $46 million as of September 30, 2015, which were not part of the revolving credit facility. The Company also had letters of credit for $52 million (valued at September 30, 2015 conversion rate), or €46 million, representing its proportional share of the letters of credit issued to support Ribera Salud's outstanding debt, which are a part of the revolving credit facility. Collectively, the letters of credit bore interest at 1.55% as of September 30, 2015. The Company had outstanding surety bonds of $304 million as of September 30, 2015.

8. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings per common share ($ in millions, except per share data):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2015	2014	2015	2014
Earnings attributable to Centene Corporation:				
Earnings from continuing operations, net of tax	$ 92	$ 81	$ 244	$ 162
Discontinued operations, net of tax	1	1	—	2
Net earnings	$ 93	$ 82	$ 244	$ 164
Shares used in computing per share amounts:				
Weighted average number of common shares outstanding	119,121,524	117,226,968	118,970,853	115,912,304
Common stock equivalents (as determined by applying the treasury stock method)	4,010,286	4,136,782	3,933,623	3,961,094
Weighted average number of common shares and potential dilutive common shares outstanding	123,131,810	121,363,750	122,904,476	119,873,398
Net earnings per common share attributable to Centene Corporation:				
Basic:				
Continuing operations	$ 0.77	$ 0.69	$ 2.05	$ 1.40
Discontinued operations	0.01	0.01	—	0.01
Basic earnings per common share	$ 0.78	$ 0.70	$ 2.05	$ 1.41
Diluted:				
Continuing operations	$ 0.75	$ 0.67	$ 1.99	$ 1.35
Discontinued operations	0.01	0.01	—	0.02
Diluted earnings per common share	$ 0.76	$ 0.68	$ 1.99	$ 1.37

The calculation of diluted earnings per common share for the three and nine months ended September 30, 2015 excludes the impact of 28,716 and 84,644 shares, respectively, related to anti-dilutive restricted stock and restricted stock units. The calculation of diluted earnings per common share for the three and nine months ended September 30, 2014 excludes the impact of 47,520 shares and 117,756 shares, respectively, related to anti-dilutive restricted stock and restricted stock units.

9. Segment Information

Centene operates in two segments: Managed Care and Specialty Services. The Managed Care segment consists of Centene's health plans including all of the functions needed to operate them. The Specialty Services segment consists of Centene's specialty companies offering auxiliary healthcare services and products.

Segment information for the three months ended September 30, 2015, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$ 4,922	$ 541	$ —	$ 5,463
Premium and service revenues from internal customers	24	1,274	(1,298)	—
Total premium and service revenues	$ 4,946	$ 1,815	$ (1,298)	$ 5,463
Earnings from operations	$ 138	$ 45	$ —	$ 183

Segment information for the three months ended September 30, 2014, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$ 3,730	$ 429	$ —	$ 4,159
Premium and service revenues from internal customers	16	806	(822)	—
Total premium and service revenues	$ 3,746	$ 1,235	$ (822)	$ 4,159
Earnings from operations	$ 80	$ 28	$ —	$ 108

Segment information for the nine months ended September 30, 2015, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$ 13,812	$ 1,596	$ —	$ 15,408
Premium and service revenues from internal customers	73	3,525	(3,598)	—
Total premium and service revenues	$ 13,885	$ 5,121	$ (3,598)	$ 15,408
Earnings from operations	$ 358	$ 127	$ —	$ 485

Segment information for the nine months ended September 30, 2014, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$ 9,925	$ 1,327	$ —	$ 11,252
Premium and service revenues from internal customers	42	2,121	(2,163)	—
Total premium and service revenues	$ 9,967	$ 3,448	$ (2,163)	$ 11,252
Earnings from operations	$ 188	$ 83	$ —	$ 271

10. Contingencies

On July 5, 2013, the Company's subsidiary, Kentucky Spirit Health Plan, Inc. (Kentucky Spirit), terminated its contract with the Commonwealth of Kentucky (the Commonwealth). Kentucky Spirit believes it had a contractual right to terminate the contract and filed a lawsuit in Franklin Circuit Court seeking a declaration of this right. The Commonwealth has alleged that Kentucky Spirit's exit constitutes a material breach of contract. The Commonwealth seeks to recover substantial damages and to enforce its rights under Kentucky Spirit's $25 million performance bond. The Commonwealth's attorneys have asserted that the Commonwealth's expenditures due to Kentucky Spirit's departure range from $28 million to $40 million plus interest, and that the associated CMS expenditures range from $92 million to $134 million. Kentucky Spirit disputes the Commonwealth's alleged damages, and is pursuing its own litigation claims for damages against the Commonwealth.

On February 6, 2015, the Kentucky Court of Appeals affirmed a Franklin Circuit Court ruling that Kentucky Spirit does not have a contractual right to terminate the contract early. The Court of Appeals also found that the contract's liquidated damages provision "is applicable in the event of a premature termination of the Contract term." On September 8, 2015, Kentucky Spirit filed a motion for discretionary review seeking Kentucky Supreme Court review of the finding that Kentucky Spirit's departure constituted a breach of contract. On October 9, 2015, the Commonwealth filed a response opposing discretionary review.

Kentucky Spirit also filed a lawsuit in April 2013, amended in October 2014, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches. On December 9, 2014, the

Franklin Circuit Court denied the Commonwealth's motion for partial summary judgment on Kentucky Spirit's damages claims. On March 15, 2015, the Franklin Circuit Court denied the Commonwealth's motion to stay discovery and ordered that discovery proceed on those claims.

On May 26, 2015, the Commonwealth issued a demand for indemnification to its actuarial firm, for "all defense costs, and any resultant monetary awards in favor of Kentucky Spirit, arising from or related to Kentucky Spirit's claims which are predicated upon the alleged omissions and errors in the Data Book and the certified actuarially sound rates." On August 19, 2015, the actuarial firm moved to intervene in the litigation. The Franklin Circuit Court granted the actuarial firm's motion on September 8, 2015 and ordered a forty-five day stay of all pretrial proceedings in order for the firm to review the record. Also, on August 19, 2015, the actuarial firm filed a petition seeking a declaratory judgment that it is not liable to the Commonwealth for indemnification related to the claims asserted by Kentucky Spirit against the Commonwealth. On October 5, 2015, the Commonwealth filed an answer to the actuarial firm's petition and asserted counterclaims/cross-claims against the firm.

On March 9, 2015, the Secretary of the Kentucky Cabinet for Health and Family Services (CHFS) issued a determination letter finding that Kentucky Spirit owed the Commonwealth $40 million in actual damages plus prejudgment interest at 8 percent. On March 18, 2015, in a letter to the Kentucky Finance and Administration Cabinet (FAC), Kentucky Spirit contested CHFS' jurisdiction to make such a determination. The FAC did not issue a decision within the required 120 days. On August 13, 2015, Kentucky Spirit filed a declaratory judgment action against the Commonwealth in Franklin Circuit Court seeking a declaration that the Commonwealth may not purport to issue a decision against Kentucky Spirit awarding damages to itself when the matter is already before the Kentucky courts, and that the Commonwealth has waived its claims against Kentucky Spirit for damages arising out of the contract.

The resolution of the Kentucky litigation matters may result in a range of possible outcomes. If Kentucky Spirit prevails on its claims, it would be entitled to damages. If the Commonwealth prevails, a liability to the Commonwealth could be recorded. The Company is unable to estimate the ultimate outcome resulting from the Kentucky litigation. As a result, the Company has not recorded any receivable or any liability for potential damages under the contract as of September 30, 2015. While uncertain, the ultimate resolution of the pending litigation could have a material effect on the financial position, cash flow or results of operations of the Company in the period it is resolved or becomes known.

Excluding the Kentucky matters discussed above, the Company is also routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters in the normal course of business is uncertain, the Company does not expect the results of any of these matters individually, or in the aggregate, to have a material effect on its financial position, results of operations or cash flows.

11. Subsequent Event

In October 2015, the Company's stockholders approved a proposal to increase the Company's authorized shares of common stock from 200 million to 400 million.

ITEM 2. Management's Discussion and Analysis of Financial Condition and Results of Operations.

The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes included elsewhere in this filing. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under Part II, Item 1A. "Risk Factors" of this Form 10-Q.

OVERVIEW

In 2013, we classified the operations for Kentucky Spirit Health Plan (KSHP) as discontinued operations for all periods presented in our consolidated financial statements. The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise identified.

On February 2, 2015, the Board of Directors declared a two-for-one split of Centene's common stock in the form of a 100% stock dividend distributed February 19, 2015 to stockholders of record on February 12, 2015. All share and per share information presented in this Form 10-Q has been adjusted for the two-for-one stock split.

Key financial metrics for the third quarter of 2015 are summarized as follows:

- Quarter-end managed care membership of 4.8 million, an increase of 933,600 members, or 24% year over year.
- Premium and service revenues of $5.5 billion, representing 31% growth year over year.
- Health Benefits Ratio of 89.0%, compared to 89.7% in 2014.
- General and Administrative expense ratio of 8.5%, compared to 8.0% in 2014.
- Operating cash flows of $62 million for the third quarter of 2015.
- Diluted net earnings per share of $0.75, or $0.84 excluding $0.09 of diluted EPS of Health Net merger related expenses, compared to $0.67 in 2014.

The following items contributed to our revenue and membership growth over the last year:

- *California.* In December 2014, the ABD membership of our California subsidiary, California Health and Wellness, increased as a result of the mandatory transition of the ABD population to managed care. The enrollment of this population to managed care was previously voluntary.

- *Centurion.* In February 2015, Centurion began operating under a new contract with the State of Vermont Department of Corrections to provide comprehensive correctional healthcare services.

  In July 2015, Centurion began operating under a new contract with the Mississippi Department of Corrections to provide comprehensive correctional healthcare services.

- *Florida.* In May 2014, our Florida subsidiary, Sunshine Health, began operating under a new contract in 9 of 11 regions of the Managed Medical Assistance (MMA) program. The MMA program includes TANF recipients as well as ABD and dual-eligible members. In addition, we began operating as the sole provider under a new statewide contract for the Child Welfare Specialty Plan (Foster Care). Enrollment for both the MMA program and Foster Care began in May 2014 and was implemented by region through August 2014.

- *Health Insurance Marketplaces (HIM).* In January 2015, we expanded our participation in Health Insurance Marketplaces to include members in certain regions of Illinois and Wisconsin.

- *Illinois.* In March 2014, our Illinois subsidiary, IlliniCare Health, began operating under a new contract as part of the Illinois Medicare-Medicaid Alignment Initiative serving dual-eligible members in Cook, DuPage, Lake, Kane, Kankakee and Will counties (Greater Chicago region).

  In July 2014, IlliniCare Health began operating under a new contract with the Cook County Health and Hospitals System to perform third party administrative services to members enrolled in the CountyCare program, as well as care coordination, behavioral health, vision care and pharmacy benefit management services.

  In September 2014, IlliniCare Health began serving additional Medicaid members under the state's Medicaid and Medicaid expansion programs.

- *Indiana.* In February 2015, our Indiana subsidiary, Managed Health Services, began operating under an expanded contract with the Indiana Family & Social Services Administration to provide Medicaid services under the state's Healthy Indiana Plan 2.0 program.

  In April 2015, Managed Health Services began operating under an expanded contract with the Indiana Family & Social Services Administration to provide services to its ABD Medicaid enrollees who qualify for the new Hoosier Care Connect Program.

- *Louisiana.* In July 2014, we completed the transaction whereby Community Health Solutions of America, Inc. (CHS) assigned its contract with the Louisiana Department of Health and Hospitals under the Bayou Health Shared Savings Program to our subsidiary, Louisiana Healthcare Connections (LHC).

  In February 2015, LHC began operating under a new contract with the Louisiana Department of Health and Hospitals to serve Bayou Health (Medicaid) beneficiaries. Members previously served under the shared savings program were transitioned to the at-risk program on February 1, 2015.

- *Michigan.* In May 2015, we completed the acquisition of Fidelis SecureCare of Michigan, Inc. (Fidelis). Fidelis began operating under a new contract with the Michigan Department of Community Health and the Centers for Medicare and Medicaid Services to provide integrated healthcare services to members who are dually eligible for Medicare and Medicaid in Macomb and Wayne counties in May 2015. Passive enrollment began in July 2015.

- *Mississippi.* In July 2014, our Mississippi subsidiary, Magnolia Health, began operating as one of two contractors under a new statewide managed care contract serving members enrolled in the Mississippi Coordinated Access Network program. Program expansion began in December 2014 and continued through July 2015.

  In January 2015, Magnolia Health began operating under a new temporary six-month contract with the State of Mississippi to provide services under the Children's Health Insurance Program (CHIP). In July 2015, Magnolia Health began operating under a two-year CHIP contract with the State of Mississippi.

- *New Hampshire.* In September 2014, our New Hampshire subsidiary, New Hampshire Healthy Families, began serving members under the state's Medicaid expansion program.

- *Ohio.* In May 2014, our Ohio subsidiary, Buckeye Health Plan (Buckeye), began operating under a new contract with the Ohio Department of Medicaid and the Centers for Medicare and Medicaid Services to serve Medicaid members in a dual-eligible demonstration program in three of seven regions: Northeast (Cleveland), Northwest (Toledo) and West Central (Dayton). This three-year program, which is part of the Integrated Care Delivery System expansion, serves those who have both Medicare and Medicaid eligibility. Passive enrollment for Medicaid began in May 2014 and implementation was completed in July 2014. Passive enrollment for Medicare began in January 2015.

- *Oregon.* In September 2015, we completed the acquisition of Agate Resources, Inc., a diversified holding company, that offers primarily Medicaid and other healthcare products and services to Oregon residents through Trillium Community Health Plan.

- *South Carolina.* In February 2015, our South Carolina subsidiary, Absolute Total Care, began operating under a new contract with the South Carolina Department of Health and Human Services and the Centers for Medicare and Medicaid Services to serve dual-eligible members as part of the state's dual demonstration program.

- *Texas.* In September 2014, we began operating under a new contract with the Texas Health and Human Services Commission (HHSC) to expand our operations and serve STAR+PLUS members in two Medicaid Rural Service Areas. We also began providing expanded coverage in September 2014 under our STAR+PLUS contracts to provide acute care services for intellectually and developmentally disabled members. In March 2015, we began operating under an expanded STAR+PLUS contract with the Texas HHSC to include nursing facility benefits.

  In March 2015, we also began operating under a new contract with the Texas HHSC and the Centers for Medicare and Medicaid Services to serve dual-eligible members in three counties as part of the state's dual demonstration program.

In addition, in July 2014, we completed an investment accounted for under the equity method for the purchase of a noncontrolling interest in Ribera Salud S.A. (Ribera Salud), a Spanish health management group. Centene is a joint shareholder with Ribera Salud's remaining investor, Banco Sabadell S.A.

We expect the following items to contribute to our future growth potential:

- We expect to realize the full year benefit in 2015 of business commenced during 2014 in Florida, Illinois, Louisiana, Mississippi, New Hampshire, Ohio and Texas as discussed above.

- In October 2015, our subsidiary, Superior HealthPlan, Inc., was awarded a contract by the Texas HHSC to serve seven delivery areas for STAR Kids Medicaid recipients, more than any other successful bidder. The new contract is expected to commence in the second half of 2016.

- In October 2015, our subsidiary, Cenpatico Integrated Care, in partnership with University of Arizona Health Plan, began operating under a contract with the Arizona Department of Health Services/Division of Behavioral Health Services to be the Regional Behavioral Health Authority for the new southern geographic service area.

- In October 2015, Sunshine Health began operating under a two-year, statewide contract with the Florida Healthy Kids Corporation to manage healthcare services for children ages five through 18 in all 11 regions of Florida.

- In September 2015, our subsidiary, Peach State Health Plan, was one of the Care Management Organizations selected to serve Medicaid recipients enrolled in the Georgia Families, PeachCare for Kids and Planning for Healthy Babies programs. The contract renewal is expected to commence in July 2016, pending regulatory approvals.

- In August 2015, our subsidiary, Coordinated Care of Washington, was selected by the Washington State Health Care Authority as the sole provider for the Apple Health Foster Care contract. The new contract is expected to commence in the first quarter of 2016, pending regulatory approvals.

- In July 2015, we entered into a definitive merger agreement with Health Net, Inc. (Health Net) under which we will acquire all of the issued and outstanding shares of Health Net. The transaction is valued at approximately $6.8 billion (based on the Centene closing stock price on July 1, 2015), including the assumption of debt. The transaction is expected to close in early 2016.

- In the fourth quarter of 2015, Louisiana Healthcare Connections expects to begin operating under an expanded contract to include behavioral health benefits, and Magnolia Health anticipates operating under an expanded contract to include the inpatient benefit for Medicaid and ABD members.

MEMBERSHIP

From September 30, 2014 to September 30, 2015, we increased our managed care membership by 933,600, or 24%. The following table sets forth our membership by state for our managed care organizations:

	September 30, 2015	December 31, 2014	September 30, 2014
Arizona	223,600	204,000	202,500
Arkansas	40,900	38,400	36,600
California	183,900	163,900	144,700
Florida	486,500	425,700	411,200
Georgia	406,700	389,100	382,600
Illinois	211,300	87,800	31,300
Indiana	276,700	197,700	199,500
Kansas	137,500	143,300	144,200
Louisiana	358,800	152,900	150,800
Massachusetts	63,700	48,400	46,600
Michigan	6,600	—	—
Minnesota	9,400	9,500	9,500
Mississippi	301,000	108,700	99,300
Missouri	88,400	71,000	64,900
New Hampshire	71,900	62,700	56,600
Ohio	308,100	280,100	261,000
Oregon	99,800	—	—
South Carolina	104,800	109,700	106,500
Tennessee	20,200	21,000	21,200
Texas	976,500	971,000	961,100
Vermont	1,500	—	—
Washington	208,600	194,400	192,500
Wisconsin	78,100	83,200	74,700
Total at-risk membership	4,664,500	3,762,500	3,597,300
Non-risk membership	169,900	298,400	303,500
Total	4,834,400	4,060,900	3,900,800

At September 30, 2015, we served 442,600 Medicaid members in Medicaid expansion programs in California, Illinois, Massachusetts, New Hampshire, Ohio, Oregon and Washington and Indiana HIP 2.0, included in the table above.

The following table sets forth our membership by line of business:

	September 30, 2015	December 31, 2014	September 30, 2014
Medicaid	3,469,800	2,754,900	2,578,300
CHIP & Foster Care	245,200	222,700	247,700
ABD, Medicare & Duals	444,100	392,700	383,400
LTC	73,800	60,800	55,200
Health Insurance Marketplaces	155,600	74,500	76,000
Hybrid Programs [1]	—	18,900	19,900
Behavioral Health	216,700	197,000	195,500
Correctional Healthcare Services	59,300	41,000	41,300
Total at-risk membership	4,664,500	3,762,500	3,597,300
Non-risk membership	169,900	298,400	303,500
Total	4,834,400	4,060,900	3,900,800

[1] In February 2015, hybrid programs were converted to Medicaid expansion contracts.

The following table identifies our dual-eligible membership by line of business. The membership tables above include these members.

	September 30, 2015	December 31, 2014	September 30, 2014
ABD	107,400	118,300	119,300
LTC	54,200	35,900	35,500
Medicare	11,400	7,200	7,100
Medicaid / Medicare Duals	27,900	3,200	2,700
Total	200,900	164,600	164,600

RESULTS OF OPERATIONS

The following discussion and analysis is based on our consolidated statements of operations, which reflect our results of operations for the three and nine months ended September 30, 2015 and 2014, prepared in accordance with generally accepted accounting principles in the United States.

Summarized comparative financial data for the three and nine months ended September 30, 2015 and 2014 is as follows ($ in millions, except per share data):

	Three Months Ended September 30,			Nine Months Ended September 30,		
	2015	2014	% Change 2014-2015	2015	2014	% Change 2014-2015
Premium	$ 4,983	$ 3,780	31.8 %	$ 13,974	$ 10,182	37.2 %
Service	480	379	26.6 %	1,434	1,070	34.0 %
Premium and service revenues	5,463	4,159	31.4 %	15,408	11,252	36.9 %
Premium tax and health insurer fee	358	193	85.5 %	1,050	584	79.8 %
Total revenues	5,821	4,352	33.8 %	16,458	11,836	39.1 %
Medical costs	4,433	3,390	30.8 %	12,475	9,093	37.2 %
Cost of services	413	327	26.3 %	1,234	935	32.0 %
General and administrative expenses	464	334	38.9 %	1,309	951	37.6 %
Premium tax expense	274	161	70.2 %	794	492	61.4 %
Health insurer fee expense	54	32	68.8 %	161	94	71.3 %
Earnings from operations	183	108	69.4 %	485	271	79.0 %
Other income (expense), net	(3)	(3)	— %	(5)	(7)	28.6 %
Earnings from continuing operations, before income tax expense	180	105	71.4 %	480	264	81.8 %
Income tax expense	87	27	222.2 %	234	107	118.7 %
Earnings from continuing operations, net of income tax	93	78	19.2 %	246	157	56.7 %
Discontinued operations, net of income tax expense of $0, $0, $0 and $1, respectively	1	1	— %	—	2	(100.0)%
Net earnings	94	79	19.0 %	246	159	54.7 %
(Earnings) loss attributable to noncontrolling interests	(1)	3	(133.3)%	(2)	5	(140.0)%
Net earnings attributable to Centene Corporation	$ 93	$ 82	13.4 %	$ 244	$ 164	48.8 %
Amounts attributable to Centene Corporation common shareholders:						
Earnings from continuing operations, net of income tax expense	$ 92	$ 81	13.6 %	$ 244	$ 162	50.6 %
Discontinued operations, net of income tax expense	1	1	— %	—	2	(100.0)%
Net earnings	$ 93	$ 82	13.4 %	$ 244	$ 164	48.8 %
Diluted earnings per common share attributable to Centene Corporation:						
Continuing operations	$ 0.75	$ 0.67	11.9 %	$ 1.99	$ 1.35	47.4 %
Discontinued operations	0.01	0.01	— %	—	0.02	(100.0)%
Total diluted earnings per common share	$ 0.76	$ 0.68	11.8 %	$ 1.99	$ 1.37	45.3 %

Three Months Ended September 30, 2015 Compared to Three Months Ended September 30, 2014

Premium and Service Revenues

Premium and service revenues increased 31% in the three months ended September 30, 2015 over the corresponding period in 2014 primarily as a result of the impact from expansions or new programs in many of our states, particularly Florida, Illinois, Louisiana, Mississippi, Ohio and Texas.

Operating Expenses

Medical Costs

Results of operations depend on our ability to manage expenses associated with health benefits and to accurately estimate costs incurred. The Health Benefits Ratio, or HBR, represents medical costs as a percentage of premium revenues (excluding Premium Tax and Health Insurer Fee revenues) and reflects the direct relationship between the premium received and the medical services provided. The table below depicts the HBR for our membership by member category for the three months ended September 30,:

	2015	2014
Medicaid, CHIP, Foster Care & HIM	85.7%	86.5%
ABD, LTC and Medicare	93.3	93.9
Specialty Services	84.8	86.8
Total	89.0	89.7

The consolidated HBR for the three months ended September 30, 2015 was 89.0%, compared to 89.7% in the same period in 2014. The decrease compared to last year is primarily attributable to a lower HBR associated with new Medicaid expansion programs, which had significant growth in membership over the prior year and have a lower HBR.

Revenue and HBR results for new business and existing business are listed below to assist in understanding our results of operations. Existing businesses are primarily state markets or significant geographic expansion in an existing state or product that we have managed for four complete quarters. New businesses are primarily new state markets or significant geographic expansion in an existing state or product that conversely, we have not managed for four complete quarters. The following table compares the results for new business and existing business for the three months ended September 30,:

	2015	2014
Premium and Service Revenue		
New business	21%	27%
Existing business	79%	73%
HBR		
New business	88.7%	91.4%
Existing business	89.1%	89.0%

The new business HBR decreased compared to last year primarily due to the movement of the Florida MMA business, which operates at a higher HBR, into existing business during the quarter and the mix of new business being weighted towards Medicaid expansion which operates at a lower HBR.

Cost of Services

Cost of services increased by $86 million in the three months ended September 30, 2015, compared to the corresponding period in 2014. This was primarily due to growth in the AcariaHealth business. The cost of service ratio for the three months ended September 30, 2015, was 86.0%, compared to 86.3% in the same period in 2014.

General & Administrative Expenses

General and administrative expenses, or G&A, increased by $130 million in the three months ended September 30, 2015, compared to the corresponding period in 2014. This was primarily due to expenses for additional staff and facilities to support

our membership growth. During the three months ended September 30, 2015, we recorded approximately $18 million of Health Net merger related expenses, which reduced our diluted earnings per share by $0.09.

During the third quarter of 2015, we experienced higher than anticipated opt-out rates and member attrition in the new Michigan dual demonstration program, resulting in lower than expected membership and lower blended premium rates. As a result, the fair value of estimated contingent consideration was reduced to $23 million, and we recorded a gain of $27 million in general and administrative expenses. In connection with the lower membership and revenue outlook, we conducted an impairment analysis of the identifiable intangible assets and goodwill, resulting in a reduction of goodwill and intangible assets of $28 million which was recorded in general and administrative expenses.

The consolidated G&A expense ratio for the three months ended September 30, 2015 and 2014 was 8.5% and 8.0%, respectively. The year over year increase in the G&A ratio primarily reflects the impact of Health Net merger related expenses. The G&A ratio for the three months ended September 30, 2015 was 8.2% excluding the impact of the Health Net merger related expenses. Excluding the impact of the Health Net merger related expenses, the increase in the G&A ratio is primarily due to the increase in performance based incentive compensation expense.

Health Insurer Fee

During the three months ended September 30, 2015, we recorded $54 million of non-deductible expense for the Affordable Care Act (ACA) annual health insurer fee. As of September 30, 2015, we had received signed agreements from all applicable states which provide for the reimbursement of the ACA insurer fee including the related gross-up for the associated income tax effects. As a result, we recorded $85 million in Premium Tax and Health Insurer Fee revenue associated with the accrual for the reimbursement of the fee. Therefore, the health insurer fee had no impact on diluted earnings per share during the third quarter of 2015.

During the three months ended September 30, 2014, we recorded $32 million of non-deductible expense for the ACA annual health insurer fee. In addition, we received signed agreements from 15 of 17 applicable states as of September 30, 2014, which provide for the reimbursement of the ACA insurer fee including the related gross-up for the associated income tax effects. As a result, we recorded $32 million of revenue in Premium Tax and Health Insurer Fee revenue associated with the accrual for the reimbursement of the fee. The net effect of the health insurer fee reduced our diluted earnings per share by $0.08 during the third quarter of 2014.

Other Income (Expense)

The following table summarizes the components of other income (expense) for the three months ended September 30, ($ in millions):

	2015	2014
Investment and other income	$ 8	$ 6
Interest expense	(11)	(9)
Other income (expense), net	$ (3)	$ (3)

The increase in investment income in 2015 reflects an increase in investment balances over 2014 and improved performance of certain equity investments. Interest expense increased in 2015 compared to 2014, primarily reflecting the issuance of an additional $200 million in Senior Notes in January 2015.

Income Tax Expense

Our effective tax rate for the three months ended September 30, 2015 and 2014, was 48.3% and 25.7%, respectively. The effective tax rate is higher than the applicable statutory rate primarily as a result of the non-deductibility of the health insurer fee expense. During the third quarter of 2014, the IRS issued a final regulation related to the compensation deduction limitation applicable to certain health insurance providers. Accordingly, we reversed previously recorded tax expense for prior periods, resulting in a decrease in the effective tax rate.

Segment Results

The following table summarizes our consolidated operating results by segment for the three months ended September 30, ($ in millions):

	2015	2014	% Change 2014-2015
Premium and Service Revenues			
Managed Care	$ 4,946	$ 3,746	32.0 %
Specialty Services	1,815	1,235	47.0 %
Eliminations	(1,298)	(822)	(57.9)%
Consolidated Total	$ 5,463	$ 4,159	31.4 %
Earnings from Operations			
Managed Care	$ 138	$ 80	72.5 %
Specialty Services	45	28	60.7 %
Consolidated Total	$ 183	$ 108	69.4 %

Managed Care

Premium and service revenues increased 32% in the three months ended September 30, 2015, primarily as a result of expansions or new programs in many of our states, particularly Florida, Illinois, Louisiana, Mississippi, Ohio and Texas. Earnings from operations increased $58 million between years primarily reflecting growth in the business.

Specialty Services

Premium and service revenues increased 47% in the three months ended September 30, 2015, resulting primarily from increased services associated with membership growth in the Managed Care segment. Earnings from operations increased $17 million in the three months ended September 30, 2015, primarily reflecting growth in the specialty services provided to our increased Managed Care membership.

Nine Months Ended September 30, 2015 Compared to Nine Months Ended September 30, 2014

Premium and Service Revenues

Premium and service revenues increased 37% in the nine months ended September 30, 2015 over the corresponding period in 2014 primarily as a result of the impact from expansions or new programs in many of our states, particularly Florida, Illinois, Louisiana, Mississippi, Ohio and Texas. During the nine months ended September 30, 2015, we received premium rate adjustments which yielded a net 0% composite change across all of our markets.

Operating Expenses

Medical Costs

Results of operations depend on our ability to manage expenses associated with health benefits and to accurately estimate costs incurred. The Health Benefits Ratio, or HBR, represents medical costs as a percentage of premium revenues (excluding Premium Tax and Health Insurer Fee revenues) and reflects the direct relationship between the premium received and the medical services provided. The table below depicts the HBR for our membership by member category for the nine months ended September 30,:

	2015	2014
Medicaid, CHIP, Foster Care & HIM	86.2%	86.1%
ABD, LTC and Medicare	93.3	94.0
Specialty Services	85.6	84.9
Total	89.3	89.3

The consolidated HBR for the nine months ended September 30, 2015, was 89.3%, compared to 89.3% in the same period in 2014.

Cost of Services

Cost of services increased by $299 million in the nine months ended September 30, 2015, compared to the corresponding period in 2014. This was primarily due to growth in the AcariaHealth business. The cost of service ratio for the nine months ended September 30, 2015, was 86.1%, compared to 87.4% in the same period in 2014.

General & Administrative Expenses

General and administrative expenses, or G&A, increased by $358 million in the nine months ended September 30, 2015, compared to the corresponding period in 2014. This was primarily due to expenses for additional staff and facilities to support our membership growth. During the nine months ended September 30, 2015, we recorded approximately $20 million of Health Net merger related expenses, which reduced our diluted earnings per share by $0.10.

During the first quarter of 2015, we recorded a gain of $10 million on the settlement of contingent consideration related to the CHS transaction. We also recorded expense of $10 million for a contribution to our charitable foundation during the first quarter of 2015.

During the third quarter of 2015, we experienced higher than anticipated opt-out rates and member attrition in the new Michigan dual demonstration program, resulting in lower than expected membership and lower blended premium rates. As a result, the fair value of estimated contingent consideration was reduced to $23 million, and we recorded a gain of $27 million in general and administrative expenses. In connection with the lower membership and revenue outlook, we conducted an impairment analysis of the identifiable intangible assets and goodwill, resulting in a reduction of goodwill and intangible assets of $28 million which was recorded in general and administrative expenses.

The consolidated G&A expense ratio for the nine months ended September 30, 2015 and 2014 was 8.5% and 8.5%, respectively. The year over year G&A ratio remained flat, reflecting the leveraging of expenses over higher revenues in 2015 as well as the impact of transaction costs recognized in 2014, offset by Health Net merger related expenses. The G&A ratio for the nine months ended September 30, 2015 was 8.4% excluding the impact of the Health Net merger related expenses.

Health Insurer Fee

During the nine months ended September 30, 2015, we recorded $161 million of non-deductible expense for the Affordable Care Act (ACA) annual health insurer fee. As of September 30, 2015, we had received signed agreements from all applicable states which provide for the reimbursement of the ACA insurer fee including the related gross-up for the associated income tax effects. As a result, we recorded $257 million in Premium Tax and Health Insurer Fee revenue associated with the accrual for the reimbursement of the fee. Therefore, the health insurer fee had no impact on diluted earnings per share during the nine months ended September 30, 2015.

During the nine months ended September 30, 2014, we recorded $94 million of non-deductible expense for the ACA annual health insurer fee. In addition, we recorded $92 million of revenue in Premium Tax and Health Insurer Fee revenue associated with the accrual for the reimbursement of the fee. The net effect of the health insurer fee reduced our diluted earnings per share by $0.25 during the nine months ended September 30, 2014.

Other Income (Expense)

The following table summarizes the components of other income (expense) for the nine months ended September 30, ($ in millions):

	2015	2014
Investment and other income	$ 27	$ 18
Interest expense	(32)	(25)
Other income (expense), net	$ (5)	$ (7)

The increase in investment income in 2015 reflects an increase in investment balances over 2014 and improved performance of certain equity investments. Interest expense increased during the nine months ended September 30, 2015 by $7 million primarily reflecting the issuance of $300 million of Senior Notes in April 2014 and the issuance of an additional $200 million in Senior Notes in January 2015.

Income Tax Expense

Our effective tax rate for the nine months ended September 30, 2015 and 2014, was 48.8% and 40.5%, respectively. The effective tax rate is higher than the applicable statutory rate primarily as a result of the non-deductibility of the health insurer fee expense. During the third quarter of 2014, the IRS issued a final regulation related to the compensation deduction limitation applicable to certain health insurance providers. Accordingly, we reversed previously recorded tax expense for prior periods, resulting in a decrease in the effective tax rate.

Segment Results

The following table summarizes our consolidated operating results by segment for the nine months ended September 30, ($ in millions):

	2015	2014	% Change 2014-2015
Premium and Service Revenues			
Managed Care	$ 13,885	$ 9,967	39.3 %
Specialty Services	5,121	3,448	48.5 %
Eliminations	(3,598)	(2,163)	(66.3)%
Consolidated Total	$ 15,408	$ 11,252	36.9 %
Earnings from Operations			
Managed Care	$ 358	$ 188	90.4 %
Specialty Services	127	83	53.0 %
Consolidated Total	$ 485	$ 271	79.0 %

Managed Care

Premium and service revenues increased 39% in the nine months ended September 30, 2015, primarily as a result of expansions or new programs in many of our states, particularly Florida, Illinois, Louisiana, Mississippi, Ohio and Texas. Earnings from operations increased $170 million between years primarily reflecting growth in the business.

Specialty Services

Premium and service revenues increased 49% in the nine months ended September 30, 2015, resulting primarily from increased services associated with membership growth in the Managed Care segment and growth in our AcariaHealth business. Earnings from operations increased $44 million in the nine months ended September 30, 2015, primarily reflecting growth in the specialty services provided to our increased Managed Care membership.

LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows used in the discussion of liquidity and capital resources ($ in millions).

	Nine Months Ended September 30,	
	2015	2014
Net cash provided by operating activities	$ 457	$ 853
Net cash used in investing activities	(769)	(581)
Net cash provided by financing activities	367	273
Net increase in cash and cash equivalents	$ 55	$ 545

Cash Flows Provided by Operating Activities

Normal operations are funded primarily through operating cash flows and borrowings under our revolving credit facility. Operating activities provided cash of $457 million in the nine months ended September 30, 2015, compared to $853 million in the comparable period in 2014. The cash provided by operations in 2015 and 2014 was primarily related to net earnings and an increase in medical claims liabilities resulting from the growth in the business, partially offset by increases in premium and related receivables.

Cash flows from operations in each year were impacted by the timing of payments we receive from our states. States may prepay the following month premium payment, which we record as unearned revenue, or they may delay our premium payment, which we record as a receivable. We typically receive capitation payments monthly, however the states in which we operate may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period.

The reimbursement of the HIF from our state customers may be settled as a separate payment or monthly in combination with our other premium payments. The vast majority of our state customers are settling the reimbursement through a separate payment after verification of each state's portion of our HIF, resulting in an increase in Premium and Related Receivables at September 30, 2015. During the third quarter of 2015, we paid the 2015 annual HIF invoice totaling $213 million. This negatively impacted our cash flows as we have not been reimbursed from the majority of our state customers.

Cash Flows Used in Investing Activities

Investing activities used cash of $769 million for the nine months ended September 30, 2015, and $581 million in the comparable period in 2014. Cash flows used in investing activities in 2015 primarily consisted of additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long term investments and capital expenditures.

In January 2015, we sold 25% of our ownership in Celtic Insurance Company. No gain or loss was recognized on the sale of the ownership interest. Celtic Insurance Company is included in the Managed Care segment. Under the terms of the agreement, we entered into a put agreement with the noncontrolling interest holder to purchase the noncontrolling interest at a later date.

Cash flows used in investing activities in 2014 primarily consisted of additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long term investments, the acquisition of U.S. Medical Management and capital expenditures.

We spent $101 million and $69 million in the nine months ended September 30, 2015 and 2014, respectively, on capital expenditures for system enhancements and market expansions.

As of September 30, 2015, our investment portfolio consisted primarily of fixed-income securities with an average duration of 3.8 years. We had unregulated cash and investments of $91 million at September 30, 2015, compared to $85 million at December 31, 2014.

Cash Flows Provided by Financing Activities

Our financing activities provided cash of $367 million in the nine months ended September 30, 2015, compared to $273 million in the comparable period in 2014. During 2015 and 2014, our financing activities primarily related to the proceeds from the issuance of Senior Debt. In January 2015, we issued an additional $200 million of 4.75% Senior Notes at par. In connection with the January 2015 issuance, we entered into interest rate swap agreements for a notional amount of $200 million. In April 2014, we issued $300 million 4.75% Senior Notes due May 14, 2022 at par. In connection with the April 2014 issuance, we entered into interest rate swap agreements of a notional amount of $300 million.

Liquidity Metrics

The $500 million revolving credit agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt-to-EBITDA ratios and minimum tangible net worth. We are required not to exceed a maximum debt-to-EBITDA ratio of 3.0 to 1.0. As of September 30, 2015, we had $275 million in borrowings outstanding under our revolving credit facility and we were in compliance with all covenants. As of September 30, 2015, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

We had outstanding letters of credit of $46 million as of September 30, 2015, which were not part of our revolving credit facility. We also had letters of credit for $52 million (valued at the September 30, 2015 conversion rate), or €46 million, representing our proportional share of the letters of credit issued to support Ribera Salud's outstanding debt which are a part of the revolving credit facility. Collectively, the letters of credit bore interest at 1.55% as of September 30, 2015. In addition, we had outstanding surety bonds of $304 million as of September 30, 2015.

The indentures governing our Senior Notes contain non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio.

At September 30, 2015, we had working capital, defined as current assets less current liabilities, of $33 million, compared to $134 million at December 31, 2014. We manage our short term and long term investments with the goal of ensuring that a sufficient portion is held in investments that are highly liquid and can be sold to fund short term requirements as needed.

At September 30, 2015, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 38.4%, compared to 33.5% at December 31, 2014. Excluding the $68 million non-recourse mortgage note, our debt to capital ratio was 37.1% as of September 30, 2015, compared to 31.7% at December 31, 2014. We utilize the debt to capital ratio as a measure, among others, of our leverage and financial flexibility.

2015 Expectations

On July 2, 2015, we entered into a definitive merger agreement with Health Net under which we will acquire all of the issued and outstanding shares of Health Net. Under the terms of the agreement, at the closing of the transaction, Health Net stockholders (with limited exception) would receive 0.622 of a validly issued, fully paid, non-assessable share of Centene common stock and $28.25 in cash for each share of Health Net common stock. The transaction is valued at approximately $6.8 billion (based on the Centene closing stock price on July 1, 2015), including the assumption of debt. The transaction is expected to close in early 2016 and is subject to approvals by relevant state insurance and healthcare regulators and other customary closing conditions. We expect to fund the cash portion of the acquisition through a combination of existing cash on hand and debt financing.

During the remainder of 2015, we expect to make net capital contributions to our insurance subsidiaries of approximately $162 million associated with our growth and spend approximately $50 million in additional capital expenditures primarily associated with system enhancements and market expansions. These amounts are expected to be funded by unregulated cash flow generation in 2015 and borrowings on our revolving credit facility.

Based on our operating plan, we expect that our available cash, cash equivalents and investments, cash from our operations and cash available under our credit facility will be sufficient to finance our general operations and capital expenditures, excluding the proposed Health Net transaction, for at least 12 months from the date of this filing.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

Our operations are conducted through our subsidiaries. As managed care organizations, these subsidiaries are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us. Generally, the amount of dividend distributions that may be paid by a regulated subsidiary without prior approval by state regulatory authorities is limited based on the entity's level of statutory net income and statutory capital and surplus.

Our subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of September 30, 2015, our subsidiaries had aggregate statutory capital and surplus of $2,095 million, compared with the required minimum aggregate statutory capital and surplus requirements of $1,091 million. During the nine months ended September 30, 2015, we contributed $561 million of statutory capital to our subsidiaries. We estimate our Risk Based Capital, or RBC, percentage (including KSHP) to be in excess of 350% of the Authorized Control Level (excluding the interim impact of the health insurer fee).

The National Association of Insurance Commissioners has adopted rules which set minimum risk based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. As of September 30, 2015, each of our health plans was in compliance with the risk-based capital requirements enacted in those states.

ITEM 3. ***Quantitative and Qualitative Disclosures About Market Risk.***

INVESTMENTS AND DEBT

As of September 30, 2015, we had short term investments of $162 million and long term investments of $2,098 million, including restricted deposits of $106 million. The short term investments generally consist of highly liquid securities with maturities between three and 12 months. The long term investments consist of municipal, corporate and U.S. Treasury securities, government sponsored obligations, life insurance contracts, asset-backed securities and equity securities and have maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states' requirements, these investments are classified as long term regardless of the contractual maturity date. Substantially all of our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at September 30, 2015, the fair value of our fixed income investments would decrease by approximately $74 million. Declines in interest rates over time will reduce our investment income.

We have interest rate swap agreements for a notional amount of $750 million with creditworthy financial institutions to manage the impact of market interest rates on interest expense. Our swap agreements convert a portion of our interest expense from fixed to variable rates to better match the impact of changes in market rates on our variable rate cash equivalent investments. As a result, the fair value of $750 million of our long term debt varies with market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at September 30, 2015, the fair value of our debt would decrease by approximately $33 million. An increase in interest rates decreases the fair value of the debt and conversely, a decrease in interest rates increases the value.

For a discussion of the interest rate risk that our investments are subject to, see Part II, Item 1A "Risk Factors–Risks Related to Our Business–Our investment portfolio may suffer losses from reductions in market interest rates and changes in market conditions which could materially and adversely affect our results of operations or liquidity."

INFLATION

The inflation rate for medical care costs has been higher than the overall inflation rate for all items. We use various strategies to mitigate the negative effects of healthcare cost inflation. Specifically, our health plans try to control medical and hospital costs through our state savings initiatives and contracts with independent providers of healthcare services. Through these contracted care providers, our health plans emphasize preventive healthcare and appropriate use of specialty and hospital services. Additionally, our contracts with states require actuarially sound premiums that include healthcare cost trend.

While we currently believe our strategies to mitigate healthcare cost inflation will continue to be successful, competitive pressures, new healthcare and pharmaceutical product introductions, demands from healthcare providers and customers, applicable regulations, an increase in the expected rate of inflation for healthcare costs or other factors may affect our ability to control the impact of healthcare cost increases.

ITEM 4. ***Controls and Procedures.***

Evaluation of Disclosure Controls and Procedures - We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Form 10-Q, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of September 30, 2015. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of September 30, 2015.

Changes in Internal Control Over Financial Reporting - No change in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) occurred during the quarter ended September 30, 2015 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

PART II
OTHER INFORMATION

ITEM 1. ***Legal Proceedings.***

On July 5, 2013, the Company's subsidiary, Kentucky Spirit Health Plan, Inc. (Kentucky Spirit), terminated its contract with the Commonwealth of Kentucky (the Commonwealth). Kentucky Spirit believes it had a contractual right to terminate the contract and filed a lawsuit in Franklin Circuit Court seeking a declaration of this right. The Commonwealth has alleged that Kentucky Spirit's exit constitutes a material breach of contract. The Commonwealth seeks to recover substantial damages and to enforce its rights under Kentucky Spirit's $25 million performance bond. The Commonwealth's attorneys have asserted that the Commonwealth's expenditures due to Kentucky Spirit's departure range from $28 million to $40 million plus interest, and that the associated CMS expenditures range from $92 million to $134 million. Kentucky Spirit disputes the Commonwealth's alleged damages, and is pursuing its own litigation claims for damages against the Commonwealth.

On February 6, 2015, the Kentucky Court of Appeals affirmed a Franklin Circuit Court ruling that Kentucky Spirit does not have a contractual right to terminate the contract early. The Court of Appeals also found that the contract's liquidated damages provision "is applicable in the event of a premature termination of the Contract term." On September 8, 2015, Kentucky Spirit filed a motion for discretionary review seeking Kentucky Supreme Court review of the finding that Kentucky Spirit's departure constituted a breach of contract. On October 9, 2015, the Commonwealth filed a response opposing discretionary review.

Kentucky Spirit also filed a lawsuit in April 2013, amended in October 2014, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches. On December 9, 2014, the Franklin Circuit Court denied the Commonwealth's motion for partial summary judgment on Kentucky Spirit's damages claims. On March 15, 2015, the Franklin Circuit Court denied the Commonwealth's motion to stay discovery and ordered that discovery proceed on those claims.

On May 26, 2015, the Commonwealth issued a demand for indemnification to its actuarial firm for "all defense costs, and any resultant monetary awards in favor of Kentucky Spirit, arising from or related to Kentucky Spirit's claims which are predicated upon the alleged omissions and errors in the Data Book and the certified actuarially sound rates." On August 19, 2015, the actuarial firm moved to intervene in the litigation. The Franklin Circuit Court granted the actuarial firm's motion on September 8, 2015 and ordered a forty-five day stay of all pretrial proceedings in order for the firm to review the record. Also, on August 19, 2015, the actuarial firm filed a petition seeking a declaratory judgment that it is not liable to the Commonwealth for indemnification related to the claims asserted by Kentucky Spirit against the Commonwealth. On October 5, 2015, the Commonwealth filed an answer to the actuarial firm's petition and asserted counterclaims/cross-claims against the firm.

On March 9, 2015, the Secretary of the Kentucky Cabinet for Health and Family Services (CHFS) issued a determination letter finding that Kentucky Spirit owed the Commonwealth $40 million in actual damages plus prejudgment interest at 8 percent. On March 18, 2015, in a letter to the Kentucky Finance and Administration Cabinet (FAC), Kentucky Spirit contested CHFS' jurisdiction to make such a determination. The FAC did not issue a decision within the required 120 days. On August 13, 2015, Kentucky Spirit filed a declaratory judgment action against the Commonwealth in Franklin Circuit Court seeking a declaration that the Commonwealth may not purport to issue a decision against Kentucky Spirit awarding damages to itself when the matter is already before the Kentucky courts, and that the Commonwealth has waived its claims against Kentucky Spirit for damages arising out of the contract.

The resolution of the Kentucky litigation matters may result in a range of possible outcomes. If Kentucky Spirit prevails on its claims, it would be entitled to damages. If the Commonwealth prevails, a liability to the Commonwealth could be recorded. The Company is unable to estimate the ultimate outcome resulting from the Kentucky litigation. As a result, the Company has not recorded any receivable or any liability for potential damages under the contract as of September 30, 2015. While uncertain, the ultimate resolution of the pending litigation could have a material effect on the financial position, cash flow or results of operations of the Company in the period it is resolved or becomes known.

Excluding the Kentucky matters discussed above, the Company is also routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters in the normal course of business is uncertain, the Company does not expect the results of any of these matters individually, or in the aggregate, to have a material effect on its financial position, results of operations or cash flows.

ITEM 1A. *Risk Factors.*

FACTORS THAT MAY AFFECT FUTURE RESULTS AND THE TRADING PRICE OF OUR COMMON STOCK

You should carefully consider the risks described below before making an investment decision. The trading price of our common stock could decline due to any of these risks, in which case you could lose all or part of your investment. You should also refer to the other information in this filing, including our consolidated financial statements and related notes. The risks and uncertainties described below are those that we currently believe may materially affect our Company. Additional risks and uncertainties that we are unaware of or that we currently deem immaterial also may become important factors that affect our Company.

Reductions in funding or changes to eligibility requirements for government sponsored healthcare programs in which we participate could substantially affect our financial position, results of operations and cash flows.

The majority of our revenues come from government subsidized healthcare programs including Medicaid, Medicare, CHIP, LTC, ABD, Foster Care and Health Insurance Marketplace premiums. The base premium rate paid for each program differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region and benefit mix. Since Medicaid was created in 1965, the federal government and the states have shared the costs, with the federal share currently averaging around 57%.

Future levels of funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints. Governments periodically consider reducing or reallocating the amount of money they spend for Medicaid, Medicare, CHIP, LTC, ABD and Foster Care. Adverse economic conditions may continue to put pressures on state budgets as tax and other state revenues decrease while the population that is eligible to participate in these programs increases, creating more need for funding. We anticipate this will require government agencies to find funding alternatives, which may result in reductions in funding for programs, contraction of covered benefits, and limited or no premium rate increases or premium rate decreases. A reduction (or less than expected increase), a protracted delay, or a change in allocation methodology in government funding for these programs, as well as termination of the contract for the convenience of the government, may materially and adversely affect our results of operations, financial position and cash flows.

Additionally, changes in these programs could reduce the number of persons enrolled in or eligible for these programs or increase our administrative or healthcare costs under these programs. Recent legislation generally requires that eligibility levels be maintained, but this could cause states to reduce reimbursement or reduce benefits in order for states to afford to maintain eligibility levels. If any state in which we operate were to decrease premiums paid to us or pay us less than the amount necessary to keep pace with our cost trends, it could have a material adverse effect on our results of operations, financial position and cash flows.

Lastly, if a federal government shutdown were to occur for a prolonged period of time, federal government payment obligations, including its obligations under Medicaid, Medicare, CHIP, LTC, ABD, Foster Care and the new Health Insurance Marketplaces, may be delayed. If the federal government fails to make payments under these programs on a timely basis, our business could suffer, and our financial position, results of operations or cash flows may be materially affected.

Failure to accurately estimate and price our medical expenses or effectively manage our medical costs or related administrative costs could negatively affect our financial position, results of operations or cash flows.

Our profitability, to a significant degree, depends on our ability to estimate and effectively manage expenses related to health benefits through our ability to contract favorably with hospitals, physicians and other healthcare providers. For example, our Medicaid revenue is often based on bids submitted before the start of the initial contract year. If our actual medical expense exceeds our estimates, our health benefits ratio, or our expenses related to medical services as a percentage of premium revenue, would increase and our profits would decline. Because of the narrow margins of our health plan business, relatively small changes in our health benefits ratio can create significant changes in our financial results. Changes in healthcare regulations and practices, the level of utilization of healthcare services, hospital and pharmaceutical costs, major epidemics or pandemics, new medical technologies, pharmaceutical compounds and other external factors, including general economic conditions such as inflation and unemployment levels, are beyond our control and could reduce our ability to accurately predict and effectively control the costs of providing health benefits.

Our medical expense includes claims reported but not paid, estimates for claims incurred but not reported, and estimates for the costs necessary to process unpaid claims at the end of each period. Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as claims receipts and payment information as well as inpatient acuity information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expense in the period in which the changes are identified. However, we still cannot be sure that our medical claims liability estimate is adequate or that adjustments to the estimate will not unfavorably impact our results of operations.

Additionally, when we commence operations in a new state, region or product, we have limited information with which to estimate our medical claims liability. For a period of time after the inception of the new business, we base our estimates on state-provided historical actuarial data and limited actual incurred and received claims and inpatient acuity information. The addition of new categories of individuals who are eligible under new legislation may pose the same difficulty in estimating our medical claims liability. Similarly, we may face difficulty in estimating our medical claims liability in 2015 for the relatively new and evolving Health Insurance Marketplaces.

From time to time in the past, our actual results have varied from our estimates, particularly in times of significant changes in the number of our members. If it is determined that our estimates are significantly different than actual results, our results of operations and financial position could be adversely affected. In addition, if there is a significant delay in our receipt of premiums, our business operations, cash flows, or earnings could be negatively impacted.

The implementation of the Health Reform Legislation and other reforms could materially and adversely affect our results of operations, financial position and cash flows.

In March 2010, the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act, collectively referred to as the Affordable Care Act (ACA), were enacted. While the constitutionality of the ACA was generally upheld by the Supreme Court in 2012, the Court determined that states could not be required to expand Medicaid and risk losing all federal money for their existing Medicaid programs.

Under the ACA, Medicaid coverage was expanded to all individuals under age 65 with incomes up to 138% of the federal poverty level beginning January 1, 2014, subject to each states' election. The federal government will pay the entire costs for Medicaid coverage for newly eligible beneficiaries for three years (2014 through 2016). Beginning in 2017, the federal share begins to decline, ending at 90% for 2020 and subsequent years. As of September 1, 2015, 31 states and the District of Columbia have expanded Medicaid eligibility, and additional states continue to discuss expansion. The ACA also maintained CHIP eligibility standards through September 2019.

The ACA required the establishment of Health Insurance Marketplaces for individuals and small employers to purchase health insurance coverage commencing in January 2014. Open enrollment for coverage in 2015 began on November 15, 2014 and continued until February 15, 2015. The ACA required insurers participating on the Health Insurance Marketplaces to offer a minimum level of benefits and included guidelines on setting premium rates and coverage limitations.

Our ability to adequately price products offered in the Health Insurance Marketplaces may have a negative impact on our results of operations, financial position and cash flow. We may be adversely selected by individuals who will have a higher acuity level than the anticipated pool of participants. In addition, the risk corridor, reinsurance and risk adjustment ("three Rs") provisions of the ACA established to reduce risk for insurers may not be effective in appropriately mitigating the financial risks related to the Marketplace product. Further, the reinsurance and risk corridor components may not be adequately funded. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, the three Rs, or other assumptions utilized in setting adequate premium rates could have a material adverse effect on our results of operations, financial position and cash flows.

The U.S. Department of Health and Human Services (HHS) has stated that it will consider a limited number of premium assistance demonstration proposals from States that want to privatize Medicaid expansion. States must provide a choice between at least two qualified health plans and offer very similar benefits as those available in the newly created Health Insurance Marketplaces. Arkansas became the first state to obtain federal approval to use Medicaid funding to purchase private insurance for low-income residents and we began operations under the program beginning January 1, 2014.

The ACA imposes an annual insurance industry assessment of $8.0 billion starting in 2014, and $11.3 billion in each of 2015 and 2016, with increasing annual amounts thereafter. Such assessments are not deductible for federal and most state income tax purposes. The fee will be allocated based on health insurers' premium revenues in the previous year. Each health insurer's fee is calculated by multiplying its market share by the annual fee. Market share is based on commercial, Medicare, and Medicaid premium revenue. Not-for-profit insurers may have a competitive advantage since they are exempt from paying the fee if they receive at least 80% of their premium revenue from Medicare, Medicaid, and CHIP, and other not-for-profit insurers are allowed to exclude 50% of their premium revenue from the fee calculation. If this federal premium assessment is imposed as enacted, and if we are not reimbursed by the states for the cost of the federal premium assessment (including the associated tax impact), or if we are unable to otherwise adjust our business model to address this new assessment, our results of operations, financial position and cash flows may be materially adversely affected.

There are numerous steps required to implement the legislation, including the promulgation of a substantial number of new and potentially more onerous federal regulations. Further, various health insurance reform proposals are also emerging at the state level. Because of the unsettled nature of these reforms and numerous steps required to implement them, we cannot predict what additional health insurance requirements will be implemented at the federal or state level, or the effect that any future legislation or regulation will have on our business or our growth opportunities. Although we believe the legislation may provide us with significant opportunities to grow our business, the enacted reforms, as well as future regulations and legislative changes, may in fact have a material adverse effect on our results of operations, financial position or liquidity. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of healthcare reform, or do not do so as effectively as our competitors, our results of operations may be materially adversely affected.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could force us to change how we operate and could harm our business.

Our business is extensively regulated by the states in which we operate and by the federal government. In addition, the managed care industry has received negative publicity that has led to increased legislation, regulation, review of industry practices and private litigation in the commercial sector. In each of the jurisdictions in which we operate, we are regulated by the relevant insurance, health and/or human services departments that oversee the activities of managed care organizations providing or arranging to provide services to Medicaid, Medicare and Health Insurance Marketplace enrollees. For example, our health plan subsidiaries, as well as our applicable specialty companies, must comply with minimum statutory capital and other financial solvency requirements, such as deposit and surplus requirements.

The frequent enactment of, changes to, or interpretations of laws and regulations could, among other things: force us to restructure our relationships with providers within our network; require us to implement additional or different programs and systems; restrict revenue and enrollment growth; increase our healthcare and administrative costs; impose additional capital and surplus requirements; and increase or change our liability to members in the event of malpractice by our contracted providers. In addition, changes in political party or administrations at the state, federal or country level may change the attitude towards healthcare programs.

Additionally, the taxes and fees paid to federal, state and local governments may increase due to several factors, including: enactment of, changes to, or interpretations of tax laws and regulations, audits by governmental authorities, geographic expansions into higher taxing jurisdictions and the effect of expansions into international markets.

Our contracts with states may require us to maintain a minimum health benefits ratio (HBR) or may require us to share profits in excess of certain levels. In certain circumstances, our plans may be required to return premium back to the state in the event profits exceed established levels or HBR does not meet the minimum requirement. Other states may require us to meet certain performance and quality metrics in order to maintain our contract or receive additional or full contractual revenue.

The governmental healthcare programs in which we participate are subject to the satisfaction of certain regulations and performance standards. For example, under Health Reform Legislation, Congress authorized CMS and the states to implement managed care demonstration programs to serve dually eligible beneficiaries to improve the coordination of their care. Participation in these demonstration programs is subject to CMS approval and the satisfaction of conditions to participation, including meeting certain performance requirements. Our inability to improve or maintain adequate quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs. Specifically, several of our Medicaid contracts require us to maintain a Medicare health plan. Although we strive to comply with all existing regulations and to meet performance standards applicable to our business, failure to meet these requirements could result in financial fines and penalties. Also, states may not allow us to continue to participate in their government programs, or we may fail to win

procurements to participate in such programs which could materially and adversely affect our results of operations, financial position and cash flows.

In addition, as a result of the expansion of our businesses and operations conducted in foreign countries, we face political, economic, legal, compliance, regulatory, operational and other risks and exposures that are unique and vary by jurisdiction. These foreign regulatory requirements with respect to, among other items, environmental, tax, licensing, intellectual property, privacy, data protection, investment, capital, management control, labor relations, and fraud and corruption regulations are different than those faced by our domestic businesses. In addition, we are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act. Our failure to comply with laws and regulations governing our conduct outside the United States or to successfully navigate international regulatory regimes that apply to us could adversely affect our ability to market our products and services, which may have a material adverse effect on our business, financial condition and results of operations.

Our businesses providing pharmacy benefit management (PBM) and specialty pharmacy services face regulatory and other risks and uncertainties which could materially and adversely affect our results of operations, financial position and cash flows.

We provide PBM and specialty pharmacy services through our US Script and AcariaHealth businesses. Each business is subject to federal and state laws that govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. They also conduct business as a mail order pharmacy and specialty pharmacy, which subjects them to extensive federal, state and local laws and regulations. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially and adversely affect current industry practices, including the receipt or disclosure of rebates from pharmaceutical companies, the development and use of formularies, and the use of average wholesale prices.

Our PBM and specialty pharmacy businesses would be materially and adversely affected by an inability to contract on favorable terms with pharmaceutical manufacturers and other suppliers, and could face potential claims in connection with purported errors by our mail order or specialty pharmacies, including in connection with the risks inherent in the authorization, compounding, packaging and distribution of pharmaceuticals and other healthcare products. Disruptions at any of our mail order or specialty pharmacies due to an event that is beyond our control could affect our ability to process and dispense prescriptions in a timely manner and could materially and adversely affect our results of operations, financial position and cash flows.

If any of our government contracts are terminated or are not renewed or we receive an adverse review, audit or investigation, our business will suffer.

We provide managed care programs and selected services to individuals receiving benefits under governmental assistance programs. We provide those healthcare services under contracts with regulatory entities in the areas in which we operate. Our government contracts are generally intended to run for three years and may be extended for additional years if the contracting entity or its agent elects to do so. When our contracts expire, they may be opened for bidding by competing healthcare providers, and there is no guarantee that our contracts will be renewed or extended. Competitors may buy their way into the market by submitting bids with lower pricing. Further, our government contracts contain certain provisions regarding eligibility, enrollment and dis-enrollment processes for covered services, eligible providers, periodic financial and informational reporting, quality assurance, timeliness of claims payment and agreement to maintain a Medicare plan in the state and financial standards and are subject to cancellation if we fail to perform in accordance with the standards set by regulatory agencies.

We are also subject to various reviews, audits and investigations to verify our compliance with the terms of our contracts with various governmental agencies and applicable laws and regulations. Any adverse review, audit or investigation could result in: cancellation of our contracts; refunding of amounts we have been paid pursuant to our contracts; imposition of fines, penalties and other sanctions on us; loss of our right to participate in various programs; increased difficulty in selling our products and services; or loss of one or more of our licenses.

If any of our government contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, or we have an adverse review, audit or investigation, our business will suffer, our goodwill could be impaired and our financial position, results of operations or cash flows may be materially affected.

Ineffectiveness of state-operated systems and subcontractors could adversely affect our business.

Our health plans rely on other state-operated systems or subcontractors to qualify, solicit, educate and assign eligible members into managed care plans. The effectiveness of these state operations and subcontractors can have a material effect on a health plan's enrollment in a particular month or over an extended period. When a state implements new programs to determine eligibility, new processes to assign or enroll eligible members into health plans, or chooses new subcontractors, there is an increased potential for an unanticipated impact on the overall number of members assigned to managed care plans.

Our investment portfolio may suffer losses which could materially and adversely affect our results of operations or liquidity.

We maintain a significant investment portfolio of cash equivalents and short term and long term investments in a variety of securities, which are subject to general credit, liquidity, market and interest rate risks and will decline in value if interest rates increase or one of the issuers' credit ratings is reduced. As a result, we may experience a reduction in value or loss of liquidity of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition.

Execution of our growth strategy may increase costs or liabilities, or create disruptions in our business.

Our growth strategy includes the acquisition of health plans participating in government sponsored healthcare programs and specialty services businesses, contract rights and related assets of other health plans both in our existing service areas and in new markets and start-up operations in new markets or new products in existing markets. Although we review the records of companies or businesses we plan to acquire, it is possible that we could assume unanticipated liabilities or adverse operating conditions, or an acquisition may not perform as well as expected or may not achieve timely profitability. We also face the risk that we will not be able to effectively integrate acquisitions into our existing operations effectively without substantial expense, delay or other operational or financial problems and we may need to divert more management resources to integration than we planned.

In connection with start-up operations, we may incur significant expenses prior to commencement of operations and the receipt of revenue. For example, in order to obtain a certificate of authority in most jurisdictions, we must first establish a provider network, have systems in place and demonstrate our ability to administer a state contract and process claims. We may experience delays in operational start dates. As a result of these factors, start-up operations may decrease our profitability. In addition, we are planning to expand our business internationally and we will be subject to additional risks, including, but not limited to, political risk, an unfamiliar regulatory regime, currency exchange risk and exchange controls, cultural and language differences, foreign tax issues, and different labor laws and practices.

If we are unable to effectively execute our growth strategy, our future growth will suffer and our results of operations could be harmed.

If competing managed care programs are unwilling to purchase specialty services from us, we may not be able to successfully implement our strategy of diversifying our business lines.

We are seeking to diversify our business lines into areas that complement our government sponsored health plan business in order to grow our revenue stream and balance our dependence on risk reimbursement. In order to diversify our business, we must succeed in selling the services of our specialty subsidiaries not only to our managed care plans, but to programs operated by third-parties. Some of these third-party programs may compete with us in some markets, and they therefore may be unwilling to purchase specialty services from us. In any event, the offering of these services will require marketing activities that differ significantly from the manner in which we seek to increase revenues from our government sponsored programs. Our ineffectiveness in marketing specialty services to third-parties may impair our ability to execute our business strategy.

Adverse credit market conditions may have a material adverse effect on our liquidity or our ability to obtain credit on acceptable terms.

The securities and credit markets have been experiencing extreme volatility and disruption over the past several years. The availability of credit, from virtually all types of lenders, has at times been restricted. In the event we need access to additional capital to pay our operating expenses, fund subsidiary surplus requirements, make payments on or refinance our indebtedness, pay capital expenditures, or fund acquisitions, our ability to obtain such capital may be limited and the cost of any such capital may be significant, particularly if we are unable to access our existing credit facility.

Our access to additional financing will depend on a variety of factors such as prevailing economic and credit market conditions, the general availability of credit, the overall availability of credit to our industry, our credit ratings and credit capacity, and perceptions of our financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain additional financing on favorable terms or at all.

If state regulators do not approve payments of dividends and distributions by our subsidiaries to us, we may not have sufficient funds to implement our business strategy.

We principally operate through our health plan subsidiaries. As part of normal operations, we may make requests for dividends and distributions from our subsidiaries to fund our operations. These subsidiaries are subject to regulations that limit the amount of dividends and distributions that can be paid to us without prior approval of, or notification to, state regulators. If these regulators were to deny our subsidiaries' request to pay dividends, the funds available to us would be limited, which could harm our ability to implement our business strategy.

We derive a majority of our premium revenues from operations in a limited number of states, and our financial position, results of operations or cash flows would be materially affected by a decrease in premium revenues or profitability in any one of those states.

Operations in a limited number of states have accounted for most of our premium revenues to date. If we were unable to continue to operate in any of our current states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly depending on legislative or other governmental or regulatory actions and decisions, economic conditions and similar factors in those states. For example, states we currently serve may bid out their Medicaid program through a request for proposal process. Our inability to continue to operate in any of the states in which we operate could harm our business.

Competition may limit our ability to increase penetration of the markets that we serve.

We compete for members principally on the basis of size and quality of provider networks, benefits provided and quality of service. We compete with numerous types of competitors, including other health plans and traditional state Medicaid programs that reimburse providers as care is provided. In addition, the impact of healthcare reform legislation and potential growth in our segment may attract new competitors.

Some of the health plans with which we compete have greater financial and other resources and offer a broader scope of products than we do. In addition, significant merger and acquisition activity has occurred in the managed care industry, as well as complementary industries, such as the hospital, physician, pharmaceutical, medical device and health information systems businesses. To the extent that competition intensifies in any market that we serve, as a result of industry consolidation or otherwise, our ability to retain or increase members and providers, or maintain or increase our revenue growth, pricing flexibility and control over medical cost trends may be adversely affected.

If we are unable to maintain relationships with our provider networks, our profitability may be harmed.

Our profitability depends, in large part, upon our ability to contract at competitive prices with hospitals, physicians and other healthcare providers. Our provider arrangements with our primary care physicians, specialists and hospitals generally may be canceled by either party without cause upon 90 to 120 days prior written notice. We cannot provide any assurance that we will be able to continue to renew our existing contracts or enter into new contracts on a timely basis or under favorable terms enabling us to service our members profitably. Healthcare providers with whom we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

In any particular market, physicians and other healthcare providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical costs or difficulty in meeting regulatory or accreditation requirements. In some markets, certain healthcare providers, particularly hospitals, physician/hospital organizations or multi-specialty physician groups, may have significant market positions or near monopolies that could result in diminished bargaining power on our part. In addition, accountable care organizations, practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, and other organizational structures that physicians, hospitals and other healthcare providers choose may change the way in which these providers interact with us and may change the competitive

landscape. Such organizations or groups of healthcare providers may compete directly with us, which could adversely affect our operations, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way that we price our products and estimate our costs, which might require us to incur costs to change our operations. Provider networks may consolidate, resulting in a reduction in the competitive environment. In addition, if these providers refuse to contract with us, use their market position to negotiate contracts unfavorable to us or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

From time to time healthcare providers assert or threaten to assert claims seeking to terminate non-cancelable agreements due to alleged actions or inactions by us. In addition, we are aware that other managed care organizations have been subject to class action lawsuits by healthcare providers with respect to claim payment procedures, and we may be subject to similar lawsuits. Regardless of whether any lawsuits brought against us are successful or have merit, they will still be time-consuming and costly and could distract our management's attention. As a result, we may incur significant expenses and may be unable to operate our business effectively. If we are unable to retain our current provider contract terms or enter into new provider contracts timely or on favorable terms, our profitability may be harmed.

We may be unable to attract, retain or effectively manage the succession of key personnel.

We are highly dependent on our ability to attract and retain qualified personnel to operate and expand our business. We would be adversely impacted if we are unable to adequately plan for the succession of our executives and senior management. While we have succession plans in place for members of our executive and senior management team, these plans do not guarantee that the services of our executive and senior management team will continue to be available to us. Our ability to replace any departed members of our executive and senior management or other key employees may be difficult and may take an extended period of time because of the limited number of individuals in the managed care and specialty services industry with the breadth of skills and experience required to operate and successfully expand a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain or motivate these personnel. If we are unable to attract, retain and effectively manage the succession plans for key personnel, executives and senior management, our business and financial position, results of operations or cash flows could be harmed.

If we are unable to integrate and manage our information systems effectively, our operations could be disrupted.

Our operations depend significantly on effective information systems. The information gathered and processed by our information systems assists us in, among other things, monitoring utilization and other cost factors, processing provider claims, and providing data to our regulators. Our healthcare providers also depend upon our information systems for membership verifications, claims status and other information. Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs and regulatory requirements. We regularly upgrade and expand our information systems' capabilities. If we experience difficulties with the transition to or from information systems or are unable to properly maintain or expand our information systems, we could suffer, among other things, operational disruptions, loss of existing members and difficulty in attracting new members, regulatory problems and increases in administrative expenses. In addition, our ability to integrate and manage our information systems may be impaired as the result of events outside our control, including acts of nature, such as earthquakes or fires, or acts of terrorists.

From time to time, we may become involved in costly and time-consuming litigation and other regulatory proceedings, which require significant attention from our management.

We are a defendant from time to time in lawsuits and regulatory actions relating to our business, including, without limitation, medical malpractice claims. Due to the inherent uncertainties of litigation and regulatory proceedings, we cannot accurately predict the ultimate outcome of any such proceedings. An unfavorable outcome could have a material adverse impact on our business and financial position, results of operations or cash flows. In addition, regardless of the outcome of any litigation or regulatory proceedings, such proceedings are costly and time consuming and require significant attention from our management, and could therefore harm our business and financial position, results of operations or cash flows.

An impairment charge with respect to our recorded goodwill and intangible assets could have a material impact on our results of operations.

We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. Changes in business strategy, government regulations or economic or market conditions have resulted and may result in impairments of our goodwill and other intangible assets at any time in the future. Our judgments regarding the existence of impairment indicators are based on, among other things, legal factors, market conditions, and operational performance. For example, the non-renewal of our health plan contracts with the state in which they operate may be an indicator of impairment. If an event or events occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill and other intangible assets, such revision could result in a non-cash impairment charge that could have a material impact on our results of operations in the period in which the impairment occurs.

If we fail to comply with applicable privacy, security, and data laws, regulations and standards, including with respect to third-party service providers that utilize sensitive personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

As part of our normal operations, we collect, process and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act and the Gramm-Leach-Bliley Act, which require us to protect the privacy of medical records and safeguard personal health information we maintain and use. Certain of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities. Despite our best attempts to maintain adherence to information privacy and security best practices as well as compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers, may be vulnerable to privacy or security breaches, acts of vandalism or theft, malware, misplaced or lost data including paper or electronic media, programming and/or human errors or other similar events. In the past, we have had data breaches resulting in disclosure of confidential or protected health information that have not resulted in any material financial loss or penalty to date. However, future data breaches could require us to expend significant resources to remediate any damage, interrupt our operations and damage our reputation, subject us to state or federal agency review and could also result in enforcement actions, material fines and penalties, litigation or other actions which could have a material adverse effect on our business, reputation and results of operations, financial position and cash flows.

In addition, HIPAA broadened the scope of fraud and abuse laws applicable to healthcare companies. HIPAA created civil penalties for, among other things, billing for medically unnecessary goods or services. HIPAA established new enforcement mechanisms to combat fraud and abuse, including civil and, in some instances, criminal penalties for failure to comply with specific standards relating to the privacy, security and electronic transmission of protected health information. The HITECH Act expanded the scope of these provisions by mandating individual notification in instances of breaches of protected health information, providing enhanced penalties for HIPAA violations, and granting enforcement authority to states' Attorneys General in addition to the HHS Office for Civil Rights. It is possible that Congress may enact additional legislation in the future to increase penalties and to create a private right of action under HIPAA, which could entitle patients to seek monetary damages for violations of the privacy rules. In addition, HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities with a focus on security risk assessments. Although we are not aware of HHS plans to audit any of our covered entities, an audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Under HIPAA, health plans are required to have the capacity to accept and send all covered transactions in a standardized electronic format. Penalties can be imposed for failure to comply with these requirements. The transaction standards have been modified to version 5010 to prepare for the implementation of the ICD-10 coding system. While we have prepared for the transition to ICD-10 in October 2015, if unforeseen circumstances arise, it is possible that we could be exposed to investigations and allegations of noncompliance. In addition, if some providers continue to use ICD-9 codes on claims after October 1, 2015, we may have to reject such claims, which may lead to claim resubmissions, increased call volume and provider and customer dissatisfaction. Further, providers may use ICD-10 codes differently than they used ICD-9 codes in the past, which could result in higher costs and reimbursement levels, or lost revenues under risk adjustment. During the transition to ICD-10, certain claims processing and payment information we have historically used to establish our reserves may not be reliable or available in a timely manner. As a result, implementation of ICD 10 may have a material adverse effect on our results of operations, financial position and cash flows.

A failure in or breach of our operational or security systems or infrastructure, or those of third parties with which we do business, including as a result of cyber attacks, could have an adverse effect on our business.

Information security risks have significantly increased in recent years in part because of the proliferation of new technologies, the use of the internet and telecommunications technologies to conduct our operations, and the increased sophistication and activities of organized crime, hackers, terrorists and other external parties, including foreign state agents. Our operations rely on the secure processing, transmission and storage of confidential, proprietary and other information in our computer systems and networks.

Security breaches may arise from external or internal threats. External breaches include hacking personal information for financial gain, attempting to cause harm to our operations, or intending to obtain competitive information. We experience attempted external hacking or malicious attacks on a regular basis. We maintain a rigorous system of preventive and detective controls through our security programs; however, our prevention and detection controls may not prevent or identify all such attacks. Internal breaches may result from inappropriate security access to confidential information by rogue employees, consultants or third party service providers. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, financial data, competitively sensitive information, or other proprietary data, whether by us or a third party, could have a material adverse effect on our business reputation, financial condition, cash flows, or results of operations.

Consummation of the merger with Health Net is subject to receipt of regulatory approvals and certain other conditions and we cannot predict when or if such conditions will be satisfied or waived or if, in connection with the receipt of necessary approvals, regulators will impose conditions on us that have an adverse effect on our business.

Consummation of the merger with Health Net is subject to receipt of certain remaining regulatory approvals and certain other conditions, including, among others:

- certain filings or consents required for the consummation of the Merger and the other transactions under applicable state and foreign insurance and health care regulatory laws having been made or obtained; and
- certain other customary conditions.

We cannot provide any assurance that the merger will be completed, that there will not be a delay in the completion of the merger or that all or any of the anticipated benefits of the merger will be realized. Any delay could also, among other things, result in additional transaction costs, loss of revenue or other negative effects associated with uncertainty about completion of the merger. In the event the merger agreement is terminated or the transaction is materially delayed for any reason, the price of our common stock may be impacted. Regulatory authorities reviewing the merger may refuse to permit the merger or may impose restrictions or conditions on the merger that may adversely affect the Company if the merger is completed.

We may be unable to successfully integrate our business with Health Net and realize the anticipated benefits of the merger.

The success of the merger will depend, in part, on our ability to successfully combine the businesses of the Company and Health Net, which currently operate as independent public companies, and realize the anticipated benefits, including synergies, cost savings, innovation and operational efficiencies, from the combination. If we are unable to achieve these objectives within the anticipated time frame, or at all, the anticipated benefits may not be realized fully or at all, or may take longer to realize than expected and the value of our common stock may be harmed.

The merger involves the integration of Health Net's business with our existing business, which is a complex, costly and time-consuming process. We have not previously completed a transaction comparable in size or scope to the proposed merger. The integration of the two companies may result in material challenges, including, without limitation:

- the diversion of management's attention from ongoing business concerns and performance shortfalls at one or both of the companies as a result of the devotion of management's attention to the merger;
- managing a larger combined company;
- maintaining employee morale and retaining key management and other employees;
- the possibility of faulty assumptions underlying expectations regarding the integration process;
- retaining existing business and operational relationships and attracting new business and operational relationships;
- consolidating corporate and administrative infrastructures and eliminating duplicative operations;
- coordinating geographically separate organizations;
- unanticipated issues in integrating information technology, communications and other systems;

- unanticipated changes in federal or state laws or regulations, including the ACA and the Health Care Education Affordability Reconciliation Act and any regulations enacted thereunder; and
- unforeseen expenses or delays associated with the merger.

Many of these factors will be outside of our control and any one of them could result in delays, increased costs, decreases in the amount of expected revenues and diversion of management's time and energy, which could materially affect our financial position, results of operations and cash flows.

We and Health Net are currently permitted to conduct only limited planning for the integration of the two companies following the merger and have not yet determined the exact nature of how the businesses and operations of the two companies will be combined after the merger. The actual integration may result in additional and unforeseen expenses, and the anticipated benefits of the integration plan may not be realized.

Our financial results after the merger will depend on our ability to maintain our and Health Net's business and operational relationships.

A substantial portion of each of our and Health Net's revenues are received under contracts with states. Our success following the merger will depend in part on our ability to maintain these state contracts and other business and operational relationships, including those of Health Net. Health Net's state contracts and other business and operational relationships may have termination or other rights that may be triggered by the merger, or the states or other business and operational relationships may decide not to renew their existing relationships with Health Net or, after the merger, with us. If Health Net (prior to the completion of the merger) and we (after the completion of the merger) are unable to maintain these contracts and other business and operational relationships, our financial position, results of operations or cash flows could be materially affected.

We are expected to incur substantial expenses related to the completion of the merger and the integration of Health Net.

We are expected to incur substantial expenses in connection with the completion of the merger and the integration of Health Net. There are a large number of processes, policies, procedures, operations, technologies and systems that must be integrated, including purchasing, accounting and finance, sales, payroll, pricing, revenue management, marketing and benefits. In addition, the businesses of Centene and Health Net will continue to maintain a presence in St. Louis, Missouri and Woodland Hills, California, respectively. The substantial majority of these costs will be non-recurring expenses related to the merger (including financing of the merger), facilities and systems consolidation costs. We may incur additional costs to maintain employee morale and to retain key employees. We will also incur transaction fees and costs related to formulating integration plans for the combined business, and the execution of these plans may lead to additional unanticipated costs. Additionally, as a result of the merger, rating agencies may take negative actions with regard to our credit ratings. This may increase our costs in connection with the financing of the merger. These incremental transaction and merger-related costs may exceed the savings the combined company expects to achieve from the elimination of duplicative costs and the realization of other efficiencies related to the integration of the businesses, particularly in the near term and in the event there are material unanticipated costs.

Failure to complete the merger could impact our stock price and our future business and financial position, results of operations and cash flows.

If the merger is not completed or our financing for the transaction becomes unavailable, our ongoing business and financial position, results of operations and cash flows may be materially affected and we will be subject to a number of risks, including the following:

- depending on the reasons leading to such termination we could be liable to Health Net for termination fees in connection with the termination of the merger agreement;
- we could be responsible for the transaction costs relating to the merger, whether or not the merger is completed;
- while the merger agreement is in force, we are subject to certain restrictions on the conduct of our business, which may adversely affect our ability to execute certain of our business strategies;
- the market price of our common stock could decline to the extent that the current market price reflects, and is positively affected by, a market assumption that the transactions contemplated by the merger will be completed; and
- matters relating to the merger (including integration planning) may require substantial commitments of time and resources by our management, whether or not the merger is completed, which could otherwise have been devoted to other opportunities that may have been beneficial to us.

In addition, if the merger is not completed, we may experience negative reactions from the financial markets and from our providers, members and employees. We may also be subject to litigation related to any failure to complete the merger or to enforcement proceedings commenced against us to perform our obligations under the merger agreement. If the merger is not completed, these risks may materialize and may materially affect our financial position, results of operations and cash flows, as well as the price of our common stock.

The market price of our common stock may decline as a result of the merger with Health Net.

The market price of the common stock of our company may decline as a result of the merger if, among other things, we are unable to achieve the expected growth in earnings, or if the operational cost savings estimates in connection with the integration of Health Net's business with ours are not realized, or if the transaction costs related to the merger are greater than expected, or if the financing related to the transaction is on unfavorable terms. The market price also may decline if we do not achieve the perceived benefits of the merger as rapidly or to the extent anticipated by financial or industry analysts or if the effect of the merger on our financial position, results of operations or cash flows is not consistent with the expectations of financial or industry analysts.

The merger will substantially reduce the percentage ownership interests of our current stockholders; it may not be accretive and may cause dilution to our earnings per share, which may negatively affect the market price of our common stock.

Our stockholders have the right to vote in the election of our Board of Directors and on certain other matters affecting the Company. If the merger is completed we will pay approximately $6.8 billion and Health Net's stockholders are expected to hold approximately 29% of the common stock of the Company after the merger. As a result, if the merger is completed, our pre-merger stockholders will own a smaller proportion of our outstanding common stock than the proportion of our outstanding common stock they owned before the merger and, as a result, they will have less influence on our management and policies following the merger than they now have on our management and policies. We currently anticipate that the merger will be accretive to our earnings per share. This expectation is based on preliminary estimates which may materially change. We could also encounter additional transaction and integration-related costs or other factors such as the failure to realize all of the benefits anticipated in the merger, or unforeseen liabilities or other issues existing or arising with the business of Health Net or otherwise resulting from the merger. All of these factors could cause dilution to our earnings per share or decrease or delay the expected accretive effect of the merger and cause a decrease in the price of our common stock.

Uncertainties associated with the merger may cause a loss of management personnel and other key employees which could adversely affect the future business and operations of the combined company.

Centene and Health Net are dependent on the experience and industry knowledge of their officers and other key employees to execute their business plans. The combined company's success after the completion of the merger will depend in part upon the ability of Centene and Health Net to retain key management personnel and other key employees. Prior to completion of the merger, current and prospective employees of Centene and Health Net may experience uncertainty about their roles within the combined company following the completion of the merger, which may have an adverse effect on the ability of each of Centene and Health Net to attract or retain key management and other key personnel. In addition, no assurance can be given that the combined company will be able to attract or retain key management personnel and other key employees of Centene and Health Net to the same extent that Centene and Health Net have previously been able to attract or retain their own employees.

The future results of the combined company may be adversely impacted if the combined company does not effectively manage its expanded operations following the completion of the merger.

Following the completion of the merger, the size of the combined company's business will be significantly larger than the current size of either Centene's or Health Net's respective businesses. The combined company's ability to successfully manage this expanded business will depend, in part, upon management's ability to design and implement strategic initiatives that address not only the integration of two discrete companies, but also the increased scale and scope of the combined business with its associated increased costs and complexity. There can be no assurances that the combined company will be successful or that it will realize the expected operating efficiencies, cost savings and other benefits currently anticipated from the merger.

The combined company will be significantly more leveraged than Centene is currently.

Upon completion of the merger, the combined company expects to incur approximately $2,382 million in additional indebtedness. The combined company will have consolidated indebtedness of approximately $4,136 million, which is greater than the current indebtedness of Centene prior to the merger. The increased indebtedness and higher debt-to-equity ratio of the combined company in comparison to that of Centene on a historical basis will have the effect, among other things, of reducing the flexibility of Centene to respond to changing business and economic conditions and increasing borrowing costs.

ITEM 2. ***Unregistered Sales of Equity Securities and Use of Proceeds.***

Issuer Purchases of Equity Securities
Third Quarter 2015

Period	Total Number of Shares Purchased [1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs[2]
July 1 - July 31, 2015	6,200	$ 72.98	—	3,335,448
August 1 - August 31, 2015	3,429	68.71	—	3,335,448
September 1 - September 30, 2015	4,515	58.92	—	3,335,448
Total	14,144	$ 67.46	—	3,335,448

(1) Shares acquired represent shares relinquished to the Company by certain employees for payment of taxes or option cost upon vesting of restricted stock units or option exercise.

(2) Our Board of Directors adopted a stock repurchase program which allows for repurchases of up to a remaining amount of 3,335,448 shares. No duration has been placed on the repurchase program.

ITEM 6. *Exhibits.*

EXHIBIT NUMBER	DESCRIPTION
12.1	Computation of ratio of earnings to fixed charges.
31.1	Certification of Chairman, President and Chief Executive Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Executive Vice President and Chief Financial Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chairman, President and Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Executive Vice President and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.1	XBRL Taxonomy Instance Document.
101.2	XBRL Taxonomy Extension Schema Document.
101.3	XBRL Taxonomy Extension Calculation Linkbase Document.
101.4	XBRL Taxonomy Extension Definition Linkbase Document.
101.5	XBRL Taxonomy Extension Label Linkbase Document.
101.6	XBRL Taxonomy Extension Presentation Linkbase Document.

SIGNATURES

Pursuant to the requirements 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 as of October 27, 2015.

CENTENE CORPORATION

By: /s/ MICHAEL F. NEIDORFF
Chairman, President and Chief Executive Officer
(principal executive officer)

By: /s/ WILLIAM N. SCHEFFEL
Executive Vice President and Chief Financial Officer
(principal financial officer)

By: /s/ JEFFREY A. SCHWANEKE
Senior Vice President, Corporate Controller and Chief Accounting Officer
(principal accounting officer)

EXHIBIT 31.1

CERTIFICATION

I, Michael F. Neidorff, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of Centene Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, 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;

   c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: October 27, 2015

/s/ MICHAEL F. NEIDORFF

Chairman, President and Chief Executive Officer
(principal executive officer)

EXHIBIT 31.2

CERTIFICATION

, William N. Scheffel, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of Centene Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, 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;

   c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting;

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: October 27, 2015

/s/ WILLIAM N. SCHEFFEL

Executive Vice President and Chief Financial Officer
(principal financial officer)

EXHIBIT 32.1

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report on Form 10-Q of Centene Corporation (the Company) for the period ended September 30, 2015, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, Michael F. Neidorff, Chairman, President and Chief Executive Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: October 27, 2015

/s/ MICHAEL F. NEIDORFF

Chairman, President and Chief Executive Officer
(principal executive officer)

EXHIBIT 32.2

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report on Form 10-Q of Centene Corporation (the Company) for the period ended September 30, 2015, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, William N. Scheffel, Executive Vice President and Chief Financial Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: October 27, 2015

/s/ WILLIAM N. SCHEFFEL

Executive Vice President and Chief Financial Officer
(principal financial officer)

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-Q

(Mark One)

[X] **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended June 30, 2015

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: 001-31826

CENTENE CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**42-1406317**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification Number)*
7700 Forsyth Boulevard **St. Louis, Missouri**	**63105**
(Address of principal executive offices)	*(Zip Code)*

Registrant's telephone number, including area code:

(314) 725-4477

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 Web site, 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 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 "small reporting company" in Rule 12b-2 of the Exchange Act. 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 ☒

As of July 17, 2015, the registrant had 119,090,635 shares of common stock outstanding.

CENTENE CORPORATION
QUARTERLY REPORT ON FORM 10-Q
TABLE OF CONTENTS

		PAGE
	Part I	
	Financial Information	
Item 1.	Financial Statements	1
	Consolidated Balance Sheets as of June 30, 2015 and December 31, 2014 (unaudited)	1
	Consolidated Statements of Operations for the Three and Six Months Ended June 30, 2015 and 2014 (unaudited)	2
	Consolidated Statements of Comprehensive Earnings for the Three and Six Months Ended June 30, 2015 and 2014 (unaudited)	3
	Consolidated Statement of Stockholders' Equity for the Six Months Ended June 30, 2015 (unaudited)	4
	Consolidated Statements of Cash Flows for the Six Months Ended June 30, 2015 and 2014 (unaudited)	5
	Notes to the Consolidated Financial Statements (unaudited)	6
Item 2.	Management's Discussion and Analysis of Financial Condition and Results of Operations	16
Item 3.	Quantitative and Qualitative Disclosures About Market Risk	29
Item 4.	Controls and Procedures	29
	Part II	
	Other Information	
Item 1.	Legal Proceedings	30
Item 1A.	Risk Factors	30
Item 2.	Unregistered Sales of Equity Securities and Use of Proceeds	42
Item 6.	Exhibits	43
Signatures		44
Certifications		45

CAUTIONARY STATEMENT ON FORWARD-LOOKING STATEMENTS

All statements, other than statements of current or historical fact, contained in this filing are forward-looking statements. We have attempted to identify these statements by terminology including "believe," "anticipate," "plan," "expect," "estimate," "intend," "seek," "target," "goal," "may," "will," "would," "could," "should," "can," "continue" and other similar words or expressions in connection with, among other things, any discussion of future operating or financial performance. In particular, these statements include statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions, including our proposed merger with Health Net, Inc. (Health Net) (Proposed Merger), investments and the adequacy of our available cash resources. These statements may be found in the various sections of this filing, including those entitled "Management's Discussion and Analysis of Financial Condition and Results of Operations," Part II, Item 1A. "Risk Factors," and Part II, Item 1 "Legal Proceedings." Readers are cautioned that matters subject to forward-looking statements involve known and unknown risks and uncertainties, including economic, regulatory, competitive and other factors that may cause our or our industry's actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

All forward-looking statements included in this filing are based on information available to us on the date of this filing and we undertake no obligation to update or revise the forward-looking statements included in this filing, whether as a result of new information, future events or otherwise, after the date of this filing. Actual results may differ from projections or estimates due to a variety of important factors applicable to both us and Health Net, including but not limited to:

- our ability to accurately predict and effectively manage health benefits and other operating expenses and reserves;
- competition;
- membership and revenue projections;
- timing of regulatory contract approval;
- changes in healthcare practices;
- changes in federal or state laws or regulations, including the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act and any regulations enacted thereunder;
- changes in expected contract start dates;
- changes in expected closing dates, estimated purchase price and accretion for acquisitions;
- inflation;
- foreign currency fluctuations;
- provider and state contract changes;
- new technologies;
- advances in medicine;
- reduction in provider payments by governmental payors;
- major epidemics;
- disasters and numerous other factors affecting the delivery and cost of healthcare;
- the expiration, cancellation or suspension of our or Health Net's managed care contracts by federal or state governments (including but not limited to Medicare and Medicaid);
- the outcome of our or Health Net's pending legal proceedings;
- availability of debt and equity financing, on terms that are favorable to us;
- changes in economic, political and market conditions;
- the expected closing date of the Proposed Merger;
- the possibility that the expected synergies and value creation from the Proposed Merger will not be realized, or will not be realized within the expected time period;
- the risk that acquired businesses will not be integrated successfully;
- disruption from the Proposed Merger making it more difficult to maintain business and operational relationships;
- the risk that unexpected costs related to the Proposed Merger will be incurred;
- the possibility that the Proposed Merger does not close, including, but not limited to, due to the failure to satisfy the closing conditions, including the receipt of approval of both Centene's stockholders and Health Net's stockholders; and
- the risk that financing for the Proposed Merger may not be available on favorable terms.

This list of important factors is not intended to be exhaustive. We discuss certain of these matters more fully, as well as certain risk factors that may affect our business operations, financial condition and results of operations, in our filings with the Securities and Exchange Commission, including our annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K.

Other Information

The discussion in Part I, Item 2. "Management's Discussion and Analysis of Financial Condition and Results of Operations" under the heading "Results of Operations" contains financial information for new and existing businesses. Existing businesses are primarily state markets, significant geographic expansion in an existing state or product that we have managed for four complete quarters. New businesses are primarily new state markets, significant geographic expansion in an existing state or product that conversely, we have not managed for four complete quarters.

Item 1A "Risk Factors" of Part II of this filing contains a further discussion of these and other important factors that could cause actual results to differ from expectations. We disclaim any current intention or obligation to update or revise any forward-looking statements, whether as a result of new information, future events or otherwise. Due to these important factors and risks, we cannot give assurances with respect to our future premium levels or our ability to control our future medical costs.

PART I
FINANCIAL INFORMATION

ITEM 1. ***Financial Statements.***

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
(In millions, except share data)
(Unaudited)

	June 30, 2015	December 31, 2014
ASSETS		
Current assets:		
Cash and cash equivalents	$ 1,967	$ 1,610
Premium and related receivables	1,248	912
Short term investments	140	177
Other current assets	483	335
Total current assets	3,838	3,034
Long term investments	1,541	1,280
Restricted deposits	101	100
Property, software and equipment, net	462	445
Goodwill	811	754
Intangible assets, net	148	120
Other long term assets	121	91
Total assets	$ 7,022	$ 5,824
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$ 2,092	$ 1,723
Accounts payable and accrued expenses	1,004	768
Return of premium payable	289	236
Unearned revenue	68	168
Current portion of long term debt	5	5
Total current liabilities	3,458	2,900
Long term debt	1,139	874
Other long term liabilities	330	159
Total liabilities	4,927	3,933
Commitments and contingencies		
Redeemable noncontrolling interests	155	148
Stockholders' equity:		
Preferred stock, $0.001 par value; authorized 10,000,000 shares; no shares issued or outstanding at June 30, 2015 and December 31, 2014	—	—
Common stock, $.001 par value; authorized 200,000,000 shares; 124,812,343 issued and 119,087,944 outstanding at June 30, 2015, and 124,274,864 issued and 118,433,416 outstanding at December 31, 2014	—	—
Additional paid-in capital	891	840
Accumulated other comprehensive loss	(4)	(1)
Retained earnings	1,154	1,003
Treasury stock, at cost (5,724,399 and 5,841,448 shares, respectively)	(101)	(98)
Total Centene stockholders' equity	1,940	1,744
Noncontrolling interest	—	(1)
Total stockholders' equity	1,940	1,743
Total liabilities and stockholders' equity	$ 7,022	$ 5,824

The accompanying notes to the consolidated financial statements are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF OPERATIONS
(In millions, except share data)
(Unaudited)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
Revenues:				
Premium	$ 4,692	$ 3,331	$ 8,991	$ 6,402
Service	492	410	954	691
Premium and service revenues	5,184	3,741	9,945	7,093
Premium tax and health insurer fee	322	283	692	391
Total revenues	5,506	4,024	10,637	7,484
Expenses:				
Medical costs	4,181	2,960	8,042	5,703
Cost of services	419	366	821	608
General and administrative expenses	442	321	845	616
Premium tax expense	239	253	520	331
Health insurer fee expense	52	31	107	63
Total operating expenses	5,333	3,931	10,335	7,321
Earnings from operations	173	93	302	163
Other income (expense):				
Investment and other income	10	7	19	12
Interest expense	(11)	(9)	(21)	(16)
Earnings from continuing operations, before income tax expense	172	91	300	159
Income tax expense	84	45	147	79
Earnings from continuing operations, net of income tax expense	88	46	153	80
Discontinued operations, net of income tax expense (benefit) of $0, $1, $(1), and $1, respectively	—	2	(1)	1
Net earnings	88	48	152	81
(Earnings) loss attributable to noncontrolling interests	—	1	(1)	1
Net earnings attributable to Centene Corporation	$ 88	$ 49	$ 151	$ 82
Amounts attributable to Centene Corporation common shareholders:				
Earnings from continuing operations, net of income tax expense	$ 88	$ 47	$ 152	$ 81
Discontinued operations, net of income tax expense (benefit)	—	2	(1)	1
Net earnings	$ 88	$ 49	$ 151	$ 82
Net earnings (loss) per common share attributable to Centene Corporation:				
Basic:				
Continuing operations	$ 0.74	$ 0.41	$ 1.28	$ 0.70
Discontinued operations	—	0.01	(0.01)	0.01
Basic earnings per common share	$ 0.74	$ 0.42	$ 1.27	$ 0.71
Diluted:				
Continuing operations	$ 0.72	$ 0.39	$ 1.24	$ 0.68
Discontinued operations	—	0.02	(0.01)	0.01
Diluted earnings per common share	$ 0.72	$ 0.41	$ 1.23	$ 0.69
Weighted average number of common shares outstanding:				
Basic	119,003,569	115,517,366	118,894,269	115,244,078
Diluted	122,965,011	119,434,516	122,785,459	119,094,840

The accompanying notes to the consolidated financial statements are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENT OF COMPREHENSIVE EARNINGS
(In millions)
(Unaudited)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
Net earnings	$ 88	$ 48	$ 152	$ 81
Reclassification adjustment, net of tax	—	—	—	(1)
Change in unrealized gain on investments, net of tax	(4)	3	1	6
Foreign currency translation adjustments	1	—	(4)	—
Other comprehensive earnings	(3)	3	(3)	5
Comprehensive earnings	85	51	149	86
Comprehensive (earnings) loss attributable to noncontrolling interests	—	1	(1)	1
Comprehensive earnings attributable to Centene Corporation	$ 85	$ 52	$ 148	$ 87

The accompanying notes to the consolidated financial statements are an integral part of this statement.

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENT OF STOCKHOLDERS' EQUITY
(In millions, except share data)
(Unaudited)

Six Months Ended June 30, 2015

	Centene Stockholders' Equity								
	Common Stock					Treasury Stock			
	$.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	$.001 Par Value Shares	Amt	Non controlling Interest	Total
Balance, December 31, 2014	124,274,864	$ —	$ 840	$ (1)	$ 1,003	5,841,448	$ (98)	$ (1)	$ 1,743
Comprehensive Earnings:									
Net earnings	—	—	—	—	151	—	—	—	151
Change in unrealized gain on investments, net of tax	—	—	—	1	—	—	—	—	1
Foreign currency translation	—	—	—	(4)	—	—	—	—	(4)
Total comprehensive earnings									148
Common stock issued for acquisition	—	—	9	—	—	(247,580)	4	—	13
Common stock issued for employee benefit plans	537,479	—	3	—	—	—	—	—	3
Common stock repurchases	—	—	—	—	—	130,531	(7)	—	(7)
Stock compensation expense	—	—	33	—	—	—	—	—	33
Excess tax benefits from stock compensation	—	—	6	—	—	—	—	—	6
Reclassification to redeemable noncontrolling interest	—	—	—	—	—	—	—	1	1
Balance, June 30, 2015	124,812,343	$ —	$ 891	$ (4)	$ 1,154	5,724,399	$ (101)	$ —	$ 1,940

The accompanying notes to the consolidated financial statements are an integral part of this statement.

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
(In millions)
(Unaudited)

	Six Months Ended June 30,	
	2015	2014
Cash flows from operating activities:		
Net earnings	$ 152	$ 81
Adjustments to reconcile net earnings to net cash provided by operating activities		
Depreciation and amortization	53	42
Stock compensation expense	33	23
Deferred income taxes	(13)	(11)
Gain on settlement of contingent consideration	(10)	—
Changes in assets and liabilities		
Premium and related receivables	(341)	(161)
Other current assets	(28)	29
Other assets	(30)	(29)
Medical claims liabilities	366	284
Unearned revenue	(102)	(18)
Accounts payable and accrued expenses	166	160
Other long term liabilities	144	10
Other operating activities	5	2
Net cash provided by operating activities	395	412
Cash flows from investing activities:		
Capital expenditures	(58)	(42)
Purchases of investments	(513)	(475)
Sales and maturities of investments	276	221
Proceeds from asset sale	7	—
Investments in acquisitions, net of cash acquired	(11)	(94)
Net cash used in investing activities	(299)	(390)
Cash flows from financing activities:		
Proceeds from exercise of stock options	3	4
Proceeds from borrowings	750	1,145
Payment of long term debt	(479)	(945)
Excess tax benefits from stock compensation	6	1
Common stock repurchases	(7)	(5)
Contribution from noncontrolling interest	—	5
Debt issue costs	(4)	(6)
Payment of contingent consideration obligation	(8)	—
Net cash provided by financing activities	261	199
Net increase in cash and cash equivalents	357	221
Cash and cash equivalents, beginning of period	1,610	1,038
Cash and cash equivalents, end of period	$ 1,967	$ 1,259
Supplemental disclosures of cash flow information:		
Interest paid	$ 27	$ 16
Income taxes paid	$ 145	$ 110
Equity issued in connection with acquisitions	$ 13	$ 132

The accompanying notes to the consolidated financial statements are an integral part of these statements.

1. Basis of Presentation

Basis of Presentation

The accompanying interim financial statements have been prepared under the presumption that users of the interim financial information have either read or have access to the audited financial statements included in the Form 10-K for the fiscal year ended December 31, 2014. The unaudited interim financial statements herein have been prepared pursuant to the rules and regulations of the Securities and Exchange Commission. Accordingly, footnote disclosures which would substantially duplicate the disclosures contained in the December 31, 2014 audited financial statements have been omitted from these interim financial statements where appropriate. In the opinion of management, these financial statements reflect all adjustments, consisting only of normal recurring adjustments, which are necessary for a fair presentation of the results of the interim periods presented.

Certain 2014 amounts in the notes to the consolidated financial statements have been reclassified to conform to the 2015 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

On February 2, 2015, the Board of Directors declared a two-for-one split of Centene's common stock in the form of a 100% stock dividend distributed February 19, 2015 to stockholders of record on February 12, 2015. All share and per share information presented in this Form 10-Q has been adjusted for the two-for-one stock split.

Recent Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board (FASB) issued an Accounting Standards Update (ASU) which supersedes existing revenue recognition standards with a single model unless those contracts are within the scope of other standards (e.g., an insurance entity's insurance contracts). Under the new standard, recognition of revenue occurs when a customer obtains control of promised goods or services in an amount that reflects the consideration which the entity expects to receive in exchange for those goods or services. In addition, the standard requires disclosure of the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers. In July 2015, the FASB deferred the effective date of the new revenue standard by one year. The new effective date is for annual and interim periods beginning after December 15, 2017. Early adoption is permitted. The Company is currently evaluating the effect of the new revenue recognition guidance.

In April 2015, the FASB issued an ASU which changes the presentation of debt issuance costs in financial statements. Under the new standard, debt issuance costs are presented in the balance sheet as a direct deduction of the related debt liability rather than as an asset. Amortization of the cost is reported as interest expense. The new standard is effective for annual and interim periods beginning after December 15, 2015 and early adoption is permitted. The Company elected to adopt this guidance beginning in the first quarter of 2015 and has applied the new standard retrospectively to all prior periods. The reclassification of debt issuance costs impacted the Consolidated Balance Sheets by decreasing both Other Long Term Assets and Long Term Debt by $14 million at December 31, 2014 and $16 million at June 30, 2015. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

In May 2015, the FASB issued an ASU which expands the disclosure requirements for insurance companies that issue short-duration contracts. The new standard will increase the level of disclosure around the Company's Medical Claims Liability to include the following: claims development by year; claim frequency; a rollforward of the claims liability; and a description of methods and assumptions used for determining the liability. It is effective for annual periods beginning after December 15, 2015 and interim periods beginning after December 15, 2016. Early adoption is permitted. The Company is currently evaluating the effect of the new disclosure requirements.

2. Acquisitions and Redeemable Noncontrolling Interest

Acquisitions

Community Health Solutions of America, Inc.

In July 2014, the Company completed a transaction whereby Community Health Solutions of America, Inc. assigned its contract with the Louisiana Department of Health and Hospitals under the Bayou Health Shared Savings Program to the Company's subsidiary, Louisiana Healthcare Connections (LHC). The fair value of consideration transferred included the present value of the estimated contingent consideration, subject to membership retained by LHC in the first quarter of 2015. The fair value of contingent consideration was $18 million at December 31, 2014. During the first quarter of 2015, the Company determined the amount of the actual contingent consideration to be $8 million. A gain of $10 million related to the settlement of the obligation was recorded in General and Administrative expense.

LiveHealthier, Inc.

In January 2015, the Company acquired the remaining 79% of LiveHealthier, Inc. (LiveHealthier) for $28 million, bringing its total ownership to 100%. LiveHealthier is a provider of technology and service-based health management solutions. The fair value of consideration of $28 million consists of cash paid of $11 million, Centene common stock issued at closing of $13 million, and the present value of contingent consideration of $4 million to be paid in cash over a three year period. The contingent consideration will not exceed $9 million.

The Company's allocation of fair value resulted in goodwill of $26 million and other identifiable intangible assets of $15 million. The goodwill is not deductible for income tax purposes. The acquisition is recorded in the Managed Care segment.

Fidelis SecureCare of Michigan, Inc.

In May 2015, the Company acquired 100% of Fidelis SecureCare of Michigan, Inc. (Fidelis) a subsidiary of Concerto Healthcare, for $57 million. Fidelis was previously selected by the Michigan Department of Community Health to provide integrated healthcare services to members who are dually eligible for Medicare and Medicaid in Macomb and Wayne counties. The fair value of consideration of $57 million consists of initial cash consideration of $7 million, the conversion of $16 million of notes funded prior to closing and the present value of the remaining contingent consideration payments of $34 million. The contingent consideration is based on duals membership and revenue per member during the first year of the contract, including reconciliation payments. The contingent consideration fair value is estimated based on expected membership during the first year of the contract as well as estimated revenue per member reflecting both member mix and risk adjustment.

The Company's preliminary allocation of fair vale resulted in goodwill of $28 million and other identifiable intangible assets of $24 million. The Company has not finalized the allocation of the fair value of assets and liabilities. 100% of the goodwill is deductible for income tax purposes. The acquisition is recorded in the Managed Care segment.

Redeemable Noncontrolling Interest

In January 2015, the Company sold 25% of its ownership in Celtic Insurance Company for $7 million. No gain or loss was recognized on the sale of the ownership interest. Celtic Insurance Company is included in the Managed Care segment. In connection with the sale of the ownership interest, the Company entered into a put agreement with the noncontrolling interest holder, allowing the noncontrolling interest holder to put its interest back to the Company beginning in 2022. As a result of put option agreements, the noncontrolling interest is considered redeemable and is classified in the Redeemable Noncontrolling Interest section of the consolidated balance sheets.

A reconciliation of the changes in the Redeemable Noncontrolling Interests is as follows ($ in millions):

Balance, December 31, 2014	$	148
Fair value of redeemable noncontrolling interest sold		7
Reclassification to redeemable noncontrolling interest		(1)
Net earnings attributable to redeemable noncontrolling interests		1
Balance, June 30, 2015	$	155

3. Short term and Long term Investments, Restricted Deposits

Short term and long term investments and restricted deposits by investment type consist of the following ($ in millions):

	June 30, 2015				December 31, 2014			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 451	$ 1	$ (1)	$ 451	$ 393	$ 1	$ (2)	$ 392
Corporate securities	632	2	(2)	632	556	2	(2)	556
Restricted certificates of deposit	6	—	—	6	6	—	—	6
Restricted cash equivalents	80	—	—	80	79	—	—	79
Municipal securities:								
General obligation	96	—	—	96	54	—	—	54
Pre-refunded	4	—	—	4	5	—	—	5
Revenue	161	1	(1)	161	101	1	—	102
Variable rate demand notes	28	—	—	28	14	—	—	14
Asset backed securities	162	—	—	162	180	—	—	180
Mortgage backed securities	77	1	—	78	84	1	—	85
Cost and equity method investments	68	—	—	68	68	—	—	68
Life insurance contracts	16	—	—	16	16	—	—	16
Total	$ 1,781	$ 5	$ (4)	$1,782	$ 1,556	$ 5	$ (4)	$1,557

The Company's investments are classified as available-for-sale with the exception of life insurance contracts and certain cost and equity method investments. The Company's investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets with the focus on high credit quality securities. The Company limits the size of investment in any single issuer other than U.S. treasury securities and obligations of U.S. government corporations and agencies. The Company's mortgage backed securities are issued by the Federal National Mortgage Association and carry guarantees by the U.S. government. As of June 30, 2015, 48% of the Company's investments in securities recorded at fair value that carry a rating by S&P or Moody's were rated AAA/Aaa, 66% were rated AA-/Aa3 or higher, and 90% were rated A-/A3 or higher. At June 30, 2015, the Company held certificates of deposit, life insurance contracts and cost and equity method investments which did not carry a credit rating.

The fair value of available-for-sale investments with gross unrealized losses by investment type and length of time that individual securities have been in a continuous unrealized loss position were as follows ($ in millions):

	June 30, 2015				December 31, 2014			
	Less Than 12 Months		12 Months or More		Less Than 12 Months		12 Months or More	
	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ (1)	$ 162	$ —	$ 16	$ —	$ 72	$ (2)	$ 180
Corporate securities	(2)	286	—	31	(2)	311	—	1
Municipal securities:								
General obligation	—	51	—	3	—	4	—	3
Revenue	(1)	52	—	5	—	16	—	3
Pre-refunded	—	—	—	—	—	—	—	1
Asset backed securities	—	37	—	15	—	70	—	10
Mortgage backed securities	—	37	—	—	—	18	—	—
Total	$ (4)	$ 625	$ —	$ 70	$ (2)	$ 491	$ (2)	$ 198

As of June 30, 2015, the gross unrealized losses were generated from 122 positions out of a total of 357 positions. The change in fair value of fixed income securities is a result of movement in interest rates subsequent to the purchase of the security.

For each security in an unrealized loss position, the Company assesses whether it intends to sell the security or if it is more likely than not the Company will be required to sell the security before recovery of the amortized cost basis for reasons such as liquidity, contractual or regulatory purposes. If the security meets this criterion, the decline in fair value is other-than-temporary and is recorded in earnings. The Company does not intend to sell these securities prior to maturity and it is not likely that the Company will be required to sell these securities prior to maturity; therefore, there is no indication of other-than-temporary impairment for these securities.

During the six months ended June 30, 2015, the Company recognized $4 million of income from equity method investments.

The contractual maturities of short term and long term investments and restricted deposits are as follows ($ in millions):

	June 30, 2015				December 31, 2014			
	Investments		Restricted Deposits		Investments		Restricted Deposits	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value
One year or less	$ 140	$ 140	$ 99	$ 99	$ 176	$ 177	$ 92	$ 92
One year through five years	1,325	1,326	2	2	1,121	1,121	8	8
Five years through ten years	135	135	—	—	121	120	—	—
Greater than ten years	80	80	—	—	38	39	—	—
Total	$ 1,680	$ 1,681	$ 101	$ 101	$ 1,456	$ 1,457	$ 100	$ 100

Actual maturities may differ from contractual maturities due to call or prepayment options. Asset backed and mortgage backed securities are included in the one year through five years category, while cost and equity method investments and life insurance contracts are included in the five years through ten years category. The Company has an option to redeem at amortized cost substantially all of the securities included in the greater than ten years category listed above.

The Company continuously monitors investments for other-than-temporary impairment. Certain investments have experienced a decline in fair value due to changes in credit quality, market interest rates and/or general economic conditions. The Company recognizes an impairment loss for cost and equity method investments when evidence demonstrates that it is other-than-temporarily impaired. Evidence of a loss in value that is other-than-temporary may include the absence of

an ability to recover the carrying amount of the investment or the inability of the investee to sustain a level of earnings that would justify the carrying amount of the investment.

4. Fair Value Measurements

Assets and liabilities recorded at fair value in the consolidated balance sheets are categorized based upon observable or unobservable inputs used to estimate fair value. Level inputs are as follows:

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

The following table summarizes fair value measurements by level at June 30, 2015, for assets and liabilities measured at fair value on a recurring basis ($ in millions):

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$ 1,967	$ —	$ —	$ 1,967
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 433	$ 3	$ —	$ 436
Corporate securities	—	632	—	632
Municipal securities:				
General obligation	—	96	—	96
Pre-refunded	—	4	—	4
Revenue	—	161	—	161
Variable rate demand notes	—	28	—	28
Asset backed securities	—	162	—	162
Mortgage backed securities	—	78	—	78
Total investments	$ 433	$ 1,164	$ —	$ 1,597
Restricted deposits available for sale:				
Cash and cash equivalents	$ 80	$ —	$ —	$ 80
Certificates of deposit	6	—	—	6
U.S. Treasury securities and obligations of U.S. government corporations and agencies	15	—	—	15
Total restricted deposits	$ 101	$ —	$ —	$ 101
Other long term assets:				
Interest rate swap agreements	$ —	$ 10	$ —	$ 10
Total assets at fair value	$ 2,501	$ 1,174	$ —	$ 3,675
Liabilities				
Other long term liabilities:				
Interest rate swap agreements	$ —	$ 5	$ —	$ 5
Total liabilities at fair value	$ —	$ 5	$ —	$ 5

The following table summarizes fair value measurements by level at December 31, 2014, for assets and liabilities measured at fair value on a recurring basis ($ in millions):

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$ 1,610	$ —	$ —	$ 1,610
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 360	$ 17	$ —	$ 377
Corporate securities	—	556	—	556
Municipal securities:				
General obligation	—	54	—	54
Pre-refunded	—	5	—	5
Revenue	—	102	—	102
Variable rate demand notes	—	14	—	14
Asset backed securities	—	180	—	180
Mortgage backed securities	—	85	—	85
Total investments	$ 360	$ 1,013	$ —	$ 1,373
Restricted deposits available for sale:				
Cash and cash equivalents	$ 79	$ —	$ —	$ 79
Certificates of deposit	6	—	—	6
U.S. Treasury securities and obligations of U.S. government corporations and agencies	15	—	—	15
Total restricted deposits	$ 100	$ —	$ —	$ 100
Other long term assets:				
Interest rate swap agreements	$ —	$ 11	$ —	$ 11
Total assets at fair value	$ 2,070	$ 1,024	$ —	$ 3,094

The Company periodically transfers U.S. Treasury securities and obligations of U.S. government corporations and agencies between Level I and Level II fair value measurements dependent upon the level of trading activity for the specific securities at the measurement date. The Company's policy regarding the timing of transfers between Level I and Level II is to measure and record the transfers at the end of the reporting period. At June 30, 2015, there were less than $1 million of transfers from Level I to Level II and $14 million of transfers from Level II to Level I. The Company utilizes matrix pricing services to estimate fair value for securities which are not actively traded on the measurement date. The Company designates these securities as Level II fair value measurements. The aggregate carrying amount of the Company's life insurance contracts and other non-majority owned investments, which approximates fair value, was $84 million and $84 million as of June 30, 2015 and December 31, 2014, respectively.

5. Health Insurance Marketplace

The Affordable Care Act (ACA) established risk spreading premium stabilization programs effective January 1, 2014 for the Health Insurance Marketplace product. These programs, commonly referred to as the "three Rs," include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. Additionally, the ACA established a minimum annual medical loss ratio for the Health Insurance Marketplace. Each of the three R programs are taken into consideration to determine if the Company's estimated annual medical costs are less than the minimum loss ratio and require an adjustment to Premium revenue to meet the minimum medical loss ratio.

In June 2015, CMS released final results on reinsurance and risk-adjustment for the 2014 plan year. These final results had an insignificant impact to the Company for the 2014 plan year.

The Company's receivables (payables) for each of these programs are as follows ($ in millions):

	June 30, 2015	December 31, 2014
Risk adjustment	$ (99)	$ (44)
Reinsurance	20	11
Risk corridor	(29)	(9)
Minimum medical loss ratio	(18)	(6)

6. Debt

Debt consists of the following ($ in millions):

	June 30, 2015	December 31, 2014
$425 million 5.75% Senior notes, due June 1, 2017	$ 429	$ 429
$500 million 4.75% Senior notes, due May 15, 2022	500	300
Fair value of interest rate swap agreements	5	11
Senior notes	934	740
Revolving credit agreement	150	75
Mortgage notes payable	69	70
Capital leases	7	8
Debt issuance costs	(16)	(14)
Total debt	1,144	879
Less current portion	(5)	(5)
Long term debt	$ 1,139	$ 874

Senior Notes

In January 2015, the Company issued an additional $200 million of 4.75% Senior Notes ($200 Million Add-on Notes) at par. The $200 Million Add-on Notes were offered as additional debt securities under the indenture governing the $300 million of 4.75% Senior Notes issued in April 2014. In connection with the January 2015 issuance, the Company entered into interest rate swap agreements for a notional amount of $200 million at a floating rate of interest based on the three month LIBOR plus 2.88%. Gains and losses due to changes in the fair value of the interest rate swap completely offset changes in the fair value of the hedged portion of the underlying debt and are recorded as an adjustment to the $200 Million Add-on Notes.

The indentures governing both the $425 million notes due 2017 and the $500 million notes due 2022 contain non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio.

Interest Rate Swaps

The Company uses interest rate swap agreements to convert a portion of its interest rate exposure from fixed rates to floating rates to more closely align interest expense with interest income received on its cash equivalent and variable rate investment balances. The Company has $750 million of notional amount of interest rate swap agreements consisting of $250 million which are scheduled to expire on June 1, 2017 and $500 million that are scheduled to expire May 15, 2022. Under the Swap Agreements, the Company receives a fixed rate of interest and pays an average variable rate of the three month LIBOR plus 2.85% adjusted quarterly. At June 30, 2015, the weighted average rate was 3.12%.

The Swap Agreements are formally designated and qualify as fair value hedges and are recorded at fair value in the Consolidated Balance Sheet in other assets or other liabilities. Gains and losses due to changes in fair value of the interest rate swap agreements completely offset changes in the fair value of the hedged portion of the underlying debt. Therefore, no gain or loss has been recognized due to hedge ineffectiveness. Offsetting changes in fair value of both the interest rate swaps and the hedged portion of the underlying debt both were recognized in interest expense in the Consolidated Statement of Operations. The Company does not hold or issue any derivative instrument for trading or speculative purposes.

Revolving Credit Agreement

The Company has an unsecured $500 million revolving credit facility. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. The agreement has a maturity date of June 1, 2018, provided it will mature 90 days prior to the maturity date of the Company's 5.75% Senior Notes due 2017 if such notes are not refinanced (or extended), certain financial conditions are not met, or the Company does not carry $100 million of unrestricted cash. As of June 30, 2015, the Company had $150 million of borrowings outstanding under the agreement with a weighted average interest rate of 3.75%.

The agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt-to-EBITDA ratios and minimum tangible net worth. The Company is required to not exceed a maximum debt-to-EBITDA ratio of 3.0 to 1.0. As of June 30, 2015, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

Letters of Credit & Surety Bonds

The Company had outstanding letters of credit of $47 million as of June 30, 2015, which were not part of the revolving credit facility. The Company also had letters of credit for $53 million (valued at June 30, 2015 conversion rate), or €48 million, representing its proportional share of the letters of credit issued to support Ribera Salud's outstanding debt, which are a part of the revolving credit facility. Collectively, the letters of credit bore interest at 1.64% as of June 30, 2015. The Company had outstanding surety bonds of $260 million as of June 30, 2015.

7. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings per common share ($ in millions, except per share data):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
Earnings attributable to Centene Corporation:				
Earnings from continuing operations, net of tax	$ 88	$ 47	$ 152	$ 81
Discontinued operations, net of tax	—	2	(1)	1
Net earnings	$ 88	$ 49	$ 151	$ 82
Shares used in computing per share amounts:				
Weighted average number of common shares outstanding	119,003,569	115,517,366	118,894,269	115,244,078
Common stock equivalents (as determined by applying the treasury stock method)	3,961,442	3,917,150	3,891,190	3,850,762
Weighted average number of common shares and potential dilutive common shares outstanding	122,965,011	119,434,516	122,785,459	119,094,840
Net earnings (loss) per common share attributable to Centene Corporation:				
Basic:				
Continuing operations	$ 0.74	$ 0.41	$ 1.28	$ 0.70
Discontinued operations	—	0.01	(0.01)	0.01
Basic earnings per common share	$ 0.74	$ 0.42	$ 1.27	$ 0.71
Diluted:				
Continuing operations	$ 0.72	$ 0.39	$ 1.24	$ 0.68
Discontinued operations	—	0.02	(0.01)	0.01
Diluted earnings per common share	$ 0.72	$ 0.41	$ 1.23	$ 0.69

The calculation of diluted earnings per common share for the three and six months ended June 30, 2015 excludes the impact of 49,754 and 59,828 shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units. The calculation of diluted earnings per common share for the three and six months ended June 30, 2014 excludes the impact of 103,710 shares and 111,088 shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

8. Segment Information

Centene operates in two segments: Managed Care and Specialty Services. The Managed Care segment consists of Centene's health plans including all of the functions needed to operate them. The Specialty Services segment consists of Centene's specialty companies offering auxiliary healthcare services and products.

Segment information for the three months ended June 30, 2015, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$ 4,647	$ 537	$ —	$ 5,184
Premium and service revenues from internal customers	25	1,176	(1,201)	—
Total premium and service revenues	$ 4,672	$ 1,713	$ (1,201)	$ 5,184
Earnings from operations	$ 125	$ 48	$ —	$ 173

Segment information for the three months ended June 30, 2014, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$ 3,225	$ 516	$ —	$ 3,741
Premium and service revenues from internal customers	13	676	(689)	—
Total premium and service revenues	$ 3,238	$ 1,192	$ (689)	$ 3,741
Earnings from operations	$ 64	$ 29	$ —	$ 93

Segment information for the six months ended June 30, 2015, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$ 8,890	$ 1,055	$ —	$ 9,945
Premium and service revenues from internal customers	49	2,251	(2,300)	—
Total premium and service revenues	$ 8,939	$ 3,306	$ (2,300)	$ 9,945
Earnings from operations	$ 220	$ 82	$ —	$ 302

Segment information for the six months ended June 30, 2014, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$ 6,195	$ 898	$ —	$ 7,093
Premium and service revenues from internal customers	26	1,315	(1,341)	—
Total premium and service revenues	$ 6,221	$ 2,213	$ (1,341)	$ 7,093
Earnings from operations	$ 108	$ 55	$ —	$ 163

9. Contingencies

On July 5, 2013, the Company's subsidiary, Kentucky Spirit Health Plan, Inc. (Kentucky Spirit), terminated its contract with the Commonwealth of Kentucky (the Commonwealth). Kentucky Spirit believes it had a contractual right to terminate the contract and filed a lawsuit in Franklin Circuit Court seeking a declaration of this right. The Commonwealth has alleged that Kentucky Spirit's exit constitutes a material breach of contract. The Commonwealth seeks to recover substantial damages and to enforce its rights under Kentucky Spirit's $25 million performance bond. The Commonwealth's attorneys have asserted that the Commonwealth's expenditures due to Kentucky Spirit's departure range from $28 million to $40 million plus interest, and

that the associated CMS expenditures range from $92 million to $134 million. Kentucky Spirit disputes the Commonwealth's alleged damages, and is pursuing its own litigation claims for damages against the Commonwealth.

On February 6, 2015, the Kentucky Court of Appeals affirmed a Franklin Circuit Court ruling that Kentucky Spirit does not have a contractual right to terminate the contract early. The Court of Appeals also found that the contract's liquidated damages provision "is applicable in the event of a premature termination of the Contract term." Kentucky Spirit intends to seek Kentucky Supreme Court review of the finding that its departure constituted a breach of contract. The Commonwealth may seek review of the ruling that the liquidated damages provision is applicable in the event of a premature termination.

Kentucky Spirit also filed a lawsuit in April 2013, amended in October 2014, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches. On December 9, 2014, the Franklin Circuit Court denied the Commonwealth's motion for partial summary judgment on Kentucky Spirit's damages claims. On March 15, 2015, the Franklin Circuit Court denied the Commonwealth's motion to stay discovery and ordered that discovery proceed on those claims.

On March 9, 2015, the Secretary of the Kentucky Cabinet for Health and Family Services (CHFS) issued a determination letter finding that Kentucky Spirit owed the Commonwealth $40 million in actual damages plus prejudgment interest at 8 percent. On March 18, 2015, in a letter to the Kentucky Finance and Administration Cabinet, Kentucky Spirit contested CHFS' jurisdiction to make such a determination. Depending on the response from the Finance and Administration Cabinet, Kentucky Spirit may bring the matter to the Franklin Circuit Court.

The resolution of the Kentucky litigation matters may result in a range of possible outcomes. If Kentucky Spirit prevails on its claims, it would be entitled to damages. If the Commonwealth prevails, a liability to the Commonwealth could be recorded. The Company is unable to estimate the ultimate outcome resulting from the Kentucky litigation. As a result, the Company has not recorded any receivable or any liability for potential damages under the contract as of June 30, 2015. While uncertain, the ultimate resolution of the pending litigation could have a material effect on the financial position, cash flow or results of operations of the Company in the period it is resolved or becomes known.

Excluding the Kentucky matters discussed above, the Company is also routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters in the normal course of business is uncertain, the Company does not expect the results of any of these matters individually, or in the aggregate, to have a material effect on its financial position, results of operations or cash flows.

10. Subsequent Events

On July 2, 2015, the Company announced that the Company and two direct, newly formed subsidiaries of the Company had entered into a definitive merger agreement with Health Net, Inc. (Health Net) under which Centene will acquire all of the issued and outstanding shares of Health Net. Under the terms of the agreement, at the closing of the transaction, Health Net stockholders (with limited exceptions) would receive 0.622 of a validly issued, fully paid, non-assessable share of Centene common stock and $28.25 in cash for each share of Health Net common stock. The transaction is valued at approximately $6.8 billion (based on the Centene closing stock price on July 1, 2015), including the assumption of debt. The transaction is expected to close in early 2016 and is subject to approval by Centene and Health Net stockholders, the expiration or termination of the applicable waiting periods under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, approvals by relevant state insurance and healthcare regulators and other customary closing conditions. The Company expects to fund the cash portion of the acquisition through a combination of existing cash on hand and debt financing.

ITEM 2. Management's Discussion and Analysis of Financial Condition and Results of Operations.

The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes included elsewhere in this filing. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under Part II, Item 1A. "Risk Factors" of this Form 10-Q.

OVERVIEW

In 2013, we classified the operations for Kentucky Spirit Health Plan (KSHP) as discontinued operations for all periods presented in our consolidated financial statements. The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise identified.

On February 2, 2015, the Board of Directors declared a two-for-one split of Centene's common stock in the form of a 100% stock dividend distributed February 19, 2015 to stockholders of record on February 12, 2015. All share and per share information presented in this Form 10-Q has been adjusted for the two-for-one stock split.

Key financial metrics for the second quarter of 2015 are summarized as follows:

- Quarter-end managed care membership of 4.6 million, an increase of 1.3 million members, or 38% year over year.
- Premium and service revenues of $5.2 billion, representing 39% growth year over year.
- Health Benefits Ratio of 89.1%, compared to 88.9% in 2014.
- General and Administrative expense ratio of 8.5%, compared to 8.6% in 2014.
- Operating cash flows of $350 million for the second quarter of 2015.
- Diluted net earnings per share of $0.72, compared to $0.39 in 2014.

The following items contributed to our revenue and membership growth over the last year:

- *California.* In December 2014, the ABD membership of our California subsidiary, California Health and Wellness, increased as a result of the mandatory transition of the ABD population to managed care. The enrollment of this population to managed care was previously voluntary.

- *Florida.* In May 2014, our Florida subsidiary, Sunshine Health, began operating under a new contract in 9 of 11 regions of the Managed Medical Assistance (MMA) program. The MMA program includes TANF recipients as well as ABD and dual-eligible members. In addition, we began operating as the sole provider under a new statewide contract for the Child Welfare Specialty Plan (Foster Care). Enrollment for both the MMA program and Foster Care began in May 2014 and was implemented by region through August 2014.

- *Health Insurance Marketplaces (HIM).* In January 2015, we expanded our participation in Health Insurance Marketplaces to include members in certain regions of Illinois and Wisconsin.

- *Illinois.* In March 2014, our Illinois subsidiary, IlliniCare Health, began operating under a new contract as part of the Illinois Medicare-Medicaid Alignment Initiative serving dual-eligible members in Cook, DuPage, Lake, Kane, Kankakee and Will counties (Greater Chicago region).

  In July 2014, IlliniCare Health began operating under a new contract with the Cook County Health and Hospitals System to perform third party administrative services to members enrolled in the CountyCare program, as well as care coordination, behavioral health, vision care and pharmacy benefit management services.

  In September 2014, IlliniCare Health began serving additional Medicaid members under the state's Medicaid and Medicaid expansion programs.

- *Indiana.* In February 2015, our Indiana subsidiary, Managed Health Services, began operating under an expanded contract with the Indiana Family & Social Services Administration to provide Medicaid services under the state's Healthy Indiana Plan 2.0 program.

In April 2015, Managed Health Services began operating under an expanded contract with the Indiana Family & Social Services Administration to provide services to its ABD Medicaid enrollees who qualify for the new Hoosier Care Connect Program.

- *Louisiana.* In July 2014, we completed the transaction whereby Community Health Solutions of America, Inc. (CHS) assigned its contract with the Louisiana Department of Health and Hospitals under the Bayou Health Shared Savings Program to our subsidiary, Louisiana Healthcare Connections (LHC).

  In February 2015, LHC began operating under a new contract with the Louisiana Department of Health and Hospitals to serve Bayou Health (Medicaid) beneficiaries. Members previously served under the shared savings program were transitioned to the at-risk program on February 1, 2015.

- *Michigan.* In May 2015, we completed the acquisition of Fidelis SecureCare of Michigan, Inc. (Fidelis). Fidelis began operating under a new contract with the Michigan Department of Community Health and the Centers for Medicare and Medicaid Services to provide integrated healthcare services to members who are dually eligible for Medicare and Medicaid in Macomb and Wayne counties in May 2015. Passive enrollment began in July 2015.

- *Mississippi.* In July 2014, our Mississippi subsidiary, Magnolia Health, began operating as one of two contractors under a new statewide managed care contract serving members enrolled in the Mississippi Coordinated Access Network program. Program expansion began in December 2014 and continued through July 2015.

  In January 2015, Magnolia Health began operating under a new temporary six-month contract with the State of Mississippi to provide services under the Children's Health Insurance Program (CHIP). In July 2015, Magnolia Health began operating under a two-year CHIP contract with the State of Mississippi.

- *New Hampshire.* In September 2014, our New Hampshire subsidiary, New Hampshire Healthy Families, began serving members under the state's Medicaid expansion program.

- *Ohio.* In May 2014, our Ohio subsidiary, Buckeye Health Plan (Buckeye), began operating under a new contract with the Ohio Department of Medicaid and the Centers for Medicare and Medicaid Services to serve Medicaid members in a dual-eligible demonstration program in three of seven regions: Northeast (Cleveland), Northwest (Toledo) and West Central (Dayton). This three-year program, which is part of the Integrated Care Delivery System expansion, serves those who have both Medicare and Medicaid eligibility. Passive enrollment for Medicaid began in May 2014 and implementation was completed in July 2014. Passive enrollment for Medicare began in January 2015.

- *South Carolina.* In February 2015, our South Carolina subsidiary, Absolute Total Care, began operating under a new contract with the South Carolina Department of Health and Human Services and the Centers for Medicare and Medicaid Services to serve dual-eligible members as part of the state's dual demonstration program.

- *Texas.* In September 2014, we began operating under a new contract with the Texas Health and Human Services Commission (HHSC) to expand our operations and serve STAR+PLUS members in two Medicaid Rural Service Areas. We also began providing expanded coverage in September 2014 under our STAR+PLUS contracts to provide acute care services for intellectually and developmentally disabled members. In March 2015, we began operating under an expanded STAR+PLUS contract with the Texas HHSC to include nursing facility benefits.

  In March 2015, we also began operating under a new contract with the Texas HHSC and the Centers for Medicare and Medicaid Services to serve dual-eligible members in three counties as part of the state's dual demonstration program.

- *Vermont.* In February 2015, Centurion began operating under a new contract with the State of Vermont Department of Corrections to provide comprehensive correctional healthcare services.

In addition, in July 2014, we completed an investment accounted for under the equity method for the purchase of a noncontrolling interest in Ribera Salud S.A. (Ribera Salud), a Spanish health management group. Centene is a joint shareholder with Ribera Salud's remaining investor, Banco Sabadell S.A.

We expect the following items to contribute to our future growth potential:

- We expect to realize the full year benefit in 2015 of business commenced during 2014 in Florida, Illinois, Louisiana, Mississippi, New Hampshire, Ohio and Texas as discussed above.

- In July 2015, we announced that we and two of our direct, newly formed subsidiaries had entered into a definitive merger agreement with Health Net, Inc. (Health Net) under which we will acquire all of the issued and outstanding shares of Health Net. The transaction is valued at approximately $6.8 billion (based on the Centene closing stock price on July 1, 2015), including the assumption of debt. The transaction is expected to close in early 2016.

- In July 2015, Centurion began operating under a new contract with the Mississippi Department of Corrections to provide comprehensive correctional healthcare services.

- In May 2015, Sunshine Health was tentatively recommended for a statewide contract award by the Florida Healthy Kids Corporation to manage healthcare services for children ages five through 18 in all 11 regions of Florida. The two-year contract award is expected to commence in the fourth quarter of 2015.

- In January 2015, we signed a definitive agreement to acquire Agate Resources, Inc., a diversified holding company that offers primarily Medicaid and other healthcare products and services to Oregon residents. The transaction is expected to close in the third quarter of 2015, subject to customary closing conditions.

- In December 2014, our subsidiary, Cenpatico Integrated Care, in partnership with University of Arizona Health Plan, was selected by the Arizona Department of Health Services/Division of Behavioral Health Services to be the Regional Behavioral Health Authority for the new southern geographic service area. The new contract is expected to commence in the fourth quarter of 2015.

- In the fourth quarter of 2015, Louisiana Healthcare Connections expects to begin operating under an expanded contract to include behavioral health benefits, and Magnolia Health anticipates operating under an expanded contract to include the inpatient benefit for Medicaid and ABD members.

MEMBERSHIP

From June 30, 2014 to June 30, 2015, we increased our managed care membership by 1.3 million, or 38%. The following table sets forth our membership by state for our managed care organizations:

	June 30, 2015	December 31, 2014	June 30, 2014
Arizona	210,900	204,000	189,200
Arkansas	45,400	38,400	31,100
California	178,700	163,900	131,100
Florida	470,300	425,700	313,800
Georgia	405,000	389,100	373,000
Illinois	209,100	87,800	29,500
Indiana	250,400	197,700	200,500
Kansas	143,000	143,300	146,100
Louisiana	358,900	152,900	148,600
Massachusetts	61,500	48,400	47,200
Michigan	2,700	—	—
Minnesota	10,900	9,500	9,400
Mississippi	250,600	108,700	97,400
Missouri	82,600	71,000	58,700
New Hampshire	70,800	62,700	39,500
Ohio	287,100	280,100	225,900
South Carolina	112,600	109,700	101,800
Tennessee	21,400	21,000	21,300
Texas	969,700	971,000	921,500
Vermont	2,800	—	—
Washington	214,100	194,400	193,800
Wisconsin	78,600	83,200	67,300
Total at-risk membership	4,437,100	3,762,500	3,346,700
Non-risk membership	176,600	298,400	—
Total	4,613,700	4,060,900	3,346,700

At June 30, 2015, we served 368,900 Medicaid members in Medicaid expansion programs in California, Illinois, Massachusetts, New Hampshire, Ohio and Washington and Indiana HIP 2.0, included in the table above.

The following table sets forth our membership by line of business:

	June 30, 2015	December 31, 2014	June 30, 2014
Medicaid	3,300,600	2,754,900	2,385,500
CHIP & Foster Care	230,500	222,700	261,800
ABD, Medicare & Duals	414,300	392,700	329,700
LTC	72,800	60,800	53,500
Health Insurance Marketplaces	167,400	74,500	75,700
Hybrid Programs [1]	—	18,900	17,000
Behavioral Health	203,900	197,000	182,200
Correctional Healthcare Services	47,600	41,000	41,300
Total at-risk membership	4,437,100	3,762,500	3,346,700
Non-risk membership	176,600	298,400	—
Total	4,613,700	4,060,900	3,346,700

[1] In February 2015, hybrid programs were converted to Medicaid expansion contracts.

The following table identifies our dual-eligible membership by line of business. The membership tables above include these members.

	June 30, 2015	December 31, 2014	June 30, 2014
ABD	106,100	118,300	89,300
LTC	53,100	35,900	41,800
Medicare	8,500	7,200	6,800
Medicaid / Medicare Duals	19,700	3,200	1,400
Total	187,400	164,600	139,300

RESULTS OF OPERATIONS

The following discussion and analysis is based on our consolidated statements of operations, which reflect our results of operations for the three and six months ended June 30, 2015 and 2014, prepared in accordance with generally accepted accounting principles in the United States.

Summarized comparative financial data for the three and six months ended June 30, 2015 and 2014 is as follows ($ in millions, except per share data):

	Three Months Ended June 30,			Six Months Ended June 30,		
	2015	2014	% Change 2014-2015	2015	2014	% Change 2014-2015
Premium	$ 4,692	$ 3,331	40.9 %	$ 8,991	$ 6,402	40.4 %
Service	492	410	20.0 %	954	691	38.1 %
Premium and service revenues	5,184	3,741	38.6 %	9,945	7,093	40.2 %
Premium tax and health insurer fee	322	283	13.8 %	692	391	77.0 %
Total revenues	5,506	4,024	36.8 %	10,637	7,484	42.1 %
Medical costs	4,181	2,960	41.3 %	8,042	5,703	41.0 %
Cost of services	419	366	14.5 %	821	608	35.0 %
General and administrative expenses	442	321	37.7 %	845	616	37.2 %
Premium tax expense	239	253	(5.5)%	520	331	57.1 %
Health insurer fee expense	52	31	67.7 %	107	63	69.8 %
Earnings from operations	173	93	86.0 %	302	163	85.3 %
Other income (expense), net	(1)	(2)	50.0 %	(2)	(4)	50.0 %
Earnings from continuing operations, before income tax expense	172	91	89.0 %	300	159	88.7 %
Income tax expense	84	45	86.7 %	147	79	86.1 %
Earnings from continuing operations, net of income tax	88	46	91.3 %	153	80	91.3 %
Discontinued operations, net of income tax expense of $0, $1, $(1) and $1, respectively	—	2	(100.0)%	(1)	1	(200.0)%
Net earnings	88	48	83.3 %	152	81	87.7 %
(Earnings) loss attributable to noncontrolling interests	—	1	(100.0)%	(1)	1	(200.0)%
Net earnings attributable to Centene Corporation	$ 88	$ 49	79.6 %	$ 151	$ 82	84.1 %
Amounts attributable to Centene Corporation common shareholders:						
Earnings from continuing operations, net of income tax expense	$ 88	$ 47	87.2 %	$ 152	$ 81	87.7 %
Discontinued operations, net of income tax expense	—	2	(100.0)%	(1)	1	(200.0)%
Net earnings	$ 88	$ 49	79.6 %	$ 151	$ 82	84.1 %
Diluted earnings (loss) per common share attributable to Centene Corporation:						
Continuing operations	$ 0.72	$ 0.39	84.6 %	$ 1.24	$ 0.68	82.4 %
Discontinued operations	—	0.02	(100.0)%	(0.01)	0.01	(200.0)%
Total diluted earnings per common share	$ 0.72	$ 0.41	75.6 %	$ 1.23	$ 0.69	78.3 %

Three Months Ended June 30, 2015 Compared to Three Months Ended June 30, 2014

Premium and Service Revenues

Premium and service revenues increased 39% in the three months ended June 30, 2015 over the corresponding period in 2014 primarily as a result of the impact from expansions or new programs in many of our states, particularly Florida, Illinois, Louisiana, Mississippi, Ohio and Texas.

Operating Expenses

Medical Costs

Results of operations depend on our ability to manage expenses associated with health benefits and to accurately estimate costs incurred. The Health Benefits Ratio, or HBR, represents medical costs as a percentage of premium revenues (excluding Premium Tax and Health Insurer Fee revenues) and reflects the direct relationship between the premium received and the medical services provided. The table below depicts the HBR for our membership by member category for the three months ended June 30,:

	2015	2014
Medicaid, CHIP, Foster Care & HIM	85.6%	84.7%
ABD, LTC and Medicare	93.7	94.9
Specialty Services	86.9	80.4
Total	89.1	88.9

The consolidated HBR for the three months ended June 30, 2015, was 89.1%, compared to 88.9% in the same period in 2014. The increase compared to last year is primarily attributable to a higher HBR associated with new programs in two of our states.

Revenue and HBR results for new business and existing business are listed below to assist in understanding our results of operations. Existing businesses are primarily state markets or significant geographic expansion in an existing state or product that we have managed for four complete quarters. New businesses are primarily new state markets or significant geographic expansion in an existing state or product that conversely, we have not managed for four complete quarters. The following table compares the results for new business and existing business for the three months ended June 30,:

	2015	2014
Premium and Service Revenue		
New business	22%	26%
Existing business	78%	74%
HBR		
New business	91.3%	91.8%
Existing business	88.5%	87.9%

The new business HBR decreased compared to last year as a result of a higher portion of new business associated with Medicaid, which operates at a lower HBR. The existing business HBR increased compared to last year as a result of higher acuity business, including Florida LTC, being classified as existing business in the current year.

Cost of Services

Cost of services increased by $53 million in the three months ended June 30, 2015, compared to the corresponding period in 2014. This was primarily due to the addition of the CountyCare contract in Illinois, which began July 1, 2014.

General & Administrative Expenses

General and administrative expenses, or G&A, increased by $121 million in the three months ended June 30, 2015, compared to the corresponding period in 2014. This was primarily due to expenses for additional staff and facilities to support

our membership growth. During the three months ended June 30, 2015, we recorded approximately $2 million of Health Net merger related expenses, which reduced our diluted earnings per share by $0.01.

The consolidated G&A expense ratio for the three months ended June 30, 2015 and 2014 was 8.5% and 8.6%, respectively. The year over year decrease in the G&A ratio reflects the leveraging of expenses over higher revenues in 2015.

Health Insurer Fee

During the three months ended June 30, 2015, we recorded $52 million of non-deductible expense for the Affordable Care Act (ACA) annual health insurer fee. As of June 30, 2015, we have received signed agreements from all applicable states which provide for the reimbursement of the ACA insurer fee including the related gross-up for the associated income tax effects. As a result, we recorded $84 million in Premium Tax and Health Insurer Fee revenue associated with the accrual for the reimbursement of the fee. Therefore, the health insurer fee had no impact on diluted earnings per share during the second quarter of 2015.

During the three months ended June 30, 2014, we recorded $31 million of non-deductible expense for the ACA annual health insurer fee. In addition, we received signed agreements from 14 of 17 applicable states as of June 30, 2014, which provide for the reimbursement of the ACA insurer fee including the related gross-up for the associated income tax effects. As a result, we recorded $30 million of revenue in Premium Tax and Health Insurer Fee revenue associated with the accrual for the reimbursement of the fee. The net effect of the health insurer fee reduced our diluted earnings per share by $0.08 during the second quarter of 2014.

Other Income (Expense)

The following table summarizes the components of other income (expense) for the three months ended June 30, ($ in millions):

	2015	2014
Investment and other income	$ 10	$ 7
Interest expense	(11)	(9)
Other income (expense), net	$ (1)	$ (2)

The increase in investment income in 2015 reflects an increase in investment balances over 2014 and improved performance of certain equity investments. Interest expense increased in 2015 compared to 2014, primarily reflecting the issuance of an additional $200 million in Senior Notes in January 2015.

Income Tax Expense

Our effective tax rate for the three months ended June 30, 2015 and 2014, was 48.8% and 49.5%, respectively. The effective tax rate is higher than the applicable statutory rate primarily as a result of the non-deductibility of the health insurer fee expense.

Segment Results

The following table summarizes our consolidated operating results by segment for the three months ended June 30, ($ in millions):

	2015	2014	% Change 2014-2015
Premium and Service Revenues			
Managed Care	$ 4,672	$ 3,238	44.3 %
Specialty Services	1,713	1,192	43.7 %
Eliminations	(1,201)	(689)	(74.3)%
Consolidated Total	$ 5,184	$ 3,741	38.6 %
Earnings from Operations			
Managed Care	$ 125	$ 64	95.3 %
Specialty Services	48	29	65.5 %
Consolidated Total	$ 173	$ 93	86.0 %

Managed Care

Premium and service revenues increased 44% in the three months ended June 30, 2015, primarily as a result of expansions or new programs in many of our states, particularly Florida, Illinois, Louisiana, Mississippi, Ohio and Texas. Earnings from operations increased $61 million between years primarily reflecting growth in the business.

Specialty Services

Premium and service revenues increased 44% in the three months ended June 30, 2015, resulting primarily from increased services associated with membership growth in the Managed Care segment. Earnings from operations increased $19 million in the three months ended June 30, 2015, primarily reflecting growth in the specialty services provided to our increased Managed Care membership.

Six Months Ended June 30, 2015 Compared to Six Months Ended June 30, 2014

Premium and Service Revenues

Premium and service revenues increased 40% in the six months ended June 30, 2015 over the corresponding period in 2014 primarily as a result of the impact from expansions or new programs in many of our states, particularly Florida, Illinois, Louisiana, Mississippi, Ohio and Texas. During the six months ended June 30, 2015, we received premium rate adjustments which yielded a net 0% composite change across all of our markets.

Operating Expenses

Medical Costs

Results of operations depend on our ability to manage expenses associated with health benefits and to accurately estimate costs incurred. The Health Benefits Ratio, or HBR, represents medical costs as a percentage of premium revenues (excluding Premium Tax and Health Insurer Fee revenues) and reflects the direct relationship between the premium received and the medical services provided. The table below depicts the HBR for our membership by member category for the six months ended June 30,:

	2015	2014
Medicaid, CHIP, Foster Care & HIM	86.5%	85.8%
ABD, LTC and Medicare	93.4	94.0
Specialty Services	86.0	84.0
Total	89.4	89.1

The consolidated HBR for the six months ended June 30, 2015, was 89.4%, compared to 89.1% in the same period in 2014. The increase compared to last year is primarily attributable to an increase in higher acuity membership and higher flu related costs over the prior year.

Cost of Services

Cost of services increased by $213 million in the six months ended June 30, 2015, compared to the corresponding period in 2014. This was primarily due to the growth in the AcariaHealth business as well as the addition of the CountyCare contract in Illinois, which began July 1, 2014

General & Administrative Expenses

General and administrative expenses, or G&A, increased by $229 million in the six months ended June 30, 2015, compared to the corresponding period in 2014. This was primarily due to expenses for additional staff and facilities to support our membership growth. During the first quarter of 2015, we recorded a gain of $10 million on the settlement of contingent consideration related to the CHS transaction. We also recorded expense of $10 million for a contribution to our charitable foundation during the first quarter of 2015.

The consolidated G&A expense ratio for the six months ended June 30, 2015 and 2014 was 8.5% and 8.7%, respectively. The year over year decrease in the G&A ratio reflects the leveraging of expenses over higher revenues in 2015 as well as the impact of transaction costs recognized in 2014.

Health Insurer Fee

During the six months ended June 30, 2015, we recorded $107 million of non-deductible expense for the Affordable Care Act (ACA) annual health insurer fee. As of June 30, 2015, we have received signed agreements from all applicable states which provide for the reimbursement of the ACA insurer fee including the related gross-up for the associated income tax effects. As a result, we recorded $172 million in Premium Tax and Health Insurer Fee revenue associated with the accrual for the reimbursement of the fee. Therefore, the health insurer fee had no impact on diluted earnings per share during the six months ended June 30, 2015.

During the six months ended June 30, 2014, we recorded $63 million of non-deductible expense for the ACA annual health insurer fee. In addition, we recorded $60 million of revenue in Premium Tax and Health Insurer Fee revenue associated with the accrual for the reimbursement of the fee. The net effect of the health insurer fee reduced our diluted earnings per share by $0.16 during the six months ended June 30, 2014.

Other Income (Expense)

The following table summarizes the components of other income (expense) for the six months ended June 30, ($ in millions):

	2015	2014
Investment and other income	$ 19	$ 12
Interest expense	(21)	(16)
Other income (expense), net	$ (2)	$ (4)

The increase in investment income in 2015 reflects an increase in investment balances over 2014 and improved performance of certain equity investments. Interest expense increased during the six months ended June 30, 2015 by $5 million primarily reflecting the issuance of $300 million of Senior Notes in April 2014 and the issuance of an additional $200 million in Senior Notes in January 2015.

Income Tax Expense

Our effective tax rate for the six months ended June 30, 2015 and 2014, was 49.0% and 49.7%, respectively. The effective tax rate is higher than the applicable statutory rate primarily as a result of the non-deductibility of the health insurer fee expense.

Segment Results

The following table summarizes our consolidated operating results by segment for the six months ended June 30, ($ in millions):

	2015	2014	% Change 2014-2015
Premium and Service Revenues			
Managed Care	$ 8,939	$ 6,221	43.7 %
Specialty Services	3,306	2,213	49.4 %
Eliminations	(2,300)	(1,341)	(71.5)%
Consolidated Total	$ 9,945	$ 7,093	40.2 %
Earnings from Operations			
Managed Care	$ 220	$ 108	103.7 %
Specialty Services	82	55	49.1 %
Consolidated Total	$ 302	$ 163	85.3 %

Managed Care

Premium and service revenues increased 44% in the six months ended June 30, 2015, primarily as a result of expansions or new programs in many of our states, particularly Florida, Illinois, Louisiana, Mississippi, Ohio and Texas. Earnings from operations increased $112 million between years primarily reflecting growth in the business.

Specialty Services

Premium and service revenues increased 49% in the six months ended June 30, 2015, resulting primarily from increased services associated with membership growth in the Managed Care segment and growth in our AcariaHealth business. Earnings from operations increased $27 million in the six months ended June 30, 2015, primarily reflecting growth in the specialty services provided to our increased Managed Care membership.

LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows used in the discussion of liquidity and capital resources ($ in millions).

	Six Months Ended June 30,	
	2015	2014
Net cash provided by operating activities	$ 395	$ 412
Net cash used in investing activities	(299)	(390)
Net cash provided by financing activities	261	199
Net increase in cash and cash equivalents	$ 357	$ 221

Cash Flows Provided by Operating Activities

Normal operations are funded primarily through operating cash flows and borrowings under our revolving credit facility. Operating activities provided cash of $395 million in the six months ended June 30, 2015, compared to $412 million in the comparable period in 2014. The cash provided by operations in 2015 and 2014 was primarily related to net earnings and an increase in medical claims liabilities resulting from the growth in the business, partially offset by increases in premium and related receivables.

Cash flows from operations in each year were impacted by the timing of payments we receive from our states. States may prepay the following month premium payment, which we record as unearned revenue, or they may delay our premium payment, which we record as a receivable. We typically receive capitation payments monthly, however the states in which we operate may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period.

The reimbursement of the HIF from our state customers may be settled as a separate payment or monthly in combination with our other premium payments. The vast majority of our state customers are settling the reimbursement through a separate

payment after verification of each state's portion of our HIF, resulting in an increase in Premium and Related Receivables at June 30, 2015.

Cash Flows Used in Investing Activities

Investing activities used cash of $299 million for the six months ended June 30, 2015, and $390 million in the comparable period in 2014. Cash flows used in investing activities in 2015 primarily consisted of additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long term investments and capital expenditures.

In January 2015, we sold 25% of our ownership in Celtic Insurance Company. No gain or loss was recognized on the sale of the ownership interest. Celtic Insurance Company is included in the Managed Care segment. Under the terms of the agreement, we entered into a put agreement with the noncontrolling interest holder to purchase the noncontrolling interest at a later date.

Cash flows used in investing activities in 2014 primarily consisted of additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long term investments, the acquisition of U.S. Medical Management and capital expenditures.

We spent $58 million and $42 million in the six months ended June 30, 2015 and 2014, respectively, on capital expenditures for system enhancements and market expansions.

As of June 30, 2015, our investment portfolio consisted primarily of fixed-income securities with an average duration of 2.9 years. We had unregulated cash and investments of $82 million at June 30, 2015, compared to $85 million at December 31, 2014.

Cash Flows Provided by Financing Activities

Our financing activities provided cash of $261 million in the six months ended June 30, 2015, compared to $199 million in the comparable period in 2014. During 2015 and 2014, our financing activities primarily related to the proceeds from the issuance of Senior Debt. In January 2015, we issued an additional $200 million of 4.75% Senior Notes at par. In connection with the January 2015 issuance, we entered into interest rate swap agreements for a notional amount of $200 million. In April 2014, we issued $300 million 4.75% Senior Notes due May 14, 2022 at par. In connection with the April 2014 issuance, we entered into interest rate swap agreements of a notional amount of $300 million.

Liquidity Metrics

The $500 million revolving credit agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt-to-EBITDA ratios and minimum tangible net worth. We are required not to exceed a maximum debt-to-EBITDA ratio of 3.0 to 1.0. As of June 30, 2015, we had $150 million in borrowings outstanding under our revolving credit facility and we were in compliance with all covenants. As of June 30, 2015, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

We had outstanding letters of credit of $47 million as of June 30, 2015, which were not part of our revolving credit facility. We also had letters of credit for $53 million (valued at the June 30, 2015 conversion rate), or €48 million, representing our proportional share of the letters of credit issued to support Ribera Salud's outstanding debt which are a part of the revolving credit facility. Collectively, the letters of credit bore interest at 1.64% as of June 30, 2015. In addition, we had outstanding surety bonds of $260 million as of June 30, 2015.

The indentures governing our Senior Notes contains non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio.

At June 30, 2015, we had working capital, defined as current assets less current liabilities, of $380 million, compared to $134 million at December 31, 2014. We manage our short term and long term investments with the goal of ensuring that a sufficient portion is held in investments that are highly liquid and can be sold to fund short term requirements as needed.

At June 30, 2015, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 37.1%, compared to 33.5% at December 31, 2014. Excluding the $69 million non-recourse mortgage note, our debt to capital

ratio was 35.7% as of June 30, 2015, compared to 31.7% at December 31, 2014. We utilize the debt to capital ratio as a measure, among others, of our leverage and financial flexibility.

2015 Expectations

As previously discussed, in January 2015, we announced a definitive agreement to acquire Agate Resources, Inc. The transaction is expected to close during the third quarter of 2015, subject to customary closing conditions.

On July 2, 2015, we announced that we and two of our direct, newly formed subsidiaries had entered into a definitive merger agreement with Health Net under which we will acquire all of the issued and outstanding shares of Health Net. Under the terms of the agreement, at the closing of the transaction, Health Net stockholders (with limited exception) would receive 0.622 of a validly issued, fully paid, non-assessable share of Centene common stock and $28.25 in cash for each share of Health Net common stock. The transaction is valued at approximately $6.8 billion (based on the Centene closing stock price on July 1, 2015), including the assumption of debt. The transaction is expected to close in early 2016 and is subject to approval by Centene and Health Net stockholders, the expiration or termination of the applicable waiting periods under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, approvals by relevant state insurance and healthcare regulators and other customary closing conditions. We expect to fund the cash portion of the acquisition through a combination of existing cash on hand and debt financing.

During the remainder of 2015, we expect to make net capital contributions to our insurance subsidiaries of approximately $305 million associated with our growth and spend approximately $110 million in additional capital expenditures primarily associated with system enhancements and market expansions. These capital contributions are expected to be funded by unregulated cash flow generation in 2015 and borrowings on our revolving credit facility.

Based on our operating plan, we expect that our available cash, cash equivalents and investments, cash from our operations and cash available under our credit facility will be sufficient to finance our general operations and capital expenditures, excluding the proposed Health Net transaction, for at least 12 months from the date of this filing.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

Our operations are conducted through our subsidiaries. As managed care organizations, these subsidiaries are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us. Generally, the amount of dividend distributions that may be paid by a regulated subsidiary without prior approval by state regulatory authorities is limited based on the entity's level of statutory net income and statutory capital and surplus.

Our subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of June 30, 2015, our subsidiaries had aggregate statutory capital and surplus of $1,827 million, compared with the required minimum aggregate statutory capital and surplus requirements of $1,008 million. During the six months ended June 30, 2015, we contributed $437 million of statutory capital to our subsidiaries. We estimate our Risk Based Capital, or RBC, percentage (including KSHP) to be in excess of 350% of the Authorized Control Level (excluding the interim impact of the health insurer fee).

The National Association of Insurance Commissioners has adopted rules which set minimum risk based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. As of June 30, 2015, each of our health plans was in compliance with the risk-based capital requirements enacted in those states.

ITEM 3. ***Quantitative and Qualitative Disclosures About Market Risk.***

INVESTMENTS AND DEBT

As of June 30, 2015, we had short term investments of $140 million and long term investments of $1,642 million, including restricted deposits of $101 million. The short term investments generally consist of highly liquid securities with maturities between three and 12 months. The long term investments consist of municipal, corporate and U.S. Treasury securities, government sponsored obligations, life insurance contracts, asset backed securities and equity securities and have maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states' requirements, these investments are classified as long term regardless of the contractual maturity date. Substantially all of our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at June 30, 2015, the fair value of our fixed income investments would decrease by approximately $43 million. Declines in interest rates over time will reduce our investment income.

We have interest rate swap agreements for a notional amount of $750 million with creditworthy financial institutions to manage the impact of market interest rates on interest expense. Our swap agreements convert a portion of our interest expense from fixed to variable rates to better match the impact of changes in market rates on our variable rate cash equivalent investments. As a result, the fair value of $750 million of our long term debt varies with market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at June 30, 2015, the fair value of our debt would decrease by approximately $35 million. An increase in interest rates decreases the fair value of the debt and conversely, a decrease in interest rates increases the value.

For a discussion of the interest rate risk that our investments are subject to, see Part II, Item 1A "Risk Factors–Risks Related to Our Business–Our investment portfolio may suffer losses from reductions in market interest rates and changes in market conditions which could materially and adversely affect our results of operations or liquidity."

INFLATION

The inflation rate for medical care costs has been higher than the overall inflation rate for all items. We use various strategies to mitigate the negative effects of healthcare cost inflation. Specifically, our health plans try to control medical and hospital costs through our state savings initiatives and contracts with independent providers of healthcare services. Through these contracted care providers, our health plans emphasize preventive healthcare and appropriate use of specialty and hospital services. Additionally, our contracts with states require actuarially sound premiums that include healthcare cost trend.

While we currently believe our strategies to mitigate healthcare cost inflation will continue to be successful, competitive pressures, new healthcare and pharmaceutical product introductions, demands from healthcare providers and customers, applicable regulations, an increase in the expected rate of inflation for healthcare costs or other factors may affect our ability to control the impact of healthcare cost increases.

ITEM 4. ***Controls and Procedures.***

Evaluation of Disclosure Controls and Procedures - We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is
(i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and
(ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Form 10-Q, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of June 30, 2015. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of June 30, 2015.

Changes in Internal Control Over Financial Reporting - No change in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) occurred during the quarter ended June 30, 2015 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

PART II
OTHER INFORMATION

ITEM 1. ***Legal Proceedings.***

On July 5, 2013, the Company's subsidiary, Kentucky Spirit Health Plan, Inc. (Kentucky Spirit), terminated its contract with the Commonwealth of Kentucky (the Commonwealth). Kentucky Spirit believes it had a contractual right to terminate the contract and filed a lawsuit in Franklin Circuit Court seeking a declaration of this right. The Commonwealth has alleged that Kentucky Spirit's exit constitutes a material breach of contract. The Commonwealth seeks to recover substantial damages and to enforce its rights under Kentucky Spirit's $25 million performance bond. The Commonwealth's attorneys have asserted that the Commonwealth's expenditures due to Kentucky Spirit's departure range from $28 million to $40 million plus interest, and that the associated CMS expenditures range from $92 million to $134 million. Kentucky Spirit disputes the Commonwealth's alleged damages, and is pursuing its own litigation claims for damages against the Commonwealth.

On February 6, 2015, the Kentucky Court of Appeals affirmed a Franklin Circuit Court ruling that Kentucky Spirit does not have a contractual right to terminate the contract early. The Court of Appeals also found that the contract's liquidated damages provision "is applicable in the event of a premature termination of the Contract term." Kentucky Spirit intends to seek Kentucky Supreme Court review of the finding that its departure constituted a breach of contract. The Commonwealth may seek review of the ruling that the liquidated damages provision is applicable in the event of a premature termination.

Kentucky Spirit also filed a lawsuit in April 2013, amended in October 2014, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches. On December 9, 2014, the Franklin Circuit Court denied the Commonwealth's motion for partial summary judgment on Kentucky Spirit's damages claims. On March 15, 2015, the Franklin Circuit Court denied the Commonwealth's motion to stay discovery and ordered that discovery proceed on those claims.

On March 9, 2015, the Secretary of the Kentucky Cabinet for Health and Family Services (CHFS) issued a determination letter finding that Kentucky Spirit owed the Commonwealth $40 million in actual damages plus prejudgment interest at 8 percent. On March 18, 2015, in a letter to the Kentucky Finance and Administration Cabinet, Kentucky Spirit contested CHFS' jurisdiction to make such a determination. Depending on the response from the Finance and Administration Cabinet, Kentucky Spirit may bring the matter to the Franklin Circuit Court.

The resolution of the Kentucky litigation matters may result in a range of possible outcomes. If Kentucky Spirit prevails on its claims, it would be entitled to damages. If the Commonwealth prevails, a liability to the Commonwealth could be recorded. The Company is unable to estimate the ultimate outcome resulting from the Kentucky litigation. As a result, the Company has not recorded any receivable or any liability for potential damages under the contract as of June 30, 2015. While uncertain, the ultimate resolution of the pending litigation could have a material effect on the financial position, cash flow or results of operations of the Company in the period it is resolved or becomes known.

Excluding the Kentucky matters discussed above, the Company is also routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters in the normal course of business is uncertain, the Company does not expect the results of any of these matters individually, or in the aggregate, to have a material effect on its financial position, results of operations or cash flows.

ITEM 1A. ***Risk Factors.***

FACTORS THAT MAY AFFECT FUTURE RESULTS AND THE TRADING PRICE OF OUR COMMON STOCK

You should carefully consider the risks described below before making an investment decision. The trading price of our common stock could decline due to any of these risks, in which case you could lose all or part of your investment. You should also refer to the other information in this filing, including our consolidated financial statements and related notes. The risks and uncertainties described below are those that we currently believe may materially affect our Company. Additional risks and uncertainties that we are unaware of or that we currently deem immaterial also may become important factors that affect our Company.

Reductions in funding or changes to eligibility requirements for government sponsored healthcare programs in which we participate could substantially affect our financial position, results of operations and cash flows.

The majority of our revenues come from government subsidized healthcare programs including Medicaid, Medicare, CHIP, LTC, ABD, Foster Care and Health Insurance Marketplace premiums. The base premium rate paid for each program differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region and benefit mix. Since Medicaid was created in 1965, the federal government and the states have shared the costs, with the federal share currently averaging around 57%.

Future levels of funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints. Governments periodically consider reducing or reallocating the amount of money they spend for Medicaid, Medicare, CHIP, LTC, ABD and Foster Care. Adverse economic conditions may continue to put pressures on state budgets as tax and other state revenues decrease while the population that is eligible to participate in these programs increases, creating more need for funding. We anticipate this will require government agencies to find funding alternatives, which may result in reductions in funding for programs, contraction of covered benefits, and limited or no premium rate increases or premium rate decreases. A reduction (or less than expected increase), a protracted delay, or a change in allocation methodology in government funding for these programs, as well as termination of the contract for the convenience of the government, may materially and adversely affect our results of operations, financial position and cash flows.

Additionally, changes in these programs could reduce the number of persons enrolled in or eligible for these programs or increase our administrative or healthcare costs under these programs. Recent legislation generally requires that eligibility levels be maintained, but this could cause states to reduce reimbursement or reduce benefits in order for states to afford to maintain eligibility levels. If any state in which we operate were to decrease premiums paid to us or pay us less than the amount necessary to keep pace with our cost trends, it could have a material adverse effect on our results of operations, financial position and cash flows.

Lastly, if a federal government shutdown were to occur for a prolonged period of time, federal government payment obligations, including its obligations under Medicaid, Medicare, CHIP, LTC, ABD, Foster Care and the new Health Insurance Marketplaces, may be delayed. If the federal government fails to make payments under these programs on a timely basis, our business could suffer, and our financial position, results of operations or cash flows may be materially affected.

Failure to accurately estimate and price our medical expenses or effectively manage our medical costs or related administrative costs could negatively affect our financial position, results of operations or cash flows.

Our profitability, to a significant degree, depends on our ability to estimate and effectively manage expenses related to health benefits through our ability to contract favorably with hospitals, physicians and other healthcare providers. For example, our Medicaid revenue is often based on bids submitted before the start of the initial contract year. If our actual medical expense exceeds our estimates, our health benefits ratio, or our expenses related to medical services as a percentage of premium revenue, would increase and our profits would decline. Because of the narrow margins of our health plan business, relatively small changes in our health benefits ratio can create significant changes in our financial results. Changes in healthcare regulations and practices, the level of utilization of healthcare services, hospital and pharmaceutical costs, major epidemics or pandemics, new medical technologies, pharmaceutical compounds and other external factors, including general economic conditions such as inflation and unemployment levels, are beyond our control and could reduce our ability to accurately predict and effectively control the costs of providing health benefits.

Our medical expense includes claims reported but not paid, estimates for claims incurred but not reported, and estimates for the costs necessary to process unpaid claims at the end of each period. Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as claims receipts and payment information as well as inpatient acuity information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expense in the period in which the changes are identified. However, we still cannot be sure that our medical claims liability estimate is adequate or that adjustments to the estimate will not unfavorably impact our results of operations.

Additionally, when we commence operations in a new state, region or product, we have limited information with which to estimate our medical claims liability. For a period of time after the inception of the new business, we base our estimates on state-provided historical actuarial data and limited actual incurred and received claims and inpatient acuity information. The addition of new categories of individuals who are eligible under new legislation may pose the same difficulty in estimating our medical claims liability. Similarly, we may face difficulty in estimating our medical claims liability in 2015 for the relatively new and evolving Health Insurance Marketplaces.

From time to time in the past, our actual results have varied from our estimates, particularly in times of significant changes in the number of our members. If it is determined that our estimates are significantly different than actual results, our results of operations and financial position could be adversely affected. In addition, if there is a significant delay in our receipt of premiums, our business operations, cash flows, or earnings could be negatively impacted.

The implementation of the Health Reform Legislation and other reforms could materially and adversely affect our results of operations, financial position and cash flows.

In March 2010, the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act, collectively referred to as the Affordable Care Act (ACA), were enacted. While the constitutionality of the ACA was generally upheld by the Supreme Court in 2012, the Court determined that states could not be required to expand Medicaid and risk losing all federal money for their existing Medicaid programs.

Under the ACA, Medicaid coverage was expanded to all individuals under age 65 with incomes up to 138% of the federal poverty level beginning January 1, 2014, subject to each states' election. The federal government will pay the entire costs for Medicaid coverage for newly eligible beneficiaries for three years (2014 through 2016). Beginning in 2017, the federal share begins to decline, ending at 90% for 2020 and subsequent years. As of March 6, 2015, 29 states and the District of Columbia have expanded Medicaid eligibility, and additional states continue to discuss expansion. The ACA also maintained CHIP eligibility standards through September 2019.

The ACA required the establishment of Health Insurance Marketplaces for individuals and small employers to purchase health insurance coverage commencing in January 2014. Open enrollment for coverage in 2015 began on November 15, 2014 and continued until February 15, 2015. The ACA required insurers participating on the Health Insurance Marketplaces to offer a minimum level of benefits and included guidelines on setting premium rates and coverage limitations.

Our ability to adequately price products offered in the Health Insurance Marketplaces may have a negative impact on our results of operations, financial position and cash flow. We may be adversely selected by individuals who will have a higher acuity level than the anticipated pool of participants. In addition, the risk corridor, reinsurance and risk adjustment ("three Rs") provisions of the ACA established to reduce risk for insurers may not be effective in appropriately mitigating the financial risks related to the Marketplace product. Further, the reinsurance and risk corridor components may not be adequately funded. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, the three Rs, or other assumptions utilized in setting adequate premium rates could have a material adverse effect on our results of operations, financial position and cash flows.

The U.S. Department of Health and Human Services (HHS) has stated that it will consider a limited number of premium assistance demonstration proposals from States that want to privatize Medicaid expansion. States must provide a choice between at least two qualified health plans and offer very similar benefits as those available in the newly created Health Insurance Marketplaces. Arkansas became the first state to obtain federal approval to use Medicaid funding to purchase private insurance for low-income residents and we began operations under the program beginning January 1, 2014.

The ACA imposes an annual insurance industry assessment of $8.0 billion starting in 2014, and $11.3 billion in each of 2015 and 2016, with increasing annual amounts thereafter. Such assessments are not deductible for federal and most state income tax purposes. The fee will be allocated based on health insurers' premium revenues in the previous year. Each health insurer's fee is calculated by multiplying its market share by the annual fee. Market share is based on commercial, Medicare, and Medicaid premium revenue. Not-for-profit insurers may have a competitive advantage since they are exempt from paying the fee if they receive at least 80% of their premium revenue from Medicare, Medicaid, and CHIP, and other not-for-profit insurers are allowed to exclude 50% of their premium revenue from the fee calculation. If this federal premium assessment is imposed as enacted, and if we are not reimbursed by the states for the cost of the federal premium assessment (including the associated tax impact), or if we are unable to otherwise adjust our business model to address this new assessment, our results of operations, financial position and cash flows may be materially adversely affected.

There are numerous steps required to implement the legislation, including the promulgation of a substantial number of new and potentially more onerous federal regulations. Further, various health insurance reform proposals are also emerging at the state level. Because of the unsettled nature of these reforms and numerous steps required to implement them, we cannot predict what additional health insurance requirements will be implemented at the federal or state level, or the effect that any future legislation or regulation will have on our business or our growth opportunities. Although we believe the legislation may provide us with significant opportunities to grow our business, the enacted reforms, as well as future regulations and legislative changes, may in fact have a material adverse effect on our results of operations, financial position or liquidity. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of healthcare reform, or do not do so as effectively as our competitors, our results of operations may be materially adversely affected.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could force us to change how we operate and could harm our business.

Our business is extensively regulated by the states in which we operate and by the federal government. In addition, the managed care industry has received negative publicity that has led to increased legislation, regulation, review of industry practices and private litigation in the commercial sector. In each of the jurisdictions in which we operate, we are regulated by the relevant insurance, health and/or human services departments that oversee the activities of managed care organizations providing or arranging to provide services to Medicaid, Medicare and Health Insurance Marketplace enrollees. For example, our health plan subsidiaries, as well as our applicable specialty companies, must comply with minimum statutory capital and other financial solvency requirements, such as deposit and surplus requirements.

The frequent enactment of, changes to, or interpretations of laws and regulations could, among other things: force us to restructure our relationships with providers within our network; require us to implement additional or different programs and systems; restrict revenue and enrollment growth; increase our healthcare and administrative costs; impose additional capital and surplus requirements; and increase or change our liability to members in the event of malpractice by our contracted providers. In addition, changes in political party or administrations at the state, federal or country level may change the attitude towards healthcare programs.

Additionally, the taxes and fees paid to federal, state and local governments may increase due to several factors, including: enactment of, changes to, or interpretations of tax laws and regulations, audits by governmental authorities, geographic expansions into higher taxing jurisdictions and the effect of expansions into international markets.

Our contracts with states may require us to maintain a minimum health benefits ratio (HBR) or may require us to share profits in excess of certain levels. In certain circumstances, our plans may be required to return premium back to the state in the event profits exceed established levels or HBR does not meet the minimum requirement. Other states may require us to meet certain performance and quality metrics in order to maintain our contract or receive additional or full contractual revenue.

The governmental healthcare programs in which we participate are subject to the satisfaction of certain regulations and performance standards. For example, under Health Reform Legislation, Congress authorized CMS and the states to implement managed care demonstration programs to serve dually eligible beneficiaries to improve the coordination of their care. Participation in these demonstration programs is subject to CMS approval and the satisfaction of conditions to participation, including meeting certain performance requirements. Our inability to improve or maintain adequate quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs. Specifically, several of our Medicaid contracts require us to maintain a Medicare health plan. Although we strive to comply with all existing regulations and to meet performance standards applicable to our business, failure to meet these requirements could result in financial fines and penalties. Also, states may not allow us to continue to participate in their government programs, or we may fail to win procurements to participate in such programs which could materially and adversely affect our results of operations, financial position and cash flows.

In addition, as a result of the expansion of our businesses and operations conducted in foreign countries, we face political, economic, legal, compliance, regulatory, operational and other risks and exposures that are unique and vary by jurisdiction. These foreign regulatory requirements with respect to, among other items, environmental, tax, licensing, intellectual property, privacy, data protection, investment, capital, management control, labor relations, and fraud and corruption regulations are different than those faced by our domestic businesses. In addition, we are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act. Our failure to comply with laws and regulations governing our conduct outside the United States or to successfully navigate international regulatory regimes that apply to us could adversely affect our ability to market our products and services, which may have a material adverse effect on our business, financial condition and results of operations.

Our businesses providing pharmacy benefit management (PBM) and specialty pharmacy services face regulatory and other risks and uncertainties which could materially and adversely affect our results of operations, financial position and cash flows.

We provide PBM and specialty pharmacy services through our US Script and AcariaHealth businesses. Each business is subject to federal and state laws that govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. They also conduct business as a mail order pharmacy and specialty pharmacy, which subjects them to extensive federal, state and local laws and regulations. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially and adversely affect current industry practices, including the receipt or disclosure of rebates from pharmaceutical companies, the development and use of formularies, and the use of average wholesale prices.

Our PBM and specialty pharmacy businesses would be materially and adversely affected by an inability to contract on favorable terms with pharmaceutical manufacturers and other suppliers, and could face potential claims in connection with purported errors by our mail order or specialty pharmacies, including in connection with the risks inherent in the authorization, compounding, packaging and distribution of pharmaceuticals and other healthcare products. Disruptions at any of our mail order or specialty pharmacies due to an event that is beyond our control could affect our ability to process and dispense prescriptions in a timely manner and could materially and adversely affect our results of operations, financial position and cash flows.

If any of our government contracts are terminated or are not renewed or we receive an adverse review, audit or investigation, our business will suffer.

We provide managed care programs and selected services to individuals receiving benefits under governmental assistance programs. We provide those healthcare services under contracts with regulatory entities in the areas in which we operate. Our government contracts are generally intended to run for three years and may be extended for additional years if the contracting entity or its agent elects to do so. When our contracts expire, they may be opened for bidding by competing healthcare providers, and there is no guarantee that our contracts will be renewed or extended. Competitors may buy their way into the market by submitting bids with lower pricing. Further, our government contracts contain certain provisions regarding eligibility, enrollment and dis-enrollment processes for covered services, eligible providers, periodic financial and informational reporting, quality assurance, timeliness of claims payment and agreement to maintain a Medicare plan in the state and financial standards and are subject to cancellation if we fail to perform in accordance with the standards set by regulatory agencies.

We are also subject to various reviews, audits and investigations to verify our compliance with the terms of our contracts with various governmental agencies and applicable laws and regulations. Any adverse review, audit or investigation could result in: cancellation of our contracts; refunding of amounts we have been paid pursuant to our contracts; imposition of fines, penalties and other sanctions on us; loss of our right to participate in various programs; increased difficulty in selling our products and services; or loss of one or more of our licenses.

If any of our government contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, or we have an adverse review, audit or investigation, our business will suffer, our goodwill could be impaired and our financial position, results of operations or cash flows may be materially affected.

Ineffectiveness of state-operated systems and subcontractors could adversely affect our business.

Our health plans rely on other state-operated systems or subcontractors to qualify, solicit, educate and assign eligible members into managed care plans. The effectiveness of these state operations and subcontractors can have a material effect on a health plan's enrollment in a particular month or over an extended period. When a state implements new programs to determine eligibility, new processes to assign or enroll eligible members into health plans, or chooses new subcontractors, there is an increased potential for an unanticipated impact on the overall number of members assigned to managed care plans.

Our investment portfolio may suffer losses which could materially and adversely affect our results of operations or liquidity.

We maintain a significant investment portfolio of cash equivalents and short term and long term investments in a variety of securities, which are subject to general credit, liquidity, market and interest rate risks and will decline in value if interest rates increase or one of the issuers' credit ratings is reduced. As a result, we may experience a reduction in value or loss of liquidity of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition.

Execution of our growth strategy may increase costs or liabilities, or create disruptions in our business.

Our growth strategy includes the acquisition of health plans participating in government sponsored healthcare programs and specialty services businesses, contract rights and related assets of other health plans both in our existing service areas and in new markets and start-up operations in new markets or new products in existing markets. Although we review the records of companies or businesses we plan to acquire, it is possible that we could assume unanticipated liabilities or adverse operating conditions, or an acquisition may not perform as well as expected or may not achieve timely profitability. We also face the risk that we will not be able to effectively integrate acquisitions into our existing operations effectively without substantial expense, delay or other operational or financial problems and we may need to divert more management resources to integration than we planned.

In connection with start-up operations, we may incur significant expenses prior to commencement of operations and the receipt of revenue. For example, in order to obtain a certificate of authority in most jurisdictions, we must first establish a provider network, have systems in place and demonstrate our ability to administer a state contract and process claims. We may experience delays in operational start dates. As a result of these factors, start-up operations may decrease our profitability. In addition, we are planning to expand our business internationally and we will be subject to additional risks, including, but not limited to, political risk, an unfamiliar regulatory regime, currency exchange risk and exchange controls, cultural and language differences, foreign tax issues, and different labor laws and practices.

If we are unable to effectively execute our growth strategy, our future growth will suffer and our results of operations could be harmed.

If competing managed care programs are unwilling to purchase specialty services from us, we may not be able to successfully implement our strategy of diversifying our business lines.

We are seeking to diversify our business lines into areas that complement our government sponsored health plan business in order to grow our revenue stream and balance our dependence on risk reimbursement. In order to diversify our business, we must succeed in selling the services of our specialty subsidiaries not only to our managed care plans, but to programs operated by third-parties. Some of these third-party programs may compete with us in some markets, and they therefore may be unwilling to purchase specialty services from us. In any event, the offering of these services will require marketing activities that differ significantly from the manner in which we seek to increase revenues from our government sponsored programs. Our ineffectiveness in marketing specialty services to third-parties may impair our ability to execute our business strategy.

Adverse credit market conditions may have a material adverse effect on our liquidity or our ability to obtain credit on acceptable terms.

The securities and credit markets have been experiencing extreme volatility and disruption over the past several years. The availability of credit, from virtually all types of lenders, has at times been restricted. In the event we need access to additional capital to pay our operating expenses, fund subsidiary surplus requirements, make payments on or refinance our indebtedness, pay capital expenditures, or fund acquisitions, our ability to obtain such capital may be limited and the cost of any such capital may be significant, particularly if we are unable to access our existing credit facility.

Our access to additional financing will depend on a variety of factors such as prevailing economic and credit market conditions, the general availability of credit, the overall availability of credit to our industry, our credit ratings and credit capacity, and perceptions of our financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain additional financing on favorable terms or at all.

If state regulators do not approve payments of dividends and distributions by our subsidiaries to us, we may not have sufficient funds to implement our business strategy.

We principally operate through our health plan subsidiaries. As part of normal operations, we may make requests for dividends and distributions from our subsidiaries to fund our operations. These subsidiaries are subject to regulations that limit the amount of dividends and distributions that can be paid to us without prior approval of, or notification to, state regulators. If these regulators were to deny our subsidiaries' request to pay dividends, the funds available to us would be limited, which could harm our ability to implement our business strategy.

We derive a majority of our premium revenues from operations in a limited number of states, and our financial position, results of operations or cash flows would be materially affected by a decrease in premium revenues or profitability in any one of those states.

Operations in a limited number of states have accounted for most of our premium revenues to date. If we were unable to continue to operate in any of our current states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly depending on legislative or other governmental or regulatory actions and decisions, economic conditions and similar factors in those states. For example, states we currently serve may bid out their Medicaid program through a request for proposal process. Our inability to continue to operate in any of the states in which we operate could harm our business.

Competition may limit our ability to increase penetration of the markets that we serve.

We compete for members principally on the basis of size and quality of provider networks, benefits provided and quality of service. We compete with numerous types of competitors, including other health plans and traditional state Medicaid programs that reimburse providers as care is provided. In addition, the impact of healthcare reform legislation and potential growth in our segment may attract new competitors.

Some of the health plans with which we compete have greater financial and other resources and offer a broader scope of products than we do. In addition, significant merger and acquisition activity has occurred in the managed care industry, as well as complementary industries, such as the hospital, physician, pharmaceutical, medical device and health information systems businesses. To the extent that competition intensifies in any market that we serve, as a result of industry consolidation or otherwise, our ability to retain or increase members and providers, or maintain or increase our revenue growth, pricing flexibility and control over medical cost trends may be adversely affected.

If we are unable to maintain relationships with our provider networks, our profitability may be harmed.

Our profitability depends, in large part, upon our ability to contract at competitive prices with hospitals, physicians and other healthcare providers. Our provider arrangements with our primary care physicians, specialists and hospitals generally may be canceled by either party without cause upon 90 to 120 days prior written notice. We cannot provide any assurance that we will be able to continue to renew our existing contracts or enter into new contracts on a timely basis or under favorable terms enabling us to service our members profitably. Healthcare providers with whom we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

In any particular market, physicians and other healthcare providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical costs or difficulty in meeting regulatory or accreditation requirements. In some markets, certain healthcare providers, particularly hospitals, physician/hospital organizations or multi-specialty physician groups, may have significant market positions or near monopolies that could result in diminished bargaining power on our part. In addition, accountable care organizations, practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, and other organizational structures that physicians, hospitals and other healthcare providers choose may change the way in which these providers interact with us and may change the competitive landscape. Such organizations or groups of healthcare providers may compete directly with us, which could adversely affect our operations, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way that we price our products and estimate our costs, which might require us to incur costs to change our operations. Provider networks may consolidate, resulting in a reduction in the competitive environment. In addition, if these providers refuse to contract with us, use their market position to negotiate contracts unfavorable to us or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

From time to time healthcare providers assert or threaten to assert claims seeking to terminate non-cancelable agreements due to alleged actions or inactions by us. In addition, we are aware that other managed care organizations have been subject to class action lawsuits by healthcare providers with respect to claim payment procedures, and we may be subject to similar lawsuits. Regardless of whether any lawsuits brought against us are successful or have merit, they will still be time-consuming and costly and could distract our management's attention. As a result, we may incur significant expenses and may be unable to operate our business effectively. If we are unable to retain our current provider contract terms or enter into new provider contracts timely or on favorable terms, our profitability may be harmed.

We may be unable to attract, retain or effectively manage the succession of key personnel.

We are highly dependent on our ability to attract and retain qualified personnel to operate and expand our business. We would be adversely impacted if we are unable to adequately plan for the succession of our executives and senior management. While we have succession plans in place for members of our executive and senior management team, these plans do not guarantee that the services of our executive and senior management team will continue to be available to us. Our ability to replace any departed members of our executive and senior management or other key employees may be difficult and may take an extended period of time because of the limited number of individuals in the managed care and specialty services industry with the breadth of skills and experience required to operate and successfully expand a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain or motivate these personnel. If we are unable to attract, retain and effectively manage the succession plans for key personnel, executives and senior management, our business and financial position, results of operations or cash flows could be harmed.

If we are unable to integrate and manage our information systems effectively, our operations could be disrupted.

Our operations depend significantly on effective information systems. The information gathered and processed by our information systems assists us in, among other things, monitoring utilization and other cost factors, processing provider claims, and providing data to our regulators. Our healthcare providers also depend upon our information systems for membership verifications, claims status and other information. Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs and regulatory requirements. We regularly upgrade and expand our information systems' capabilities. If we experience difficulties with the transition to or from information systems or are unable to properly maintain or expand our information systems, we could suffer, among other things, operational disruptions, loss of existing members and difficulty in attracting new members, regulatory problems and increases in administrative expenses. In addition, our ability to integrate and manage our information systems may be impaired as the result of events outside our control, including acts of nature, such as earthquakes or fires, or acts of terrorists.

From time to time, we may become involved in costly and time-consuming litigation and other regulatory proceedings, which require significant attention from our management.

We are a defendant from time to time in lawsuits and regulatory actions relating to our business, including, without limitation, medical malpractice claims. Due to the inherent uncertainties of litigation and regulatory proceedings, we cannot accurately predict the ultimate outcome of any such proceedings. An unfavorable outcome could have a material adverse impact on our business and financial position, results of operations or cash flows. In addition, regardless of the outcome of any litigation or regulatory proceedings, such proceedings are costly and time consuming and require significant attention from our management, and could therefore harm our business and financial position, results of operations or cash flows.

An impairment charge with respect to our recorded goodwill and intangible assets could have a material impact on our results of operations.

We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. Changes in business strategy, government regulations or economic or market conditions have resulted and may result in impairments of our goodwill and other intangible assets at any time in the future. Our judgments regarding the existence of impairment indicators are based on, among other things, legal factors, market conditions, and operational performance. For example, the non-renewal of our health plan contracts with the state in which they operate may be an indicator of impairment. If an event or events occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill and other intangible assets, such revision could result in a non-cash impairment charge that could have a material impact on our results of operations in the period in which the impairment occurs.

If we fail to comply with applicable privacy, security, and data laws, regulations and standards, including with respect to third-party service providers that utilize sensitive personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

As part of our normal operations, we collect, process and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act and the Gramm-Leach-Bliley Act, which require us to protect the privacy of medical records and safeguard personal health information we maintain and use. Certain of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities. Despite our best attempts to maintain adherence to information privacy and security best practices as well as compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers, may be vulnerable to privacy or security breaches, acts of vandalism or theft, malware, misplaced or lost data including paper or electronic media, programming and/or human errors or other similar events. In the past, we have had data breaches resulting in disclosure of confidential or protected health information that have not resulted in any material financial loss or penalty to date. However, future data breaches could require us to expend significant resources to remediate any damage, interrupt our operations and damage our reputation, subject us to state or federal agency review and could also result in enforcement actions, material fines and penalties, litigation or other actions which could have a material adverse effect on our business, reputation and results of operations, financial position and cash flows.

In addition, HIPAA broadened the scope of fraud and abuse laws applicable to healthcare companies. HIPAA created civil penalties for, among other things, billing for medically unnecessary goods or services. HIPAA established new enforcement mechanisms to combat fraud and abuse, including civil and, in some instances, criminal penalties for failure to comply with specific standards relating to the privacy, security and electronic transmission of protected health information. The HITECH Act expanded the scope of these provisions by mandating individual notification in instances of breaches of protected health information, providing enhanced penalties for HIPAA violations, and granting enforcement authority to states' Attorneys General in addition to the HHS Office for Civil Rights. It is possible that Congress may enact additional legislation in the future to increase penalties and to create a private right of action under HIPAA, which could entitle patients to seek monetary damages for violations of the privacy rules. In addition, HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities with a focus on security risk assessments. Although we are not aware of HHS plans to audit any of our covered entities, an audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Under HIPAA, health plans are required to have the capacity to accept and send all covered transactions in a standardized electronic format. Penalties can be imposed for failure to comply with these requirements. The transaction standards have been modified to version 5010 to prepare for the implementation of the ICD-10 coding system. While we have prepared for the transition to ICD-10 in October 2015, if unforeseen circumstances arise, it is possible that we could be exposed to investigations and allegations of noncompliance. In addition, if some providers continue to use ICD-9 codes on claims after October 1, 2015, we may have to reject such claims, which may lead to claim resubmissions, increased call volume and provider and customer dissatisfaction. Further, providers may use ICD-10 codes differently than they used ICD-9 codes in the past, which could result in higher costs and reimbursement levels, or lost revenues under risk adjustment. During the transition to ICD-10, certain claims processing and payment information we have historically used to establish our reserves may not be reliable or available in a timely manner. As a result, implementation of ICD 10 may have a material adverse effect on our results of operations, financial position and cash flows.

A failure in or breach of our operational or security systems or infrastructure, or those of third parties with which we do business, including as a result of cyber attacks, could have an adverse effect on our business.

Information security risks have significantly increased in recent years in part because of the proliferation of new technologies, the use of the internet and telecommunications technologies to conduct our operations, and the increased sophistication and activities of organized crime, hackers, terrorists and other external parties, including foreign state agents. Our operations rely on the secure processing, transmission and storage of confidential, proprietary and other information in our computer systems and networks.

Security breaches may arise from external or internal threats. External breaches include hacking personal information for financial gain, attempting to cause harm to our operations, or intending to obtain competitive information. We experience attempted external hacking or malicious attacks on a regular basis. We maintain a rigorous system of preventive and detective controls through our security programs; however, our prevention and detection controls may not prevent or identify all such attacks. Internal breaches may result from inappropriate security access to confidential information by rogue employees, consultants or third party service providers. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, financial data, competitively sensitive information, or other proprietary data, whether by us or a third party, could have a material adverse effect on our business reputation, financial condition, cash flows, or results of operations.

Consummation of the merger with Health Net is subject to receipt of regulatory approvals and certain other conditions and we cannot predict when or if such conditions will be satisfied or waived or if, in connection with the receipt of necessary approvals, regulators will impose conditions on us that have an adverse effect on our business.

Consummation of the merger with Health Net is subject to receipt of regulatory approvals and certain other conditions, including, among others:

- the approval of the stockholders of both our Company and Health Net;
- the expiration or termination of the applicable waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended;
- certain filings or consents required for the consummation of the Merger and the other transactions under applicable state and foreign insurance and health care regulatory laws having been made or obtained;
- the effectiveness of a registration statement covering the shares of our common stock to be issued to the stockholders of Health Net; and
- certain other customary conditions.

We cannot provide any assurance that the merger will be completed, that there will not be a delay in the completion of the merger or that all or any of the anticipated benefits of the merger will be realized. Any delay could also, among other things, result in additional transaction costs, loss of revenue or other negative effects associated with uncertainty about completion of the merger. In the event the merger agreement is terminated or the transaction is materially delayed for any reason, the price of our common stock may be impacted. Regulatory authorities reviewing the merger may refuse to permit the merger or may impose restrictions or conditions on the merger that may adversely affect the Company if the merger is completed.

The anticipated benefits of the merger with Health Net may not be realized fully and may take longer to realize than expected.

The success of the merger will depend, in part, on our ability to successfully combine the businesses of the Company and Health Net, which currently operate as independent public companies, and realize the anticipated benefits, including synergies, cost savings, innovation and operational efficiencies, from the combination. If we are unable to achieve these objectives within the anticipated time frame, or at all, the anticipated benefits may not be realized fully or at all, or may take longer to realize than expected and the value of our common stock may be harmed.

The merger involves the integration of Health Net's businesses with our existing business, which is a complex, costly and time-consuming process. We have not previously completed a transaction comparable in size or scope to the proposed merger. The integration of the two companies may result in material challenges, including, without limitation:

- the diversion of management's attention from ongoing business concerns and performance shortfalls at one or both of the companies as a result of the devotion of management's attention to the merger;
- managing a larger combined company;
- maintaining employee morale and retaining key management and other employees;
- the possibility of faulty assumptions underlying expectations regarding the integration process;
- retaining existing business and operational relationships and attracting new business and operational relationships;
- consolidating corporate and administrative infrastructures and eliminating duplicative operations;
- coordinating geographically separate organizations;
- unanticipated issues in integrating information technology, communications and other systems;
- unanticipated changes in federal or state laws or regulations, including the Patient Protection and Affordable Care Act and the Health Care Education Affordability Reconciliation Act and any regulations enacted thereunder; and
- unforeseen expenses or delays associated with the merger.

Many of these factors will be outside of our control and any one of them could result in delays, increased costs, decreases in the amount of expected revenues and diversion of management's time and energy, which could materially affect our financial position, results of operations and cash flows.

We and Health Net are currently permitted to conduct only limited planning regarding the integration of the two companies following the merger and have not yet determined the exact nature of how the businesses and operations of the two companies will be combined after the merger. The actual integration may result in additional and unforeseen expenses, and the anticipated benefits of the integration plan may not be realized.

Our financial results after the merger will depend on our ability to maintain our and Health Net's business and operational relationships.

A substantial portion of each of our and Health Net's revenues are received under contracts with states. Our success following the merger will depend in part on our ability to maintain these state contracts and other business and operational relationships, including those of Health Net. Health Net's state contracts and other business and operational relationships may have termination or other rights that may be triggered by the merger, or the states or other business and operational relationships may decide not to renew their existing relationships with Health Net or, after the merger, with us. If Health Net (prior to the completion of the merger) and we (after the completion of the merger) are unable to maintain these contracts and other business and operational relationships, our financial position, results of operations or cash flows could be materially affected.

We will incur significant transaction and merger-related costs in connection with the merger.

We will incur significant costs in connection with the integration process. The substantial majority of these costs will be non-recurring expenses related to the merger (including financing of the merger), facilities and systems consolidation costs. We may incur additional costs to maintain employee morale and to retain key employees. We will also incur transaction fees and costs related to formulating integration plans. Additional unanticipated costs may be incurred in the integration of Health Net's businesses. Although we expect that the elimination of duplicative costs, as well as the realization of other efficiencies related to the integration of the businesses, should allow us to more than offset incremental transaction and merger-related costs over time, this net benefit may not be achieved in the near term, or at all. Additionally, as a result of the merger, rating agencies may take negative actions with regard to our credit ratings. This may increase our costs in connection with the financing of the merger.

Failure to complete the merger could impact our stock price and our future business and financial position, results of operations and cash flows.

If the merger is not completed or our financing for the transaction becomes unavailable, our ongoing business and financial position, results of operations and cash flows may be materially affected and we will be subject to a number of risks, including the following:

- depending on the reasons leading to such termination we could be liable to Health Net for termination fees in connection with the termination of the merger agreement;
- we could be responsible for the transaction costs relating to the merger, whether or not the merger is completed;
- while the merger agreement is in force, we are subject to certain restrictions on the conduct of our business, which may adversely affect our ability to execute certain of our business strategies;
- the market price of our common stock could decline to the extent that the current market price reflects, and is positively affected by, a market assumption that the transactions contemplated by the merger will be completed; and
- matters relating to the merger (including integration planning) may require substantial commitments of time and resources by our management, whether or not the merger is completed, which could otherwise have been devoted to other opportunities that may have been beneficial to us.

In addition, if the merger is not completed, we may experience negative reactions from the financial markets and from our providers, members and employees. We may also be subject to litigation related to any failure to complete the merger or to enforcement proceedings commenced against us to perform our obligations under the merger agreement. If the merger is not completed, these risks may materialize and may materially affect our financial position, results of operations and cash flows, as well as the price of our common stock.

The market price of our common stock may decline as a result of the merger with Health Net.

The market price of the common stock of our company may decline as a result of the merger if, among other things, we are unable to achieve the expected growth in earnings, or if the operational cost savings estimates in connection with the integration of Health Net's business with ours are not realized, or if the transaction costs related to the merger are greater than expected, or if the financing related to the transaction is on unfavorable terms. The market price also may decline if we do not achieve the perceived benefits of the merger as rapidly or to the extent anticipated by financial or industry analysts or if the effect of the merger on our financial position, results of operations or cash flows is not consistent with the expectations of financial or industry analysts.

The merger will substantially reduce the percentage ownership interests of our current stockholders; it may not be accretive and may cause dilution to our earnings per share, which may negatively affect the market price of our common stock.

Our stockholders have the right to vote in the election of our Board of Directors and on certain other matters affecting the Company. If the merger is completed we will pay approximately $6.8 billion and Health Net's stockholders are expected to hold approximately 29% of the common stock of the Company after the merger. As a result, if the merger is completed, our pre-merger stockholders will own a smaller proportion of our outstanding common stock than the proportion of our outstanding common stock they owned before the merger and, as a result, they will have less influence on our management and policies following the merger than they now have on our management and policies. We currently anticipate that the merger will be accretive to our earnings per share. This expectation is based on preliminary estimates which may materially change. We could also encounter additional transaction and integration-related costs or other factors such as the failure to realize all of the benefits anticipated in the merger, or unforeseen liabilities or other issues existing or arising with the business of Health Net or otherwise resulting from the merger. All of these factors could cause dilution to our earnings per share or decrease or delay the expected accretive effect of the merger and cause a decrease in the price of our common stock.

ITEM 2. ***Unregistered Sales of Equity Securities and Use of Proceeds.***

Issuer Purchases of Equity Securities
Second Quarter 2015

Period	Total Number of Shares Purchased [1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs[2]
April 1 – April 30, 2015	20,935	$ 70.55	—	3,335,448
May 1 - May 31, 2015	18,232	67.69	—	3,335,448
June 1 - June 30, 2015	9,185	76.67	—	3,335,448
Total	48,352	$ 70.64	—	3,335,448

[1] Shares acquired represent shares relinquished to the Company by certain employees for payment of taxes or option cost upon vesting of restricted stock units or option exercise.

[2] Our Board of Directors adopted a stock repurchase program which allows for repurchases of up to a remaining amount of 3,335,448 shares. No duration has been placed on the repurchase program.

ITEM 6. ***Exhibits.***

EXHIBIT NUMBER	DESCRIPTION
2.1	Agreement and Plan of Merger, dated as of July 2, 2015, by and among Centene Corporation, Health Net, Inc. Chopin Merger Sub I, Inc., and Chopin Merger Sub II, Inc., incorporated by reference to Exhibit 2.1 to Centene Corporation's Current Report on Form 8-K dated July 7, 2015.
10.1*	Amended and Restated Non-Employee Directors Deferred Stock Compensation Plan.
10.2	Voting Agreement, dated as of July 2, 2015, by and between Centene Corporation and Jay M. Gellert, incorporated by reference to Exhibit 10.1 to Centene Corporation's Current Report on Form 8-K dated July 7, 2015.
12.1	Computation of ratio of earnings to fixed charges.
31.1	Certification of Chairman, President and Chief Executive Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Executive Vice President and Chief Financial Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chairman, President and Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Executive Vice President and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.1	XBRL Taxonomy Instance Document.
101.2	XBRL Taxonomy Extension Schema Document.
101.3	XBRL Taxonomy Extension Calculation Linkbase Document.
101.4	XBRL Taxonomy Extension Definition Linkbase Document.
101.5	XBRL Taxonomy Extension Label Linkbase Document.
101.6	XBRL Taxonomy Extension Presentation Linkbase Document.

* Indicates a management contract or compensatory plan or arrangement.

SIGNATURES

Pursuant to the requirements 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 as of July 28, 2015.

CENTENE CORPORATION

By: /s/ MICHAEL F. NEIDORFF
Chairman, President and Chief Executive Officer
(principal executive officer)

By: /s/ WILLIAM N. SCHEFFEL
Executive Vice President and Chief Financial Officer
(principal financial officer)

By: /s/ JEFFREY A. SCHWANEKE
Senior Vice President, Corporate Controller and Chief Accounting Officer
(principal accounting officer)

EXHIBIT 31.1

CERTIFICATION

I, Michael F. Neidorff, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of Centene Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, 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;

   c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: July 28, 2015

/s/ MICHAEL F. NEIDORFF

Chairman, President and Chief Executive Officer
(principal executive officer)

EXHIBIT 31.2

CERTIFICATION

, William N. Scheffel, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of Centene Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, 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;

   c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting;

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: July 28, 2015

/s/ WILLIAM N. SCHEFFEL

Executive Vice President and Chief Financial Officer
(principal financial officer)

EXHIBIT 32.1

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report on Form 10-Q of Centene Corporation (the Company) for the period ended June 30, 2015, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, Michael F. Neidorff, Chairman, President and Chief Executive Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: July 28, 2015

/s/ MICHAEL F. NEIDORFF

Chairman, President and Chief Executive Officer
(principal executive officer)

EXHIBIT 32.2

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report on Form 10-Q of Centene Corporation (the Company) for the period ended June 30, 2015, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, William N. Scheffel, Executive Vice President and Chief Financial Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: July 28, 2015

/s/ WILLIAM N. SCHEFFEL

Executive Vice President and Chief Financial Officer
(principal financial officer)

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-Q

(Mark One)

[X] **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended March 31, 2015

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: 001-31826

CENTENE CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**42-1406317**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification Number)*
7700 Forsyth Boulevard **St. Louis, Missouri**	**63105**
(Address of principal executive offices)	*(Zip Code)*

Registrant's telephone number, including area code:

(314) 725-4477

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 Web site, 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 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 "small reporting company" in Rule 12b-2 of the Exchange Act. 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 ☒

As of April 17, 2015, the registrant had 118,914,646 shares of common stock outstanding.

CENTENE CORPORATION
QUARTERLY REPORT ON FORM 10-Q
TABLE OF CONTENTS

		PAGE
	Part I	
	Financial Information	
Item 1.	Financial Statements	1
	Consolidated Balance Sheets as of March 31, 2015 and December 31, 2014 (unaudited)	1
	Consolidated Statements of Operations for the Three Months Ended March 31, 2015 and 2014 (unaudited)	2
	Consolidated Statements of Comprehensive Earnings for the Three Months Ended March 31, 2015 and 2014 (unaudited)	3
	Consolidated Statements of Stockholders' Equity for the Three Months Ended March 31, 2015 (unaudited)	4
	Consolidated Statements of Cash Flows for the Three Months Ended March 31, 2015 and 2014 (unaudited)	5
	Notes to the Consolidated Financial Statements (unaudited)	6
Item 2.	Management's Discussion and Analysis of Financial Condition and Results of Operations	14
Item 3.	Quantitative and Qualitative Disclosures About Market Risk	24
Item 4.	Controls and Procedures	24
	Part II	
	Other Information	
Item 1.	Legal Proceedings	25
Item 1A.	Risk Factors	25
Item 2.	Unregistered Sales of Equity Securities and Use of Proceeds	35
Item 6.	Exhibits	36
Signatures		37
Certifications		38

CAUTIONARY STATEMENT ON FORWARD-LOOKING STATEMENTS

All statements, other than statements of current or historical fact, contained in this filing are forward-looking statements. We have attempted to identify these statements by terminology including "believe," "anticipate," "plan," "expect," "estimate," "intend," "seek," "target," "goal," "may," "will," "should," "can," "continue" and other similar words or expressions in connection with, among other things, any discussion of future operating or financial performance. In particular, these statements include statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions, investments and the adequacy of our available cash resources. These statements may be found in the various sections of this filing, including those entitled "Management's Discussion and Analysis of Financial Condition and Results of Operations," Part II, Item 1A. "Risk Factors," and Part II, Item 1 "Legal Proceedings." Readers are cautioned that matters subject to forward-looking statements involve known and unknown risks and uncertainties, including economic, regulatory, competitive and other factors that may cause our or our industry's actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

All forward-looking statements included in this filing are based on information available to us on the date of this filing and we undertake no obligation to update or revise the forward-looking statements included in this filing, whether as a result of new information, future events or otherwise, after the date of this filing. Actual results may differ from projections or estimates due to a variety of important factors, including but not limited to:

- our ability to accurately predict and effectively manage health benefits and other operating expenses and reserves;
- competition;
- membership and revenue projections;
- timing of regulatory contract approval;
- changes in healthcare practices;
- changes in federal or state laws or regulations, including the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act and any regulations enacted thereunder;
- changes in expected contract start dates;
- changes in expected closing dates, estimated purchase price and accretion for acquisitions;
- inflation;
- foreign currency fluctuations;
- provider and state contract changes;
- new technologies;
- advances in medicine;
- reduction in provider payments by governmental payors;
- major epidemics;
- disasters and numerous other factors affecting the delivery and cost of healthcare;
- the expiration, cancellation or suspension of our Medicare or Medicaid managed care contracts by federal or state governments;
- the outcome of pending legal proceedings;
- availability of debt and equity financing, on terms that are favorable to us; and
- general economic and market conditions.

This list of important factors is not intended to be exhaustive. We discuss certain of these matters more fully, as well as certain risk factors that may affect our business operations, financial condition and results of operations, in our filings with the Securities and Exchange Commission, including our annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K.

Other Information

The discussion in Part I, Item 2. "Management's Discussion and Analysis of Financial Condition and Results of Operations" under the heading "Results of Operations" contains financial information for new and existing businesses. Existing businesses are primarily state markets, significant geographic expansion in an existing state or product that we have managed for four complete quarters. New businesses are primarily new state markets, significant geographic expansion in an existing state or product that conversely, we have not managed for four complete quarters.

Item 1A "Risk Factors" of Part II of this filing contains a further discussion of these and other important factors that could cause actual results to differ from expectations. We disclaim any current intention or obligation to update or revise any forward-looking statements, whether as a result of new information, future events or otherwise. Due to these important factors and risks, we cannot give assurances with respect to our future premium levels or our ability to control our future medical costs.

PART I
FINANCIAL INFORMATION

ITEM 1. ***Financial Statements.***

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
(In millions, except share data)
(Unaudited)

	March 31, 2015	December 31, 2014
ASSETS		
Current assets:		
Cash and cash equivalents	$ 1,666	$ 1,610
Premium and related receivables	1,245	912
Short term investments	151	177
Other current assets	528	335
Total current assets	3,590	3,034
Long term investments	1,527	1,280
Restricted deposits	98	100
Property, software and equipment, net	450	445
Goodwill	786	754
Intangible assets, net	131	120
Other long term assets	114	91
Total assets	$ 6,696	$ 5,824
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$ 1,950	$ 1,723
Accounts payable and accrued expenses	1,002	768
Return of premium payable	269	236
Unearned revenue	117	168
Current portion of long term debt	5	5
Total current liabilities	3,343	2,900
Long term debt	1,123	874
Other long term liabilities	238	159
Total liabilities	4,704	3,933
Commitments and contingencies		
Redeemable noncontrolling interests	155	148
Stockholders' equity:		
Preferred stock, $0.001 par value; authorized 10,000,000 shares; no shares issued or outstanding at March 31, 2015 and December 31, 2014	—	—
Common stock, $.001 par value; authorized 200,000,000 shares; 124,562,959 issued and 118,886,912 outstanding at March 31, 2015, and 124,274,864 issued and 118,433,416 outstanding at December 31, 2014	—	—
Additional paid-in capital	870	840
Accumulated other comprehensive loss	(1)	(1)
Retained earnings	1,066	1,003
Treasury stock, at cost (5,676,047 and 5,841,448 shares, respectively)	(98)	(98)
Total Centene stockholders' equity	1,837	1,744
Noncontrolling interest	—	(1)
Total stockholders' equity	1,837	1,743
Total liabilities and stockholders' equity	$ 6,696	$ 5,824

The accompanying notes to the consolidated financial statements are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF OPERATIONS
(In millions, except share data)
(Unaudited)

	Three Months Ended March 31,	
	2015	2014
Revenues:		
Premium	$ 4,299	$ 3,071
Service	462	281
Premium and service revenues	4,761	3,352
Premium tax and health insurer fee	370	108
Total revenues	5,131	3,460
Expenses:		
Medical costs	3,861	2,743
Cost of services	402	242
General and administrative expenses	403	296
Premium tax expense	281	78
Health insurer fee expense	55	31
Total operating expenses	5,002	3,390
Earnings from operations	129	70
Other income (expense):		
Investment and other income	9	5
Interest expense	(10)	(7)
Earnings from continuing operations, before income tax expense	128	68
Income tax expense	63	35
Earnings from continuing operations, net of income tax expense	65	33
Discontinued operations, net of income tax expense of $0 and $0, respectively	(1)	(1)
Net earnings	64	32
(Earnings) loss attributable to noncontrolling interests	(1)	1
Net earnings attributable to Centene Corporation	$ 63	$ 33
Amounts attributable to Centene Corporation common shareholders:		
Earnings from continuing operations, net of income tax expense	$ 64	$ 34
Discontinued operations, net of income tax expense (benefit)	(1)	(1)
Net earnings	$ 63	$ 33
Net earnings (loss) per common share attributable to Centene Corporation:		
Basic:		
Continuing operations	$ 0.54	$ 0.30
Discontinued operations	(0.01)	(0.01)
Basic earnings per common share	$ 0.53	$ 0.29
Diluted:		
Continuing operations	$ 0.52	$ 0.29
Discontinued operations	(0.01)	(0.01)
Diluted earnings per common share	$ 0.51	$ 0.28
Weighted average number of common shares outstanding:		
Basic	118,783,755	114,967,752
Diluted	122,572,366	118,722,532

The accompanying notes to the consolidated financial statements are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENT OF COMPREHENSIVE EARNINGS
(In millions)
(Unaudited)

	Three Months Ended March 31,	
	2015	2014
Net earnings	$ 64	$ 32
Change in unrealized gain on investments, net of tax	5	2
Foreign currency translation adjustments	(5)	—
Other comprehensive earnings	—	2
Comprehensive earnings	64	34
Comprehensive (earnings) loss attributable to noncontrolling interests	(1)	1
Comprehensive earnings attributable to Centene Corporation	$ 63	$ 35

The accompanying notes to the consolidated financial statements are an integral part of this statement.

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENT OF STOCKHOLDERS' EQUITY
(In millions, except share data)
(Unaudited)

Three Months Ended March 31, 2015

	Centene Stockholders' Equity								
	Common Stock					Treasury Stock			
	$.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	$.001 Par Value Shares	Amt	Non controlling Interest	Total
Balance, December 31, 2014	124,274,864	$ —	$ 840	$ (1)	$ 1,003	5,841,448	$ (98)	$ (1)	$ 1,743
Comprehensive Earnings:									
Net earnings	—	—	—	—	63	—	—	—	63
Change in unrealized investment loss, net of $3 tax	—	—	—	5	—	—	—	—	5
Foreign currency translation	—	—	—	(5)	—	—	—	—	(5)
Total comprehensive earnings									63
Common stock issued for acquisition	—	—	9	—	—	(247,580)	4	—	13
Common stock issued for employee benefit plans	288,095	—	2	—	—	—	—	—	2
Common stock repurchases	—	—	—	—	—	82,179	(4)	—	(4)
Stock compensation expense	—	—	16	—	—	—	—	—	16
Excess tax benefits from stock compensation	—	—	3	—	—	—	—	—	3
Reclassification to redeemable noncontrolling interest	—	—	—	—	—	—	—	1	1
Balance, March 31, 2015	124,562,959	$ —	$ 870	$ (1)	$ 1,066	5,676,047	$ (98)	$ —	$ 1,837

The accompanying notes to the consolidated financial statements are an integral part of this statement.

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
(In millions)
(Unaudited)

	Three Months Ended March 31,	
	2015	2014
Cash flows from operating activities:		
Net earnings	$ 64	$ 32
Adjustments to reconcile net earnings to net cash provided by operating activities		
Depreciation and amortization	27	20
Stock compensation expense	16	11
Deferred income taxes	(6)	(8)
Gain on settlement of contingent consideration	(10)	—
Changes in assets and liabilities		
Premium and related receivables	(334)	(119)
Other current assets	(3)	3
Other assets	(13)	(14)
Medical claims liabilities	227	196
Unearned revenue	(51)	35
Accounts payable and accrued expenses	58	91
Other long term liabilities	68	4
Other operating activities	2	1
Net cash provided by operating activities	45	252
Cash flows from investing activities:		
Capital expenditures	(27)	(18)
Purchases of investments	(307)	(167)
Sales and maturities of investments	111	112
Proceeds from asset sale	7	—
Investments in acquisitions, net of cash acquired	(9)	(77)
Net cash used in investing activities	(225)	(150)
Cash flows from financing activities:		
Proceeds from exercise of stock options	2	2
Proceeds from borrowings	500	645
Payment of long term debt	(253)	(519)
Excess tax benefits from stock compensation	3	—
Common stock repurchases	(4)	(2)
Contribution from noncontrolling interest	—	5
Debt issue costs	(4)	—
Payment of contingent consideration obligation	(8)	—
Net cash provided by financing activities	236	131
Net increase in cash and cash equivalents	56	233
Cash and cash equivalents, beginning of period	1,610	1,038
Cash and cash equivalents, end of period	$ 1,666	$ 1,271
Supplemental disclosures of cash flow information:		
Interest paid	$ 2	$ 2
Income taxes paid	$ 24	$ 21
Equity issued in connection with acquisitions	$ 13	$ 132

The accompanying notes to the consolidated financial statements are an integral part of these statements.

1. Basis of Presentation

Basis of Presentation

The accompanying interim financial statements have been prepared under the presumption that users of the interim financial information have either read or have access to the audited financial statements included in the Form 10-K for the fiscal year ended December 31, 2014. The unaudited interim financial statements herein have been prepared pursuant to the rules and regulations of the Securities and Exchange Commission. Accordingly, footnote disclosures which would substantially duplicate the disclosures contained in the December 31, 2014 audited financial statements have been omitted from these interim financial statements where appropriate. In the opinion of management, these financial statements reflect all adjustments, consisting only of normal recurring adjustments, which are necessary for a fair presentation of the results of the interim periods presented.

Certain 2014 amounts in the notes to the consolidated financial statements have been reclassified to conform to the 2015 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

On February 2, 2015, the Board of Directors declared a two-for-one split of Centene's common stock in the form of a 100% stock dividend distributed February 19, 2015 to stockholders of record on February 12, 2015. All share and per share information presented in this Form 10-Q has been adjusted for the two-for-one stock split.

Recently Adopted Accounting Pronouncement

In April 2015, the Financial Accounting Standards Board (FASB) issued an Accounting Standards Update which changes the presentation of debt issuance costs in financial statements. Under the new standard, debt issuance costs are presented in the balance sheet as a direct deduction of the related debt liability rather than as an asset. Amortization of the cost is reported as interest expense. The new standard is effective for annual and interim periods beginning after December 15, 2015 and early adoption is permitted. The Company has elected to adopt this guidance in the current fiscal quarter and applied the new standard retrospectively to all prior periods. The reclassification of debt issuance costs impacted the Consolidated Balance Sheets by decreasing both Other Long Term Assets and Long Term Debt by $14 million at December 31, 2014 and $17 million at March 31, 2015. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

2. Acquisitions and Redeemable Noncontrolling Interest

Acquisitions

Community Health Solutions of America, Inc.

In July 2014, the Company completed a transaction whereby Community Health Solutions of America, Inc. assigned its contract with the Louisiana Department of Health and Hospitals under the Bayou Health Shared Savings Program to the Company's subsidiary, Louisiana Healthcare Connections (LHC). The fair value of consideration transferred included the present value of the estimated contingent consideration, subject to membership retained by LHC in the first quarter of 2015. The fair value of contingent consideration was $18 million at December 31, 2014. During the three months ended March 31, 2015, the Company determined the amount of the actual contingent consideration to be $8 million. A gain of $10 million related to the settlement of the obligation was recorded in General and Administrative expense.

LiveHealthier, Inc.

In January 2015, the Company acquired the remaining 79% of LiveHealthier, Inc. (LiveHealthier) for $28 million, bringing its total ownership to 100%. LiveHealthier is a provider of technology and service-based health management solutions. The fair value of consideration of $28 million consists of cash paid of $11 million, Centene common stock issued at closing of $13 million, and the present value of contingent consideration of $4 million to be paid in cash over a three year period. The contingent consideration will not exceed $9 million.

The Company's preliminary allocation of fair value resulted in goodwill of $29 million and other identifiable intangible assets of $16 million. The Company has not finalized the allocation of the fair value of assets and liabilities. The goodwill is not deductible for income tax purposes. The acquisition is recorded in the Managed Care segment.

Redeemable Noncontrolling Interest

In January 2015, the Company sold 25% of its ownership in Celtic Insurance Company for $7 million. No gain or loss was recognized on the sale of the ownership interest. Celtic Insurance Company is included in the Managed Care segment. In connection with the sale of the ownership interest, the Company entered into a put agreement with the noncontrolling interest holder, allowing the noncontrolling interest holder to put its interest back to the Company beginning in 2022. As a result of put option agreements, noncontrolling interest is considered redeemable and is classified in the Redeemable Noncontrolling Interest section of the consolidated balance sheets.

A reconciliation of the changes in the Redeemable Noncontrolling Interests is as follows ($ in millions):

Balance, December 31, 2014	$ 148
Fair value of redeemable noncontrolling interest sold	7
Reclassification to redeemable noncontrolling interest	(1)
Net earnings attributable to redeemable noncontrolling interests	1
Balance, March 31, 2015	$ 155

3. Short term and Long term Investments, Restricted Deposits

Short term and long term investments and restricted deposits by investment type consist of the following ($ in millions):

	March 31, 2015				December 31, 2014			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 451	$ 2	$ (1)	$ 452	$ 393	$ 1	$ (2)	$ 392
Corporate securities	618	4	(1)	621	556	2	(2)	556
Restricted certificates of deposit	6	—	—	6	6	—	—	6
Restricted cash equivalents	77	—	—	77	79	—	—	79
Municipal securities:								
General obligation	97	1	—	98	54	—	—	54
Pre-refunded	4	—	—	4	5	—	—	5
Revenue	158	—	—	158	101	1	—	102
Variable rate demand notes	27	—	—	27	14	—	—	14
Asset backed securities	170	—	—	170	180	—	—	180
Mortgage backed securities	81	2	—	83	84	1	—	85
Cost and equity method investments	64	—	—	64	68	—	—	68
Life insurance contracts	16	—	—	16	16	—	—	16
Total	$ 1,769	$ 9	$ (2)	$1,776	$ 1,556	$ 5	$ (4)	$1,557

The Company's investments are classified as available-for-sale with the exception of life insurance contracts and certain cost and equity method investments. The Company's investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets with the focus on high credit quality securities. The Company limits the size of investment in any single issuer other than U.S. treasury securities and obligations of U.S. government corporations and agencies. The Company's mortgage backed securities are issued by the Federal National Mortgage Association and carry guarantees by the U.S. government. As of March 31, 2015, 47% of the Company's investments in securities recorded at fair value that carry a rating by S&P or Moody's were rated AAA/Aaa, 66% were rated AA-/Aa3 or higher, and 91% were rated A-/

A3 or higher. At March 31, 2015, the Company held certificates of deposit, life insurance contracts and cost and equity method investments which did not carry a credit rating.

The fair value of available-for-sale investments with gross unrealized losses by investment type and length of time that individual securities have been in a continuous unrealized loss position were as follows ($ in millions):

	March 31, 2015				December 31, 2014			
	Less Than 12 Months		12 Months or More		Less Than 12 Months		12 Months or More	
	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ (1)	$ 80	$ —	$ 16	$ —	$ 72	$ (2)	$ 180
Corporate securities	(1)	185	—	1	(2)	311	—	1
Municipal securities:								
General obligation	—	22	—	4	—	4	—	3
Revenue	—	72	—	3	—	16	—	3
Pre-refunded	—	—	—	—	—	—	—	1
Asset backed securities	—	40	—	10	—	70	—	10
Mortgage backed securities	—	—	—	—	—	18	—	—
Total	$ (2)	$ 399	$ —	$ 34	$ (2)	$ 491	$ (2)	$ 198

As of March 31, 2015, the gross unrealized losses were generated from 90 positions out of a total of 363 positions. The change in fair value of fixed income securities is a result of movement in interest rates subsequent to the purchase of the security.

For each security in an unrealized loss position, the Company assesses whether it intends to sell the security or if it is more likely than not the Company will be required to sell the security before recovery of the amortized cost basis for reasons such as liquidity, contractual or regulatory purposes. If the security meets this criterion, the decline in fair value is other-than-temporary and is recorded in earnings. The Company does not intend to sell these securities prior to maturity and it is not likely that the Company will be required to sell these securities prior to maturity; therefore, there is no indication of other-than-temporary impairment for these securities.

During the quarter ended March 31, 2015, the company recognized $1 million of income from equity method investments.

The contractual maturities of short term and long term investments and restricted deposits are as follows ($ in millions):

	March 31, 2015				December 31, 2014			
	Investments		Restricted Deposits		Investments		Restricted Deposits	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value
One year or less	$ 151	$ 151	$ 90	$ 90	$ 176	$ 177	$ 92	$ 92
One year through five years	1,316	1,322	8	8	1,121	1,121	8	8
Five years through ten years	120	120	—	—	121	120	—	—
Greater than ten years	84	85	—	—	38	39	—	—
Total	$ 1,671	$ 1,678	$ 98	$ 98	$ 1,456	$ 1,457	$ 100	$ 100

Actual maturities may differ from contractual maturities due to call or prepayment options. Asset backed and mortgage backed securities are included in the one year through five years category, while cost and equity method investments and life insurance contracts are included in the five years through ten years category. The Company has an option to redeem at amortized cost substantially all of the securities included in the greater than ten years category listed above.

The Company continuously monitors investments for other-than-temporary impairment. Certain investments have experienced a decline in fair value due to changes in credit quality, market interest rates and/or general economic

conditions. The Company recognizes an impairment loss for cost and equity method investments when evidence demonstrates that it is other-than-temporarily impaired. Evidence of a loss in value that is other-than-temporary may include the absence of an ability to recover the carrying amount of the investment or the inability of the investee to sustain a level of earnings that would justify the carrying amount of the investment.

4. Fair Value Measurements

Assets and liabilities recorded at fair value in the consolidated balance sheets are categorized based upon observable or unobservable inputs used to estimate fair value. Level inputs are as follows:

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

The following table summarizes fair value measurements by level at March 31, 2015, for assets and liabilities measured at fair value on a recurring basis ($ in millions):

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$ 1,666	$ —	$ —	$ 1,666
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 434	$ 3	$ —	$ 437
Corporate securities	—	621	—	621
Municipal securities:				
General obligation	—	98	—	98
Pre-refunded	—	4	—	4
Revenue	—	158	—	158
Variable rate demand notes	—	27	—	27
Asset backed securities	—	170	—	170
Mortgage backed securities	—	83	—	83
Total investments	$ 434	$ 1,164	$ —	$ 1,598
Restricted deposits available for sale:				
Cash and cash equivalents	$ 77	$ —	$ —	$ 77
Certificates of deposit	6	—	—	6
U.S. Treasury securities and obligations of U.S. government corporations and agencies	15	—	—	15
Total restricted deposits	$ 98	$ —	$ —	$ 98
Other long term assets:				
Interest rate swap agreements	$ —	$ 16	$ —	$ 16
Total assets at fair value	$ 2,198	$ 1,180	$ —	$ 3,378
Liabilities				
Other long term liabilities:				
Interest rate swap agreements	$ —	$ 2	$ —	$ 2
Total liabilities at fair value	$ —	$ 2	$ —	$ 2

The following table summarizes fair value measurements by level at December 31, 2014, for assets and liabilities measured at fair value on a recurring basis ($ in millions):

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$ 1,610	$ —	$ —	$ 1,610
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 360	$ 17	$ —	$ 377
Corporate securities	—	556	—	556
Municipal securities:				
General obligation	—	54	—	54
Pre-refunded	—	5	—	5
Revenue	—	102	—	102
Variable rate demand notes	—	14	—	14
Asset backed securities	—	180	—	180
Mortgage backed securities	—	85	—	85
Total investments	$ 360	$ 1,013	$ —	$ 1,373
Restricted deposits available for sale:				
Cash and cash equivalents	$ 79	$ —	$ —	$ 79
Certificates of deposit	6	—	—	6
U.S. Treasury securities and obligations of U.S. government corporations and agencies	15	—	—	15
Total restricted deposits	$ 100	$ —	$ —	$ 100
Other long term assets:				
Interest rate swap agreements	$ —	$ 11	$ —	$ 11
Total assets at fair value	$ 2,070	$ 1,024	$ —	$ 3,094

The Company periodically transfers U.S. Treasury securities and obligations of U.S. government corporations and agencies between Level I and Level II fair value measurements dependent upon the level of trading activity for the specific securities at the measurement date. The Company's policy regarding the timing of transfers between Level I and Level II is to measure and record the transfers at the end of the reporting period. At March 31, 2015, there were less than $1 million of transfers from Level I to Level II and $14 million of transfers from Level II to Level I. The Company utilizes matrix pricing services to estimate fair value for securities which are not actively traded on the measurement date. The Company designates these securities as Level II fair value measurements. The aggregate carrying amount of the Company's life insurance contracts and other non-majority owned investments, which approximates fair value, was $80 million and $84 million as of March 31, 2015 and December 31, 2014, respectively.

5. Health Insurance Marketplace

The Affordable Care Act (ACA) established risk spreading premium stabilization programs effective January 1, 2014 for the Health Insurance Marketplace product. These programs, commonly referred to as the "three Rs," include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. Additionally, the ACA established a minimum annual medical loss ratio for the Health Insurance Marketplace. Each of the three R programs are taken into consideration to determine if the Company's estimated annual medical costs are less than the minimum loss ratio and require an adjustment to Premium revenue to meet the minimum medical loss ratio.

The Company's receivables (payables) for each of these programs are as follows ($ in millions):

	March 31, 2015	December 31, 2014
Risk adjustment	$ (72)	$ (44)
Reinsurance	15	11
Risk corridor	(23)	(9)
Minimum medical loss ratio	(16)	(6)

6. Debt

Debt consists of the following ($ in millions):

	March 31, 2015	December 31, 2014
$425 million 5.75% Senior notes, due June 1, 2017	$ 429	$ 429
$500 million 4.75% Senior notes, due May 15, 2022	500	300
Fair value of interest rate swap agreements	14	11
Senior notes	943	740
Revolving credit agreement	125	75
Mortgage notes payable	69	70
Capital leases	8	8
Debt issuance costs	(17)	(14)
Total debt	1,128	879
Less current portion	(5)	(5)
Long term debt	$ 1,123	$ 874

Senior Notes

In January 2015, the Company issued an additional $200 million of 4.75% Senior Notes ($200 Million Add-on Notes) at par. The $200 million Add-on Notes were offered as additional debt securities under the indenture governing the $300 Million of 4.75% Senior Notes issued in April 2014. In connection with the January 2015 issuance, the Company entered into interest rate swap agreements for a notional amount of $200 million at a floating rate of interest based on the three month LIBOR plus 2.88%. Gains and losses due to changes in the fair value of the interest rate swap completely offset changes in the fair value of the hedged portion of the underlying debt and are recorded as an adjustment to the $200 Million Add-on Notes.

The indentures governing both the $425 million notes due 2017 and the $500 million notes due 2022 contain non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio.

Interest Rate Swaps

The Company uses interest rate swap agreements to convert a portion of its interest rate exposure from fixed rates to floating rates to more closely align interest expense with interest income received on its cash equivalent and variable rate investment balances. The Company has $750 million of notional amount of interest rate swap agreements consisting of $250 million which are scheduled to expire on June 1, 2017 and $500 million that are scheduled to expire May 15, 2022. Under the Swap Agreements, the Company receives a fixed rate of interest and pays an average variable rate of the three month LIBOR plus 2.85% adjusted quarterly. At March 31, 2015, the weighted average rate was 3.10%.

The Swap Agreements are formally designated and qualify as fair value hedges and are recorded at fair value in the Consolidated Balance Sheet in other assets or other liabilities. Gains and losses due to changes in fair value of the interest rate swap agreements completely offset changes in the fair value of the hedged portion of the underlying debt. Therefore, no gain or loss has been recognized due to hedge ineffectiveness. Offsetting changes in fair value of both the interest rate swaps and the hedged portion of the underlying debt both were recognized in interest expense in the Consolidated Statement of Operations. The Company does not hold or issue any derivative instrument for trading or speculative purposes.

Revolving Credit Agreement

The Company has an unsecured $500 million revolving credit facility. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. The agreement has a maturity date of June 1, 2018, provided it will mature 90 days prior to the maturity date of the Company's 5.75% Senior Notes due 2017 if such notes are not refinanced (or extended), certain financial conditions are not met, or the Company does not carry $100 million of unrestricted cash. As of March 31, 2015, the Company had $125 million of borrowings outstanding under the agreement with a weighted average interest rate of 2.51%.

The agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt-to-EBITDA ratios and minimum tangible net worth. The Company is required to not exceed a maximum debt-to-EBITDA ratio of 3.0 to 1.0. As of March 31, 2015, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

Letters of Credit & Surety Bonds

The Company had outstanding letters of credit of $30 million as of March 31, 2015, which were not part of the revolving credit facility. The Company also had letters of credit for $52 million (valued at March 31, 2015 conversion rate), or €48 million, representing its proportional share of the letters of credit issued to support Ribera Salud's outstanding debt which are a part of the revolving credit facility. Collectively, the letters of credit bore interest at 1.73% as of March 31, 2015. The Company had outstanding surety bonds of $196 million as of March 31, 2015.

7. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings per common share ($ in millions, except per share data):

	Three Months Ended March 31,	
	2015	2014
Earnings attributable to Centene Corporation:		
Earnings from continuing operations, net of tax	$ 64	$ 34
Discontinued operations, net of tax	(1)	(1)
Net earnings	$ 63	$ 33
Shares used in computing per share amounts:		
Weighted average number of common shares outstanding	118,783,755	114,967,752
Common stock equivalents (as determined by applying the treasury stock method)	3,788,611	3,754,780
Weighted average number of common shares and potential dilutive common shares outstanding	122,572,366	118,722,532
Net earnings (loss) per common share attributable to Centene Corporation:		
Basic:		
Continuing operations	$ 0.54	$ 0.30
Discontinued operations	(0.01)	(0.01)
Basic earnings per common share	$ 0.53	$ 0.29
Diluted:		
Continuing operations	$ 0.52	$ 0.29
Discontinued operations	(0.01)	(0.01)
Diluted earnings per common share	$ 0.51	$ 0.28

The calculation of diluted earnings per common share for the three months ended March 31, 2015 and 2014 excludes the impact of 26,376 shares and 45,912 shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

8. Segment Information

Centene operates in two segments: Managed Care and Specialty Services. The Managed Care segment consists of Centene's health plans including all of the functions needed to operate them. The Specialty Services segment consists of Centene's specialty companies offering auxiliary healthcare services and products.

Segment information for the three months ended March 31, 2015, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$ 4,243	$ 518	$ —	$ 4,761
Premium and service revenues from internal customers	24	1,075	(1,099)	—
Total premium and service revenues	$ 4,267	$ 1,593	$ (1,099)	$ 4,761
Earnings from operations	$ 95	$ 34	$ —	$ 129

Segment information for the three months ended March 31, 2014, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$ 2,970	$ 382	$ —	$ 3,352
Premium and service revenues from internal customers	13	639	(652)	—
Total premium and service revenues	$ 2,983	$ 1,021	$ (652)	$ 3,352
Earnings from operations	$ 44	$ 26	$ —	$ 70

9. Contingencies

On July 5, 2013, the Company's subsidiary, Kentucky Spirit Health Plan, Inc. (Kentucky Spirit), terminated its contract with the Commonwealth of Kentucky (the Commonwealth). Kentucky Spirit believes it had a contractual right to terminate the contract and filed a lawsuit in Franklin Circuit Court seeking a declaration of this right. The Commonwealth has alleged that Kentucky Spirit's exit constitutes a material breach of contract. The Commonwealth seeks to recover substantial damages and to enforce its rights under Kentucky Spirit's $25 million performance bond. The Commonwealth's attorneys have asserted that the Commonwealth's expenditures due to Kentucky Spirit's departure range from $28 million to $40 million plus interest, and that the associated CMS expenditures range from $92 million to $134 million. Kentucky Spirit disputes the Commonwealth's alleged damages, and is pursuing its own litigation claims for damages against the Commonwealth.

On February 6, 2015, the Kentucky Court of Appeals affirmed a Franklin Circuit Court ruling that Kentucky Spirit does not have a contractual right to terminate the contract early. The Court of Appeals also found that the contract's liquidated damages provision "is applicable in the event of a premature termination of the Contract term." Kentucky Spirit intends to seek Kentucky Supreme Court review of the finding that its departure constituted a breach of contract. The Commonwealth may seek review of the ruling that the liquidated damages provision is applicable in the event of a premature termination.

Kentucky Spirit also filed a lawsuit in April 2013, amended in October 2014, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches. On December 9, 2014, the Franklin Circuit Court denied the Commonwealth's motion for partial summary judgment on Kentucky Spirit's damages claims. On March 15, 2015, the Franklin Circuit Court denied the Commonwealth's motion to stay discovery and ordered that discovery proceed on those claims.

On March 9, 2015, the Secretary of the Kentucky Cabinet for Health and Family Services (CHFS) issued a determination letter finding that Kentucky Spirit owed the Commonwealth $40 million in actual damages plus prejudgment interest at 8 percent. On March 18, 2015, in a letter to the Kentucky Finance and Administration Cabinet, Kentucky Spirit contested CHFS' jurisdiction to make such a determination. Depending on the response from the Finance and Administration Cabinet, Kentucky Spirit may bring the matter to the Franklin Circuit Court.

The resolution of the Kentucky litigation matters may result in a range of possible outcomes. If Kentucky Spirit prevails on its claims, it would be entitled to damages. If the Commonwealth prevails, a liability to the Commonwealth could be recorded. The Company is unable to estimate the ultimate outcome resulting from the Kentucky litigation. As a result, the Company has not recorded any receivable or any liability for potential damages under the contract as of March 31, 2015. While uncertain, the ultimate resolution of the pending litigation could have a material effect on the financial position, cash flow or results of operations of the Company in the period it is resolved or becomes known.

Excluding the Kentucky matters discussed above, the Company is also routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters in the normal course of business is uncertain, the Company does not expect the results of any of these matters individually, or in the aggregate, to have a material effect on its financial position, results of operations or cash flows.

ITEM 2. Management's Discussion and Analysis of Financial Condition and Results of Operations.

The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes included elsewhere in this filing. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under Part II, Item 1A. "Risk Factors" of this Form 10-Q.

OVERVIEW

In 2013, we classified the operations for Kentucky Spirit Health Plan (KSHP) as discontinued operations for all periods presented in our consolidated financial statements. The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise identified.

On February 2, 2015, the Board of Directors declared a two-for-one split of Centene's common stock in the form of a 100% stock dividend distributed February 19, 2015 to stockholders of record on February 12, 2015. All share and per share information presented in this Form 10-Q has been adjusted for the two-for-one stock split.

Key financial metrics for the first quarter of 2015 are summarized as follows:

- Quarter-end managed care membership of 4.4 million, an increase of 1.4 million members, or 44% year over year.
- Premium and service revenues of $4.8 billion, representing 42% growth year over year.
- Health Benefits Ratio of 89.8%, compared to 89.3% in 2014.
- General and Administrative expense ratio of 8.5%, compared to 8.8% in 2014.
- Operating cash flows of $45 million for the first quarter of 2015.
- Diluted net earnings per share of $0.52, compared to $0.29 in 2014.

The following items contributed to our revenue and membership growth over the last year:

- *Florida.* In May 2014, our Florida subsidiary, Sunshine Health, began operating under a new contract in 9 of 11 regions of the Managed Medical Assistance (MMA) program. The MMA program includes TANF recipients as well as ABD and dual-eligible members. In addition, we began operating as the sole provider under a new statewide contract for the Child Welfare Specialty Plan (Foster Care). Enrollment for both the MMA program and Foster Care began in May 2014 and was implemented by region through August 2014.

- *Health Insurance Marketplaces (HIM).* In January 2015, we expanded our participation in Health Insurance Marketplaces to include members in certain regions of Illinois and Wisconsin.

- *Illinois.* In March 2014, our Illinois subsidiary, IlliniCare Health, began operating under a new contract as part of the Illinois Medicare-Medicaid Alignment Initiative serving dual-eligible members in Cook, DuPage, Lake, Kane, Kankakee and Will counties (Greater Chicago region).

  In July 2014, IlliniCare Health began operating under a new contract with the Cook County Health and Hospitals System to perform third party administrative services to members enrolled in the CountyCare program, as well as care coordination, behavioral health, vision care and pharmacy benefit management services.

  In September 2014, IlliniCare Health began serving additional Medicaid members under the state's Medicaid and Medicaid expansion programs.

- *Indiana.* In February 2015, our Indiana subsidiary, Managed Health Services, began operating under an expanded contract with the Indiana Family & Social Services Administration to provide Medicaid services under the state's Healthy Indiana Plan 2.0 program.

- *Louisiana.* In July 2014, we completed the transaction whereby Community Health Solutions of America, Inc. (CHS) assigned its contract with the Louisiana Department of Health and Hospitals under the Bayou Health Shared Savings Program to our subsidiary, Louisiana Healthcare Connections (LHC).

In February 2015, LHC began operating under a new contract with the Louisiana Department of Health and Hospitals to serve Bayou Health (Medicaid) beneficiaries. Members previously served under the shared savings program were transitioned to the at-risk program on February 1, 2015.

- *Mississippi.* In July 2014, our Mississippi subsidiary, Magnolia Health, began operating as one of two contractors under a new statewide managed care contract serving members enrolled in the Mississippi Coordinated Access Network program. Program expansion began in December 2014.

  In January 2015, Magnolia Health began operating under a new contract with the State of Mississippi to provide services under the Children's Health Insurance Program (CHIP).

- *New Hampshire.* In September 2014, our New Hampshire subsidiary, New Hampshire Healthy Families, began serving members under the state's Medicaid expansion program.

- *Ohio.* In May 2014, our Ohio subsidiary, Buckeye Health Plan (Buckeye), began operating under a new contract with the Ohio Department of Medicaid and the Centers for Medicare and Medicaid Services to serve Medicaid members in a dual-eligible demonstration program in three of seven regions: Northeast (Cleveland), Northwest (Toledo) and West Central (Dayton). This three-year program, which is part of the Integrated Care Delivery System expansion, serves those who have both Medicare and Medicaid eligibility. Passive enrollment for Medicaid began in May 2014 and implementation was completed in July 2014. Passive enrollment for Medicare began in January 2015.

- *South Carolina.* In February 2015, our South Carolina subsidiary, Absolute Total Care, began operating under a new contract with the South Carolina Department of Health and Human Services and the Centers for Medicare and Medicaid Services to serve dual-eligible members as part of the state's dual demonstration program.

- *Texas.* In September 2014, we began operating under a new contract with the Texas Health and Human Services Commission (HHSC) to expand our operations and serve STAR+PLUS members in two Medicaid Rural Service Areas. We also began providing expanded coverage in September 2014 under our STAR+PLUS contracts to provide acute care services for intellectually and developmentally disabled members. In March 2015, we began operating under an expanded STAR+PLUS contract with the Texas HHSC to include nursing facility benefits.

  In March 2015, we also began operating under a new contract with the Texas HHSC and the Centers for Medicare and Medicaid Services to serve dual-eligible members in three counties as part of the state's dual demonstration program.

- *Vermont.* In February 2015, Centurion began operating under a new contract with the State of Vermont Department of Corrections to provide comprehensive correctional healthcare services.

In addition, in July 2014, we completed an investment accounted for under the equity method for the purchase of a noncontrolling interest in Ribera Salud S.A. (Ribera Salud), a Spanish health management group. Centene is a joint shareholder with Ribera Salud's remaining investor, Banco Sabadell S.A.

We expect the following items to contribute to our future growth potential:

- We expect to realize the full year benefit in 2015 of business commenced during 2014 in Florida, Illinois, Louisiana, Mississippi, New Hampshire, Ohio and Texas as discussed above.

- In April 2015, Managed Health Services began operating under an expanded contract with the Indiana Family & Social Services Administration to provide services to its ABD Medicaid enrollees who qualify for the new Hoosier Care Connect Program.

- In April 2015, Centurion was recommended for an award by the Mississippi Department of Corrections to provide comprehensive correctional healthcare services. The contract is expected to commence in the third quarter of 2015.

- In March 2015, our Missouri subsidiary, Home State Health, was selected by the Missouri Division of Purchasing and Materials Management to continue providing managed care services to MO HealthNet Managed Care beneficiaries. The new contract will be effective in the third quarter of 2015.

- In February 2015, our Texas subsidiary, Superior HealthPlan, was tentatively recommended for a contract award by the Texas HHSC to continue to serve STAR Health (Foster Care) Medicaid recipients. The new contract is expected to commence in the third quarter of 2015.

- In January 2015, we signed a definitive agreement to acquire Agate Resources, Inc., a diversified holding company that offers primarily Medicaid and other healthcare products and services to Oregon residents. The transaction is expected to close in the third quarter of 2015, subject to customary closing conditions, including Oregon regulatory approval.

- In December 2014, our subsidiary, Cenpatico Integrated Care, in partnership with University of Arizona Health Plan, was selected by the Arizona Department of Health Services/Division of Behavioral Health Services to be the Regional Behavioral Health Authority for the new southern geographic service area. The new contract is expected to commence in the fourth quarter of 2015.

- In December 2013, we signed a definitive agreement to purchase a majority stake in Fidelis SecureCare of Michigan, Inc. (Fidelis), a subsidiary of Fidelis SeniorCare, Inc. The transaction is expected to close in the second quarter of 2015, subject to certain closing conditions including regulatory approvals. Fidelis was selected by the Michigan Department of Community Health to provide integrated healthcare services to members who are dually eligible for Medicare and Medicaid in Macomb and Wayne counties. Enrollment is expected to commence in the second quarter of 2015.

MEMBERSHIP

From March 31, 2014 to March 31, 2015, we increased our managed care membership by 1.4 million, or 44%. The following table sets forth our membership by state for our managed care organizations:

	March 31, 2015	December 31, 2014	March 31, 2014
Arizona	202,200	204,000	169,800
Arkansas	43,200	38,400	16,400
California	171,200	163,900	118,100
Florida	463,100	425,700	230,300
Georgia	405,600	389,100	331,400
Illinois	184,800	87,800	22,400
Indiana	227,700	197,700	198,700
Kansas	143,700	143,300	145,000
Louisiana	359,500	152,900	149,800
Massachusetts	64,500	48,400	50,800
Minnesota	9,500	9,500	9,400
Mississippi	141,900	108,700	85,400
Missouri	75,600	71,000	58,100
New Hampshire	67,500	62,700	37,100
Ohio	296,000	280,100	181,800
South Carolina	106,000	109,700	96,300
Tennessee	20,800	21,000	21,100
Texas	974,900	971,000	904,000
Vermont	1,600	—	—
Washington	207,100	194,400	151,700
Wisconsin	82,100	83,200	70,800
Total at-risk membership	4,248,500	3,762,500	3,048,400
Non-risk membership	153,200	298,400	—
Total	4,401,700	4,060,900	3,048,400

At March 31, 2015, we served 331,800 Medicaid members in Medicaid expansion programs in California, Illinois, Indiana, Massachusetts, New Hampshire, Ohio and Washington included in the table above.

The following table sets forth our membership by line of business:

	March 31, 2015	December 31, 2014	March 31, 2014
Medicaid	3,133,900	2,754,900	2,169,100
CHIP & Foster Care	233,600	222,700	269,200
ABD, Medicare & Duals	410,400	392,700	300,500
LTC	71,200	60,800	51,800
Health Insurance Marketplaces	161,700	74,500	39,700
Hybrid Programs [1]	—	18,900	14,400
Behavioral Health	195,100	197,000	162,700
Correctional Healthcare Services	42,600	41,000	41,000
Total at-risk membership	4,248,500	3,762,500	3,048,400
Non-risk membership	153,200	298,400	—
Total	4,401,700	4,060,900	3,048,400

[1] In February 2015, hybrid programs in Indiana and Massachusetts were converted to Medicaid expansion contracts.

The following table identifies our dual-eligible membership by line of business. The membership tables above include these members.

	March 31, 2015	December 31, 2014	March 31, 2014
ABD	112,600	118,300	72,800
LTC	52,000	35,900	41,300
Medicare	6,800	7,200	6,500
Medicaid / Medicare Duals	12,600	3,200	—
Total	184,000	164,600	120,600

RESULTS OF OPERATIONS

The following discussion and analysis is based on our consolidated statements of operations, which reflect our results of operations for the three months ended March 31, 2015 and 2014, prepared in accordance with generally accepted accounting principles in the United States.

Summarized comparative financial data for the three months ended March 31, 2015 and 2014 is as follows ($ in millions, except per share data):

	Three Months Ended March 31,		
	2015	2014	% Change 2014-2015
Premium	$ 4,299	$ 3,071	40.0%
Service	462	281	64.4%
Premium and service revenues	4,761	3,352	42.0%
Premium tax and health insurer fee	370	108	242.6%
Total revenues	5,131	3,460	48.3%
Medical costs	3,861	2,743	40.8%
Cost of services	402	242	66.1%
General and administrative expenses	403	296	36.1%
Premium tax expense	281	78	260.3%
Health insurer fee expense	55	31	77.4%
Earnings from operations	129	70	84.3%
Other income (expense), net	(1)	(2)	50.0%
Earnings from continuing operations, before income tax expense	128	68	88.2%
Income tax expense	63	35	80.0%
Earnings from continuing operations, net of income tax	65	33	97.0%
Discontinued operations, net of income tax expense of $0 and $0, respectively	(1)	(1)	—%
Net earnings	64	32	100.0%
(Earnings) loss attributable to noncontrolling interests	(1)	1	200.0%
Net earnings attributable to Centene Corporation	$ 63	$ 33	90.9%
Amounts attributable to Centene Corporation common shareholders:			
Earnings from continuing operations, net of income tax expense	$ 64	$ 34	88.2%
Discontinued operations, net of income tax expense	(1)	(1)	—%
Net earnings	$ 63	$ 33	90.9%
Diluted earnings (loss) per common share attributable to Centene Corporation:			
Continuing operations	$ 0.52	$ 0.29	79.3%
Discontinued operations	(0.01)	(0.01)	—%
Total diluted earnings per common share	$ 0.51	$ 0.28	82.1%

Three Months Ended March 31, 2015 Compared to Three Months Ended March 31, 2014

Premium and Service Revenues

Premium and service revenues increased 42.0% in the three months ended March 31, 2015 over the corresponding period in 2014 primarily as a result of a full quarter's impact from expansions or new programs in 2014 in many of our states, particularly Florida, Illinois and Ohio. During the three months ended March 31, 2015, we received premium rate adjustments which yielded a net 0% composite change across all of our markets.

Operating Expenses

Medical Costs

Results of operations depend on our ability to manage expenses associated with health benefits and to accurately estimate costs incurred. The Health Benefits Ratio, or HBR, represents medical costs as a percentage of premium revenues (excluding Premium Tax and Health Insurer Fee revenues) and reflects the direct relationship between the premium received and the medical services provided. The table below depicts the HBR for our membership by member category for the three months ended March 31,:

	2015	2014
Medicaid, CHIP, Foster Care & HIM	87.6%	86.9%
ABD, LTC and Medicare	92.9	92.9
Specialty Services	85.2	87.7
Total	89.8	89.3

The consolidated HBR for the three months ended March 31, 2015, was 89.8%, compared to 89.3% in the same period in 2014. The increase compared to last year is primarily attributable to an increase in higher acuity membership and higher flu related costs over the prior year.

Revenue and HBR results for new business and existing business are listed below to assist in understanding our results of operations. Existing businesses are primarily state markets or significant geographic expansion in an existing state or product that we have managed for four complete quarters. New businesses are primarily new state markets or significant geographic expansion in an existing state or product that conversely, we have not managed for four complete quarters. The following table compares the results for new business and existing business for the three months ended March 31,:

	2015	2014
Premium and Service Revenue		
New business	23%	20%
Existing business	77%	80%
HBR		
New business	91.0%	93.1%
Existing business	89.5%	88.3%

Cost of Services

Cost of services increased by $160 million in the three months ended March 31, 2015, compared to the corresponding period in 2014. This was primarily due to the growth in the AcariaHealth business.

General & Administrative Expenses

General and administrative expenses, or G&A, increased by $107 million in the three months ended March 31, 2015, compared to the corresponding period in 2014. This was primarily due to expenses for additional staff and facilities to support our membership growth. During the three months ended March 31, 2015, we recorded a gain of $10 million on the settlement of contingent consideration related to the CHS transaction. We also recorded expense of $10 million for a contribution to our charitable foundation during the first quarter of 2015.

The consolidated G&A expense ratio for the three months ended March 31, 2015 and 2014 was 8.5% and 8.8%, respectively. The year over year decrease in the G&A ratio reflects the leveraging of expenses over higher revenues in 2015 as well as the impact of transaction costs recognized in 2014.

Health Insurer Fee

During the three months ended March 31, 2015, we recorded $55 million of non-deductible expense for the Affordable Care Act (ACA) annual health insurer fee. As of March 31, 2015, we have received signed agreements from all applicable states which provide for the reimbursement of the ACA insurer fee including the related gross-up for the associated income tax effects. As a result, we recorded $88 million in Premium Tax and Health Insurer Fee revenue associated with the accrual for the reimbursement of the fee. Therefore, the health insurer fee had no impact on diluted earnings per share during the first quarter of 2015.

During the three months ended March 31, 2014, we recorded $31 million of non-deductible expense for the ACA annual health insurer fee. In addition, we received signed agreements from 13 of 17 applicable states as of March 31, 2014, which provide for the reimbursement of the ACA insurer fee including the related gross-up for the associated income tax effects (representing approximately 60% of the necessary reimbursements). As a result, we recorded $29 million of revenue in Premium Tax and Health Insurer Fee revenue associated with the accrual for the reimbursement of the fee. The net effect of the health insurer fee reduced our diluted earnings per share by $0.08 during the first quarter of 2014 due to the timing of the recognition of the revenue associated with the reimbursement from our state customers.

Other Income (Expense)

The following table summarizes the components of other income (expense) for the three months ended March 31, ($ in millions):

	2015	2014
Investment and other income	$ 9	$ 5
Interest expense	(10)	(7)
Other income (expense), net	$ (1)	$ (2)

The increase in investment income in 2015 reflects an increase in investment balances over 2014 and improved performance of certain equity investments. Interest expense increased in 2015 compared to 2014, primarily reflecting the issuance of $300 million of Senior Notes in April 2014 and the issuance of an additional $200 million in Senior Notes in January 2015.

Income Tax Expense

Our effective tax rate for the three months ended March 31, 2015 and 2014, was 49.2% and 51.5%, respectively. The effective tax rate is higher than the applicable statutory rate primarily as a result of the non-deductibility of the health insurer fee expense.

Segment Results

The following table summarizes our consolidated operating results by segment for the three months ended March 31, ($ in millions):

	2015	2014	% Change 2014-2015
Premium and Service Revenues			
Managed Care	$ 4,267	$ 2,983	43.0 %
Specialty Services	1,593	1,021	56.0 %
Eliminations	(1,099)	(652)	(68.6)%
Consolidated Total	$ 4,761	$ 3,352	42.0 %
Earnings from Operations			
Managed Care	$ 95	$ 44	115.9 %
Specialty Services	34	26	30.8 %
Consolidated Total	$ 129	$ 70	84.3 %

Managed Care

Premium and service revenues increased 43.0% in the three months ended March 31, 2015, primarily as a result of expansions or new programs in many of our states, particularly Florida, Illinois and Ohio. Earnings from operations increased $51 million, or 115.9%, between years primarily reflecting growth in the business.

Specialty Services

Premium and service revenues increased 56.0% in the three months ended March 31, 2015, resulting primarily from increased services associated with membership growth in the Managed Care segment and growth in our AcariaHealth business. Earnings from operations increased $8 million, or 30.8% in the three months ended March 31, 2015, primarily reflecting growth in the specialty services provided to our increased Managed Care membership as well as external growth in the AcariaHealth business.

LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows used in the discussion of liquidity and capital resources ($ in millions).

	Three Months Ended March 31,	
	2015	2014
Net cash provided by operating activities	$ 45	$ 252
Net cash used in investing activities	(225)	(150)
Net cash provided by financing activities	236	131
Net increase in cash and cash equivalents	$ 56	$ 233

Cash Flows Provided by Operating Activities

Normal operations are funded primarily through operating cash flows and borrowings under our revolving credit facility. Operating activities provided cash of $45 million in the three months ended March 31, 2015, compared to $252 million in the comparable period in 2014. The cash provided by operations in 2015 and 2014 was primarily related to net earnings and an increase in medical claims liabilities resulting from the growth in the business, partially offset by increases in premium and related receivables.

Cash flows from operations in each year were impacted by the timing of payments we receive from our states. States may prepay the following month premium payment, which we record as unearned revenue, or they may delay our premium payment, which we record as a receivable. We typically receive capitation payments monthly, however the states in which we operate may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period. Cash flow from operations was reduced in the first quarter of 2015 as a result of a one time change in payment terms for one of our states.

The reimbursement of the HIF from our state customers may be settled as a separate payment or monthly in combination with our other premium payments. The vast majority of our state customers are settling the reimbursement through a separate payment after verification of each state's portion of our HIF, resulting in an increase in Premium and Related Receivables at March 31, 2015. The table below details the impact to cash flows from operations from the timing of payments from our states ($ in millions).

	Three Months Ended March 31,	
	2015	2014
Increase in premium and related receivables	$ (334)	$ (119)
Increase (decrease) in unearned revenue	(51)	35
Net decrease in operating cash flow	$ (385)	$ (84)

Cash Flows Used in Investing Activities

Investing activities used cash of $225 million for the three months ended March 31, 2015, and $150 million in the comparable period in 2014. Cash flows used in investing activities in 2015 primarily consisted of additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long term investments, capital expenditures, the acquisition of LiveHealthier and proceeds from the sale of Celtic Insurance Company.

In January 2015, we sold 25% of our ownership in Celtic Insurance Company. No gain or loss was recognized on the sale of the ownership interest. Celtic Insurance Company is included in the Specialty Services segment. Under the terms of the agreement, we entered into a put agreement with the noncontrolling interest holder to purchase the noncontrolling interest at a later date.

Cash flows used in investing activities in 2014 primarily consisted of additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long term investments, the acquisition of U.S. Medical Management and capital and capital expenditures.

We spent $27 million and $18 million in the three months ended March 31, 2015 and 2014, respectively, on capital expenditures for system enhancements and market expansions.

As of March 31, 2015, our investment portfolio consisted primarily of fixed-income securities with an average duration of 3.1 years. We had unregulated cash and investments of $97 million at March 31, 2015, compared to $85 million at December 31, 2014.

Cash Flows Provided by Financing Activities

Our financing activities provided cash of $236 million in the three months ended March 31, 2015, compared to $131 million in the comparable period in 2014. In January 2015, we issued an additional $200 million of 4.75% Senior Notes at par. In connection with the January 2015 issuance, we entered into interest rate swap agreements for a notional amount of $200 million. During 2014, our financing activities primarily related to net borrowings under our revolving credit facility.

Liquidity Metrics

The $500 million revolving credit agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt-to-EBITDA ratios and minimum tangible net worth. We are required not to exceed a maximum debt-to-EBITDA ratio of 3.0 to 1.0. As of March 31, 2015, we had $125 million in borrowings outstanding under our revolving credit facility and we were in compliance with all covenants. As of March 31, 2015, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

We had outstanding letters of credit of $30 million as of March 31, 2015, which were not part of our revolving credit facility. We also had letters of credit for $52 million (valued at the March 31, 2015 conversion rate), or €48 million, representing our proportional share of the letters of credit issued to support Ribera Salud's outstanding debt which are a part of the revolving credit facility. Collectively, the letters of credit bore interest at 1.73% as of March 31, 2015. In addition, we had outstanding surety bonds of $196 million as of March 31, 2015.

The indentures governing our Senior Notes contains non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio.

At March 31, 2015, we had working capital, defined as current assets less current liabilities, of $247 million, compared to $134 million at December 31, 2014. We manage our short term and long term investments with the goal of ensuring that a sufficient portion is held in investments that are highly liquid and can be sold to fund short term requirements as needed.

At March 31, 2015, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 38.0%, compared to 33.5% at December 31, 2014. Excluding the $69 million non-recourse mortgage note, our debt to capital ratio was 36.6% as of March 31, 2015, compared to 31.7% at December 31, 2014. We utilize the debt to capital ratio as a measure, among others, of our leverage and financial flexibility.

2015 Expectations

As previously discussed, in January 2015, we announced a definitive agreement to acquire Agate Resources, Inc. The transaction is expected to close during the third quarter of 2015, subject to customary closing conditions and regulatory approvals.

During the remainder of 2015, we expect to make net capital contributions to our insurance subsidiaries of approximately $390 million associated with our growth and spend approximately $117 million in additional capital expenditures primarily associated with system enhancements and market expansions. These capital contributions are expected to be funded by unregulated cash flow generation in 2015 and borrowings on our revolving credit facility.

Based on our operating plan, we expect that our available cash, cash equivalents and investments, cash from our operations and cash available under our credit facility will be sufficient to finance our general operations and capital expenditures for at least 12 months from the date of this filing.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

Our operations are conducted through our subsidiaries. As managed care organizations, these subsidiaries are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us. Generally, the amount of dividend distributions that may be paid by a regulated subsidiary without prior approval by state regulatory authorities is limited based on the entity's level of statutory net income and statutory capital and surplus.

Our subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of March 31, 2015, our subsidiaries had aggregate statutory capital and surplus of $1,624 million, compared with the required minimum aggregate statutory capital and surplus requirements of $871 million. During the three months ended March 31, 2015, we contributed $301 million of statutory capital to our subsidiaries. We estimate our Risk Based Capital, or RBC, percentage (including KSHP) to be in excess of 350% of the Authorized Control Level (excluding the interim impact of the health insurer fee).

The National Association of Insurance Commissioners has adopted rules which set minimum risk based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. As of March 31, 2015, each of our health plans was in compliance with the risk-based capital requirements enacted in those states.

ITEM 3. ***Quantitative and Qualitative Disclosures About Market Risk.***

INVESTMENTS AND DEBT

As of March 31, 2015, we had short term investments of $151 million and long term investments of $1,625 million, including restricted deposits of $98 million. The short term investments generally consist of highly liquid securities with maturities between three and 12 months. The long term investments consist of municipal, corporate and U.S. Treasury securities, government sponsored obligations, life insurance contracts, asset backed securities and equity securities and have maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states' requirements, these investments are classified as long term regardless of the contractual maturity date. Substantially all of our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at March 31, 2015, the fair value of our fixed income investments would decrease by approximately $46 million. Declines in interest rates over time will reduce our investment income.

We have interest rate swap agreements for a notional amount of $750 million with creditworthy financial institutions to manage the impact of market interest rates on interest expense. Our swap agreements convert a portion of our interest expense from fixed to variable rates to better match the impact of changes in market rates on our variable rate cash equivalent investments. As a result, the fair value of $750 million of our long term debt varies with market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at March 31, 2015, the fair value of our debt would decrease by approximately $36 million. An increase in interest rates decreases the fair value of the debt and conversely, a decrease in interest rates increases the value.

For a discussion of the interest rate risk that our investments are subject to, see Part II, Item 1A "Risk Factors–Risks Related to Our Business–Our investment portfolio may suffer losses from reductions in market interest rates and changes in market conditions which could materially and adversely affect our results of operations or liquidity."

INFLATION

The inflation rate for medical care costs has been higher than the overall inflation rate for all items. We use various strategies to mitigate the negative effects of healthcare cost inflation. Specifically, our health plans try to control medical and hospital costs through our state savings initiatives and contracts with independent providers of healthcare services. Through these contracted care providers, our health plans emphasize preventive healthcare and appropriate use of specialty and hospital services. Additionally, our contracts with states require actuarially sound premiums that include healthcare cost trend.

While we currently believe our strategies to mitigate healthcare cost inflation will continue to be successful, competitive pressures, new healthcare and pharmaceutical product introductions, demands from healthcare providers and customers, applicable regulations, an increase in the expected rate of inflation for healthcare costs or other factors may affect our ability to control the impact of healthcare cost increases.

ITEM 4. ***Controls and Procedures.***

Evaluation of Disclosure Controls and Procedures - We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is
(i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and
(ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Form 10-Q, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of March 31, 2015. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of March 31, 2015.

Changes in Internal Control Over Financial Reporting - No change in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) occurred during the quarter ended March 31, 2015 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

PART II
OTHER INFORMATION

ITEM 1. ***Legal Proceedings.***

On July 5, 2013, the Company's subsidiary, Kentucky Spirit Health Plan, Inc. (Kentucky Spirit), terminated its contract with the Commonwealth of Kentucky (the Commonwealth). Kentucky Spirit believes it had a contractual right to terminate the contract and filed a lawsuit in Franklin Circuit Court seeking a declaration of this right. The Commonwealth has alleged that Kentucky Spirit's exit constitutes a material breach of contract. The Commonwealth seeks to recover substantial damages and to enforce its rights under Kentucky Spirit's $25 million performance bond. The Commonwealth's attorneys have asserted that the Commonwealth's expenditures due to Kentucky Spirit's departure range from $28 million to $40 million plus interest, and that the associated CMS expenditures range from $92 million to $134 million. Kentucky Spirit disputes the Commonwealth's alleged damages, and is pursuing its own litigation claims for damages against the Commonwealth.

On February 6, 2015, the Kentucky Court of Appeals affirmed a Franklin Circuit Court ruling that Kentucky Spirit does not have a contractual right to terminate the contract early. The Court of Appeals also found that the contract's liquidated damages provision "is applicable in the event of a premature termination of the Contract term." Kentucky Spirit intends to seek Kentucky Supreme Court review of the finding that its departure constituted a breach of contract. The Commonwealth may seek review of the ruling that the liquidated damages provision is applicable in the event of a premature termination.

Kentucky Spirit also filed a lawsuit in April 2013, amended in October 2014, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches. On December 9, 2014, the Franklin Circuit Court denied the Commonwealth's motion for partial summary judgment on Kentucky Spirit's damages claims. On March 15, 2015, the Franklin Circuit Court denied the Commonwealth's motion to stay discovery and ordered that discovery proceed on those claims.

On March 9, 2015, the Secretary of the Kentucky Cabinet for Health and Family Services (CHFS) issued a determination letter finding that Kentucky Spirit owed the Commonwealth $40 million in actual damages plus prejudgment interest at 8 percent. On March 18, 2015, in a letter to the Kentucky Finance and Administration Cabinet, Kentucky Spirit contested CHFS' jurisdiction to make such a determination. Depending on the response from the Finance and Administration Cabinet, Kentucky Spirit may bring the matter to the Franklin Circuit Court.

The resolution of the Kentucky litigation matters may result in a range of possible outcomes. If Kentucky Spirit prevails on its claims, it would be entitled to damages. If the Commonwealth prevails, a liability to the Commonwealth could be recorded. The Company is unable to estimate the ultimate outcome resulting from the Kentucky litigation. As a result, the Company has not recorded any receivable or any liability for potential damages under the contract as of March 31, 2015. While uncertain, the ultimate resolution of the pending litigation could have a material effect on the financial position, cash flow or results of operations of the Company in the period it is resolved or becomes known.

Excluding the Kentucky matters discussed above, the Company is also routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters in the normal course of business is uncertain, the Company does not expect the results of any of these matters individually, or in the aggregate, to have a material effect on its financial position, results of operations or cash flows.

ITEM 1A. ***Risk Factors.***

FACTORS THAT MAY AFFECT FUTURE RESULTS AND THE TRADING PRICE OF OUR COMMON STOCK

You should carefully consider the risks described below before making an investment decision. The trading price of our common stock could decline due to any of these risks, in which case you could lose all or part of your investment. You should also refer to the other information in this filing, including our consolidated financial statements and related notes. The risks and uncertainties described below are those that we currently believe may materially affect our Company. Additional risks and uncertainties that we are unaware of or that we currently deem immaterial also may become important factors that affect our Company.

Reductions in funding or changes to eligibility requirements for government sponsored healthcare programs in which we participate could substantially affect our financial position, results of operations and cash flows.

The majority of our revenues come from government subsidized healthcare programs including Medicaid, Medicare, CHIP, LTC, ABD, Foster Care and Health Insurance Marketplace premiums. The base premium rate paid for each program differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region and benefit mix. Since Medicaid was created in 1965, the federal government and the states have shared the costs, with the federal share currently averaging around 57%.

Future levels of funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints. Governments periodically consider reducing or reallocating the amount of money they spend for Medicaid, Medicare, CHIP, LTC, ABD and Foster Care. Adverse economic conditions may continue to put pressures on state budgets as tax and other state revenues decrease while the population that is eligible to participate in these programs increases, creating more need for funding. We anticipate this will require government agencies to find funding alternatives, which may result in reductions in funding for programs, contraction of covered benefits, and limited or no premium rate increases or premium rate decreases. A reduction (or less than expected increase), a protracted delay, or a change in allocation methodology in government funding for these programs, as well as termination of the contract for the convenience of the government, may materially and adversely affect our results of operations, financial position and cash flows.

Additionally, changes in these programs could reduce the number of persons enrolled in or eligible for these programs or increase our administrative or healthcare costs under these programs. Recent legislation generally requires that eligibility levels be maintained, but this could cause states to reduce reimbursement or reduce benefits in order for states to afford to maintain eligibility levels. If any state in which we operate were to decrease premiums paid to us or pay us less than the amount necessary to keep pace with our cost trends, it could have a material adverse effect on our results of operations, financial position and cash flows.

Lastly, if a federal government shutdown were to occur for a prolonged period of time, federal government payment obligations, including its obligations under Medicaid, Medicare, CHIP, LTC, ABD, Foster Care and the new Health Insurance Marketplaces, may be delayed. If the federal government fails to make payments under these programs on a timely basis, our business could suffer, and our financial position, results of operations or cash flows may be materially affected.

Failure to accurately estimate and price our medical expenses or effectively manage our medical costs or related administrative costs could negatively affect our financial position, results of operations or cash flows.

Our profitability, to a significant degree, depends on our ability to estimate and effectively manage expenses related to health benefits through our ability to contract favorably with hospitals, physicians and other healthcare providers. For example, our Medicaid revenue is often based on bids submitted before the start of the initial contract year. If our actual medical expense exceeds our estimates, our health benefits ratio, or our expenses related to medical services as a percentage of premium revenue, would increase and our profits would decline. Because of the narrow margins of our health plan business, relatively small changes in our health benefits ratio can create significant changes in our financial results. Changes in healthcare regulations and practices, the level of utilization of healthcare services, hospital and pharmaceutical costs, major epidemics or pandemics, new medical technologies, pharmaceutical compounds and other external factors, including general economic conditions such as inflation and unemployment levels, are beyond our control and could reduce our ability to accurately predict and effectively control the costs of providing health benefits.

Our medical expense includes claims reported but not paid, estimates for claims incurred but not reported, and estimates for the costs necessary to process unpaid claims at the end of each period. Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as claims receipts and payment information as well as inpatient acuity information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expense in the period in which the changes are identified. However, we still cannot be sure that our medical claims liability estimate is adequate or that adjustments to the estimate will not unfavorably impact our results of operations.

Additionally, when we commence operations in a new state, region or product, we have limited information with which to estimate our medical claims liability. For a period of time after the inception of the new business, we base our estimates on state-provided historical actuarial data and limited actual incurred and received claims and inpatient acuity information. The addition of new categories of individuals who are eligible under new legislation may pose the same difficulty in estimating our

medical claims liability. Similarly, we may face difficulty in estimating our medical claims liability in 2015 for the relatively new and evolving Health Insurance Marketplaces.

From time to time in the past, our actual results have varied from our estimates, particularly in times of significant changes in the number of our members. If it is determined that our estimates are significantly different than actual results, our results of operations and financial position could be adversely affected. In addition, if there is a significant delay in our receipt of premiums, our business operations, cash flows, or earnings could be negatively impacted.

The implementation of the Health Reform Legislation and other reforms could materially and adversely affect our results of operations, financial position and cash flows.

In March 2010, the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act, collectively referred to as the Affordable Care Act (ACA), were enacted. While the constitutionality of the ACA was generally upheld by the Supreme Court in 2012, the Court determined that states could not be required to expand Medicaid and risk losing all federal money for their existing Medicaid programs.

Under the ACA, Medicaid coverage was expanded to all individuals under age 65 with incomes up to 138% of the federal poverty level beginning January 1, 2014, subject to each states' election. The federal government will pay the entire costs for Medicaid coverage for newly eligible beneficiaries for three years (2014 through 2016). Beginning in 2017, the federal share begins to decline, ending at 90% for 2020 and subsequent years. As of March 6, 2015, 29 states and the District of Columbia have expanded Medicaid eligibility, and additional states continue to discuss expansion. The ACA also maintained CHIP eligibility standards through September 2019.

The ACA required the establishment of Health Insurance Marketplaces for individuals and small employers to purchase health insurance coverage commencing in January 2014. Open enrollment for coverage in 2015 began on November 15, 2014 and continued until February 15, 2015. The ACA required insurers participating on the Health Insurance Marketplaces to offer a minimum level of benefits and included guidelines on setting premium rates and coverage limitations.

Our ability to adequately price products offered in the Health Insurance Marketplaces may have a negative impact on our results of operations, financial position and cash flow. We may be adversely selected by individuals who will have a higher acuity level than the anticipated pool of participants. In addition, the risk corridor, reinsurance and risk adjustment ("three Rs") provisions of the ACA established to reduce risk for insurers may not be effective in appropriately mitigating the financial risks related to the Marketplace product. Further, the reinsurance and risk corridor components may not be adequately funded. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, the three Rs, or other assumptions utilized in setting adequate premium rates could have a material adverse effect on our results of operations, financial position and cash flows.

Our attempts to diversify our business lines through participation in Health Insurance Marketplaces established by the federal government, or "Federally-Facilitated Marketplaces," may be impacted if the United States Supreme Court determines that the Internal Revenue Service may not extend tax-credit subsidies to health insurance coverage purchased through Federally-Facilitated Marketplaces. Individuals who would have otherwise received a tax-credit subsidy may choose not to enroll for coverage through a Federally-Facilitated Marketplace if the Supreme Court makes this determination and other changes are not made by the states to remedy this.

The U.S. Department of Health and Human Services (HHS) has stated that it will consider a limited number of premium assistance demonstration proposals from States that want to privatize Medicaid expansion. States must provide a choice between at least two qualified health plans and offer very similar benefits as those available in the newly created Health Insurance Marketplaces. Arkansas became the first state to obtain federal approval to use Medicaid funding to purchase private insurance for low-income residents and we began operations under the program beginning January 1, 2014.

The ACA imposes an annual insurance industry assessment of $8.0 billion starting in 2014, and $11.3 billion in each of 2015 and 2016, with increasing annual amounts thereafter. Such assessments are not deductible for income tax purposes. The fee will be allocated based on health insurers' premium revenues in the previous year. Each health insurer's fee is calculated by multiplying its market share by the annual fee. Market share is based on commercial, Medicare, and Medicaid premium revenue. Not-for-profit insurers may have a competitive advantage since they are exempt from paying the fee if they receive at least 80% of their premium revenue from Medicare, Medicaid, and CHIP, and other not-for-profit insurers are allowed to exclude 50% of their premium revenue from the fee calculation. If this federal premium assessment is imposed as enacted, and if we are not reimbursed by the states for the cost of the federal premium assessment (including the associated tax impact), or if

we are unable to otherwise adjust our business model to address this new assessment, our results of operations, financial position and cash flows may be materially adversely affected.

There are numerous steps required to implement the legislation, including the promulgation of a substantial number of new and potentially more onerous federal regulations. Further, various health insurance reform proposals are also emerging at the state level. Because of the unsettled nature of these reforms and numerous steps required to implement them, we cannot predict what additional health insurance requirements will be implemented at the federal or state level, or the effect that any future legislation or regulation will have on our business or our growth opportunities. Although we believe the legislation may provide us with significant opportunities to grow our business, the enacted reforms, as well as future regulations and legislative changes, may in fact have a material adverse effect on our results of operations, financial position or liquidity. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of healthcare reform, or do not do so as effectively as our competitors, our results of operations may be materially adversely affected.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could force us to change how we operate and could harm our business.

Our business is extensively regulated by the states in which we operate and by the federal government. In addition, the managed care industry has received negative publicity that has led to increased legislation, regulation, review of industry practices and private litigation in the commercial sector. In each of the jurisdictions in which we operate, we are regulated by the relevant insurance, health and/or human services departments that oversee the activities of managed care organizations providing or arranging to provide services to Medicaid, Medicare and Health Insurance Marketplace enrollees. For example, our health plan subsidiaries, as well as our applicable specialty companies, must comply with minimum statutory capital and other financial solvency requirements, such as deposit and surplus requirements.

The frequent enactment of, changes to, or interpretations of laws and regulations could, among other things: force us to restructure our relationships with providers within our network; require us to implement additional or different programs and systems; restrict revenue and enrollment growth; increase our healthcare and administrative costs; impose additional capital and surplus requirements; and increase or change our liability to members in the event of malpractice by our contracted providers. In addition, changes in political party or administrations at the state, federal or country level may change the attitude towards healthcare programs.

Additionally, the taxes and fees paid to federal, state and local governments may increase due to several factors, including: enactment of, changes to, or interpretations of tax laws and regulations, audits by governmental authorities, geographic expansions into higher taxing jurisdictions and the effect of expansions into international markets.

Our contracts with states may require us to maintain a minimum health benefits ratio (HBR) or may require us to share profits in excess of certain levels. In certain circumstances, our plans may be required to return premium back to the state in the event profits exceed established levels or HBR does not meet the minimum requirement. Other states may require us to meet certain performance and quality metrics in order to maintain our contract or receive additional or full contractual revenue.

The governmental healthcare programs in which we participate are subject to the satisfaction of certain regulations and performance standards. For example, under Health Reform Legislation, Congress authorized CMS and the states to implement managed care demonstration programs to serve dually eligible beneficiaries to improve the coordination of their care. Participation in these demonstration programs is subject to CMS approval and the satisfaction of conditions to participation, including meeting certain performance requirements. Our inability to improve or maintain adequate quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs. Specifically, several of our Medicaid contracts require us to maintain a Medicare health plan. Although we strive to comply with all existing regulations and to meet performance standards applicable to our business, failure to meet these requirements could result in financial fines and penalties. Also, states may not allow us to continue to participate in their government programs, or we may fail to win procurements to participate in such programs which could materially and adversely affect our results of operations, financial position and cash flows.

In addition, as a result of the expansion of our businesses and operations conducted in foreign countries, we face political, economic, legal, compliance, regulatory, operational and other risks and exposures that are unique and vary by jurisdiction. These foreign regulatory requirements with respect to, among other items, environmental, tax, licensing, intellectual property, privacy, data protection, investment, capital, management control, labor relations, and fraud and corruption regulations are different than those faced by our domestic businesses. In addition, we are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act. Our failure to comply with laws

and regulations governing our conduct outside the United States or to successfully navigate international regulatory regimes that apply to us could adversely affect our ability to market our products and services, which may have a material adverse effect on our business, financial condition and results of operations.

Our businesses providing pharmacy benefit management (PBM) and specialty pharmacy services face regulatory and other risks and uncertainties which could materially and adversely affect our results of operations, financial position and cash flows.

We provide PBM and specialty pharmacy services through our US Script and AcariaHealth businesses. Each business is subject to federal and state laws that govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. They also conduct business as a mail order pharmacy and specialty pharmacy, which subjects them to extensive federal, state and local laws and regulations. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially and adversely affect current industry practices, including the receipt or disclosure of rebates from pharmaceutical companies, the development and use of formularies, and the use of average wholesale prices.

Our PBM and specialty pharmacy businesses would be materially and adversely affected by an inability to contract on favorable terms with pharmaceutical manufacturers and other suppliers, and could face potential claims in connection with purported errors by our mail order or specialty pharmacies, including in connection with the risks inherent in the authorization, compounding, packaging and distribution of pharmaceuticals and other healthcare products. Disruptions at any of our mail order or specialty pharmacies due to an event that is beyond our control could affect our ability to process and dispense prescriptions in a timely manner and could materially and adversely affect our results of operations, financial position and cash flows.

If any of our government contracts are terminated or are not renewed or we receive an adverse review, audit or investigation, our business will suffer.

We provide managed care programs and selected services to individuals receiving benefits under governmental assistance programs. We provide those healthcare services under contracts with regulatory entities in the areas in which we operate. Our government contracts are generally intended to run for three years and may be extended for additional years if the contracting entity or its agent elects to do so. When our contracts expire, they may be opened for bidding by competing healthcare providers, and there is no guarantee that our contracts will be renewed or extended. Competitors may buy their way into the market by submitting bids with lower pricing. Further, our government contracts contain certain provisions regarding eligibility, enrollment and dis-enrollment processes for covered services, eligible providers, periodic financial and informational reporting, quality assurance, timeliness of claims payment and agreement to maintain a Medicare plan in the state and financial standards and are subject to cancellation if we fail to perform in accordance with the standards set by regulatory agencies.

We are also subject to various reviews, audits and investigations to verify our compliance with the terms of our contracts with various governmental agencies and applicable laws and regulations. Any adverse review, audit or investigation could result in: cancellation of our contracts; refunding of amounts we have been paid pursuant to our contracts; imposition of fines, penalties and other sanctions on us; loss of our right to participate in various programs; increased difficulty in selling our products and services; or loss of one or more of our licenses.

If any of our government contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, or we have an adverse review, audit or investigation, our business will suffer, our goodwill could be impaired and our financial position, results of operations or cash flows may be materially affected.

Ineffectiveness of state-operated systems and subcontractors could adversely affect our business.

Our health plans rely on other state-operated systems or subcontractors to qualify, solicit, educate and assign eligible members into managed care plans. The effectiveness of these state operations and subcontractors can have a material effect on a health plan's enrollment in a particular month or over an extended period. When a state implements new programs to determine eligibility, new processes to assign or enroll eligible members into health plans, or chooses new subcontractors, there is an increased potential for an unanticipated impact on the overall number of members assigned to managed care plans.

Our investment portfolio may suffer losses which could materially and adversely affect our results of operations or liquidity.

We maintain a significant investment portfolio of cash equivalents and short term and long term investments in a variety of securities, which are subject to general credit, liquidity, market and interest rate risks and will decline in value if interest rates increase or one of the issuers' credit ratings is reduced. As a result, we may experience a reduction in value or loss of liquidity of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition.

Execution of our growth strategy may increase costs or liabilities, or create disruptions in our business.

Our growth strategy includes the acquisition of health plans participating in government sponsored healthcare programs and specialty services businesses, contract rights and related assets of other health plans both in our existing service areas and in new markets and start-up operations in new markets or new products in existing markets. Although we review the records of companies or businesses we plan to acquire, it is possible that we could assume unanticipated liabilities or adverse operating conditions, or an acquisition may not perform as well as expected or may not achieve timely profitability. We also face the risk that we will not be able to effectively integrate acquisitions into our existing operations effectively without substantial expense, delay or other operational or financial problems and we may need to divert more management resources to integration than we planned.

In connection with start-up operations, we may incur significant expenses prior to commencement of operations and the receipt of revenue. For example, in order to obtain a certificate of authority in most jurisdictions, we must first establish a provider network, have systems in place and demonstrate our ability to administer a state contract and process claims. We may experience delays in operational start dates. As a result of these factors, start-up operations may decrease our profitability. In addition, we are planning to expand our business internationally and we will be subject to additional risks, including, but not limited to, political risk, an unfamiliar regulatory regime, currency exchange risk and exchange controls, cultural and language differences, foreign tax issues, and different labor laws and practices.

If we are unable to effectively execute our growth strategy, our future growth will suffer and our results of operations could be harmed.

If competing managed care programs are unwilling to purchase specialty services from us, we may not be able to successfully implement our strategy of diversifying our business lines.

We are seeking to diversify our business lines into areas that complement our government sponsored health plan business in order to grow our revenue stream and balance our dependence on risk reimbursement. In order to diversify our business, we must succeed in selling the services of our specialty subsidiaries not only to our managed care plans, but to programs operated by third-parties. Some of these third-party programs may compete with us in some markets, and they therefore may be unwilling to purchase specialty services from us. In any event, the offering of these services will require marketing activities that differ significantly from the manner in which we seek to increase revenues from our government sponsored programs. Our ineffectiveness in marketing specialty services to third-parties may impair our ability to execute our business strategy.

Adverse credit market conditions may have a material adverse effect on our liquidity or our ability to obtain credit on acceptable terms.

The securities and credit markets have been experiencing extreme volatility and disruption over the past several years. The availability of credit, from virtually all types of lenders, has at times been restricted. In the event we need access to additional capital to pay our operating expenses, fund subsidiary surplus requirements, make payments on or refinance our indebtedness, pay capital expenditures, or fund acquisitions, our ability to obtain such capital may be limited and the cost of any such capital may be significant, particularly if we are unable to access our existing credit facility.

Our access to additional financing will depend on a variety of factors such as prevailing economic and credit market conditions, the general availability of credit, the overall availability of credit to our industry, our credit ratings and credit capacity, and perceptions of our financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain additional financing on favorable terms or at all.

If state regulators do not approve payments of dividends and distributions by our subsidiaries to us, we may not have sufficient funds to implement our business strategy.

We principally operate through our health plan subsidiaries. As part of normal operations, we may make requests for dividends and distributions from our subsidiaries to fund our operations. These subsidiaries are subject to regulations that limit the amount of dividends and distributions that can be paid to us without prior approval of, or notification to, state regulators. If these regulators were to deny our subsidiaries' request to pay dividends, the funds available to us would be limited, which could harm our ability to implement our business strategy.

We derive a majority of our premium revenues from operations in a limited number of states, and our financial position, results of operations or cash flows would be materially affected by a decrease in premium revenues or profitability in any one of those states.

Operations in a limited number of states have accounted for most of our premium revenues to date. If we were unable to continue to operate in any of our current states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly depending on legislative or other governmental or regulatory actions and decisions, economic conditions and similar factors in those states. For example, states we currently serve may bid out their Medicaid program through a request for proposal process. Our inability to continue to operate in any of the states in which we operate could harm our business.

Competition may limit our ability to increase penetration of the markets that we serve.

We compete for members principally on the basis of size and quality of provider networks, benefits provided and quality of service. We compete with numerous types of competitors, including other health plans and traditional state Medicaid programs that reimburse providers as care is provided. In addition, the impact of healthcare reform legislation and potential growth in our segment may attract new competitors.

Some of the health plans with which we compete have greater financial and other resources and offer a broader scope of products than we do. In addition, significant merger and acquisition activity has occurred in the managed care industry, as well as complementary industries, such as the hospital, physician, pharmaceutical, medical device and health information systems businesses. To the extent that competition intensifies in any market that we serve, as a result of industry consolidation or otherwise, our ability to retain or increase members and providers, or maintain or increase our revenue growth, pricing flexibility and control over medical cost trends may be adversely affected.

If we are unable to maintain relationships with our provider networks, our profitability may be harmed.

Our profitability depends, in large part, upon our ability to contract at competitive prices with hospitals, physicians and other healthcare providers. Our provider arrangements with our primary care physicians, specialists and hospitals generally may be canceled by either party without cause upon 90 to 120 days prior written notice. We cannot provide any assurance that we will be able to continue to renew our existing contracts or enter into new contracts on a timely basis or under favorable terms enabling us to service our members profitably. Healthcare providers with whom we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

In any particular market, physicians and other healthcare providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical costs or difficulty in meeting regulatory or accreditation requirements. In some markets, certain healthcare providers, particularly hospitals, physician/hospital organizations or multi-specialty physician groups, may have significant market positions or near monopolies that could result in diminished bargaining power on our part. In addition, accountable care organizations, practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, and other organizational structures that physicians, hospitals and other healthcare providers choose may change the way in which these providers interact with us and may change the competitive landscape. Such organizations or groups of healthcare providers may compete directly with us, which could adversely affect our operations, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way that we price our products and estimate our costs, which might require us to incur costs to change our operations. Provider networks may consolidate, resulting in a reduction in the competitive environment. In addition, if these providers refuse to contract with us, use their market position to negotiate contracts unfavorable to us or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

From time to time healthcare providers assert or threaten to assert claims seeking to terminate non-cancelable agreements due to alleged actions or inactions by us. In addition, we are aware that other managed care organizations have been subject to class action lawsuits by healthcare providers with respect to claim payment procedures, and we may be subject to similar lawsuits. Regardless of whether any lawsuits brought against us are successful or have merit, they will still be time-consuming and costly and could distract our management's attention. As a result, we may incur significant expenses and may be unable to operate our business effectively. If we are unable to retain our current provider contract terms or enter into new provider contracts timely or on favorable terms, our profitability may be harmed.

We may be unable to attract, retain or effectively manage the succession of key personnel.

We are highly dependent on our ability to attract and retain qualified personnel to operate and expand our business. We would be adversely impacted if we are unable to adequately plan for the succession of our executives and senior management. While we have succession plans in place for members of our executive and senior management team, these plans do not guarantee that the services of our executive and senior management team will continue to be available to us. Our ability to replace any departed members of our executive and senior management or other key employees may be difficult and may take an extended period of time because of the limited number of individuals in the managed care and specialty services industry with the breadth of skills and experience required to operate and successfully expand a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain or motivate these personnel. If we are unable to attract, retain and effectively manage the succession plans for key personnel, executives and senior management, our business and financial position, results of operations or cash flows could be harmed.

If we are unable to integrate and manage our information systems effectively, our operations could be disrupted.

Our operations depend significantly on effective information systems. The information gathered and processed by our information systems assists us in, among other things, monitoring utilization and other cost factors, processing provider claims, and providing data to our regulators. Our healthcare providers also depend upon our information systems for membership verifications, claims status and other information. Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs and regulatory requirements. We regularly upgrade and expand our information systems' capabilities. If we experience difficulties with the transition to or from information systems or are unable to properly maintain or expand our information systems, we could suffer, among other things, operational disruptions, loss of existing members and difficulty in attracting new members, regulatory problems and increases in administrative expenses. In addition, our ability to integrate and manage our information systems may be impaired as the result of events outside our control, including acts of nature, such as earthquakes or fires, or acts of terrorists.

From time to time, we may become involved in costly and time-consuming litigation and other regulatory proceedings, which require significant attention from our management.

We are a defendant from time to time in lawsuits and regulatory actions relating to our business, including, without limitation, medical malpractice claims. Due to the inherent uncertainties of litigation and regulatory proceedings, we cannot accurately predict the ultimate outcome of any such proceedings. An unfavorable outcome could have a material adverse impact on our business and financial position, results of operations or cash flows. In addition, regardless of the outcome of any litigation or regulatory proceedings, such proceedings are costly and time consuming and require significant attention from our management, and could therefore harm our business and financial position, results of operations or cash flows.

An impairment charge with respect to our recorded goodwill and intangible assets could have a material impact on our results of operations.

We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. Changes in business strategy, government regulations or economic or market conditions have resulted and may result in impairments of our goodwill and other intangible assets at any time in the future. Our judgments regarding the existence of impairment indicators are based on, among other things, legal factors, market conditions, and operational performance. For example, the non-renewal of our health plan contracts with the state in which they operate may be an indicator of impairment. If an event or events occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill and other intangible assets, such revision could result in a non-cash impairment charge that could have a material impact on our results of operations in the period in which the impairment occurs.

If we fail to comply with applicable privacy, security, and data laws, regulations and standards, including with respect to third-party service providers that utilize sensitive personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

As part of our normal operations, we collect, process and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act and the Gramm-Leach-Bliley Act, which require us to protect the privacy of medical records and safeguard personal health information we maintain and use. Certain of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities. Despite our best attempts to maintain adherence to information privacy and security best practices as well as compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers, may be vulnerable to privacy or security breaches, acts of vandalism or theft, malware, misplaced or lost data including paper or electronic media, programming and/or human errors or other similar events. In the past, we have had data breaches resulting in disclosure of confidential or protected health information that have not resulted in any material financial loss or penalty to date. However, future data breaches could require us to expend significant resources to remediate any damage, interrupt our operations and damage our reputation, subject us to state or federal agency review and could also result in enforcement actions, material fines and penalties, litigation or other actions which could have a material adverse effect on our business, reputation and results of operations, financial position and cash flows.

In addition, HIPAA broadened the scope of fraud and abuse laws applicable to healthcare companies. HIPAA created civil penalties for, among other things, billing for medically unnecessary goods or services. HIPAA established new enforcement mechanisms to combat fraud and abuse, including civil and, in some instances, criminal penalties for failure to comply with specific standards relating to the privacy, security and electronic transmission of protected health information. The HITECH Act expanded the scope of these provisions by mandating individual notification in instances of breaches of protected health information, providing enhanced penalties for HIPAA violations, and granting enforcement authority to states' Attorneys General in addition to the HHS Office for Civil Rights. It is possible that Congress may enact additional legislation in the future to increase penalties and to create a private right of action under HIPAA, which could entitle patients to seek monetary damages for violations of the privacy rules. In addition, HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities with a focus on security risk assessments. Although we are not aware of HHS plans to audit any of our covered entities, an audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Under HIPAA, health plans are required to have the capacity to accept and send all covered transactions in a standardized electronic format. Penalties can be imposed for failure to comply with these requirements. The transaction standards have been modified to version 5010 to prepare for the implementation of the ICD-10 coding system. While we have prepared for the transition to ICD-10 in October 2015, if unforeseen circumstances arise, it is possible that we could be exposed to investigations and allegations of noncompliance. In addition, if some providers continue to use ICD-9 codes on claims after October 1, 2015, we may have to reject such claims, which may lead to claim resubmissions, increased call volume and provider and customer dissatisfaction. Further, providers may use ICD-10 codes differently than they used ICD-9 codes in the past, which could result in higher costs and reimbursement levels, or lost revenues under risk adjustment. During the transition to ICD-10, certain claims processing and payment information we have historically used to establish our reserves may not be reliable or available in a timely manner. As a result, implementation of ICD 10 may have a material adverse effect on our results of operations, financial position and cash flows.

A failure in or breach of our operational or security systems or infrastructure, or those of third parties with which we do business, including as a result of cyber attacks, could have an adverse effect on our business.

Information security risks have significantly increased in recent years in part because of the proliferation of new technologies, the use of the internet and telecommunications technologies to conduct our operations, and the increased sophistication and activities of organized crime, hackers, terrorists and other external parties, including foreign state agents. Our operations rely on the secure processing, transmission and storage of confidential, proprietary and other information in our computer systems and networks.

Security breaches may arise from external or internal threats. External breaches include hacking personal information for financial gain, attempting to cause harm to our operations, or intending to obtain competitive information. We experience attempted external hacking or malicious attacks on a regular basis. We maintain a rigorous system of preventive and detective controls through our security programs; however, our prevention and detection controls may not prevent or identify all such attacks. Internal breaches may result from inappropriate security access to confidential information by rogue employees,

consultants or third party service providers. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, financial data, competitively sensitive information, or other proprietary data, whether by us or a third party, could have a material adverse effect on our business reputation, financial condition, cash flows, or results of operations.

ITEM 2. ***Unregistered Sales of Equity Securities and Use of Proceeds.***

On January 2, 2015, the Company completed the acquisition of LiveHealthier, Inc. whereby the initial transaction consideration was partially financed through an issuance of $13 million (247,580 shares) of Centene common stock. The Company issued shares in reliance upon the exemption contained in Section 4(a)(2) of the Securities Act of 1933, as amended, as a transaction not involving a public offering.

Issuer Purchases of Equity Securities
First Quarter 2015

Period	Total Number of Shares Purchased [1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs[2]
January 1 – January 31, 2015	8,314	$ 52.99	—	3,335,448
February 1 - February 28, 2015	67,047	54.83	—	3,335,448
March 1 - March 31, 2015	6,818	64.11	—	3,335,448
Total	82,179	$ 55.41	—	3,335,448

[1] Shares acquired represent shares relinquished to the Company by certain employees for payment of taxes or option cost upon vesting of restricted stock units or option exercise.

[2] Our Board of Directors adopted a stock repurchase program which allows for repurchases of up to a remaining amount of 3,335,448 shares. No duration has been placed on the repurchase program.

ITEM 6. ***Exhibits.***

EXHIBIT NUMBER	DESCRIPTION
10.1*	Form of Amendment of Executive Severance and Change in Control Agreement.
12.1	Computation of ratio of earnings to fixed charges.
31.1	Certification of Chairman, President and Chief Executive Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Executive Vice President and Chief Financial Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chairman, President and Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Executive Vice President and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.1	XBRL Taxonomy Instance Document.
101.2	XBRL Taxonomy Extension Schema Document.
101.3	XBRL Taxonomy Extension Calculation Linkbase Document.
101.4	XBRL Taxonomy Extension Definition Linkbase Document.
101.5	XBRL Taxonomy Extension Label Linkbase Document.
101.6	XBRL Taxonomy Extension Presentation Linkbase Document.

* Indicates a management contract or compensatory plan or arrangement.

SIGNATURES

Pursuant to the requirements 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 as of April 28, 2015.

CENTENE CORPORATION

By: /s/ MICHAEL F. NEIDORFF
Chairman, President and Chief Executive Officer
(principal executive officer)

By: /s/ WILLIAM N. SCHEFFEL
Executive Vice President and Chief Financial Officer
(principal financial officer)

By: /s/ JEFFREY A. SCHWANEKE
Senior Vice President, Corporate Controller and Chief Accounting Officer
(principal accounting officer)

EXHIBIT 31.1

CERTIFICATION

I, Michael F. Neidorff, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of Centene Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, 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;

   c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: April 28, 2015

/s/ MICHAEL F. NEIDORFF

Chairman, President and Chief Executive Officer
(principal executive officer)

EXHIBIT 31.2

CERTIFICATION

I, William N. Scheffel, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of Centene Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, 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;

   c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting;

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: April 28, 2015

/s/ WILLIAM N. SCHEFFEL

Executive Vice President and Chief Financial Officer
(principal financial officer)

EXHIBIT 32.1

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report on Form 10-Q of Centene Corporation (the Company) for the period ended March 31, 2015, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, Michael F. Neidorff, Chairman, President and Chief Executive Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: April 28, 2015

/s/ MICHAEL F. NEIDORFF

Chairman, President and Chief Executive Officer
(principal executive officer)

EXHIBIT 32.2

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report on Form 10-Q of Centene Corporation (the Company) for the period ended March 31, 2015, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, William N. Scheffel, Executive Vice President and Chief Financial Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: April 28, 2015

/s/ WILLIAM N. SCHEFFEL

Executive Vice President and Chief Financial Officer
(principal financial officer)

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

☒ **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: 001-31826

Centene Corporation

(Exact name of registrant as specified in its charter)

Delaware	**42-1406317**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification Number)
7700 Forsyth Boulevard St. Louis, Missouri	**63105**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: (314) 725-4477

Securities registered pursuant to Section 12(b) of the Act:

Common Stock, $0.001 Par Value	**New York Stock Exchange**
Title of Each Class	Name of Each Exchange on Which Registered

Securities registered pursuant to Section 12(g) of the Act:

None

(Title of Each Class)

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 or 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 Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was require 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 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 "small reporting company" in Rule 12b-2 of the Exchange Act. 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 Act). Yes ☐ No ☒

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 30, 2014, was $4.4 billion.

As of February 20, 2015, the registrant had 118,820,237 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2015 annual meeting of stockholders are incorporated by reference in Part III, Items 10, 11, 12, 13 and 14.

CENTENE CORPORATION
ANNUAL REPORT ON FORM 10-K
TABLE OF CONTENTS

		PAGE
	Part I	
Item 1.	Business	1
Item 1A.	Risk Factors	20
Item 1B.	Unresolved Staff Comments	29
Item 2.	Properties	30
Item 3.	Legal Proceedings	30
Item 4.	Mine Safety Disclosures	30
	Part II	
Item 5.	Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities	31
Item 6.	Selected Financial Data	33
Item 7.	Management's Discussion and Analysis of Financial Condition and Results of Operations	35
Item 7A.	Quantitative and Qualitative Disclosures About Market Risk	55
Item 8.	Financial Statements and Supplementary Data	57
Item 9.	Changes in and Disagreements with Accountants on Accounting and Financial Disclosure	93
Item 9A.	Controls and Procedures	93
Item 9B.	Other Information	95
	Part III	
Item 10.	Directors, Executive Officers and Corporate Governance	95
Item 11.	Executive Compensation	95
Item 12.	Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters	95
Item 13.	Certain Relationships and Related Transactions, and Director Independence	95
Item 14.	Principal Accountant Fees and Services	95
	Part IV	
Item 15.	Exhibits and Financial Statement Schedules	96
Signatures		101
Certifications		102

CAUTIONARY STATEMENT ON FORWARD-LOOKING STATEMENTS

All statements, other than statements of current or historical fact, contained in this filing are forward-looking statements. We have attempted to identify these statements by terminology including "believe," "anticipate," "plan," "expect," "estimate," "intend," "seek," "target," "goal," "may," "will," "should," "can," "continue" and other similar words or expressions in connection with, among other things, any discussion of future operating or financial performance. In particular, these statements include statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions, investments and the adequacy of our available cash resources. These statements may be found in the various sections of this filing, including those entitled "Management's Discussion and Analysis of Financial Condition and Results of Operations," Part I, Item 1A. "Risk Factors," and Part I, Item 3 "Legal Proceedings." Readers are cautioned that matters subject to forward-looking statements involve known and unknown risks and uncertainties, including economic, regulatory, competitive and other factors that may cause our or our industry's actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

All forward-looking statements included in this filing are based on information available to us on the date of this filing and we undertake no obligation to update or revise the forward-looking statements included in this filing, whether as a result of new information, future events or otherwise, after the date of this filing. Actual results may differ from projections or estimates due to a variety of important factors, including:

- our ability to accurately predict and effectively manage health benefits and other operating expenses and reserves;
- competition;
- membership and revenue projections;
- timing of regulatory contract approval;
- changes in healthcare practices;
- changes in federal or state laws or regulations, including the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act and any regulations enacted thereunder;
- changes in expected contract start dates;
- changes in expected closing dates, estimated purchase price and accretion for acquisitions;
- inflation;
- foreign currency fluctuations;
- provider and state contract changes;
- new technologies;
- advances in medicine;
- reduction in provider payments by governmental payors;
- major epidemics;
- disasters and numerous other factors affecting the delivery and cost of healthcare;
- the expiration, cancellation or suspension of our Medicare or Medicaid managed care contracts by federal or state governments;
- the outcome of pending legal proceedings;
- availability of debt and equity financing, on terms that are favorable to us; and
- general economic and market conditions.

Item 1A "Risk Factors" of Part I of this filing contains a further discussion of these and other important factors that could cause actual results to differ from expectations. We disclaim any current intention or obligation to update or revise any forward-looking statements, whether as a result of new information, future events or otherwise. Due to these important factors and risks, we cannot give assurances with respect to our future premium levels or our ability to control our future medical costs.

PART I

ITEM 1. ***Business.***

OVERVIEW

We are a diversified, multi-national healthcare enterprise that provides programs and services to government sponsored healthcare programs, focusing on under-insured and uninsured individuals. We provide member-focused services through locally based staff by assisting in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions. We also provide education and outreach programs to inform and assist members in accessing quality, appropriate healthcare services. We believe our local approach, including member and provider services, enables us to provide accessible, quality, culturally-sensitive healthcare coverage to our communities. Our health management, educational and other initiatives are designed to help members best utilize the healthcare system to ensure they receive appropriate, medically necessary services and effective management of routine, severe and chronic health problems, resulting in better health outcomes. We combine our decentralized local approach for care with a centralized infrastructure of support functions such as finance, information systems and claims processing.

We operate in two segments: Managed Care and Specialty Services. Our Managed Care segment provides health plan coverage to individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program (CHIP), Long Term Care (LTC), Foster Care, dual-eligible individuals (Duals) and the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program, or collectively ABD. Beginning in 2014, our Managed Care segment also provides health plan coverage to individuals covered through federally-facilitated and state-based Health Insurance Marketplaces (HIM). Our Specialty Services segment consists of our specialty companies offering diversified healthcare services and products to state programs, correctional facilities, healthcare organizations, employer groups and other commercial organizations, as well as to our own subsidiaries. For the year ended December 31, 2014, our Managed Care and Specialty Services segments accounted for 89% and 11%, respectively, of our total external premium and service revenues.

Our subsidiary, Kentucky Spirit Health Plan (KSHP), ceased serving members in Kentucky as of July 6, 2013. Accordingly, the results of operations for KSHP are classified as discontinued operations for all periods presented in our consolidated financial statements. The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise identified.

Our managed care membership totaled 4.1 million as of December 31, 2014. For the year ended December 31, 2014, our premium and service revenues and net earnings from continuing operations attributable to Centene were $15.7 billion and $268 million, respectively, and our total cash flow from operations was $1.2 billion.

On February 2, 2015, the Board of Directors declared a two-for-one split of Centene's common stock in the form of a 100% stock dividend distributed February 19, 2015 to stockholders of record on February 12, 2015. All share, per share and stock price information presented in this Form 10-K has been adjusted for the two-for-one stock split.

Our initial health plan commenced operations in Wisconsin in 1984. We were organized in Wisconsin in 1993 as a holding company for our initial health plan and reincorporated in Delaware in 2001. Our corporate office is located at 7700 Forsyth Boulevard, St. Louis, Missouri 63105, and our telephone number is (314) 725-4477. Our stock is publicly traded on the New York Stock Exchange under the ticker symbol "CNC."

INDUSTRY

We provide our services primarily through Medicaid, CHIP, LTC, Foster Care, ABD, Medicare and other state and federal programs for the uninsured. The federal Centers for Medicare and Medicaid Services, or CMS, estimated the total Medicaid and CHIP market was approximately $421 billion in 2012, and estimate the market

will grow to $919 billion by 2023. According to the most recent information provided by the Kaiser Commission on Medicaid and the Uninsured, Medicaid spending increased by 10.2% in fiscal 2014 and states appropriated an increase of 14.3% for Medicaid in fiscal 2015 budgets.

Established in 1965, Medicaid is the largest publicly funded program in the United States, and provides health insurance to low-income families and individuals with disabilities. Authorized by Title XIX of the Social Security Act, Medicaid is an entitlement program funded jointly by the federal and state governments and administered by the states. The majority of funding is provided at the federal level. Each state establishes its own eligibility standards, benefit packages, payment rates and program administration within federal standards. As a result, there are 56 Medicaid programs—one for each U.S. state, each U.S. territory and the District of Columbia. Eligibility is based on a combination of household income and assets, often determined by an income level relative to the federal poverty level. Historically, children have represented the largest eligibility group. Many states have selected Medicaid managed care as a means of delivering quality healthcare and controlling costs. We refer to these states as mandated managed care states.

Established in 1972, and authorized by Title XVI of the Social Security Act, ABD covers low-income persons with chronic physical disabilities or behavioral health impairments. ABD beneficiaries represent a growing portion of all Medicaid recipients. In addition, ABD recipients typically utilize more services because of their critical health issues.

The Balanced Budget Act of 1997 created CHIP to help states expand coverage primarily to children whose families earned too much to qualify for Medicaid, yet not enough to afford private health insurance. Some states include the parents of these children in their CHIP programs. Costs related to the largest eligibility group, children, are primarily composed of pediatrics and family care. These costs tend to be more predictable than those associated with other healthcare issues which predominantly affect the adult population.

A portion of Medicaid beneficiaries are dual-eligible, low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare. According to the Kaiser Commission on Medicaid and the Uninsured, there were approximately 9.6 million dual-eligible enrollees in 2014. These dual-eligible members may receive assistance from Medicaid for Medicaid benefits, such as nursing home care and/or assistance with Medicare premiums and cost sharing. Dual-eligibles also use more services due to their tendency to have more chronic health issues. We serve dual-eligibles through our ABD and LTC programs and through Medicare Special Needs Plans.

While Medicaid programs have directed funds to many individuals who cannot afford or otherwise maintain health insurance coverage, they did not initially address the inefficient and costly manner in which the Medicaid population tends to access healthcare. Medicaid recipients in non-managed care programs typically have not sought preventive care or routine treatment for chronic conditions, such as asthma and diabetes. Rather, they have sought healthcare in hospital emergency rooms, which tends to be more expensive. As a result, many states have found that the costs of providing Medicaid benefits have increased while the medical outcomes for the recipients remained unsatisfactory.

We expect that continued pressure on state Medicaid budgets will cause public policy to recognize the value of managed care as a means of delivering improved health outcomes for Medicaid beneficiaries and effectively controlling costs. A growing number of states have mandated that their Medicaid recipients enroll in managed care plans. Other states are considering moving to a mandated managed care approach. As a result, we believe a significant market opportunity exists for managed care organizations with operations and programs focused on the distinct socio-economic, cultural and healthcare needs of the uninsured population and the Medicaid, CHIP, LTC, Foster Care and ABD populations.

In March 2010, the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act collectively referred to as the Affordable Care Act (ACA), were enacted. While the constitutionality of the ACA was subsequently challenged in a number of legal actions, in June 2012, the Supreme Court upheld the constitutionality of the ACA, with one limited exception relating to the Medicaid expansion provision. The Supreme Court held that states could not be required to expand Medicaid and

risk losing all federal money for their existing Medicaid programs. Under the ACA, Medicaid coverage was expanded to all individuals under age 65 with incomes up to 138% of the federal poverty level beginning January 1, 2014, subject to the states' elections. The federal government will pay the entire costs for Medicaid coverage for newly eligible beneficiaries for three years, from 2014 through 2016. In 2017, the federal share declines to 95%; in 2018 it is 94%; in 2019 it is 93%; and it will be 90% in 2020 and subsequent years. States may delay Medicaid expansion after 2014.

Health Insurance Marketplaces are a key component of the ACA and provide an opportunity for individuals and small businesses to obtain health insurance. States have the option of operating their own Marketplace or partnering with the federal government. States choosing neither option will default to a federally-facilitated Marketplace. Premium and cost-sharing subsidies are available to make coverage more affordable and access to Marketplaces is limited to U.S. citizens and legal immigrants. Insurers are required to offer a minimum level of benefits with three levels of coverage that vary based on premiums and out-of-pocket costs. Premium subsidies are provided to families without access to other coverage and with incomes between 100-400% of the federal poverty level to help them purchase insurance through the Marketplaces. These subsidies are offered on a sliding scale basis. The Congressional Budget Office (CBO) anticipates that coverage through the exchanges will increase substantially over time as more people respond to subsidies and to penalties for failure to obtain coverage. CBO projects coverage through the exchanges to increase to an average of 13 million in 2015, 24 million in 2016, and 25 million in each year between 2017 and 2024.

OUR COMPETITIVE STRENGTHS

Our multi-national managed care approach is based on the following key attributes:

- *Strong Historic Operating Performance.* We have increased revenues as we have grown in existing markets, expanded into new markets and broadened our product offerings. We entered the Wisconsin market in 1984 as a single health plan and have grown to serve 21 states. Our operating performance has been demonstrated by the following:

	2014	2013	% Change 2013 - 2014
Total membership	4,060,900	2,879,800	41%
Premium and service revenues ($ in millions)	$ 15,667	$ 10,526	49%
Diluted earnings per share	$ 2.23	$ 1.43	56%
Total operating cash flow ($ in millions)	$ 1,223	$ 382	220%

For the year ended December 31, 2014, premium and service revenues of $15,667 million represented a five year Compound Annual Growth Rate (CAGR) of 32% and diluted earnings per share of $2.23 represented a five year CAGR of 18%.

- *Innovative Technology and Scalable Systems.* The ability to access data and translate it into meaningful information is essential to operating across a multi-state service area in a cost-effective manner. Our centralized information systems support our core processing functions under a set of integrated databases and are designed to be both replicable and scalable to accommodate organic growth and growth from acquisitions. We continue to enhance our systems in order to leverage the platform we have developed for our existing states for configuration into new states or health plan acquisitions. Our predictive modeling technology enables our medical management operations to proactively case and disease manage specific high risk members. It can recommend medical care opportunities using a mix of company defined algorithms and evidence based medical guidelines. Interventions are determined by the clinical indicators, the ability to improve health outcomes, and the risk profile of members. Our integrated approach helps to assure that consistent sources of claim and member information are provided across all of our health plans. Our membership and claims processing system is capable of expanding to support additional members in an efficient manner.

- *Expertise in Government Sponsored Programs.* For more than 30 years, we have developed a specialized government services expertise that has helped us establish and maintain relationships with members, providers and state governments. We have implemented programs developed to achieve savings for state governments and improve medical outcomes for members by reducing inappropriate emergency room use, inpatient days and high cost interventions, as well as by managing care of chronic illnesses. We work with state agencies in order to maximize the effectiveness of their programs. Our approach is to accomplish this while maintaining adequate levels of provider compensation and protecting our profitability.
- *Diversified Business Lines.* We continue to broaden our service offerings to address areas that we believe have been traditionally under-served by Medicaid managed care organizations. In addition to our Medicaid and Medicaid-related managed care services, our service offerings include behavioral health management, care management software, correctional healthcare services, dental benefits management, HIM, in-home health services, life and health management, managed vision, pharmacy benefits management, specialty pharmacy and telehealth services. Through the utilization of a multi-business line approach, we are able to improve the quality of care, improve outcomes, diversify our revenues and help control our medical costs.
- *Localized Approach with Centralized Support Infrastructure.* We take a localized approach to managing our subsidiaries, including provider and member services. This approach enables us to facilitate access by our members to high quality, culturally sensitive healthcare services. Our systems and procedures have been designed to address these community-specific challenges through outreach, education, transportation and other member support activities. For example, our community outreach programs work with our members and their communities to promote health and self-improvement through employment and education on how best to access care. We complement this localized approach with a centralized infrastructure of support functions such as finance, information systems and claims processing, which allows us to minimize general and administrative expenses and to integrate and realize synergies from acquisitions. We believe this combined approach allows us to efficiently integrate new business opportunities in both Medicaid and specialty services while maintaining our local accountability and improved access.
- *Quality and Innovation.* Our innovative medical management programs focus on improving quality of care in areas that have the greatest impact on our members. We concentrate on serving the whole person to impact outcomes and costs. We recognize the importance of member-focused delivery of quality managed care services and have developed award winning education and outreach programs including the CentAccount program, Start Smart For Your Baby, and MemberConnections.

OUR BUSINESS STRATEGY

Our objective is to become the leading multi-national healthcare enterprise focusing on the uninsured and under-insured population through government sponsored healthcare initiatives. We intend to achieve this objective by implementing the following key components of our strategy:

- *Increase Penetration of Existing State Markets.* We seek to continue to increase our Medicaid membership in states in which we currently operate through alliances with key providers, outreach efforts, development and implementation of community-specific products and acquisitions. For example, in 2014, we expanded our health plan in Florida with an expanded Medicaid managed care contract.
- *Diversify Business Lines.* We seek to broaden our business lines into areas that complement our existing business to enable us to grow and diversify our revenue. We are constantly evaluating new opportunities for expansion both domestically and abroad. For instance, in 2014, we acquired U.S. Medical Management, a management services organization and provider of in-home health services for high acuity populations. We employ a disciplined acquisition strategy that is based on defined criteria

including internal rate of return, accretion to earnings per share, market leadership and compatibility with our information systems. We engage our executives in the relevant operational units or functional areas to ensure consistency between the diligence and integration process.

- *Address Emerging State Needs.* We work to assist the states in which we operate in addressing the operating challenges they face. We seek to assist the states in balancing premium rates, benefit levels, member eligibility, policies and practices, provider compensation and minimizing fraud and abuse. By helping states structure an appropriate level and range of Medicaid, CHIP and specialty services, we seek to ensure that we are able to continue to provide those services on terms that achieve targeted gross margins, provide an acceptable return and grow our business.
- *Develop and Acquire Additional Markets.* We continue to leverage our experience to identify and develop new domestic and international markets by seeking both to acquire existing business and to build our own operations. Domestically, we focus expansion in states where Medicaid recipients are mandated to enroll in managed care organizations because we believe member enrollment levels are more predictable in these states. In addition, we focus on states where managed care programs can help address states' financial needs. For example, in 2013, we began managing care for Medicaid members in California, Kansas and New Hampshire. In 2014, we entered the international market with our investment in Ribera Salud, a Spanish health management group.
- *Leverage Established Infrastructure to Enhance Operating Efficiencies.* We intend to continue to invest in infrastructure to further drive efficiencies in operations and to add functionality to improve the service provided to members and other organizations at a low cost. Information technology, or IT, investments complement our overall efficiency goals by increasing the automated processing of transactions and growing the base of decision-making analytical tools. Our centralized functions and common systems enable us to add members and markets quickly and economically.
- *Maintain Operational Discipline.* We seek to operate in markets that allow us to meet our internal metrics including membership growth, plan size, market leadership and operating efficiency. We use multiple techniques to monitor and reduce our medical costs, including on-site hospital review by staff nurses and involvement of medical management in significant cases. Our executive dashboard is utilized to quickly identify cost drivers and medical trends. Our management team regularly evaluates the financial impact of proposed changes in provider relationships, contracts, changes in membership and mix of members, potential state rate changes and cost reduction initiatives. We may divest contracts or health plans in markets where the state's Medicaid environment, over a long term basis, does not allow us to meet our targeted performance levels. For example, as a result of lower than anticipated financial performance, in July 2013, we terminated our Kentucky Medicaid managed care contract with the Commonwealth of Kentucky.

We have subsidiaries offering healthcare services in each state we serve. The table below provides summary data for the state markets we currently serve:

State	Local Plan Name	First Year of Operations Under the Company	Counties Served at December 31, 2014	Managed Care Membership at December 31, 2014
Arizona	Bridgeway Health Solutions	2006	6	7,000
Arizona	Cenpatico of Arizona	2005	8	197,000
Arkansas	Arkansas Health and Wellness Solutions	2014	75	38,400
California	California Health and Wellness	2013	19	163,900
Florida	Sunshine Health	2009	67	425,700
Georgia	Peach State Health Plan	2006	159	389,100
Illinois	IlliniCare Health	2011	12	87,800
Indiana	Managed Health Services	1995	92	197,700
Kansas	Sunflower State Health Plan	2013	105	143,300
Louisiana	Louisiana Healthcare Connections	2012	64	152,900
Massachusetts	CeltiCare Health	2009	14	37,900
Massachusetts	Massachusetts Partnership for Correctional Healthcare	2013	N/A	10,500
Minnesota	Centurion of Minnesota	2014	N/A	9,500
Mississippi	Magnolia Health	2011	82	108,700
Missouri	Home State Health	2012	54	71,000
New Hampshire	New Hampshire Healthy Families	2013	10	62,700
Ohio	Buckeye Health Plan	2004	88	280,100
South Carolina	Absolute Total Care	2007	46	109,700
Tennessee	Centurion of Tennessee	2013	N/A	21,000
Texas	Superior HealthPlan	1999	254	971,000
Vermont	Centurion Managed Care	2015	N/A	—
Washington	Coordinated Care	2012	35	194,400
Wisconsin	MHS Health Wisconsin	1984	51	83,200
Total at-risk membership				3,762,500
Non-risk membership				298,400
Total				4,060,900

Substantially all of our revenue is derived from operations within the United States and its territories, and all of the Company's long lived assets are based in the United States and its territories. We generally receive a fixed premium per member per month pursuant to our state contracts. Our medical costs have a seasonality component due to cyclical illness, for example cold and flu season, resulting in higher medical expenses beginning in the fourth quarter and continuing throughout the first quarter of the following year. Our managed care subsidiaries in Texas and Florida had revenues from their respective state governments that each exceeded 10% of our consolidated total revenues in 2014.

MANAGED CARE

Benefits to States

Our ability to establish and maintain a leadership position in the markets we serve results primarily from our demonstrated success in providing quality care while reducing and managing costs, and from our specialized

programs in working with state governments. Among the benefits we are able to provide to the states with which we contract are:

- *Significant cost savings and budget predictability compared to state paid reimbursement for services.* We bring experience relating to quality of care improvement methods, utilization management procedures, an efficient claims payment system, and provider performance reporting, as well as managers and staff experienced in using these key elements to improve the quality of and access to care. We generally receive a contracted premium on a per member basis and are responsible for the medical costs and as a result, provide budget predictability.
- *Data-driven approaches to balance cost and verify eligibility.* We seek to ensure effective outreach procedures for new members, then educate them and ensure they receive needed services as quickly as possible. Our IT department has created mapping/translation programs for loading membership and linking membership eligibility status to all of Centene's subsystems. We utilize predictive modeling technology to proactively case and disease manage specific high risk members. In addition, we have developed Centelligence, our enterprise data warehouse system to provide a seamless flow of data across our organization, enabling providers and case managers to access information, apply analytical insight and make informed decisions.
- *Establishment of realistic and meaningful expectations for quality deliverables.* We have collaborated with state agencies in redefining benefits, eligibility requirements and provider fee schedules with the goal of maximizing the number of individuals covered through Medicaid.
- *Managed care expertise in government subsidized programs.* Our expertise in Medicaid has helped us establish and maintain strong relationships with our constituent communities of members, providers and state governments. We provide access to services through local providers and staff that focus on the cultural norms of their individual communities. To that end, systems and procedures have been designed to address community-specific challenges through outreach, education, transportation and other member support activities.
- *Improved quality and medical outcomes.* We have implemented programs developed to improve the quality of healthcare delivered to our members including Start Smart for your Baby, Living Well With Sickle Cell and The CentAccount Program.
- *Timely payment of provider claims.* We are committed to ensuring that our information systems and claims payment systems meet or exceed state requirements. We continuously endeavor to update our systems and processes to improve the timeliness of our provider payments.
- *Provider outreach and programs.* Our health plans have adopted a physician-driven approach where network providers are actively engaged in developing and implementing healthcare delivery policies and strategies. We prepare provider comparisons on a severity adjusted basis. This approach is designed to eliminate unnecessary costs, improve services to members and simplify the administrative burdens placed on providers.
- *Responsible collection and dissemination of utilization data.* We gather utilization data from multiple sources, allowing for an integrated view of our members' utilization of services. These sources include medical, vision and behavioral health claims and encounter data, pharmacy data, dental vendor claims and authorization data from the authorization and case management system utilized by us to coordinate care.
- *Timely and accurate reporting.* Our information systems have reporting capabilities which have been instrumental in identifying the need for new and/or improved healthcare and specialty programs. For state agencies, our reporting capability is important in demonstrating an auditable program.
- *Fraud and abuse prevention.* We have several systems in place to help identify, detect and investigate potential waste, abuse and fraud including pre and post payment review software. We collaborate with state and federal agencies and assist with investigation requests. We use nationally recognized standards to benchmark our processes.

Member Programs and Services

We recognize the importance of member-focused delivery of quality managed care services. Our locally-based staff assists members in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions. While covered healthcare benefits vary from state to state, our health plans generally provide the following services:

- primary and specialty physician care
- inpatient and outpatient hospital care
- emergency and urgent care
- prenatal care
- laboratory and x-ray services
- home health and durable medical equipment
- behavioral health and substance abuse services
- 24-hour nurse advice line
- transportation assistance
- vision care
- dental care
- immunizations
- prescriptions and limited over-the-counter drugs
- specialty pharmacy
- therapies
- social work services
- care coordination

We also provide the following education and outreach programs to inform, assist and incentivize members in accessing quality, appropriate healthcare services in an efficient manner. Many of these programs have been recognized with awards for their excellence in education, outreach and/or case management techniques including Case In Point, Hermes Awards, U.S. Environmental Protection Agency and National Health Information Awards.

- *Start Smart For Your Baby,* or Start Smart, is our award winning prenatal and infant health program designed to increase the percentage of pregnant women receiving early prenatal care, reduce the incidence of low birth weight babies, identify high-risk pregnancies, increase participation in the federal Women, Infant and Children program, prevent hospital admissions in the first year of life and increase well-child visits.
- *Connections Plus* is a cell phone program developed for high-risk members who have limited or no access to a safe, reliable telephone. This program seeks to eliminate lack of safe, reliable access to a telephone as a barrier to coordinating care, thus reducing avoidable adverse events such as inappropriate emergency room utilization, hospital admissions and premature birth.
- *MemberConnections* is a community face-to-face outreach and education program designed to create a link between the member and the provider and help identify potential challenges or risk elements to a member's health, such as nutritional challenges and health education shortcomings.
- *The ScriptAssist for Hepatitis C Adherence Program* seeks to empower patients towards Hepatitis C virus treatment success through a series of telephonic interventions. Goals of the program include preventing premature treatment discontinuation due to medication side effects and access to therapy. NurseWise clinicians and AcariaHealth patient care coordinators collaborate throughout a patient's treatment course to ensure appropriate therapy management and regimen access.
- *Health Initiatives for Children* is aimed at educating child members on a variety of health topics. In order to empower and educate children, we have partnered with a nationally recognized children's author to develop our own children's book series on topics such as obesity prevention and healthy eating, asthma, diabetes, foster care, the ills of smoking, anti-bullying and heart health.
- *Health Initiatives for Teens* is aimed at empowering, educating and reinforcing life skills with our teenage members. We have developed an educational series that addresses health issues, dealing with chronic diseases including diabetes and asthma, as well as teen pregnancy.
- *Living Well with Sickle Cell* is our innovative program that assists with coordination of care for our sickle cell members. Our program ensures that sickle cell members have established a medical home and work on strategies to reduce unnecessary emergency room visits through proper treatment to control symptoms and chronic complications, as well as promote self-management.

- *My Route for Health* is our adult educational series used with our case management and disease management programs. The topics of this series include how to manage asthma, COPD, diabetes, heart disease and HIV.
- *Nurtur Diabetes Program* is an innovative program that is a collaboration with our life and health management subsidiary, Nurtur, and our health plans that targets diabetic patients and educates them on their disease state.
- *Community Health Record,* our patient-centric electronic database, collects patient demographic data, clinician visit records, dispensed medications, vital sign history, lab results, allergy charts, and immunization data. Providers can directly input additional or updated patient data and documentation into the database. All information is accessible anywhere, anytime to all authorized users, including health plan staff, greatly facilitating coordinated care among providers.
- *The CentAccount Program* offers members financial incentives for performing certain healthy behaviors. The incentives are delivered through a restricted-use prepaid debit card. This incentive-based approach effectively increases the utilization of preventive services while strengthening the relationships between members and their primary care providers.
- *The Asthma Management Program* integrates a hands-on approach with a flexible outreach methodology that can be customized to suit different age groups and populations affected by asthma. Working through Nurtur, we provide proactive identification of members, stratification into appropriate levels of intervention including home visits, culturally sensitive education, and robust outcome reporting. The program also includes aggressive care coordination to ensure patients have basic services such as transportation to the doctor, electricity to power the nebulizer, and a clean, safe home environment.
- *Fluvention* is an outreach program aimed at educating members on preventing the transmission of the influenza virus by encouraging members to get the seasonal influenza vaccines and take everyday precautions to prevent illness.
- *Preventive Care Programs* are designed to educate our members on the benefits of Early and Periodic Screening, Diagnosis and Treatment, or EPSDT, services. We have a systematic program of communicating, tracking, outreach, reporting and follow-through that promotes state EPSDT programs.
- *Life and Health Management Programs* are designed to help members understand their disease and treatment plans and improve their wellness in a cost effective manner. These programs address medical conditions that are common within the Medicaid population such as asthma, diabetes and pregnancy.

Providers

For each of our service areas, we establish a provider network consisting of primary and specialty care physicians, hospitals and ancillary providers. As of December 31, 2014, we contracted with over 59,000 primary care physicians, 178,000 specialty care physicians and 2,000 hospitals.

Our network of primary care physicians is a critical component in care delivery, management of costs and the attraction and retention of new members. Primary care physicians include family and general practitioners, pediatricians, internal medicine physicians and obstetricians and gynecologists. Specialty care physicians provide medical care to members generally upon referral by the primary care physicians. Specialty care physicians include, but are not limited to, orthopedic surgeons, cardiologists and otolaryngologists. We also provide education and outreach programs to inform and assist members in accessing quality, appropriate healthcare services.

Our health plans facilitate access to healthcare services for our members primarily through contracts with our providers. Our contracts with primary and specialty care physicians and hospitals usually are for one to two-year periods and renew automatically for successive one-year terms, but generally are subject to termination by either party upon 90 to 120 days prior written notice. In the absence of a contract, we typically pay providers at state Medicaid reimbursement levels. We pay hospitals under a variety of methods, including fee-for-service,

capitation arrangements, per diems, diagnostic related grouping and case rates. We pay physicians under a fee-for-service, capitation arrangement, or risk-sharing performance-based arrangement. In addition, we are governed by state prompt payment policies.

- Under our fee-for-service contracts with physicians, particularly specialty care physicians, we pay a negotiated fee for covered services. This model is characterized as having no financial risk for the physician. In addition, this model requires management oversight because our total cost may increase as the units of services increase or as more expensive services replace less expensive services. We have prior authorization procedures in place that are intended to make sure that certain high cost diagnostic and other services are medically appropriate.
- Under our capitated contracts, primary care physicians are paid a monthly fee for each of our members assigned to his or her practice for all ambulatory care. In return for this payment, these physicians provide all primary care and preventive services, including primary care office visits and EPSDT services, and are at risk for all costs associated with such services. If these physicians also provide non-capitated services to their assigned members, they may receive payment under fee-for-service arrangements at standard Medicaid rates.
- Under risk-sharing performance-based arrangements, physicians are paid under a capitated or fee-for-service arrangement. The arrangement, however, contains provisions for additional bonus to the physicians or reimbursement from the physicians based upon cost and quality measures.

We work with physicians to help them operate efficiently by providing financial and utilization information, physician and patient educational programs and disease and medical management programs. Our programs are also designed to help the physicians coordinate care outside of their offices.

We believe our collaborative approach with physicians gives us a competitive advantage in entering new markets. Our physicians serve on local committees that assist us in implementing preventive care programs, managing costs and improving the overall quality of care delivered to our members, while also simplifying the administrative burdens on our providers. This approach has enabled us to strengthen our provider networks through improved physician recruitment and retention that, in turn, have helped to increase our membership base. The following are among the services we provide to support physicians:

- *Customized Utilization Reports* provide certain of our contracted physicians with information that enables them to run their practices more efficiently and focuses them on specific patient needs. For example, quarterly detail reports update physicians on their status within their risk pools. Equivalency reports provide physicians with financial comparisons of capitated versus fee-for-service arrangements.
- *Case Management Support* helps the physician coordinate specialty care and ancillary services for patients with complex conditions and direct members to appropriate community resources to address both their health and socio-economic needs.
- *Web-based Claims and Eligibility Resources* have been implemented to provide physicians with on-line access to perform claims and eligibility inquiries.

Our contracted physicians also benefit from several of the services offered to our members, including the MemberConnections, EPSDT case management and health management programs. For example, the MemberConnections staff facilitates doctor/patient relationships by connecting members with physicians, the EPSDT programs encourage routine checkups for children with their physicians and the health management programs assist physicians in managing their patients with chronic disease.

Where appropriate, our health plans contract with our specialty services organizations to provide services and programs such as behavioral health management, care management software, dental benefits management, in-home health services, life and health management, managed vision, pharmacy benefits management, specialty pharmacy and telehealth services. When necessary, we also contract with third-party providers on a negotiated fee arrangement for physical therapy, home healthcare, dental, diagnostic laboratory tests, x-ray examinations, transportation, ambulance services and durable medical equipment.

Quality Management

Our medical management programs focus on improving quality of care in areas that have the greatest impact on our members. We employ strategies, including health management and complex case management, that are adjusted for implementation in our individual markets by a system of physician committees chaired by local physician leaders. This process promotes physician participation and support, both critical factors in the success of any clinical quality improvement program.

We have implemented specialized information systems to support our medical quality management activities. Information is drawn from our data warehouse, clinical databases and our membership and claims processing system to identify opportunities to improve care and to track the outcomes of the interventions implemented to achieve those improvements. Some examples of these intervention programs include:

- appropriate leveling of care for neonatal intensive care unit hospital admissions, other inpatient hospital admissions, and observation admissions, in accordance with Interqual criteria
- tightening of our pre-authorization list and more stringent review of durable medical equipment and injectibles
- Emergency room program designed to collaboratively work with hospitals to steer non-emergency care away from the costly emergency room setting (through patient education, on-site alternative urgent care settings, etc.)
- increase emphasis on case management and clinical rounding where case managers are nurses or social workers who are employed by the health plan to assist selected members with the coordination of healthcare services in order to meet a member's specific healthcare needs
- incorporation of disease management, which is a comprehensive, multidisciplinary, collaborative approach to chronic illnesses such as asthma and diabetes
- Start Smart For Your Baby, a prenatal case management program aimed at helping women with high-risk pregnancies deliver full-term, healthy infants
- Pharmacy treatment compliance programs are driven by clinical policy and focus on identifying the appropriate medication in the correct dose, delivered in the most efficient format and utilized for the correct duration.

We provide reporting on a regular basis using our data warehouse. State and Health Employer Data and Information Set, or HEDIS, reporting constitutes the core of the information base that drives our clinical quality performance efforts. This reporting is monitored by Plan Quality Improvement Committees and our corporate medical management team.

In an effort to ensure the quality of our provider networks, we undertake to verify the credentials and background of our providers using standards that are supported by the National Committee for Quality Assurance, or NCQA.

It is our objective to provide access to the highest quality of care for our members. As a validation of that objective, we often pursue accreditation by independent organizations that have been established to promote healthcare quality. The NCQA Health Plan Accreditation and URAC Health Plan Accreditation programs provide unbiased, third party reviews to verify and publicly report results on specific quality care metrics. While we have achieved or are pursuing accreditation for all of our plans, accreditation is only one measure of our ability to provide access to quality care for our members. We currently have 15 health plans and four specialty companies with NCQA accreditation.

SPECIALTY SERVICES

Our specialty services are a key component of our healthcare enterprise and complement our core Managed Care business. Specialty services diversify our revenue stream, provide higher quality health outcomes to our membership and others, and assist in controlling costs. Our specialty services are provided primarily through the following businesses:

- *Behavioral Health Management.* Cenpatico manages behavioral healthcare for members via a contracted network of providers. Cenpatico works with providers to determine the best services to help people overcome mental illness and lead productive lives. Our networks feature a full range of services and levels of care to help people with mental illness reach their recovery and wellness goals. In addition, we operate school-based programs that focus on students with special needs and also provide speech and other therapy services.
- *Care Management Software.* Casenet is a software provider of innovative care management solutions that automate the clinical, administrative and technical components of care management programs, which is available for sale to third parties and used by our health plans.
- *Correctional Healthcare Services.* Centurion, our joint venture subsidiary with MHM Services Inc., provides comprehensive healthcare services to individuals incarcerated in Massachusetts, Minnesota, and Tennessee state correctional facilities. Beginning in February 2015, Centurion also began operating under a new contract with the State of Vermont, Department of Corrections.
- *Dental Benefits Management.* Dental Health & Wellness is a dental benefit manager dedicated to improving oral health through a contracted network of dental healthcare providers.
- *In-Home Health Services.* U.S. Medical Management, our majority owned subsidiary acquired in January 2014, provides in-home health services for high acuity populations.
- *Life and Health Management.* Nurtur specializes in implementing life and health management programs that encourage healthy behaviors, promote healthier workplaces, improve workforce and societal productivity and reduce healthcare costs. Health risk appraisals, biometric screenings, online and telephonic wellness programs, disease management and work-life/employee assistance services are areas of focus. Nurtur uses telephonic health and work/life balance coaching, in-home and online interaction and informatics processes to deliver effective clinical outcomes, enhanced patient-provider satisfaction and lower overall healthcare cost.
- *Managed Vision.* OptiCare administers routine and medical surgical eye care benefits via its own contracted national network of eye care providers. OptiCare clients include Medicaid, Medicare, and commercial health plans, as well as employer groups. OptiCare has been providing vision network services for over 25 years and offers a variety of plan designs to meet the individual needs of its clients and members.
- *Pharmacy Benefits Management.* US Script offers progressive pharmacy benefits management services that are specifically designed to improve quality of care while containing costs. This is achieved through a low cost strategy that helps optimize clients' pharmacy benefits. Services include claims processing, pharmacy network management, benefit design consultation, drug utilization review, formulary and rebate management, mail order pharmacy services, and patient and physician intervention.
- *Specialty Pharmacy.* AcariaHealth offers comprehensive specialized pharmacy benefit services for complex diseases, including Cystic Fibrosis, Hemophilia, Hepatitis C, Infertility, Multiple Sclerosis, Oncology and Rheumatoid Arthritis. AcariaHealth offers specialized care management services in these disease states and enhances the patient care offering, collaboration with providers and the capture of relevant data to measure patient outcomes. AcariaHealth connects patients, physicians, payers and manufacturers to their specialty pharmacy needs.

- *Telehealth Services.* NurseWise provides a toll-free nurse triage line 24 hours per day, 7 days per week, 52 weeks per year. Our members call one number and reach bilingual customer service representatives and nursing staff who provide health education, triage advice and offer continuous access to health plan functions. Additionally, our representatives verify eligibility, confirm primary care provider assignments and provide benefit and network referral coordination for members and providers after business hours. Our staff can arrange for urgent pharmacy refills, transportation and qualified behavioral health professionals for crisis stabilization assessments.

CORPORATE COMPLIANCE

Our Corporate Ethics and Compliance Program provides controls by which we assure that our values are reflected in everything we do, further enhancing operations, improving access to quality care and safeguarding against fraud and abuse.

Two standards by which corporate compliance programs in the healthcare industry are measured are the Federal Organizational Sentencing Guidelines and Compliance Program Guidance series issued by the Department of Health and Human Services' Office of the Inspector General, or OIG. Our program contains each of the seven elements suggested by the Sentencing Guidelines and the OIG guidance. These key components are:

- written standards of conduct
- designation of a corporate compliance officer and compliance committee
- effective training and education
- effective lines for reporting and communication
- enforcement of standards through well publicized disciplinary guidelines and actions
- internal monitoring and auditing
- prompt response to detected offenses and development of corrective action plans

The goal of the program is to build a culture of ethics and compliance, which is assessed periodically using a diagnostic survey to measure the integrity of the organization. Our internal Corporate Compliance intranet site, accessible to all employees, contains our Business Ethics and Conduct Policy (Code of Conduct), Compliance Program description and resources for employees to report concerns or ask questions. If needed, employees have access to the contact information for the members of our Board of Directors' Audit Committee to report concerns. Our Ethics and Compliance Helpline is a toll-free number and web-based reporting tool operated by a third party independent of the Company and allows employees or other persons to report suspected incidents of misconduct, fraud, abuse or other compliance violations anonymously. Furthermore, the Board of Directors reviews an ethics and compliance report on a quarterly basis.

COMPETITION

We continue to face varying and increasing levels of competition as we expand in our existing service areas or enter new markets. Federal regulations require at least two competitors in each service area. Healthcare reform may cause a number of commercial managed care organizations to decide to enter or exit the Medicaid market.

In our business, our principal competitors for state contracts, members and providers consist of the following types of organizations:

- *Medicaid Managed Care Organizations* focus on providing healthcare services to Medicaid recipients. These organizations consist of national and regional organizations, as well as not-for-profits and smaller organizations that operate in one city or state and are owned by providers, primarily hospitals.
- *National and Regional Commercial Managed Care Organizations* have Medicaid members in addition to members in private commercial plans. Some of these organizations offer a range of specialty services including pharmacy benefits management, behavioral health management, health management, and nurse triage call support centers.

- *Primary Care Case Management Programs* are programs established by the states through contracts with primary care providers. Under these programs, physicians provide primary care services to Medicaid recipients, as well as limited medical management oversight.
- *Accountable Care Organizations* are groups of doctors, hospitals, and other health care providers, who come together to give coordinated high quality care to their patients.

We compete with other managed care organizations and specialty companies for state contracts. In order to grant a contract, state governments consider many factors. These factors include quality of care, financial requirements, an ability to deliver services and establish provider networks and infrastructure. In addition, our specialty companies also compete with other providers, such as disease management companies, individual health insurance companies, and pharmacy benefits managers for non-governmental contracts.

We also compete to enroll new members and retain existing members. People who wish to enroll in a managed healthcare plan or to change healthcare plans typically choose a plan based on the quality of care and services offered, ease of access to services, a specific provider being part of the network and the availability of supplemental benefits.

We also compete with other managed care organizations to enter into contracts with physicians, physician groups and other providers. We believe the factors that providers consider in deciding whether to contract with us include existing and potential member volume, reimbursement rates, medical management programs, speed of reimbursement and administrative service capabilities. See "Risk Factors—Competition may limit our ability to increase penetration of the markets that we serve."

REGULATION

Our operations are regulated at both state and federal levels. Government regulation of the provision of healthcare products and services is a changing 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 and rules also may occur periodically.

Our regulated subsidiaries are licensed to operate as health maintenance organizations, third party administrators, utilization review organizations, pharmacies, direct care providers and/or insurance companies in their respective states. In each of the jurisdictions in which we operate, we are regulated by the relevant insurance, health and/or human services departments, departments of insurance, boards of pharmacy and other health care providers, and departments of health that oversee the activities of managed care organizations providing or arranging to provide services to Medicaid, Medicare and Health Insurance Marketplace commercial enrollees.

The process for obtaining authorization to operate as a managed care organization and provider organizations is complex and requires us to demonstrate to the regulators the adequacy of the health plan's organizational structure, financial resources, utilization review, quality assurance programs, complaint procedures, provider network and procedures for covering emergency medical conditions. Under both state managed care organization statutes and insurance laws, our health plan subsidiaries, as well as our applicable specialty companies, must comply with minimum statutory capital and other financial solvency requirements, such as deposit and surplus requirements. Insurance regulations may also require prior state approval of acquisitions of other managed care organization businesses and the payment of dividends, as well as notice for loans or the transfer of funds. Our subsidiaries are also subject to periodic state and federal reporting requirements. In addition, each health plan and individual health care provider must meet criteria to secure the approval of state regulatory authorities before implementing operational changes, including the development of new product offerings and, in some states, the expansion of service areas.

States have adopted a number of regulations that may affect our business and results of operations. These regulations in certain states include:

- premium taxes or similar assessments
- stringent prompt payment laws
- disclosure requirements regarding provider fee schedules and coding procedures
- programs to monitor and supervise the activities and financial solvency of provider groups

We are regulated as an insurance holding company and are subject to the insurance holding company acts of the states in which our insurance company and HMO subsidiaries are domiciled. These acts contain certain reporting requirements as well as restrictions on transactions between an insurer or HMO and its affiliates. These holding company laws and regulations generally require insurance companies and HMOs within an insurance holding company system to register with the insurance department of each state where they are domiciled and to file with those states' insurance departments reports describing capital structure, ownership, financial condition, intercompany transactions and general business operations. In addition, depending on the size and nature of the transaction, there are various notice and reporting requirements that generally apply to transactions between insurance companies and HMOs and their affiliates within an insurance holding company structure. Some insurance holding company laws and regulations require prior regulatory approval or, in certain circumstances, prior notice of certain material intercompany transfers of assets as well as certain transactions between insurance companies, HMOs, their parent holding companies and affiliates. Among other provisions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends.

Additionally, the holding company acts of the states in which our subsidiaries are domiciled restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval or an exemption, no person may acquire any voting security of an insurance holding company, which controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would "control" the insurance holding company. "Control" is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a company and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of a company.

Our pharmacies must be licensed to do business as pharmacies in the states in which they are located. Our pharmacies must also register with the U.S. Drug Enforcement Administration and individual state controlled substance authorities to dispense controlled substances. In many of the states where our pharmacies deliver pharmaceuticals, there are laws and regulations that require out-of-state mail order pharmacies to register with that state's board of pharmacy or similar regulatory body. These states generally permit the pharmacy to follow the laws of the state in which the mail order pharmacy is located, although some states require that we also comply with certain laws in that state.

Our health care providers must be licensed to practice medicine and do business as care providers in the state which they are located. In addition, they must be in good standing with the applicable medical board, board of nursing or applicable entity. Furthermore, they cannot be excluded from participation at both state and federal level. Our facilities are periodically reviewed by state departments of health and other regulatory agencies to ensure the environment is safe to provide care.

State and Federal Contracts

In addition to being a licensed insurance company or health maintenance organization, in order to be a Medicaid managed care organization in each of the states in which we operate, we must operate under a contract with the state's Medicaid agency. States generally use either a formal proposal process, reviewing a number of bidders, or award individual contracts to qualified applicants that apply for entry to the program. We receive monthly payments based on specified capitation rates determined on an actuarial basis. These rates differ by membership category and by state depending on the specific benefits and policies adopted by each state. In addition, several of our Medicaid contracts require us to maintain Medicare Advantage special needs plans, which are regulated by CMS, for dual eligible individuals.

Our state and federal contracts and the regulatory provisions applicable to us generally set forth the requirements for operating in the Medicaid and Medicare sectors, including provisions relating to:

- eligibility, enrollment and dis-enrollment processes
- covered services
- eligible providers
- subcontractors
- record-keeping and record retention
- periodic financial and informational reporting
- quality assurance
- accreditation
- health education and wellness and prevention programs
- timeliness of claims payment
- financial standards
- safeguarding of member information
- fraud and abuse detection and reporting
- grievance procedures
- organization and administrative systems

A health plan or individual health insurance provider's compliance with these requirements is subject to monitoring by state regulators and by CMS. A health plan is also subject to periodic comprehensive quality assurance evaluations by a third-party reviewing organization and generally by the insurance department of the jurisdiction that licenses the health plan. A health plan or individual health insurance provider must also submit reports to various regulatory agencies, including quarterly and annual statutory financial statements and utilization reports.

The table below sets forth the terms of our contracts and provides details regarding related renewal or extension and termination provisions. The contracts are subject to termination for cause, an event of default or lack of funding.

Contract	Expiration Date	Renewal or Extension
Arizona – Behavioral Health	September 30, 2015	(1)
Arizona – LTC	September 30, 2015	Renewable for one additional one-year term.
Arizona – Special Needs Plan (Medicare)	December 31, 2015	Renewable annually for successive 12-month periods.
California – Medicaid & ABD	October 31, 2018	Renewable up to three additional one-year terms.
Florida – Medicaid, ABD, LTC & Foster Care	December 31, 2018	Renewable through the state's recertification process.
Florida – CHIP	September 30, 2015	May be extended for one additional one-year term.
Florida – Special Needs Plan (Medicare)	December 31, 2015	Renewable annually for successive 12-month periods.
Georgia – Medicaid & CHIP	June 30, 2015	Renewable for one additional one-year term.
Georgia – Special Needs Plan (Medicare)	December 31, 2015	Renewable annually for successive 12-month periods.
Illinois – ABD & LTC	April 30, 2016	May be extended for up to five additional years.
Illinois – Duals	December 31, 2015	Renewable for two additional one-year terms.
Illinois – Medicaid	June 30, 2019	May be extended for up to five additional years.
Indiana – Medicaid, CHIP & Hybrid (Healthy Indiana Plan)	December 31, 2015	Renewable for one additional one-year term.
Kansas – Medicaid, ABD, CHIP, LTC & Foster Care	December 31, 2015	Renewable for two additional one-year terms.
Louisiana – Medicaid, CHIP, ABD & Foster Care	January 31, 2018	May be extended for up to two additional one-year terms.
Massachusetts – Correctional Healthcare Services	June 30, 2018	Renewable for two additional one-year terms.
Massachusetts – Medicaid	September 30, 2015	May be extended for five additional one-year terms.

(1) The current contract expires September 2015. In December 2014, the Arizona Department of Health Services/Division of Behavioral Health Services awarded the Southern Arizona Integrated RBHA contract to our Arizona subsidiary, Cenpatico Integrated Care. The contract is expected to have an initial three-year term with two additional two-year renewal options for a potential maximum length of seven years, and is expected to commence in the fourth quarter of 2015.

Contract	Expiration Date	Renewal or Extension
Minnesota – Correctional Healthcare Services	June 30, 2016	May be extended for up to two and a half additional years.
Mississippi – Medicaid, ABD & Foster Care	June 30, 2017	May be extended for up to two additional one-year terms.
Mississippi – CHIP	June 30, 2015	Renewable through the state's reprocurement process.
Missouri – Medicaid, CHIP & Foster Care	June 30, 2015	Renewable through the state's reprocurement process.
New Hampshire – Medicaid, CHIP, Foster Care & ABD	June 30, 2015	Renewable for one additional two-year term.
Ohio – Duals	December 31, 2015	Renewable for two additional one-year terms.
Ohio – Medicaid, CHIP & ABD	June 30, 2015	Renewable annually for successive 12-month periods.
Ohio – Special Needs Plan (Medicare)	December 31, 2015	Renewable annually for successive 12-month periods.
South Carolina – Medicaid & ABD	June 30, 2016	Renewable through the state's recertification process.
South Carolina – Duals	December 31, 2017	Renewable through the state's recertification process.
Tennessee – Correctional Healthcare Services	August 31, 2016	Renewable through the state's reprocurement process.
Texas – ABD Dallas Expansion	August 31, 2015	May be extended for up to three additional years.
Texas – ABD MRSA	August 31, 2017	May be extended for up to five additional years.
Texas – CHIP Rural Service Area	August 31, 2015	May be extended for up to three additional years.
Texas – Foster Care	August 31, 2015	Renewable through the state's reprocurement process.
Texas – Medicaid, CHIP & ABD	August 31, 2015	May be extended for up to four and a half additional years.
Texas – Duals	December 31, 2015	May be renewed for three additional one-year terms.
Texas – Special Needs Plan (Medicare)	December 31, 2015	Renewable annually for successive 12-month periods.
Vermont – Correctional Healthcare Services	January 31, 2018	May be extended for up to two additional one-year terms.
Washington – Medicaid, CHIP, Foster Care & ABD	December 31, 2015	Renewable through the state's reprocurement process.
Wisconsin – Medicaid, CHIP & ABD	December 31, 2015	Renewable through the state's recertification process every two years.
Wisconsin – Network Health Plan Subcontract	December 31, 2017	Renews automatically for successive three-year terms.
Wisconsin – Special Needs Plan (Medicare)	December 31, 2015	Renewable annually for successive 12-month periods.

Marketplace Contracts

In 2014, we began operating under federally facilitated Marketplace contracts with CMS in Florida, Georgia, Indiana, Mississippi, Ohio and Texas. In 2015, we began operating under additional federally facilitated Marketplace contracts in Illinois and Wisconsin. The federally facilitated contracts expire annually and are renewable upon mutual consent.

In 2014, we also began operating under two state based Marketplace contracts in Massachusetts and Washington that expire annually. The Massachusetts contract has been extended to December 31, 2015 and may be extended for up to one additional one-year term. The Washington contract has been extended through December 31, 2015 and is renewable annually through the state's recertification process. In addition, we began operating under a state based Marketplace contract with the Arkansas Department of Human Services Division of Medical Services and the Arkansas Insurance Department to participate in the Medicaid expansion model that Arkansas has adopted (referred to as the "private option") in January 2014. This contract expires December 31, 2015 and may be extended for subsequent and consecutive one-year terms.

HIPAA Omnibus Rule and HITECH

In 1996, Congress enacted the Health Insurance Portability and Accountability Act, or HIPAA. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including HIPAA and the Gramm-Leach-Bliley Act. HIPAA is designed to improve the portability and continuity of health insurance coverage, simplify the administration of health insurance through standard transactions and ensure the privacy and security of individual health information. Among the main requirements of HIPAA are the Administrative Simplification provisions which include: standards for processing health insurance claims and related transactions (Transactions Standards); requirements for protecting the privacy and limiting the use and disclosure of medical records and other personal health information (Privacy Rule); and standards and specifications for safeguarding personal health information which is maintained, stored or transmitted in electronic format (Security Rule). The Health Information Technology for Economic and Clinical Health (HITECH) Act amended certain provisions of HIPAA and introduced new data security obligations for covered entities and their business associates. HITECH also mandated individual notifications in instances of a data breach, provided enhanced penalties for HIPAA violations, and granted enforcement authority to states' Attorneys General in addition to the HHS Office of Civil Rights. The HIPAA Omnibus Rule is based on the changes under the HITECH Acts and the Genetic Information Nondiscrimination Act of 2008 (GINA) which clarifies that genetic information is protected under the HIPAA Privacy Rule and prohibits most health plans from using or disclosing genetic information for underwriting purposes. This Omnibus rule enhances the privacy protections and strengthens the government's ability to enforce the law. The preemption provisions of HIPAA provide that the federal standards will not preempt state laws that are more stringent than the related federal requirements.

The Privacy and Security Rules and HITECH/Omnibus enhancements establish requirements to protect the privacy of medical records and safeguard personal health information maintained and used by healthcare providers, health plans, healthcare clearinghouses, and their business associates.

The Security Rule requires healthcare providers, health plans, healthcare clearinghouses, and their business associates to implement administrative, physical and technical safeguards to ensure the privacy and confidentiality of health information when it is electronically stored, maintained or transmitted. The HITECH Act and Omnibus Rule established a federal requirement for notification when the security of protected health information is breached. In addition, there are state laws that have been adopted to provide for, among other things, private rights of action for breaches of data security and mandatory notification to persons whose identifiable information is obtained without authorization.

The requirements of the Transactions Standards apply to certain healthcare related transactions conducted using "electronic media." Since "electronic media" is defined broadly to include "transmissions that are physically moved from one location to another using portable data, magnetic tape, disk or compact disk media," many communications are considered to be electronically transmitted. Under HIPAA, health plans and providers are required to have the capacity to accept and send all covered transactions in a standardized electronic format. Penalties can be imposed for failure to comply with these requirements. The transaction standards have been modified to version 5010 to prepare for the implementation of the ICD-10 coding system. We are planning for an expected transition to ICD-10 in October 2015.

We have implemented processes, policies and procedures to comply with HIPAA, HITECH and the Omnibus Rule, including administrative, technical and physical safeguards to prevent against electronic data breach. We provide education and training for employees specifically designed to help prevent any unauthorized use or access to health information and enhance the reporting of suspected breaches. In addition, our corporate privacy officer and health plan privacy officials handle privacy complaints and serve as resources to employees to address questions or concerns they may have. We periodically review our privacy and security procedures and conduct risk assessments to ensure we promptly identify gaps in our processes.

Other Fraud and Abuse Laws

Investigating and prosecuting healthcare fraud and abuse continues to be a top priority for state and federal law enforcement entities. The focus of these efforts has been directed at participants in public government healthcare programs such as Medicare and Medicaid. The laws and regulations relating to fraud and abuse and the requirements applicable to health plans and providers participating in these programs are complex and regularly changing and compliance with them may require substantial resources. We are constantly looking for ways to improve our waste, fraud and abuse detection methods. While we have both prospective and retrospective processes to identify abusive patterns and fraudulent billing, we continue to increase our capabilities to proactively detect inappropriate billing prior to payment.

EMPLOYEES

As of December 31, 2014, we had approximately 13,400 employees. None of our employees are represented by a union. We believe our relationships with our employees are positive.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following table sets forth information regarding our executive officers, including their ages, at February 15, 2015:

Name	Age	Position
Michael F. Neidorff	72	Chairman, President and Chief Executive Officer
K. Rone Baldwin	56	Executive Vice President, Insurance Group Business Unit
Carol E. Goldman	57	Executive Vice President and Chief Administrative Officer
Jesse N. Hunter	39	Executive Vice President, Chief Business Development Officer
Donald G. Imholz	62	Executive Vice President, Operations and Chief Information Officer
William N. Scheffel	61	Executive Vice President, Chief Financial Officer and Treasurer
Jeffrey A. Schwaneke	39	Senior Vice President, Corporate Controller and Chief Accounting Officer
Keith H. Williamson	62	Executive Vice President, General Counsel and Secretary

Michael F. Neidorff. Mr. Neidorff has served as our Chairman and Chief Executive Officer since May 2004. From May 1996 to May 2004, Mr. Neidorff served as President, Chief Executive Officer and as a member of our Board of Directors. Mr. Neidorff also serves as a director of Brown Shoe Company, Inc., a publicly-traded footwear company with global operations.

K. Rone Baldwin. Mr. Baldwin has served as our Executive Vice President, Insurance Group Business Unit since December 2012. Prior to joining Centene, he served as Executive Vice President and Business Leader of Group Insurance Business, which included both group health and ancillary product lines, for Guardian Life Insurance Company, which he joined in 2006.

Carol E. Goldman. Ms. Goldman is our Executive Vice President and Chief Administrative Officer and has served in that capacity since June 2007.

Jesse N. Hunter. Mr. Hunter has served as our Executive Vice President, Chief Business Development Officer since December 2012. From February 2012 to December 2012, he served as our Executive Vice President, Operations. He previously served as our Executive Vice President, Corporate Development from April 2008 to February 2012.

Donald G. Imholz. Mr. Imholz is our Executive Vice President, Operations and Chief Information Officer and has served in that capacity since September 2008.

William N. Scheffel. Mr. Scheffel is our Executive Vice President, Chief Financial Officer and Treasurer and has served in that capacity since May 2009.

Jeffrey A. Schwaneke. Mr. Schwaneke is our Senior Vice President, Corporate Controller and has served in that capacity since July 2008 and has been our Chief Accounting Officer since September 2008.

Keith H. Williamson. Mr. Williamson has served as our Executive Vice President, General Counsel and Secretary since November 2012. He served as Senior Vice President and General Counsel from November 2006 to November 2012.

Available Information

We are subject to the reporting and information requirements of the Securities Exchange Act of 1934, as amended (Exchange Act) and, as a result, we file periodic reports and other information with the Securities and Exchange Commission, or SEC. We make these filings available on our website free of charge, the URL of which is http://www.centene.com, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. The SEC maintains a website (http://www.sec.gov) that contains our annual, quarterly and current reports and other information we file electronically with the SEC. You can read and copy any materials we file with the SEC at the SEC's Public Reference Room at 100 F Street, N.E., Room 1850, Washington, D.C. 20549. You may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. Information on our website does not constitute part of this Annual Report on Form 10-K.

ITEM 1A. ***Risk Factors.***

FACTORS THAT MAY AFFECT FUTURE RESULTS AND THE TRADING PRICE OF OUR COMMON STOCK

You should carefully consider the risks described below before making an investment decision. The trading price of our common stock could decline due to any of these risks, in which case you could lose all or part of your investment. You should also refer to the other information in this filing, including our consolidated financial statements and related notes. The risks and uncertainties described below are those that we currently believe may materially affect our Company. Additional risks and uncertainties that we are unaware of or that we currently deem immaterial also may become important factors that affect our Company.

Reductions in funding or changes to eligibility requirements for government sponsored healthcare programs in which we participate could substantially affect our financial position, results of operations and cash flows.

The majority of our revenues come from government subsidized healthcare programs including Medicaid, Medicare, CHIP, LTC, ABD, Foster Care and Health Insurance Marketplace premiums. The base premium rate paid for each program differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region and benefit mix. Since Medicaid was created in 1965, the federal government and the states have shared the costs, with the federal share currently averaging around 57%.

Future levels of funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints. Governments periodically consider reducing or reallocating the amount of money they spend for Medicaid, Medicare, CHIP, LTC, ABD and Foster Care. Adverse economic conditions may continue to put pressures on state budgets as tax and other state revenues decrease while the population that is eligible to participate in these programs increases, creating more need for funding. We anticipate this will require government agencies to find funding alternatives, which may result in reductions in funding for programs, contraction of covered benefits, and limited or no premium rate increases or premium rate decreases. A reduction (or less than expected increase), a protracted delay, or a change in allocation methodology in government funding for these programs, as well as termination of the contract for the convenience of the government, may materially and adversely affect our results of operations, financial position and cash flows.

Additionally, changes in these programs could reduce the number of persons enrolled in or eligible for these programs or increase our administrative or healthcare costs under these programs. Recent legislation generally requires that eligibility levels be maintained, but this could cause states to reduce reimbursement or reduce benefits in order for states to afford to maintain eligibility levels. If any state in which we operate were to decrease premiums paid to us or pay us less than the amount necessary to keep pace with our cost trends, it could have a material adverse effect on our results of operations, financial position and cash flows.

Lastly, if a federal government shutdown were to occur for a prolonged period of time, federal government payment obligations, including its obligations under Medicaid, Medicare, CHIP, LTC, ABD, Foster Care and the new Health Insurance Marketplaces, may be delayed. If the federal government fails to make payments under these programs on a timely basis, our business could suffer, and our financial position, results of operations or cash flows may be materially affected.

Failure to accurately estimate and price our medical expenses or effectively manage our medical costs or related administrative costs could negatively affect our financial position, results of operations or cash flows.

Our profitability, to a significant degree, depends on our ability to estimate and effectively manage expenses related to health benefits through our ability to contract favorably with hospitals, physicians and other healthcare providers. For example, our Medicaid revenue is often based on bids submitted before the start of the initial contract year. If our actual medical expense exceeds our estimates, our health benefits ratio, or our expenses related to medical services as a percentage of premium revenue, would increase and our profits would decline. Because of the narrow margins of our health plan business, relatively small changes in our health benefits ratio can create significant changes in our financial results. Changes in healthcare regulations and practices, the level of utilization of healthcare services, hospital and pharmaceutical costs, major epidemics or pandemics, new medical technologies, pharmaceutical compounds and other external factors, including general economic conditions such as inflation and unemployment levels, are beyond our control and could reduce our ability to accurately predict and effectively control the costs of providing health benefits.

Our medical expense includes claims reported but not paid, estimates for claims incurred but not reported, and estimates for the costs necessary to process unpaid claims at the end of each period. Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as claims receipts and payment information as well as inpatient acuity information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expense in the period in which the changes are identified. However, we still cannot be sure that our medical claims liability estimate is adequate or that adjustments to the estimate will not unfavorably impact our results of operations.

Additionally, when we commence operations in a new state, region or product, we have limited information with which to estimate our medical claims liability. For a period of time after the inception of the new business, we base our estimates on state-provided historical actuarial data and limited actual incurred and received claims and inpatient acuity information. The addition of new categories of individuals who are eligible under new legislation may pose the same difficulty in estimating our medical claims liability. Similarly, we may face difficulty in estimating our medical claims liability in 2015 for the relatively new and evolving Health Insurance Marketplaces.

From time to time in the past, our actual results have varied from our estimates, particularly in times of significant changes in the number of our members. If it is determined that our estimates are significantly different than actual results, our results of operations and financial position could be adversely affected. In addition, if there is a significant delay in our receipt of premiums, our business operations, cash flows, or earnings could be negatively impacted.

The implementation of the Health Reform Legislation and other reforms could materially and adversely affect our results of operations, financial position and cash flows.

In March 2010, the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act, collectively referred to as the Affordable Care Act (ACA), were

enacted. While the constitutionality of the ACA was generally upheld by the Supreme Court in 2012, the Court determined that states could not be required to expand Medicaid and risk losing all federal money for their existing Medicaid programs.

Under the ACA, Medicaid coverage was expanded to all individuals under age 65 with incomes up to 138% of the federal poverty level beginning January 1, 2014, subject to each states' election. The federal government will pay the entire costs for Medicaid coverage for newly eligible beneficiaries for three years (2014 through 2016). Beginning in 2017, the federal share begins to decline, ending at 90% for 2020 and subsequent years. As of August 28, 2014, 27 states and the District of Columbia have expanded Medicaid eligibility or will be doing so in 2014, and additional states continue to discuss expansion. The ACA also maintained CHIP eligibility standards through September 2019.

The ACA required the establishment of Health Insurance Marketplaces for individuals and small employers to purchase health insurance coverage commencing in January 2014. Open enrollment for coverage in 2015 began on November 15, 2014 and continued until February 15, 2015. The ACA required insurers participating on the Health Insurance Marketplaces to offer a minimum level of benefits and included guidelines on setting premium rates and coverage limitations.

Our ability to adequately price products offered in the Health Insurance Marketplaces may have a negative impact on our results of operations, financial position and cash flow. We may be adversely selected by individuals who will have a higher acuity level than the anticipated pool of participants. In addition, the risk corridor, reinsurance and risk adjustment ("three Rs") provisions of the ACA established to reduce risk for insurers may not be effective in appropriately mitigating the financial risks related to the Marketplace product. Further, the reinsurance and risk corridor components may not be adequately funded. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, the three Rs, or other assumptions utilized in setting adequate premium rates could have a material adverse effect on our results of operations, financial position and cash flows.

Our attempts to diversify our business lines through participation in Health Insurance Marketplaces established by the federal government, or "Federally-Facilitated Marketplaces," may be impacted if the United States Supreme Court determines that the Internal Revenue Service may not extend tax-credit subsidies to health insurance coverage purchased through Federally-Facilitated Marketplaces. Individuals who would have otherwise received a tax-credit subsidy may choose not to enroll for coverage through a Federally-Facilitated Marketplace if the Supreme Court makes this determination and other changes are not made by the states to remedy this.

The U.S. Department of Health and Human Services (HHS) has stated that it will consider a limited number of premium assistance demonstration proposals from States that want to privatize Medicaid expansion. States must provide a choice between at least two qualified health plans and offer very similar benefits as those available in the newly created Health Insurance Marketplaces. Arkansas became the first state to obtain federal approval to use Medicaid funding to purchase private insurance for low-income residents and we began operations under the program beginning January 1, 2014.

The ACA imposes an annual insurance industry assessment of $8.0 billion starting in 2014, and $11.3 billion in each of 2015 and 2016, with increasing annual amounts thereafter. Such assessments are not deductible for income tax purposes. The fee will be allocated based on health insurers' premium revenues in the previous year. Each health insurer's fee is calculated by multiplying its market share by the annual fee. Market share is based on commercial, Medicare, and Medicaid premium revenue. Not-for-profit insurers may have a competitive advantage since they are exempt from paying the fee if they receive at least 80% of their premium revenue from Medicare, Medicaid, and CHIP, and other not-for-profit insurers are allowed to exclude 50% of their premium revenue from the fee calculation. If this federal premium assessment is imposed as enacted, and if we are not reimbursed by the states for the cost of the federal premium assessment (including the associated tax impact), or if we are unable to otherwise adjust our business model to address this new assessment, our results of operations, financial position and cash flows may be materially adversely affected.

There are numerous steps required to implement the legislation, including the promulgation of a substantial number of new and potentially more onerous federal regulations. Further, various health insurance reform proposals are also emerging at the state level. Because of the unsettled nature of these reforms and numerous steps required to implement them, we cannot predict what additional health insurance requirements will be implemented at the federal or state level, or the effect that any future legislation or regulation will have on our business or our growth opportunities. Although we believe the legislation may provide us with significant opportunities to grow our business, the enacted reforms, as well as future regulations and legislative changes, may in fact have a material adverse effect on our results of operations, financial position or liquidity. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of healthcare reform, or do not do so as effectively as our competitors, our results of operations may be materially adversely affected.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could force us to change how we operate and could harm our business.

Our business is extensively regulated by the states in which we operate and by the federal government. In addition, the managed care industry has received negative publicity that has led to increased legislation, regulation, review of industry practices and private litigation in the commercial sector. In each of the jurisdictions in which we operate, we are regulated by the relevant insurance, health and/or human services departments that oversee the activities of managed care organizations providing or arranging to provide services to Medicaid, Medicare and Health Insurance Marketplace enrollees. For example, our health plan subsidiaries, as well as our applicable specialty companies, must comply with minimum statutory capital and other financial solvency requirements, such as deposit and surplus requirements.

The frequent enactment of, changes to, or interpretations of laws and regulations could, among other things: force us to restructure our relationships with providers within our network; require us to implement additional or different programs and systems; restrict revenue and enrollment growth; increase our healthcare and administrative costs; impose additional capital and surplus requirements; and increase or change our liability to members in the event of malpractice by our contracted providers. In addition, changes in political party or administrations at the state, federal or country level may change the attitude towards healthcare programs.

Additionally, the taxes and fees paid to federal, state and local governments may increase due to several factors, including: enactment of, changes to, or interpretations of tax laws and regulations, audits by governmental authorities, geographic expansions into higher taxing jurisdictions and the effect of expansions into international markets.

Our contracts with states may require us to maintain a minimum health benefits ratio (HBR) or may require us to share profits in excess of certain levels. In certain circumstances, our plans may be required to return premium back to the state in the event profits exceed established levels or HBR does not meet the minimum requirement. Other states may require us to meet certain performance and quality metrics in order to maintain our contract or receive additional or full contractual revenue.

The governmental healthcare programs in which we participate are subject to the satisfaction of certain regulations and performance standards. For example, under Health Reform Legislation, Congress authorized CMS and the states to implement managed care demonstration programs to serve dually eligible beneficiaries to improve the coordination of their care. Participation in these demonstration programs is subject to CMS approval and the satisfaction of conditions to participation, including meeting certain performance requirements. Our inability to improve or maintain adequate quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs. Specifically, several of our Medicaid contracts require us to maintain a Medicare health plan. Although we strive to comply with all existing regulations and to meet performance standards applicable to our business, failure to meet these requirements could result in financial fines and penalties. Also, states may not allow us to continue to participate in their government programs, or we

may fail to win procurements to participate in such programs which could materially and adversely affect our results of operations, financial position and cash flows.

In addition, as a result of the expansion of our businesses and operations conducted in foreign countries, we face political, economic, legal, compliance, regulatory, operational and other risks and exposures that are unique and vary by jurisdiction. These foreign regulatory requirements with respect to, among other items, environmental, tax, licensing, intellectual property, privacy, data protection, investment, capital, management control, labor relations, and fraud and corruption regulations are different than those faced by our domestic businesses. In addition, we are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act. Our failure to comply with laws and regulations governing our conduct outside the United States or to successfully navigate international regulatory regimes that apply to us could adversely affect our ability to market our products and services, which may have a material adverse effect on our business, financial condition and results of operations.

Our businesses providing pharmacy benefit management (PBM) and specialty pharmacy services face regulatory and other risks and uncertainties which could materially and adversely affect our results of operations, financial position and cash flows.

We provide PBM and specialty pharmacy services through our US Script and AcariaHealth businesses. Each business is subject to federal and state laws that govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. They also conduct business as a mail order pharmacy and specialty pharmacy, which subjects them to extensive federal, state and local laws and regulations. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially and adversely affect current industry practices, including the receipt or disclosure of rebates from pharmaceutical companies, the development and use of formularies, and the use of average wholesale prices.

Our PBM and specialty pharmacy businesses would be materially and adversely affected by an inability to contract on favorable terms with pharmaceutical manufacturers and other suppliers, and could face potential claims in connection with purported errors by our mail order or specialty pharmacies, including in connection with the risks inherent in the authorization, compounding, packaging and distribution of pharmaceuticals and other healthcare products. Disruptions at any of our mail order or specialty pharmacies due to an event that is beyond our control could affect our ability to process and dispense prescriptions in a timely manner and could materially and adversely affect our results of operations, financial position and cash flows.

If any of our government contracts are terminated or are not renewed or we receive an adverse review, audit or investigation, our business will suffer.

We provide managed care programs and selected services to individuals receiving benefits under governmental assistance programs. We provide those healthcare services under contracts with regulatory entities in the areas in which we operate. Our government contracts are generally intended to run for three years and may be extended for additional years if the contracting entity or its agent elects to do so. When our contracts expire, they may be opened for bidding by competing healthcare providers, and there is no guarantee that our contracts will be renewed or extended. Competitors may buy their way into the market by submitting bids with lower pricing. Further, our government contracts contain certain provisions regarding eligibility, enrollment and dis-enrollment processes for covered services, eligible providers, periodic financial and informational reporting, quality assurance, timeliness of claims payment and agreement to maintain a Medicare plan in the state and financial standards and are subject to cancellation if we fail to perform in accordance with the standards set by regulatory agencies.

We are also subject to various reviews, audits and investigations to verify our compliance with the terms of our contracts with various governmental agencies and applicable laws and regulations. Any adverse review, audit or investigation could result in: cancellation of our contracts; refunding of amounts we have been paid pursuant to our contracts; imposition of fines, penalties and other sanctions on us; loss of our right to participate in various programs; increased difficulty in selling our products and services; or loss of one or more of our licenses.

If any of our government contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, or we have an adverse review, audit or investigation, our business will suffer, our goodwill could be impaired and our financial position, results of operations or cash flows may be materially affected.

Ineffectiveness of state-operated systems and subcontractors could adversely affect our business.

Our health plans rely on other state-operated systems or subcontractors to qualify, solicit, educate and assign eligible members into managed care plans. The effectiveness of these state operations and subcontractors can have a material effect on a health plan's enrollment in a particular month or over an extended period. When a state implements new programs to determine eligibility, new processes to assign or enroll eligible members into health plans, or chooses new subcontractors, there is an increased potential for an unanticipated impact on the overall number of members assigned to managed care plans.

Our investment portfolio may suffer losses which could materially and adversely affect our results of operations or liquidity.

We maintain a significant investment portfolio of cash equivalents and short term and long term investments in a variety of securities, which are subject to general credit, liquidity, market and interest rate risks and will decline in value if interest rates increase or one of the issuers' credit ratings is reduced. As a result, we may experience a reduction in value or loss of liquidity of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition.

Execution of our growth strategy may increase costs or liabilities, or create disruptions in our business.

Our growth strategy includes the acquisition of health plans participating in government sponsored healthcare programs and specialty services businesses, contract rights and related assets of other health plans both in our existing service areas and in new markets and start-up operations in new markets or new products in existing markets. Although we review the records of companies or businesses we plan to acquire, it is possible that we could assume unanticipated liabilities or adverse operating conditions, or an acquisition may not perform as well as expected or may not achieve timely profitability. We also face the risk that we will not be able to effectively integrate acquisitions into our existing operations effectively without substantial expense, delay or other operational or financial problems and we may need to divert more management resources to integration than we planned.

In connection with start-up operations, we may incur significant expenses prior to commencement of operations and the receipt of revenue. For example, in order to obtain a certificate of authority in most jurisdictions, we must first establish a provider network, have systems in place and demonstrate our ability to administer a state contract and process claims. We may experience delays in operational start dates. As a result of these factors, start-up operations may decrease our profitability. In addition, we are planning to expand our business internationally and we will be subject to additional risks, including, but not limited to, political risk, an unfamiliar regulatory regime, currency exchange risk and exchange controls, cultural and language differences, foreign tax issues, and different labor laws and practices.

If we are unable to effectively execute our growth strategy, our future growth will suffer and our results of operations could be harmed.

If competing managed care programs are unwilling to purchase specialty services from us, we may not be able to successfully implement our strategy of diversifying our business lines.

We are seeking to diversify our business lines into areas that complement our government sponsored health plan business in order to grow our revenue stream and balance our dependence on risk reimbursement. In order to diversify our business, we must succeed in selling the services of our specialty subsidiaries not only to our managed care plans, but to programs operated by third-parties. Some of these third-party programs may compete with us in some markets, and they therefore may be unwilling to purchase specialty services from us. In any event, the offering of these services will require marketing activities that differ significantly from the manner in which we seek to increase revenues from our government sponsored programs. Our ineffectiveness in marketing specialty services to third-parties may impair our ability to execute our business strategy.

Adverse credit market conditions may have a material adverse effect on our liquidity or our ability to obtain credit on acceptable terms.

The securities and credit markets have been experiencing extreme volatility and disruption over the past several years. The availability of credit, from virtually all types of lenders, has at times been restricted. In the event we need access to additional capital to pay our operating expenses, fund subsidiary surplus requirements, make payments on or refinance our indebtedness, pay capital expenditures, or fund acquisitions, our ability to obtain such capital may be limited and the cost of any such capital may be significant, particularly if we are unable to access our existing credit facility.

Our access to additional financing will depend on a variety of factors such as prevailing economic and credit market conditions, the general availability of credit, the overall availability of credit to our industry, our credit ratings and credit capacity, and perceptions of our financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain additional financing on favorable terms or at all.

If state regulators do not approve payments of dividends and distributions by our subsidiaries to us, we may not have sufficient funds to implement our business strategy.

We principally operate through our health plan subsidiaries. As part of normal operations, we may make requests for dividends and distributions from our subsidiaries to fund our operations. These subsidiaries are subject to regulations that limit the amount of dividends and distributions that can be paid to us without prior approval of, or notification to, state regulators. If these regulators were to deny our subsidiaries' request to pay dividends, the funds available to us would be limited, which could harm our ability to implement our business strategy.

We derive a majority of our premium revenues from operations in a limited number of states, and our financial position, results of operations or cash flows would be materially affected by a decrease in premium revenues or profitability in any one of those states.

Operations in a limited number of states have accounted for most of our premium revenues to date. If we were unable to continue to operate in any of our current states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly depending on legislative or other governmental or regulatory actions and decisions, economic conditions and similar factors in those states. For example, states we currently serve may bid out their Medicaid program through a request for proposal process. Our inability to continue to operate in any of the states in which we operate could harm our business.

Competition may limit our ability to increase penetration of the markets that we serve.

We compete for members principally on the basis of size and quality of provider networks, benefits provided and quality of service. We compete with numerous types of competitors, including other health plans and traditional state Medicaid programs that reimburse providers as care is provided. In addition, the impact of healthcare reform legislation and potential growth in our segment may attract new competitors.

Some of the health plans with which we compete have greater financial and other resources and offer a broader scope of products than we do. In addition, significant merger and acquisition activity has occurred in the managed care industry, as well as complementary industries, such as the hospital, physician, pharmaceutical, medical device and health information systems businesses. To the extent that competition intensifies in any market that we serve, our ability to retain or increase members and providers, or maintain or increase our revenue growth, pricing flexibility and control over medical cost trends may be adversely affected.

If we are unable to maintain relationships with our provider networks, our profitability may be harmed.

Our profitability depends, in large part, upon our ability to contract at competitive prices with hospitals, physicians and other healthcare providers. Our provider arrangements with our primary care physicians,

specialists and hospitals generally may be canceled by either party without cause upon 90 to 120 days prior written notice. We cannot provide any assurance that we will be able to continue to renew our existing contracts or enter into new contracts on a timely basis or under favorable terms enabling us to service our members profitably. Healthcare providers with whom we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

In any particular market, physicians and other healthcare providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical costs or difficulty in meeting regulatory or accreditation requirements. In some markets, certain healthcare providers, particularly hospitals, physician/hospital organizations or multi-specialty physician groups, may have significant market positions or near monopolies that could result in diminished bargaining power on our part. In addition, accountable care organizations, practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, and other organizational structures that physicians, hospitals and other healthcare providers choose may change the way in which these providers interact with us and may change the competitive landscape. Such organizations or groups of healthcare providers may compete directly with us, which could adversely affect our operations, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way that we price our products and estimate our costs, which might require us to incur costs to change our operations. Provider networks may consolidate, resulting in a reduction in the competitive environment. In addition, if these providers refuse to contract with us, use their market position to negotiate contracts unfavorable to us or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

From time to time healthcare providers assert or threaten to assert claims seeking to terminate non-cancelable agreements due to alleged actions or inactions by us. In addition, we are aware that other managed care organizations have been subject to class action suits by healthcare providers with respect to claim payment procedures, and we may be subject to similar suits. Regardless of whether any suits brought against us are successful or have merit, they will still be time-consuming and costly and could distract our management's attention. As a result, we may incur significant expenses and may be unable to operate our business effectively. If we are unable to retain our current provider contract terms or enter into new provider contracts timely or on favorable terms, our profitability may be harmed.

We may be unable to attract, retain or effectively manage the succession of key personnel.

We are highly dependent on our ability to attract and retain qualified personnel to operate and expand our business. We would be adversely impacted if we are unable to adequately plan for the succession of our executives and senior management. While we have succession plans in place for members of our executive and senior management team, these plans do not guarantee that the services of our executive and senior management team will continue to be available to us. Our ability to replace any departed members of our executive and senior management or other key employees may be difficult and may take an extended period of time because of the limited number of individuals in the managed care and specialty services industry with the breadth of skills and experience required to operate and successfully expand a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain or motivate these personnel. If we are unable to attract, retain and effectively manage the succession plans for key personnel, executives and senior management, our business and financial position, results of operations or cash flows could be harmed.

If we are unable to integrate and manage our information systems effectively, our operations could be disrupted.

Our operations depend significantly on effective information systems. The information gathered and processed by our information systems assists us in, among other things, monitoring utilization and other cost factors, processing provider claims, and providing data to our regulators. Our healthcare providers also depend upon our information systems for membership verifications, claims status and other information. Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs and regulatory requirements. We regularly upgrade and expand our information systems' capabilities. If

we experience difficulties with the transition to or from information systems or are unable to properly maintain or expand our information systems, we could suffer, among other things, operational disruptions, loss of existing members and difficulty in attracting new members, regulatory problems and increases in administrative expenses. In addition, our ability to integrate and manage our information systems may be impaired as the result of events outside our control, including acts of nature, such as earthquakes or fires, or acts of terrorists.

From time to time, we may become involved in costly and time-consuming litigation and other regulatory proceedings, which require significant attention from our management.

We are a defendant from time to time in lawsuits and regulatory actions relating to our business, including, without limitation, medical malpractice claims. Due to the inherent uncertainties of litigation and regulatory proceedings, we cannot accurately predict the ultimate outcome of any such proceedings. An unfavorable outcome could have a material adverse impact on our business and financial position, results of operations or cash flows. In addition, regardless of the outcome of any litigation or regulatory proceedings, such proceedings are costly and time consuming and require significant attention from our management, and could therefore harm our business and financial position, results of operations or cash flows.

An impairment charge with respect to our recorded goodwill and intangible assets could have a material impact on our results of operations.

We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. Changes in business strategy, government regulations or economic or market conditions have resulted and may result in impairments of our goodwill and other intangible assets at any time in the future. Our judgments regarding the existence of impairment indicators are based on, among other things, legal factors, market conditions, and operational performance. For example, the non-renewal of our health plan contracts with the state in which they operate may be an indicator of impairment. If an event or events occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill and other intangible assets, such revision could result in a non-cash impairment charge that could have a material impact on our results of operations in the period in which the impairment occurs.

If we fail to comply with applicable privacy, security, and data laws, regulations and standards, including with respect to third-party service providers that utilize sensitive personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

As part of our normal operations, we collect, process and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act and the Gramm-Leach-Bliley Act, which require us to protect the privacy of medical records and safeguard personal health information we maintain and use. Despite our best attempts to maintain adherence to information privacy and security best practices as well as compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers, may be vulnerable to privacy or security breaches, acts of vandalism or theft, malware, misplaced or lost data including paper or electronic media, programming and/or human errors or other similar events. In the past, we have had data breaches resulting in disclosure of confidential or protected health information that have not resulted in any material financial loss or penalty to date. However, future data breaches could require us to expend significant resources to remediate any damage, interrupt our operations and damage our reputation, subject us to state or federal agency review and could also result in enforcement actions, material fines and penalties, litigation or other actions which could have a material adverse effect on our business, reputation and results of operations, financial position and cash flows.

Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities.

HIPAA broadened the scope of fraud and abuse laws applicable to healthcare companies. HIPAA created civil penalties for, among other things, billing for medically unnecessary goods or services. HIPAA established new enforcement mechanisms to combat fraud and abuse, including civil and, in some instances, criminal penalties for failure to comply with specific standards relating to the privacy, security and electronic transmission of protected health information. The HITECH Act expanded the scope of these provisions by mandating individual notification in instances of breaches of protected health information, providing enhanced penalties for HIPAA violations, and granting enforcement authority to states' Attorneys General in addition to the HHS Office for Civil Rights. It is possible that Congress may enact additional legislation in the future to increase penalties and to create a private right of action under HIPAA, which could entitle patients to seek monetary damages for violations of the privacy rules. In addition, HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities with a focus on security risk assessments. Although we are not aware of HHS plans to audit any of our covered entities, an audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Under HIPAA, health plans are required to have the capacity to accept and send all covered transactions in a standardized electronic format. Penalties can be imposed for failure to comply with these requirements. The transaction standards have been modified to version 5010 to prepare for the implementation of the ICD-10 coding system. While we have prepared for the transition to ICD-10 in October 2015, if unforeseen circumstances arise, it is possible that we could be exposed to investigations and allegations of noncompliance. In addition, if some providers continue to use ICD-9 codes on claims after October 1, 2015, we may have to reject such claims, which may lead to claim resubmissions, increased call volume and provider and customer dissatisfaction. Further, providers may use ICD-10 codes differently than they used ICD-9 codes in the past, which could result in higher costs and reimbursement levels, or lost revenues under risk adjustment. During the transition to ICD-10, certain claims processing and payment information we have historically used to establish our reserves may not be reliable or available in a timely manner. As a result, implementation of ICD 10 may have a material adverse effect on our results of operations, financial position and cash flows.

A failure in or breach of our operational or security systems or infrastructure, or those of third parties with which we do business, including as a result of cyber attacks, could have an adverse effect on our business.

Information security risks have significantly increased in recent years in part because of the proliferation of new technologies, the use of the internet and telecommunications technologies to conduct our operations, and the increased sophistication and activities of organized crime, hackers, terrorists and other external parties, including foreign state agents. Our operations rely on the secure processing, transmission and storage of confidential, proprietary and other information in our computer systems and networks.

Security breaches may arise from external or internal threats. External breaches include hacking personal information for financial gain, attempting to cause harm to our operations, or intending to obtain competitive information. We experience attempted external hacking or malicious attacks on a regular basis. We maintain a rigorous system of preventive and detective controls through our security programs; however, our prevention and detection controls may not prevent or identify all such attacks. Internal breaches may result from inappropriate security access to confidential information by rogue employees, consultants or third party service providers. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, financial data, competitively sensitive information, or other proprietary data, whether by us or a third party, could have a material adverse effect on our business reputation, financial condition, cash flows, or results of operations.

Item 1B. ***Unresolved Staff Comments***

None.

Item 2. ***Properties***

We own our corporate office headquarters buildings and land located in St. Louis, Missouri. We generally lease space in the states where our health plans, specialty companies and claims processing facilities operate. We are required by various insurance and regulatory authorities to have offices in the service areas where we provide benefits. We believe our current facilities are adequate to meet our operational needs for the foreseeable future.

Item 3. ***Legal Proceedings.***

On July 5, 2013, the Company's subsidiary, Kentucky Spirit Health Plan, Inc. (Kentucky Spirit), terminated its contract with the Commonwealth of Kentucky (the Commonwealth). Kentucky Spirit believes it had a contractual right to terminate the contract and filed a lawsuit in Franklin Circuit Court seeking a declaration of this right. The Commonwealth has alleged that Kentucky Spirit's exit constitutes a material breach of contract. The Commonwealth seeks to recover substantial damages and to enforce its rights under Kentucky Spirit's $25 million performance bond. On July 3, 2014, the Commonwealth's attorneys asserted in a letter to the Cabinet for Health and Family Services that the Commonwealth's expenditures due to Kentucky Spirit's departure range from $28 million to $40 million plus interest, and that the associated CMS expenditures range from $92 million to $134 million. Kentucky Spirit disputes the Commonwealth's alleged damages, and is pursuing its own litigation claims for damages against the Commonwealth.

On February 6, 2015, the Kentucky Court of Appeals affirmed a Franklin Circuit Court ruling that Kentucky Spirit does not have a contractual right to terminate the contract early. The Court of Appeals also found that the contract's liquidated damages provision "is applicable in the event of a premature termination of the Contract term." Kentucky Spirit intends to seek Kentucky Supreme Court review of the finding that its departure constituted a breach of contract. The Commonwealth may seek review of the ruling that the liquidated damages provision is applicable in the event of a premature termination.

Kentucky Spirit also filed a lawsuit in April 2013, amended in October 2014, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches. On December 9, 2014, the Franklin Circuit Court denied the Commonwealth's motion for partial summary judgment on Kentucky Spirit's damages claims. Discovery is proceeding on those claims.

The resolution of the Kentucky litigation matters may result in a range of possible outcomes. If Kentucky Spirit prevails on its claims, it would be entitled to damages. If the Commonwealth prevails, a liability to the Commonwealth could be recorded. The Company is unable to estimate the ultimate outcome resulting from the Kentucky litigation. As a result, the Company has not recorded any receivable or any liability for potential damages under the contract as of December 31, 2014. While uncertain, the ultimate resolution of the pending litigation could have a material effect on the financial position, cash flow or results of operations of the Company in the period it is resolved or becomes known.

Excluding the Kentucky matters discussed above, the Company is also routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters in the normal course of business is uncertain, the Company does not expect the results of any of these matters individually, or in the aggregate, to have a material effect on its financial position, results of operations or 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; Dividends

Our common stock has been traded and quoted on the New York Stock Exchange under the symbol "CNC" since October 16, 2003. On February 2, 2015, the Board of Directors declared a two-for-one split of Centene's common stock in the form of a 100% stock dividend distributed February 19, 2015 to stockholders of record on February 12, 2015. All share, per share and stock price information presented in this Form 10-K has been adjusted for the two-for-one stock split. The high and low prices, as reported by the NYSE, are set forth below for the periods indicated.

	2015 Stock Price (through February 20, 2015)		2014 Stock Price		2013 Stock Price	
	High	Low	High	Low	High	Low
First Quarter	$61.00	$51.73	$33.18	$28.44	$24.28	$20.29
Second Quarter			38.84	27.56	26.37	21.07
Third Quarter			41.99	35.49	32.52	26.01
Fourth Quarter			54.24	37.53	33.92	27.06

As of February 20, 2015, there were 55 holders of record of our common stock.

We have never declared any cash dividends on our capital stock and currently anticipate that we will retain any future earnings for the development, operation and expansion of our business.

Issuer Purchases of Equity Securities

On October 26, 2009, the Company's Board of Directors extended the Company's stock repurchase program. The program authorizes the repurchase of up to 8,000,000 shares of the Company's common stock from time to time on the open market or through privately negotiated transactions. We have 3,335,448 available shares remaining under the program for repurchases as of December 31, 2014. No duration has been placed on the repurchase program. The Company reserves the right to discontinue the repurchase program at any time. During the year ended December 31, 2014, we did not repurchase any shares through this publicly announced program.

Issuer Purchases of Equity Securities
Fourth Quarter 2014

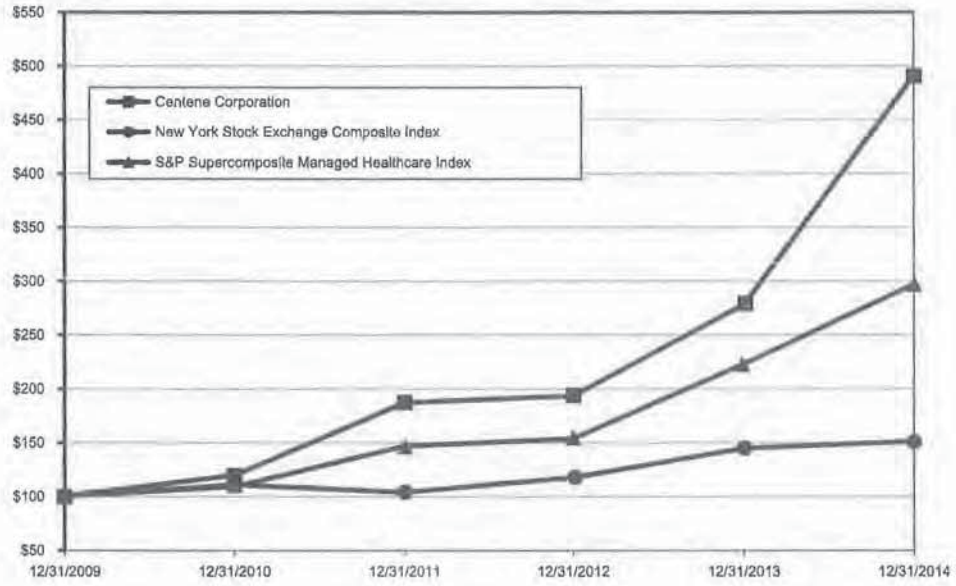
Period	Total Number of Shares Purchased[1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs[2]
October 1 – October 31, 2014	9,808	$41.04	—	3,335,448
November 1 – November 30, 2014	3,726	49.20	—	3,335,448
December 1 – December 31, 2014	446,728	49.98	—	3,335,448
Total	460,262	$49.78	—	3,335,448

(1) Shares acquired represent shares relinquished to the Company by certain employees for payment of taxes or option cost upon vesting of restricted stock units or option exercise.

(2) Our Board of Directors adopted a stock repurchase program which allows for repurchases of up to a remaining amount of 3,335,448 shares. No duration has been placed on the repurchase program.

Stock Performance Graph

The graph below 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 of the New York Stock Exchange Composite Index and the Standard & Poor's Supercomposite Managed Healthcare Index over the same period. The graph assumes an investment of $100 on December 31, 2009 in our common stock (at the last reported sale price on such day), the New York Stock Exchange Composite Index and the Standard & Poor's Supercomposite Managed Healthcare Index and assumes the reinvestment of any dividends.



	December 31,					
	2009	2010	2011	2012	2013	2014
Centene Corporation	$100.00	$119.64	$186.97	$193.58	$278.38	$490.37
New York Stock Exchange Composite Index	100.00	110.84	104.07	117.52	144.75	150.86
S&P Supercomposite Managed Healthcare Index	100.00	109.51	146.70	153.82	223.21	296.87
Centene Corporation closing stock price	$ 10.59	$ 12.67	$ 19.80	$ 20.50	$ 29.48	$ 51.93
Centene Corporation annual shareholder return	7.4%	19.6%	56.3%	3.5%	43.8%	76.2%

In accordance with the rules of the SEC, the information contained in the Stock Performance Graph on this page shall not be deemed to be "soliciting material," or to be "filed" with the SEC or subject to the SEC's Regulation 14A, or to the liabilities of Section 18 of the Exchange Act, except to the extent that Centene specifically requests that the information be treated as soliciting material or specifically incorporates it by reference into a document filed under the Securities Act, or the Exchange Act.

Item 6. *Selected Financial Data*

The following selected consolidated financial data should be read in conjunction with the consolidated financial statements and related notes and "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" included in our Annual Report on Form 10-K. The assets, liabilities and results of operations of Kentucky Spirit Health Plan and University Health Plans have been classified as discontinued operations for all periods presented.

	Year Ended December 31,				
	2014	2013	2012	2011	2010
	(In millions, except share data)				
Revenues:					
Premium	$ 14,198	$ 10,153	$ 7,569	$ 4,948	$ 4,192
Service	1,469	373	113	104	92
Premium and service revenues	15,667	10,526	7,682	5,052	4,284
Premium tax and health insurer fee	893	337	428	159	164
Total revenues	16,560	10,863	8,110	5,211	4,448
Expenses:					
Medical costs	12,678	8,995	6,781	4,191	3,584
Cost of services	1,280	327	88	78	64
General and administrative expenses	1,314	931	677	578	478
Premium tax expense	698	333	428	161	165
Health insurer fee expense	126	—	—	—	—
Impairment loss	—	—	28	—	—
Total operating expenses	16,096	10,586	8,002	5,008	4,291
Earnings from operations	464	277	108	203	157
Other income (expense):					
Investment and other income	28	19	35	13	15
Debt extinguishment costs	—	—	—	(8)	—
Interest expense	(35)	(27)	(20)	(20)	(18)
Earnings from continuing operations, before income tax expense	457	269	123	188	154
Income tax expense	196	107	47	71	60
Earnings from continuing operations, net of income tax expense	261	162	76	117	94
Discontinued operations, net of income tax expense (benefit) of $1, $2, $(48), $(4), and $4, respectively	3	4	(87)	(9)	4
Net earnings (loss)	264	166	(11)	108	98
(Earnings) loss attributable to noncontrolling interests	7	(1)	13	3	(3)
Net earnings attributable to Centene Corporation	$ 271	$ 165	$ 2	$ 111	$ 95
Amounts attributable to Centene Corporation common shareholders:					
Earnings from continuing operations, net of income tax expense	$ 268	$ 161	$ 89	$ 120	$ 91
Discontinued operations, net of income tax expense (benefit)	3	4	(87)	(9)	4
Net earnings	$ 271	$ 165	$ 2	$ 111	$ 95
Net earnings (loss) per common share attributable to Centene Corporation:					
Basic:					
Continuing operations	$ 2.30	$ 1.49	$ 0.86	$ 1.20	$ 0.93
Discontinued operations	0.03	0.03	(0.84)	(0.09)	0.04
Basic earnings per common share	$ 2.33	$ 1.52	$ 0.02	$ 1.11	$ 0.97
Diluted:					
Continuing operations	$ 2.23	$ 1.43	$ 0.83	$ 1.15	$ 0.90
Discontinued operations	0.02	0.04	(0.81)	(0.09)	0.04
Diluted earnings per common share	$ 2.25	$ 1.47	$ 0.02	$ 1.06	$ 0.94
Weighted average number of common shares outstanding:					
Basic	116,345,764	108,253,090	103,018,732	100,397,908	97,509,894
Diluted	120,360,212	112,494,346	107,428,750	104,948,476	100,895,776

	December 31,				
	2014	2013	2012	2011	2010
			(In millions)		
Consolidated Balance Sheet Data:					
Cash and cash equivalents[1]	$1,546	$ 974	$ 746	$ 494	$ 434
Investments and restricted deposits[1]	1,557	941	727	653	640
Total assets	5,838	3,529	2,774	2,190	1,944
Medical claims liability[1]	1,723	1,112	815	519	457
Long term debt[1]	888	666	535	348	328
Total stockholders' equity	1,743	1,243	954	936	797

[1] From continuing operations.

ITEM 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations.*

The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes included elsewhere in this filing. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under Part I, Item 1A. "Risk Factors" of this Form 10-K.

OVERVIEW

In 2013, we classified the operations for Kentucky Spirit Health Plan (KSHP) as discontinued operations for all periods presented in our consolidated financial statements. The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise identified.

On February 2, 2015, the Board of Directors declared a two-for-one split of Centene's common stock in the form of a 100% stock dividend distributed February 19, 2015 to stockholders of record on February 12, 2015. All share, per share and stock price information presented in this Form 10-K has been adjusted for the two-for-one stock split.

Our financial performance for 2014 is summarized as follows:

- Year-end managed care membership of 4.1 million, an increase of 1.2 million members, or 41% over 2013.
- Premium and service revenues of $15.7 billion, representing 48.8% growth year over year.
- Health Benefits Ratio of 89.3%, compared to 88.6% in 2013.
- General and Administrative expense ratio of 8.4%, compared to 8.8% in 2013.
- Total operating cash flows of $1.2 billion, or 4.6 times net earnings.
- Diluted net earnings per share of $2.23, compared to $1.43 in 2013.

The following items contributed to our revenue and membership growth over the last two years:

- *AcariaHealth*. In April 2013, we completed the acquisition of AcariaHealth, a specialty pharmacy company.
- *California*. In November 2013, our California subsidiary, California Health and Wellness (CHW), began operating under a new contract with the California Department of Health Care Services to serve Medicaid beneficiaries in 18 rural counties under the state's Medi-Cal Managed Care Rural Expansion program and Medi-Cal beneficiaries in Imperial County. In January 2014, CHW also began serving members under the state's Medicaid expansion program.
- *Centurion*. Centurion is a joint venture between Centene and MHM Services Inc. In July 2013, Centurion began operating under a new contract with the Department of Corrections in Massachusetts to provide comprehensive healthcare services to individuals incarcerated in Massachusetts state correctional facilities. In September 2013, Centurion began operating under a new contract to provide healthcare services to individuals incarcerated in Tennessee state correctional facilities. In January 2014, Centurion began operating under a new agreement with the Minnesota Department of Corrections to provide managed healthcare services to offenders in the state's correctional facilities.
- *Florida*. In August 2013, our Florida subsidiary, Sunshine Health, began operating under a contract in 10 of 11 regions with the Florida Agency for Health Care Administration to serve members of the Medicaid managed care Long Term Care (LTC) program. Enrollment began in August 2013 and was implemented by region through March 2014.

  In May 2014, Sunshine Health also began operating under a new contract in 9 of 11 regions of the Managed Medical Assistance (MMA) program. The MMA program includes TANF recipients as well as ABD and dual- eligible members. In addition, we began operating as the sole provider under a new statewide contract for the Child Welfare Specialty Plan (Foster Care). Enrollment for both the MMA program and Foster Care began in May 2014 and was implemented by region through August 2014.

- *Health Insurance Marketplaces (HIM).* In January 2014, we began serving members enrolled in Health Insurance Marketplaces in certain regions of nine states: Arkansas, Florida, Georgia, Indiana, Massachusetts, Mississippi, Ohio, Texas and Washington.
- *Illinois.* In March 2014, our Illinois subsidiary, IlliniCare Health, began operating under a new contract as part of the Illinois Medicare-Medicaid Alignment Initiative serving dual-eligible members in Cook, DuPage, Lake, Kane, Kankakee and Will counties (Greater Chicago region).

  In July 2014, IlliniCare Health began operating under a new contract with the Cook County Health and Hospitals System to perform third party administrative services to members enrolled in the CountyCare program, as well as care coordination, behavioral health, vision care and pharmacy benefit management services.

  In September 2014, IlliniCare Health began serving additional Medicaid members under the state's Medicaid and Medicaid expansion programs.
- *Louisiana.* In July 2014, we completed the transaction whereby Community Health Solutions of America, Inc. (CHS) assigned its contract with the Louisiana Department of Health and Hospitals under the Bayou Health Shared Savings Program to our subsidiary, Louisiana Healthcare Connections (LHC).
- *Massachusetts.* In January 2014, our CeltiCare Health subsidiary began operating under a new contract with the Massachusetts Executive Office of Health and Human Services to participate in the Medicaid expansion MassHealth CarePlus program in all five regions.
- *Mississippi.* In July 2014, our Mississippi subsidiary, Magnolia Health, began operating as one of two contractors under a new statewide managed care contract serving members enrolled in the Mississippi Coordinated Access Network program. Program expansion began in December 2014.
- *New Hampshire.* In December 2013, our subsidiary, New Hampshire Healthy Families, began operating under a new contract with the Department of Health and Human Services to serve Medicaid beneficiaries. In addition, Medicaid expansion began in late 2014.
- *Ohio.* In July 2013, our Ohio subsidiary, Buckeye Health Plan (Buckeye), began operating under a new and expanded contract with Ohio Department of Medicaid (ODM) to serve Medicaid members statewide through Ohio's three newly aligned regions (West, Central/Southeast, and Northeast). Buckeye also began serving members under the ABD Children program in July 2013. In January 2014, Buckeye began serving members under the state's Medicaid expansion program.

  In May 2014, Buckeye began operating under a new contract with the ODM and the Centers for Medicare and Medicaid Services to serve Medicaid members in a dual-eligible demonstration program in three of seven regions: Northeast (Cleveland), Northwest (Toledo) and West Central (Dayton). This three-year program, which is part of the Integrated Care Delivery System expansion, serves those who have both Medicare and Medicaid eligibility. Enrollment began in May 2014 and implementation was completed in July 2014.
- *Texas.* In September 2014, we began operating under a new contract with the Texas Health and Human Services Commission to expand our operations and serve STAR+PLUS members in two Medicaid Rural Service Areas. We also began providing expanded coverage in September 2014 under our STAR+PLUS contracts to provide acute care services for intellectually and developmentally disabled members.
- *U.S. Medical Management.* In January 2014, we acquired a majority interest in U.S. Medical Management, LLC, a management services organization and provider of in-home health services for high acuity populations.
- *Washington.* In January 2014, our subsidiary, Coordinated Care, began serving additional Medicaid members under the state's Medicaid expansion program.

In addition, in July 2014, we completed an investment accounted for under the equity method for the purchase of a noncontrolling interest in Ribera Salud S.A. (Ribera Salud), a Spanish health management group. Centene is a joint shareholder with Ribera Salud's remaining investor, Banco Sabadell S.A.

We expect the following items to contribute to our future growth potential:

- We expect to realize the full year benefit in 2015 of business commenced during 2014 in Florida, Illinois, Louisiana, Mississippi, New Hampshire, Ohio, and Texas as discussed above.
- In February 2015, LHC began operating under a new contract with the Louisiana Department of Health and Hospitals to serve Bayou Health (Medicaid) beneficiaries. Members previously served under the shared savings program were transitioned to the at-risk program on February 1, 2015.
- In February 2015, our South Carolina subsidiary, Absolute Total Care, began operating under a new contract with the South Carolina Department of Health and Human Services and the Centers for Medicare and Medicaid Services to serve dual-eligible members as part of the state's dual demonstration program.
- In February 2015, our Indiana subsidiary, Managed Health Services, began operating under an expanded contract with the Indiana Family & Social Services Administration to provide Medicaid services under the state's Healthy Indiana Plan 2.0 program.
- In February 2015, Centurion began operating under a new contract with the State of Vermont Department of Corrections to provide comprehensive correctional healthcare services.
- In January 2015, we signed a definitive agreement to acquire Agate Resources, Inc., a diversified holding company that offers an array of healthcare products and services to Oregon residents. The transaction is expected to close in the third quarter of 2015, subject to customary closing conditions, including Oregon regulatory approval.
- In January 2015, Magnolia Health began operating under a new contract with the State of Mississippi to provide services under the Children's Health Insurance Program (CHIP).
- In January 2015, we expanded our participation in Health Insurance Marketplaces to include members in certain regions of Illinois and Wisconsin.
- In December 2014, our subsidiary, Cenpatico of Arizona, in partnership with University of Arizona Health Plan, was selected by the Arizona Department of Health Services/Division of Behavioral Health Services to be the Regional Behavioral Health Authority for the new southern geographic service area. The new contract is expected to commence in the fourth quarter of 2015.
- In December 2014, Managed Health Services, was selected by the Indiana Family & Social Services Administration to begin contract negotiations to serve its ABD Medicaid enrollees who will qualify for the new Hoosier Care Connect Program. The contract is expected to commence in the first half of 2015.
- In May 2014, our Texas subsidiary, Superior HealthPlan, was selected by the Texas Health and Human Services Commission with the Centers for Medicare and Medicaid Services to serve dual-eligible members in three counties to provide integrated and coordinated care for individuals who are eligible for both Medicare and Medicaid. Operations are expected to commence in the first quarter of 2015.
- In February 2014, the Texas Health and Human Service commission expanded our STAR+PLUS contracts to include nursing facility benefits. The additional coverage is expected to commence in the first quarter of 2015.
- In December 2013, we signed a definitive agreement to purchase a majority stake in Fidelis SecureCare of Michigan, Inc. (Fidelis), a subsidiary of Fidelis SeniorCare, Inc. The transaction is expected to close in the first half of 2015, subject to certain closing conditions including regulatory approvals, and will include cash payments contingent on the performance of the plan. Fidelis was selected by the Michigan Department of Community Health to provide integrated healthcare services to members who are dually eligible for Medicare and Medicaid in Macomb and Wayne counties. Enrollment is expected to commence in the first half of 2015.

MEMBERSHIP

From December 31, 2012 to December 31, 2014, we increased our managed care membership by 1.5 million, or 57%. The following table sets forth our membership by state for our managed care organizations:

	December 31,		
	2014	2013	2012
Arizona	204,000	163,700	181,400
Arkansas	38,400	—	—
California	163,900	97,200	—
Florida	425,700	222,000	214,000
Georgia	389,100	318,700	313,700
Illinois	87,800	22,300	18,000
Indiana	197,700	195,500	204,000
Kansas	143,300	139,900	—
Louisiana	152,900	152,300	165,600
Massachusetts	48,400	22,600	21,500
Minnesota	9,500	—	—
Mississippi	108,700	78,300	77,200
Missouri	71,000	59,200	59,600
New Hampshire	62,700	33,600	—
Ohio	280,100	173,200	157,800
South Carolina	109,700	91,900	90,100
Tennessee	21,000	20,700	—
Texas	971,000	935,100	949,900
Washington	194,400	82,100	57,200
Wisconsin	83,200	71,500	72,400
Total at-risk membership	3,762,500	2,879,800	2,582,400
Non-risk membership	298,400	—	—
Total	4,060,900	2,879,800	2,582,400

At December 31, 2014, we served 201,300 Medicaid members in Medicaid expansion programs in California, Illinois, Massachusetts, New Hampshire, Ohio and Washington included in the table above.

The following table sets forth our membership by line of business:

	December 31,		
	2014	2013	2012
Medicaid	2,754,900	2,054,700	1,877,100
CHIP & Foster Care	222,700	275,100	235,200
ABD, Medicare & Duals	392,700	305,300	274,600
Health Insurance Marketplaces	74,500	—	—
Hybrid Programs	18,900	19,000	29,100
LTC	60,800	37,800	8,500
Behavioral Health	197,000	156,600	157,900
Correctional Healthcare Services	41,000	31,300	—
Total at-risk membership	3,762,500	2,879,800	2,582,400
Non-risk membership	298,400	—	—
Total	4,060,900	2,879,800	2,582,400

The following table identifies the Company's dual-eligible membership by line of business. The membership tables above include these members.

	December 31,		
	2014	2013	2012
ABD	118,300	71,700	62,600
LTC	35,900	28,800	7,700
Medicare	10,400	6,500	5,100
Total	164,600	107,000	75,400

From December 31, 2013 to December 31, 2014 our membership increased as a result of:

- product and geographic expansions in Florida and Illinois;
- the assignment of members in Louisiana under the CHS transaction;
- the commencement of Medicaid expansion programs in California, Illinois, Massachusetts, New Hampshire, Ohio, and Washington;
- the commencement of Health Insurance Marketplaces in certain regions of nine states: Arkansas, Florida, Georgia, Indiana, Massachusetts, Mississippi, Ohio, Texas and Washington;
- product expansions in Mississippi and Texas;
- growth in South Carolina; and
- the commencement of a correctional healthcare service contract in Minnesota.

From December 31, 2012 to December 31, 2013 our membership increased as a result:

- operations commencing in California, Kansas and New Hampshire;
- geographic expansion in Ohio;
- growth in Washington; and,
- the commencement of correctional healthcare services contracts in Massachusetts and Tennessee.

RESULTS OF OPERATIONS

The following discussion and analysis is based on our consolidated statements of operations, which reflect our results of operations for each of the three years ended December 31, 2014, prepared in accordance with generally accepted accounting principles in the United States ($ in millions, except per share data):

	2014	2013	2012	% Change 2013-2014	% Change 2012-2013
Premium	$14,198	$10,153	$7,569	39.8%	34.1%
Service	1,469	373	113	293.8%	230.1%
Premium and service revenues	15,667	10,526	7,682	48.8%	37.0%
Premium tax and health insurer fee	893	337	428	165.0%	(21.3)%
Total revenues	16,560	10,863	8,110	52.4%	33.9%
Medical costs	12,678	8,995	6,781	40.9%	32.7%
Cost of services	1,280	327	88	291.4%	271.6%
General and administrative expenses	1,314	931	677	41.1%	37.5%
Premium tax expense	698	333	428	109.6%	(22.2)%
Health insurer fee expense	126	—	—	n.m.	n.m.
Impairment loss	—	—	28	n.m.	n.m.
Earnings from operations	464	277	108	67.5%	156.5%
Investment and other income, net	(7)	(8)	15	12.5%	(153.3)%
Earnings from continuing operations, before income tax expense	457	269	123	69.9%	118.7%
Income tax expense	196	107	47	83.2%	127.7%
Earnings from continuing operations, net of income tax	261	162	76	61.1%	113.2%
Discontinued operations, net of income tax expense (benefit) of $1, $2, and $(48), respectively	3	4	(87)	(25.0)%	104.6%
Net earnings (loss)	264	166	(11)	59.0%	n.m.
(Earnings) loss attributable to noncontrolling interests	7	(1)	13	n.m.	n.m.
Net earnings attributable to Centene Corporation	$ 271	$ 165	$ 2	64.2%	n.m.
Amounts attributable to Centene Corporation common shareholders:					
Earnings from continuing operations, net of income tax expense	$ 268	$ 161	$ 89	66.5%	80.9%
Discontinued operations, net of income tax expense	3	4	(87)	(25.0)%	104.6%
Net earnings	$ 271	$ 165	$ 2	64.2%	n.m.
Diluted earnings (loss) per common share attributable to Centene Corporation:					
Continuing operations	$ 2.23	$ 1.43	$ 0.83	55.9%	72.3%
Discontinued operations	0.02	0.04	(0.81)	(50.0)%	104.9%
Total diluted earnings per common share	$ 2.25	$ 1.47	$ 0.02	53.1%	n.m.

n.m.: not meaningful.

Revenues and Revenue Recognition

Our health plans generate revenues primarily from premiums we receive from the states in which we operate. We generally receive a fixed premium per member per month pursuant to our state contracts. We generally receive premium payments and recognize premium revenue during the month in which we are obligated to provide services to our members. In some instances, our base premiums are subject to an adjustment, or risk score, based on the acuity of our membership. Generally, the risk score is determined by the state analyzing submissions of processed claims data to determine the acuity of our membership relative to the entire state's membership. Some contracts allow for additional premiums associated with certain supplemental services provided such as maternity deliveries.

Our contracts with states may require us to maintain a minimum health benefits ratio or may require us to share profits in excess of certain levels. In certain circumstances, our plans may be required to return premium to the state in the event profits exceed established levels. We recognize reductions in revenue in the current period for these programs. Other states may require us to meet certain performance and quality metrics in order to receive additional or full contractual revenue. For performance-based contracts, we do not recognize revenue subject to refund until data is sufficient to measure performance.

Revenues are recorded based on membership and eligibility data provided by the states, which is adjusted on a monthly basis by the states for retroactive additions or deletions to membership data. These eligibility adjustments are estimated monthly and subsequently adjusted in the period known. We continuously review and update those estimates as new information becomes available. It is possible that new information could require us to make additional adjustments, which could be significant, to these estimates.

Our specialty services generate revenues under contracts with state programs, healthcare organizations, and other commercial organizations, as well as from our own subsidiaries. Revenues are recognized when the related services are provided or as ratably earned over the covered period of services.

Premium and service revenues collected in advance are recorded as unearned revenue. Premium and service revenues due to us are recorded as premium and related receivables and are recorded net of an allowance based on historical trends and our management's judgment of the collectibility of these accounts. As we generally receive payments during the month in which services are provided, the allowance is typically not significant in comparison to total revenues and does not have a material impact on the presentation of our financial condition or results of operations.

Some states enact premium taxes, similar assessments and provider and hospital pass-through payments, collectively, premium taxes, and these taxes are recorded as a component of revenues as well as operating expenses. Additionally, our insurance subsidiaries are subject to the Affordable Care Act annual Health Insurer Fee (HIF). The Company recognizes revenue associated with the HIF on a straight line basis when we have binding agreements for the reimbursement of the fee, including the "gross-up" to reflect the HIFs non-tax deductible nature. We exclude the HIF and premium taxes from our key ratios as we believe they are a pass-through of costs and not indicative of our operating performance. Collectively, this revenue is recorded as Premium Tax and HIF revenue in the consolidated statement of operations.

The Centers for Medicare and Medicaid Services (CMS) deploys a risk adjustment model that retroactively apportions Medicare premiums paid according to health severity and certain demographic factors. The model pays more for members whose medical history indicates they have certain medical conditions. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient, physician treatment settings as well as prescription drug events. The Company estimates the amount of risk adjustment based upon the diagnosis and pharmacy data submitted and expected to be submitted to CMS and records revenues on a risk adjusted basis.

Operating Expenses

Medical Costs

Medical costs include payments to physicians, hospitals, and other providers for healthcare and specialty services claims. Medical costs also include estimates of medical expenses incurred but not yet reported, or IBNR, and estimates of the cost to process unpaid claims. We use our judgment to determine the assumptions to be used in the calculation of the required IBNR estimate. The assumptions we consider include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims.

Our development of the IBNR estimate is a continuous process which we monitor and refine on a monthly basis as claims receipts and payment information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expense in the period in which the changes are identified.

Additionally, we contract with independent actuaries to review our estimates on a quarterly basis. The independent actuaries provide us with a review letter that includes the results of their analysis of our medical claims liability. We do not solely rely on their report to adjust our claims liability. We utilize their calculation of our claims liability only as additional information, together with management's judgment, to determine the assumptions to be used in the calculation of our liability for medical costs.

While we believe our IBNR estimate is appropriate, it is possible future events could require us to make significant adjustments for revisions to these estimates. Accordingly, we cannot assure you that medical costs will not materially differ from our estimates.

Results of operations depend on our ability to manage expenses associated with health benefits and to accurately estimate costs incurred. The Health Benefits Ratio, or HBR, represents medical costs as a percentage of premium revenues (excluding Premium Tax and Health Insurer Fee revenues) and reflects the direct relationship between the premium received and the medical services provided.

Cost of Services

Cost of services expense includes the pharmaceutical costs associated with our pharmacy benefit manager and specialty pharmacy's external revenues and certain direct costs to support the functions responsible for generation of our service revenues. These expenses consist of the salaries and wages of the professionals who provide the services and associated expenses.

General and Administrative Expenses

General and administrative expenses, or G&A, primarily reflect wages and benefits, including stock compensation expense, and other administrative costs associated with our health plans, specialty companies and centralized functions that support all of our business units. Our major centralized functions are finance, information systems and claims processing. G&A expenses also include business expansion costs, such as wages and benefits for administrative personnel, contracting costs, and information technology buildouts, incurred prior to the commencement of a new contract or health plan.

The G&A expense ratio represents G&A expenses as a percentage of premium and service revenues, and reflects the relationship between revenues earned and the costs necessary to earn those revenues.

Health Insurer Fee

The Health Insurer Fee reflects the annual fee mandated by the Affordable Care Act (ACA) to health insurers. The fee is determined based on our premium revenues in the previous year. Each health insurer's fee is

calculated by multiplying its market share by the annual fee. Market share is based on commercial, Medicare, and Medicaid premium revenue.

Other Income (Expense)

Other income (expense) consists principally of investment income from cash and investments, earnings in equity method investments, and interest expense on debt.

Discontinued Operations

Our subsidiary, Kentucky Spirit Health Plan (KSHP), ceased serving Medicaid members in Kentucky as of July 6, 2013. Accordingly, the results of operations for KSHP are classified as discontinued operations for all periods presented in our consolidated financial statements. The following discussion and analysis is presented primarily in the context of continuing operations unless otherwise identified.

Year Ended December 31, 2014 Compared to Year Ended December 31, 2013

Premium and Service Revenues

Premium and service revenues increased 48.8% in the year ended December 31, 2014 over the corresponding period in 2013 as a result of expansions in Florida, Ohio, Washington, Texas and Illinois, growth in the AcariaHealth business, the addition of the California and New Hampshire operations and our participation in the Health Insurance Marketplaces. During the year ended December 31, 2014, we received premium rate adjustments which yielded an approximate net 1% composite increase across all of our markets.

Operating Expenses

Medical Costs

The table below depicts the HBR for our membership by member category for the year ended December 31,:

	2014	2013
Medicaid, CHIP, Foster Care & HIM	86.3%	87.5%
ABD, LTC and Medicare	93.5	90.4
Specialty Services	85.5	85.4
Total	89.3	88.6

The consolidated HBR for the year ended December 31, 2014, of 89.3% was an increase of 70 basis points over the comparable period in 2013. The increase compared to last year is primarily attributable to an increase in complex care membership over the prior year.

Cost of Services

Cost of services increased by $953 million in the year ended December 31, 2014, compared to the corresponding period in 2013. This was primarily due to the acquisition of and growth in our AcariaHealth business as well as the acquisition of U.S. Medical Management.

General & Administrative Expenses

General and administrative expenses, or G&A, increased by $383 million in the year ended December 31, 2014, compared to the corresponding period in 2013. This was primarily due to expenses for additional staff and facilities to support our membership growth.

The consolidated G&A expense ratio for the years ended December 31, 2014 and 2013 was 8.4% and 8.8%, respectively. The year over year decrease in the G&A ratio reflects the leveraging of expenses over higher revenues in 2014, offset by the acquisition of U.S. Medical Management and start up of Health Insurance Marketplaces which operate at higher G&A ratios.

Health Insurer Fee

During the year ended December 31, 2014, we recorded $126 million of non-deductible expense for the Affordable Care Act (ACA) annual health insurer fee. As of December 31, 2014, we have received signed agreements representing 99% of the total revenue associated with the reimbursement of the ACA insurer fee including the related gross-up for the associated income tax effects. As a result, we recorded $195 million in Premium Tax and Health Insurer Fee revenue associated with the reimbursement of the fee.

Other Income (Expense)

The following table summarizes the components of other income (expense) for the year ended December 31, ($ in millions):

	2014	2013
Investment income	$ 22	$ 18
Earnings from equity method investments	6	1
Interest expense	(35)	(27)
Other income (expense), net	$ (7)	$ (8)

The increase in investment income in 2014 reflects an increase in investment balances over 2013 and improved performance of certain equity investments. Interest expense increased during the year ended December 31, 2014 by $8 million reflecting the issuance of an additional $300 million in Senior Notes in April 2014 and a higher level of borrowings under our revolving credit agreement.

Income Tax Expense

Our effective tax rate for the year ended December 31, 2014 was 42.9% compared to 39.8% in 2013. The increase is due to the non-deductibility of the health insurer fee which increased our effective tax rate. This was partially offset by a reduction of tax expense associated with the compensation deduction limitation. During 2014, the IRS issued final regulations related to the compensation deduction limitation applicable to certain health insurance providers. As a result, we no longer believe the deduction limitation applies for 2013 and 2014. Accordingly, we reversed previously recorded tax expense of $14 million for prior years resulting in a decrease in the effective tax rate which offset the health insurer fee impact.

Segment Results

The following table summarizes our operating results by segment for the year ended December 31, ($ in millions):

	2014	2013	% Change 2013-2014
Premium and Service Revenues			
Managed Care	$13,946	$ 9,782	42.6%
Specialty Services	4,800	2,932	63.7%
Eliminations	(3,079)	(2,188)	(40.7)%
Consolidated Total	$15,667	$10,526	48.8%
Earnings from Operations			
Managed Care	$ 353	$ 198	78.3%
Specialty Services	111	79	40.5%
Consolidated Total	$ 464	$ 277	67.5%

Managed Care

Premium and service revenues increased 42.6% in the year ended December 31, 2014, primarily as a result of expansions in Florida, Ohio, Washington, Mississippi, Texas and Illinois, the addition of the California and New Hampshire operations and our participation in the Health Insurance Marketplaces. Earnings from operations increased $155 million in the year ended December 31, 2014, primarily reflecting growth in the business.

Specialty Services

Premium and service revenues increased 63.7% in the year ended December 31, 2014, resulting from growth in our AcariaHealth business, increased services associated with membership growth in the Managed Care segment, the addition of three Centurion contracts and the acquisition of U.S. Medical Management. Earnings from operations increased $32 million in the year ended December 31, 2014, primarily reflecting growth in the AcariaHealth business as well as favorable performance in our legacy individual health business.

Year Ended December 31, 2013 Compared to Year Ended December 31, 2012

Revenues

Premium and service revenues increased 37.0% in the year ended December 31, 2013 over the corresponding period in 2012 as a result of the Texas, Mississippi, Louisiana and Florida expansions, pharmacy carve-ins in Texas and Louisiana, the additions of the Kansas, Missouri, Washington, California and New Hampshire contracts, commencement of the correctional healthcare contracts in Massachusetts and Tennessee, rate increases in several of our markets and the acquisition of AcariaHealth. During the year ended December 31, 2013, we received premium rate adjustments which yielded a net 2.7% composite increase across all of our markets.

Operating Expenses

Medical Costs

The table below depicts the HBR for our membership by member category for the year ended December 31,:

	2013	2012
Medicaid, CHIP & Foster Care	87.5%	88.8%
ABD, LTC and Medicare	90.4	90.7
Specialty Services	85.4	92.0
Total	88.6	89.6

The consolidated HBR for the year ended December 31, 2013, of 88.6% was a decrease of 100 basis points over the comparable period in 2012. The 2013 HBR reflects performance improvement in Texas and our individual insurance business from 2012.

Costs of Services

Cost of services increased by $239 million in the year ended December 31, 2013, compared to the corresponding period in 2012. This was primarily due to the additional volume resulting from the acquisition of AcariaHealth.

General and Administrative Expenses

General and administrative expenses, or G&A, increased by $254 million in the year ended December 31, 2013, compared to the corresponding period in 2012. This was primarily due to expenses for additional staff and facilities to support our membership growth, AcariaHealth transaction costs, as well as performance based compensation.

The consolidated G&A expense ratio for the years ended December 31, 2013 and 2012 was 8.8% and 8.8%, respectively. The G&A expense ratio reflects an increase in performance based compensation expense in 2013 as well as AcariaHealth transaction costs, offset by the benefits of leveraging of expenses over higher revenue in 2013 and our efforts to control costs.

Impairment Loss

During 2012, an impairment analysis of our subsidiary, Celtic Insurance Company, resulted in goodwill and intangible asset impairments of $28 million. The impaired identifiable intangible assets of $2 million and goodwill of $26 million were reported under the Specialty Services segment; $27 million of the impairment loss was not deductible for income tax purposes.

Investment and Other Income, Net

The following table summarizes the components of other income (expense) for the year ended December 31, ($ in millions):

	2013	2012
Investment income	$ 18	$ 15
Earnings from equity method investments	1	1
Gain on sale of investments	—	1
Gain on sale of investment in convertible note	—	18
Interest expense	(27)	(20)
Other income (expense), net	$ (8)	$ 15

Investment income. The increase in investment income in 2013 primarily reflects an increase in investment balances over 2012.

Gain on sale of investments. During 2012, we recognized $1 million in net gains primarily as a result of the liquidation of $76 million of investments held by the Georgia health plan in order to meet short term liquidity needs due to delays in premium receipts from the state.

Gain on sale of investment in convertible note. During 2012, we executed an agreement with a third party borrower whereby the borrower agreed to pay us total consideration of $50 million for retirement of $30 million of outstanding notes and equity ownership conversion features in certain Medicaid and Medicare related businesses. As a result, we recorded a pre-tax gain of $18 million in other income representing the fair value of the total consideration in excess of the carrying value of the loans on the balance sheet.

Interest expense. Interest expense increased during the year ended December 31, 2013 by $7 million reflecting the addition of $175 million of Senior Notes in the fourth quarter of 2012.

Income Tax Expense

Our effective tax rate for 2013 was 39.8% compared to 38.2% in 2012. The increase in the income tax rate over 2012 resulted from a tax benefit in 2012 resulting from the clarification by a state taxing authority regarding a state income tax calculation, partially offset by a non-deductible goodwill impairment in 2012.

Segment Results

The following table summarizes our operating results by segment for the year ended December 31, (in millions):

	2013	2012	% Change 2012-2013
Premium and Service Revenues			
Managed Care	$ 9,782	$ 7,212	35.6%
Specialty Services	2,932	2,107	39.2%
Eliminations	(2,188)	(1,637)	(33.7)%
Consolidated Total	$10,526	$ 7,682	37.0%
Earnings from Operations			
Managed Care	$ 198	$ 63	214.3%
Specialty Services	79	45	75.6%
Consolidated Total	$ 277	$ 108	156.5%

Managed Care

Premium and service revenues increased 35.6% in the year ended December 31, 2013, due to the Texas, Mississippi, Louisiana and Florida expansions, pharmacy carve-ins in Texas and Louisiana, the additions of the California, Kansas, Missouri, New Hampshire and Washington contracts and rate increases in several of our markets. Earnings from operations increased $135 million in the year ended December 31, 2013, primarily due to improvements in the performance of the Texas business from 2012.

Specialty Services

Premium and service revenues increased 39.2% in the year ended December 31, 2013, due to the carve-in of pharmacy services in Texas and Louisiana, growth in our Medicaid segment and the associated services provided to this increased membership, the acquisition of AcariaHealth and the additions of the Centurion contracts in Massachusetts and Tennessee. Earnings from operations increased $34 million in the year ended December 31, 2013. This reflects improvement in our individual health insurance business in 2013 and the impact of a $28 million impairment loss in 2012 in our individual insurance business.

LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows for the years ended December 31, 2014, 2013 and 2012, used in the discussion of liquidity and capital resources ($ in millions).

	Year Ended December 31,		
	2014	2013	2012
Net cash provided by operating activities	$1,223	$ 382	$ 279
Net cash used in investing activities	(848)	(342)	(188)
Net cash provided by financing activities	198	154	179
Effect of exchange rate changes on cash and cash equivalents	(1)	—	—
Net increase in cash and cash equivalents	$ 572	$ 194	$ 270

Cash Flows Provided by Operating Activities

Normal operations are funded primarily through operating cash flows and borrowings under our revolving credit facility.

Cash flows from operating activities for 2014 increased $841 million, or 220% compared to 2013 due to an increase in medical claims liabilities resulting from the growth in the business as well as an increase in accounts payable and accrued expenses resulting from an increase in payables associated with various programs requiring a return of premium to state customers in certain circumstances.

Cash flows from operating activities for 2013 increased $103 million, or 37% compared to 2012 due to an increase in net earnings between years and growth in our business. Additionally, incentive compensation accruals increased from 2012 due to the performance of the Company.

Cash flows from operations in each year were impacted by the timing of payments we receive from our states. States may prepay the following month premium payment, which we record as unearned revenue, or they may delay our premium payment, which we record as a receivable. We typically receive capitation payments monthly, however the states in which we operate may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period.

The reimbursement of the HIF from our state customers may be settled as a separate payment or monthly in combination with our other premium payments. The vast majority of our state customers are settling the reimbursement through a separate payment after verification of each state's portion of our HIF, resulting in an increase in Premium and Related Receivables at December 31, 2014. During 2014, we paid the 2014 annual HIF invoice totaling $126 million. The table below details the impact to cash flows from operations from the timing of payments from our states ($ in millions).

	Year Ended December 31,		
	2014	2013	2012
Increase in premium and related receivables	$(463)	$(143)	$(117)
Increase in unearned revenue	129	3	25
Net decrease in operating cash flow	$(334)	$(140)	$ (92)

Cash Flows Used in Investing Activities

Investing activities used cash of $848 million for the year ended December 31, 2014, and $342 million in the comparable period in 2013. Cash flows used in investing activities in 2014 primarily consisted of additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long term investments, the acquisition of U.S. Medical Management and CHS, an equity investment in Ribera Salud and capital expenditures.

During 2014, we acquired 68% of U.S. Medical Management for $213 million in total consideration. The transaction was financed through a combination of Centene common stock as well as $80 million of cash. We also completed a transaction with CHS for initial cash consideration of $56 million as well as common stock. Additionally, we purchased a noncontrolling interest in Ribera Salud S.A. (Ribera Salud), a Spanish health management group for $17 million.

Cash flows used in investing activities in 2013 primarily consisted of additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long term investments, the acquisition of AcariaHealth and capital expenditures. We completed the acquisition of AcariaHealth for $142 million in total consideration. The transaction was financed through a combination of Centene common stock as well as $67 million of cash. During 2012, our investing activities primarily related to additions to the investment portfolio of our regulated subsidiaries and capital expenditures.

Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets within our guidelines. Net cash provided by and used in investing activities will fluctuate from year to year due to the timing of investment purchases, sales and maturities. As of December 31, 2014, our investment portfolio consisted primarily of fixed-income securities with an average duration of 2.7 years. These securities generally are actively traded in secondary markets and the reported fair market value is determined based on recent trading activity, recent trading activity in similar securities and other observable inputs. Our

investment guidelines comply with the regulatory restrictions enacted in each state. We had unregulated cash and investments of $85 million at December 31, 2014, compared to $45 million at December 31, 2013.

We spent $103 million, $68 million and $82 million in 2014, 2013 and 2012, respectively, on capital expenditures for system enhancements, and market expansions.

Cash Flows Provided by Financing Activities

Our financing activities provided cash of $198 million, $154 million and $179 million in 2014, 2013 and 2012, respectively. Financing activities in 2014, 2013 and 2012 are discussed below.

2014 In April 2014, pursuant to a shelf registration statement, we issued $300 million 4.75% Senior Notes due May 15, 2022 at par. Interest is paid semi-annually in May and November. In connection with the issuance, we entered into $300 million notional amount of interest rate swap agreements (2014 Swap Agreements) that are scheduled to expire May 15, 2022. Under the 2014 Swap Agreements, we receive a fixed rate of 4.75% and pay a variable rate of LIBOR plus 2.27% adjusted quarterly, which allows us to adjust the $300 million Notes to a floating rate. We do not hold or issue any derivative instrument for trading or speculative purposes.

2013 During 2013, our financing activities primarily related to borrowings under our revolving credit facility, the sale of $15 million of common stock to fund the escrow account for the acquisition of AcariaHealth and the repayment of a mortgage note.

In May 2013, we entered into a new unsecured $500 million revolving credit facility and terminated our previous $350 million revolving credit facility. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. The agreement has a maturity date of June 1, 2018, provided it will mature 90 days prior to the maturity date of the 5.75% Senior Notes due 2017 if such notes are not refinanced (or extended) or certain financial conditions are not met, including carrying $100 million of unrestricted cash on deposit.

2012 In November 2012, pursuant to a shelf registration statement, we issued an additional $175 million of non-callable 5.75% Senior Notes due June 1, 2017 at a premium to yield 4.29%. The indenture governing the $175 million Add-on Notes contains non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio. Interest is paid semi-annually in June and December. We used the net proceeds from the offering to make capital contributions to our regulated subsidiaries.

Liquidity Metrics

The $500 million revolving credit agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt-to-EBITDA ratios and minimum tangible net worth. We are required not to exceed a maximum debt-to-EBITDA ratio of 3.0 to 1.0. As of December 31, 2014, we had $75 million in borrowings outstanding under our revolving credit facility, and we were in compliance with all covenants. As of December 31, 2014, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

We had outstanding letters of credit of $30 million as of December 31, 2014, which were not part of our revolving credit facility. We also had letters of credit for $58 million (valued at the December 31, 2014 conversion rate), or €48 million, representing our proportional share of the letters of credit issued to support Ribera Salud's outstanding debt which are a part of the revolving credit facility. Collectively, the letters of credit bore interest at 1.73% as of December 31, 2014. In addition, we had outstanding surety bonds of $142 million as of December 31, 2014.

The indenture governing our Senior Notes contains non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio.

At December 31, 2014, we had working capital, defined as current assets less current liabilities, of $134 million, as compared to $241 million at December 31, 2013. We manage our short term and long term investments with the goal of ensuring that a sufficient portion is held in investments that are highly liquid and can be sold to fund short term requirements as needed.

At December 31, 2014, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 33.9%, compared to 35.0% at December 31, 2013. Excluding the $70 million non-recourse mortgage note, our debt to capital ratio was 32.1% as of December 31, 2014, compared to 32.4% at December 31, 2013. We utilize the debt to capital ratio as a measure, among others, of our leverage and financial flexibility.

We have a stock repurchase program authorizing us to repurchase up to 8 million shares of common stock from time to time on the open market or through privately negotiated transactions. We have 3 million available shares remaining under the program for repurchases as of December 31, 2014. No duration has been placed on the repurchase program. We reserve the right to discontinue the repurchase program at any time. We did not make any repurchases under this plan during 2014, 2013 or 2012.

During the year ended December 31, 2014, 2013 and 2012, we received dividends of $50 million, $18 million, and $29 million, respectively, from our regulated subsidiaries.

2015 Expectations

In January 2015, we issued an additional $200 million 4.75% Senior Notes ($200 million Add-on Notes) at par. The $200 million Add-on Notes were offered as additional debt securities under an indenture dated as of April 29, 2014, pursuant to which we previously issued $300 million aggregate principal amount of 4.75% Senior Notes due 2022. In connection with the January 2015 issuance, we entered into interest rate swap agreements for a notional amount of $200 million at a floating rate of interest based on the three month LIBOR plus 2.88%. Gains and losses due to changes in the fair value of the interest rate swap will completely offset changes in the fair value of the hedged portion of the underlying debt and will be recorded as an adjustment to the $200 million Add-on Notes.

As previously discussed, in January 2015, we announced a definitive agreement to acquire Agate Resources, Inc. The transaction is expected to close during the third quarter of 2015. Also, in January 2015, we acquired LiveHealthier, a provider of technology and service-based health management solutions.

In January 2015, we sold 25% of our ownership in Celtic Insurance Company. No gain or loss was recognized on the sale of the ownership interest. Celtic Insurance Company is included in the Specialty Services segment. Under the terms of the agreement, we entered into a put agreement with the noncontrolling interest holder to purchase the noncontrolling interest at a later date.

We expect to make net capital contributions to our insurance subsidiaries of approximately $630 million during 2015 associated with our growth and spend approximately $120 million in additional capital expenditures primarily associated with system enhancements and market expansions. These capital contributions are expected to be funded by unregulated cash flow generation in 2015, borrowings on our revolving credit facility and the $200 million Add-on Notes.

In July 2014, the Company completed a transaction whereby CHS assigned its contract with the Louisiana Department of Health and Hospitals under the Bayou Health Shared Savings Program to the Company's subsidiary, Louisiana Healthcare Connections (LHC). The Company may pay additional cash consideration up to $28.2 million based on membership retained by LHC in the first quarter of 2015.

Based on our operating plan, we expect that our available cash, cash equivalents and investments, cash from our operations and cash available under our credit facility will be sufficient to finance our general operations and capital expenditures for at least 12 months from the date of this filing.

CONTRACTUAL OBLIGATIONS

The following table summarizes future contractual obligations. These obligations contain estimates and are subject to revision under a number of circumstances. Our debt consists of borrowings from our senior notes, credit facility, mortgages and capital leases. The purchase obligations consist primarily of software purchases and

maintenance contracts. The contractual obligations and estimated period of payment over the next five years and beyond are as follows (in millions):

	Payments Due by Period				
	Total	Less Than 1 Year	1-3 Years	3-5 Years	More Than 5 Years
Medical claims liability	$1,723	$1,723	$ —	$ —	$ —
Debt and interest	1,086	47	505	117	417
Redeemable Noncontrolling Interest	148	—	148	—	—
Operating lease obligations	252	45	89	56	62
Purchase obligations	57	32	18	6	1
Other long term liabilities[1]	—	—	—	—	—
Total	$3,266	$1,847	$ 760	$ 179	$ 480

[1] Our Consolidated Balance Sheet as of December 31, 2014, includes $158 million of other long term liabilities. This consists primarily of long term deferred income taxes, liabilities under our deferred compensation plan, and reserves for uncertain tax positions. These liabilities have been excluded from the table above as the timing and/or amount of any cash payment is uncertain.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

Our operations are conducted through our subsidiaries. As managed care organizations, these subsidiaries are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us. Generally, the amount of dividend distributions that may be paid by a regulated subsidiary without prior approval by state regulatory authorities is limited based on the entity's level of statutory net income and statutory capital and surplus.

Our subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of December 31, 2014, our subsidiaries had aggregate statutory capital and surplus of $1,699 million, compared with the required minimum aggregate statutory capital and surplus requirements of $851 million. During the year ended December 31, 2014, we contributed $401 million of statutory capital to our subsidiaries. We estimate our Risk Based Capital, or RBC, percentage (including KSHP) to be in excess of 350% of the Authorized Control Level.

The National Association of Insurance Commissioners has adopted rules which set minimum risk-based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. As of December 31, 2014, each of our health plans was in compliance with the risk-based capital requirements enacted in those states.

RECENT ACCOUNTING PRONOUNCEMENTS

For this information, refer to Note 2, *Summary of Significant Accounting Policies*, in the Notes to the Consolidated Financial Statements, included herein.

CRITICAL ACCOUNTING POLICIES AND ESTIMATES

Our discussion and analysis of our results of operations and liquidity and capital resources are based on our consolidated financial statements which have been prepared in accordance with GAAP. Our significant accounting policies are more fully described in Note 2, *Summary of Significant Accounting Policies,* to our consolidated financial statements included elsewhere herein. Our accounting policies regarding medical claims liability and intangible assets are particularly important to the portrayal of our financial position and results of operations and require the application of significant judgment by our management. As a result, they are subject to

an inherent degree of uncertainty. We have reviewed these critical accounting policies and related disclosures with the Audit Committee of our Board of Directors.

Medical Claims Liability

Our medical claims liability includes claims reported but not yet paid, or inventory, estimates for claims incurred but not reported, or IBNR, and estimates for the costs necessary to process unpaid claims at the end of each period. We estimate our medical claims liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors.

Actuarial Standards of Practice generally require that the medical claims liability estimates be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate. In many situations, the claims amounts ultimately settled will be different than the estimate that satisfies the Actuarial Standards of Practice. We include in our IBNR an estimate for medical claims liability under moderately adverse conditions which represents the risk of adverse deviation of the estimates in our actuarial method of reserving.

We use our judgment to determine the assumptions to be used in the calculation of the required estimates. The assumptions we consider when estimating IBNR include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to fee schedules, and the incidence of high dollar or catastrophic claims.

We apply various estimation methods depending on the claim type and the period for which claims are being estimated. For more recent periods, incurred non-inpatient claims are estimated based on historical per member per month claims experience adjusted for known factors. Incurred hospital inpatient claims are estimated based on known inpatient utilization data and prior claims experience adjusted for known factors. For older periods, we utilize an estimated completion factor based on our historical experience to develop IBNR estimates. The completion factor is an actuarial estimate of the percentage of claims incurred during a given period that have been received or adjudicated as of the reporting period to the estimate of the total ultimate incurred costs. When we commence operations in a new state or region, we have limited information with which to estimate our medical claims liability. See "Risk Factors—Failure to accurately predict our medical expenses could negatively affect our financial position, results of operations or cash flows." These approaches are consistently applied to each period presented.

Additionally, we contract with independent actuaries to review our estimates on a quarterly basis. The independent actuaries provide us with a review letter that includes the results of their analysis of our medical claims liability. We do not solely rely on their report to adjust our claims liability. We utilize their calculation of our claims liability only as additional information, together with management's judgment, to determine the assumptions to be used in the calculation of our liability for claims.

Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as additional claims receipts and payment information becomes available. As more complete claims information becomes available, we adjust the amount of the estimates, and include the changes in estimates in medical costs in the period in which the changes are identified. In every reporting period, our operating results include the effects of more completely developed medical claims liability estimates associated with previously reported periods. We consistently apply our reserving methodology from period to period. As additional information becomes known to us, we adjust our actuarial models accordingly to establish medical claims liability estimates.

The paid and received completion factors, claims per member per month and per diem cost trend factors are the most significant factors affecting the IBNR estimate. The following table illustrates the sensitivity of these

factors and the estimated potential impact on our operating results caused by changes in these factors based on December 31, 2014 data:

Completion Factors:[1]		Cost Trend Factors:[2]	
(Decrease) Increase in Factors	Increase (Decrease) in Medical Claims Liabilities	(Decrease) Increase in Factors	Increase (Decrease) in Medical Claims Liabilities
	(in millions)		(in millions)
(2.0)%	$ 182	(2.0)%	$(54)
(1.5)	135	(1.5)	(40)
(1.0)	90	(1.0)	(27)
(0.5)	45	(0.5)	(14)
0.5	(44)	0.5	14
1.0	(88)	1.0	27
1.5	(131)	1.5	41
2.0	(174)	2.0	54

[1] Reflects estimated potential changes in medical claims liability caused by changes in completion factors.
[2] Reflects estimated potential changes in medical claims liability caused by changes in cost trend factors for the most recent periods.

While we believe our estimates are appropriate, it is possible future events could require us to make significant adjustments for revisions to these estimates. For example, a 1% increase or decrease in our estimated medical claims liability would have affected net earnings by $11 million for the year ended December 31, 2014, excluding the effect of any return of premium, risk corridor, or minimum medical loss ratio programs. The estimates are based on our historical experience, terms of existing contracts, our observance of trends in the industry, information provided by our providers and information available from other outside sources.

The change in medical claims liability is summarized as follows (in millions):

	Year Ended December 31,		
	2014	2013	2012
Balance, January 1,	$ 1,112	$ 815	$ 519
Incurred related to:			
Current year	12,820	9,073	6,836
Prior years	(142)	(78)	(55)
Total incurred	12,678	8,995	6,781
Paid related to:			
Current year	11,122	7,975	6,025
Prior years	945	723	460
Total paid	12,067	8,698	6,485
Balance, December 31,	$ 1,723	$ 1,112	$ 815
Days in claims payable[1]	44.2	42.4	38.5

[1] Days in claims payable is a calculation of medical claims liability at the end of the period divided by average expense per calendar day for the fourth quarter of each year.

Medical claims are usually paid within a few months of the member receiving service from the physician or other healthcare provider. As a result, the liability generally is described as having a "short-tail," which causes less than 5% of our medical claims liability as of the end of any given year to be outstanding the following year. We believe that substantially all the development of the estimate of medical claims liability as of December 31, 2014 will be known by the end of 2015.

Changes in estimates of incurred claims for prior years are primarily attributable to reserving under moderately adverse conditions. In addition, claims processing initiatives yielded increased claim payment recoveries and coordination of benefits related to prior year dates of service. Changes in medical utilization and cost trends and the effect of medical management initiatives may also contribute to changes in medical claim liability estimates. While we have evidence that medical management initiatives are effective on a case by case basis, medical management initiatives primarily focus on events and behaviors prior to the incurrence of the medical event and generation of a claim. Accordingly, any change in behavior, leveling of care, or coordination of treatment occurs prior to claim generation and as a result, the costs prior to the medical management initiative are not known by us. Additionally, certain medical management initiatives are focused on member and provider education with the intent of influencing behavior to appropriately align the medical services provided with the member's acuity. In these cases, determining whether the medical management initiative changed the behavior cannot be determined. Because of the complexity of our business, the number of states in which we operate, and the volume of claims that we process, we are unable to practically quantify the impact of these initiatives on our changes in estimates of IBNR.

The following are examples of medical management initiatives that may have contributed to the favorable development through lower medical utilization and cost trends:

- Appropriate leveling of care for neonatal intensive care unit hospital admissions, other inpatient hospital admissions, and observation admissions, in accordance with Interqual or other criteria.
- Management of our pre-authorization list and more stringent review of durable medical equipment and injectibles.
- Emergency room program designed to collaboratively work with hospitals to steer non-emergency care away from the costly emergency room setting (through patient education, on-site alternative urgent care settings, etc.)
- Increase emphasis on case management and clinical rounding where case managers are nurses or social workers who are employed by the health plan to assist selected patients with the coordination of healthcare services in order to meet a patient's specific healthcare needs.
- Incorporation of disease management which is a comprehensive, multidisciplinary, collaborative approach to chronic illnesses such as asthma.
- Prenatal and infant health programs utilized in our *Start Smart For Your Baby* outreach service.

Goodwill and Intangible Assets

We have made several acquisitions that have resulted in our recording of intangible assets. These intangible assets primarily consist of customer relationships, purchased contract rights, provider contracts, trade names and goodwill. At December 31, 2014, we had $754 million of goodwill and $120 million of other intangible assets.

Intangible assets are amortized using the straight-line method over the following periods:

Intangible Asset	Amortization Period
Purchased contract rights	5 – 15 years
Provider contracts	4 – 15 years
Customer relationships	3 – 15 years
Trade names	7 – 20 years

Our management evaluates whether events or circumstances have occurred that may affect the estimated useful life or the recoverability of the remaining balance of goodwill and other identifiable intangible assets. If the events or circumstances indicate that the remaining balance of the intangible asset or goodwill may be impaired, the potential impairment will be measured based upon the difference between the carrying amount of the intangible asset or goodwill and the fair value of such asset. Our management must make assumptions and estimates, such as the discount factor, future utility and other internal and external factors, in determining the

estimated fair values. While we believe these assumptions and estimates are appropriate, other assumptions and estimates could be applied and might produce significantly different results.

Goodwill is reviewed annually during the fourth quarter for impairment. In addition, an impairment analysis of intangible assets would be performed based on other factors. These factors include significant changes in membership, state funding, medical contracts and provider networks and contracts.

We first assess qualitative factors to determine whether it is necessary to perform the two-step quantitative goodwill impairment test. We generally do not calculate the fair value of a reporting unit unless we determine, based on a qualitative assessment, that it is more likely than not that its fair value is less than its carrying amount. However, in certain circumstances, such as recent acquisitions, we may elect to perform a quantitative assessment without first assessing qualitative factors.

The fair value of all reporting units with material amounts of goodwill was substantially in excess of the carrying value as of our annual impairment testing date, with the exception of the U.S. Medical Management reporting unit that was acquired in the current year without excess fair value on the acquisition date. The fair value of the U.S. Medical Management reporting unit was in excess of the carrying value as of our annual impairment testing date.

ITEM 7A. ***Quantitative and Qualitative Disclosures About Market Risk.***

INVESTMENTS AND DEBT

As of December 31, 2014, we had short term investments of $177 million and long term investments of $1,380 million, including restricted deposits of $100 million. The short term investments generally consist of highly liquid securities with maturities between three and 12 months. The long term investments consist of municipal, corporate and U.S. Treasury securities, government sponsored obligations, life insurance contracts, asset backed securities and equity securities and have maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states' requirements, these investments are classified as long term regardless of the contractual maturity date. Substantially all of our investments are subject to interest rate risk and will decrease in value if market rates increase. 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 $35 million. Declines in interest rates over time will reduce our investment income.

We entered into interest rate swap agreements for a notional amount of $550 million with creditworthy financial institutions to manage the impact of market interest rates on interest expense. Our swap agreements convert a portion of our interest expense from fixed to variable rates to better match the impact of changes in market rates on our variable rate cash equivalent investments. As a result, the fair value of $550 million of our long term debt varies with market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2014, the fair value of our debt would decrease by approximately $25 million. An increase in interest rates decreases the fair value of the debt and conversely, a decrease in interest rates increases the value.

For a discussion of the interest rate risk that our investments are subject to, see "Risk Factors–Risks Related to Our Business–Our investment portfolio may suffer losses from reductions in market interest rates and changes in market conditions which could materially and adversely affect our results of operations or liquidity."

INFLATION

The inflation rate for medical care costs has been higher than the inflation rate for all items. We use various strategies to mitigate the negative effects of healthcare cost inflation. Specifically, our health plans try to control medical and hospital costs through our state savings initiatives and contracts with independent providers of healthcare services. Through these contracted care providers, our health plans emphasize preventive healthcare

and appropriate use of specialty and hospital services. Additionally, our contracts with states require actuarially sound premiums that include healthcare cost trend.

While we currently believe our strategies to mitigate healthcare cost inflation will continue to be successful, competitive pressures, new healthcare and pharmaceutical product introductions, demands from healthcare providers and customers, applicable regulations or other factors may affect our ability to control the impact of healthcare cost increases.

Item 8. ***Financial Statements and Supplementary Data***

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
Centene Corporation:

We have audited the accompanying consolidated balance sheets of Centene Corporation and subsidiaries as of December 31, 2014 and 2013, and the related consolidated statements of operations, comprehensive earnings, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2014. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements 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 includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes 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, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Centene Corporation and subsidiaries as of December 31, 2014 and 2013, and the results of their operations and their cash flows for each of the years in the three-year period ended December 31, 2014, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Centene Corporation's internal control over financial reporting 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 (COSO), and our report dated February 23, 2015 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

KPMG LLP

St. Louis, Missouri
February 23, 2015

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS
(In millions, except share data)

	December 31, 2014	December 31, 2013
ASSETS		
Current assets:		
Cash and cash equivalents of continuing operations	$ 1,546	$ 974
Cash and cash equivalents of discontinued operations	64	64
Total cash and cash equivalents	1,610	1,038
Premium and related receivables	912	429
Short term investments	177	102
Other current assets	324	217
Other current assets of discontinued operations	11	14
Total current assets	3,034	1,800
Long term investments	1,280	792
Restricted deposits	100	47
Property, software and equipment, net	445	395
Goodwill	754	348
Intangible assets, net	120	49
Other long term assets	80	60
Long term assets of discontinued operations	25	38
Total assets	$ 5,838	$ 3,529
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$ 1,723	$ 1,112
Accounts payable and accrued expenses	751	338
Return of premium payable	236	38
Unearned revenue	168	38
Current portion of long term debt	5	3
Current liabilities of discontinued operations	17	30
Total current liabilities	2,900	1,559
Long term debt	888	666
Other long term liabilities	158	60
Long term liabilities of discontinued operations	1	1
Total liabilities	3,947	2,286
Commitments and contingencies		
Redeemable noncontrolling interest	148	—
Stockholders' equity:		
Common stock, $.001 par value; authorized 200,000,000 shares; 124,274,864 issued and 118,433,416 outstanding at December 31, 2014, and 117,346,430 issued and 110,638,478 outstanding at December 31, 2013	—	—
Additional paid-in capital	840	594
Accumulated other comprehensive loss	(1)	(3)
Retained earnings	1,003	732
Treasury stock, at cost (5,841,448 and 6,707,952 shares, respectively)	(98)	(89)
Total Centene stockholders' equity	1,744	1,234
Noncontrolling interest	(1)	9
Total stockholders' equity	1,743	1,243
Total liabilities and stockholders' equity	$ 5,838	$ 3,529

The accompanying notes to the consolidated financial statements are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS
(In millions, except share data)

	Year Ended December 31,		
	2014	2013	2012
Revenues:			
Premium	$ 14,198	$ 10,153	$ 7,569
Service	1,469	373	113
Premium and service revenues	15,667	10,526	7,682
Premium tax and health insurer fee	893	337	428
Total revenues	16,560	10,863	8,110
Expenses:			
Medical costs	12,678	8,995	6,781
Cost of services	1,280	327	88
General and administrative expenses	1,314	931	677
Premium tax expense	698	333	428
Health insurer fee expense	126	—	—
Impairment loss	—	—	28
Total operating expenses	16,096	10,586	8,002
Earnings from operations	464	277	108
Other income (expense):			
Investment and other income	28	19	35
Interest expense	(35)	(27)	(20)
Earnings from continuing operations, before income tax expense	457	269	123
Income tax expense	196	107	47
Earnings from continuing operations, net of income tax expense	261	162	76
Discontinued operations, net of income tax expense (benefit) of $1, $2, and $(48), respectively	3	4	(87)
Net earnings (loss)	264	166	(11)
(Earnings) loss attributable to noncontrolling interests	7	(1)	13
Net earnings attributable to Centene Corporation	$ 271	$ 165	$ 2
Amounts attributable to Centene Corporation common shareholders:			
Earnings from continuing operations, net of income tax expense	$ 268	$ 161	$ 89
Discontinued operations, net of income tax expense (benefit)	3	4	(87)
Net earnings	$ 271	$ 165	$ 2
Net earnings (loss) per common share attributable to Centene Corporation:			
Basic:			
Continuing operations	$ 2.30	$ 1.49	$ 0.86
Discontinued operations	0.03	0.03	(0.84)
Basic earnings per common share	$ 2.33	$ 1.52	$ 0.02
Diluted:			
Continuing operations	$ 2.23	$ 1.43	$ 0.83
Discontinued operations	0.02	0.04	(0.81)
Diluted earnings per common share	$ 2.25	$ 1.47	$ 0.02
Weighted average number of common shares outstanding:			
Basic	116,345,764	108,253,090	103,018,732
Diluted	120,360,212	112,494,346	107,428,750

The accompanying notes to the consolidated financial statements are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF COMPREHENSIVE EARNINGS
(In millions)

	Year Ended December 31,		
	2014	2013	2012
Net earnings (loss)	$ 264	$ 166	$ (11)
Reclassification adjustment, net of tax	—	(1)	(2)
Change in unrealized gain (loss) on investments, net of tax	3	(7)	1
Foreign currency translation adjustments, net of tax	(1)	—	—
Other comprehensive earnings (loss)	2	(8)	(1)
Comprehensive earnings (loss)	266	158	(12)
Comprehensive (earnings) loss attributable to the noncontrolling interest	7	(1)	13
Comprehensive earnings attributable to Centene Corporation	$ 273	$ 157	$ 1

The accompanying notes to the consolidated financial statements are an integral part of this statement.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

(In millions, except share data)

	Centene Stockholders' Equity								
	Common Stock					Treasury Stock			
	$.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	$.001 Par Value Shares	Amt	Non controlling Interest	Total
Balance, December 31, 2011	107,173,452	$—	$ 422	$ 6	$ 565	5,444,216	$(57)	$ 1	$ 937
Comprehensive Earnings:									
Net earnings (loss)	—	—	—	—	2	—	—	(13)	(11)
Change in unrealized investment gain, net of ($0) tax	—	—	—	(1)	—	—	—	—	(1)
Total comprehensive earnings (loss)									(12)
Common stock issued for employee benefit plans	3,504,868	—	17	—	—	—	—	—	17
Common stock repurchases	—	—	—	—	—	575,608	(13)	—	(13)
Stock compensation expense	—	—	25	—	—	—	—	—	25
Excess tax benefits from stock compensation	—	—	11	—	—	—	—	—	11
Purchase of noncontrolling interest	—	—	(24)	—	—	—	—	12	(12)
Contribution from noncontrolling interest	—	—	—	—	—	—	—	1	1
Balance, December 31, 2012	110,678,320	$—	$ 451	$ 5	$ 567	6,019,824	$(70)	$ 1	$ 954
Comprehensive Earnings:									
Net earnings	—	—	—	—	165	—	—	1	166
Change in unrealized investment gain, net of $(4) tax	—	—	—	(8)	—	—	—	—	(8)
Total comprehensive earnings									158
Common stock issued for acquisition	3,433,380	—	75	—	—	—	—	—	75
Common stock issued for stock offering	685,280	—	15	—	—	—	—	—	15
Common stock issued for employee benefit plans	2,549,450	—	10	—	—	—	—	—	10
Common stock repurchases	—	—	—	—	—	688,128	(19)	—	(19)
Stock compensation expense	—	—	37	—	—	—	—	—	37
Excess tax benefits from stock compensation	—	—	6	—	—	—	—	—	6
Contribution from noncontrolling interest	—	—	—	—	—	—	—	7	7
Balance, December 31, 2013	117,346,430	$—	$ 594	$ (3)	$ 732	6,707,952	$(89)	$ 9	$ 1,243
Comprehensive Earnings:									
Net earnings (loss)	—	—	—	—	271	—	—	(1)	270
Change in unrealized investment loss, net of $1 tax	—	—	—	3	—	—	—	—	3
Foreign currency translation, net of ($0) tax	—	—	—	(1)	—	—	—	—	(1)
Total comprehensive earnings									272
Common stock issued for acquisitions	4,486,434	—	170	—	—	(1,492,738)	20	—	190
Common stock issued for employee benefit plans	2,442,000	—	9	—	—	—	—	—	9
Common stock repurchases	—	—	—	—	—	626,234	(29)	—	(29)
Stock compensation expense	—	—	48	—	—	—	—	—	48
Excess tax benefits from stock compensation	—	—	19	—	—	—	—	—	19
Reclassification to redeemable noncontrolling interest	—	—	—	—	—	—	—	(9)	(9)
Balance, December 31, 2014	124,274,864	$—	$ 840	$ (1)	$ 1,003	5,841,448	$(98)	$ (1)	$ 1,743

The accompanying notes to the consolidated financial statements are an integral part of this statement.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS
(In millions)

	Year Ended December 31,		
	2014	2013	2012
Cash flows from operating activities:			
Net earnings (loss)	$ 264	$ 166	$ (11)
Adjustments to reconcile net earnings to net cash provided by operating activities			
Depreciation and amortization	89	67	66
Stock compensation expense	48	37	25
Impairment loss	—	—	28
Gain on sale of investment in convertible note	—	—	(18)
Deferred income taxes	(42)	(2)	(14)
Changes in assets and liabilities			
Premium and related receivables	(463)	(143)	(117)
Other current assets	(5)	(80)	(37)
Other assets	(8)	(1)	3
Medical claims liabilities	609	172	360
Unearned revenue	129	3	25
Accounts payable and accrued expenses	506	152	(22)
Other operating activities	96	11	(9)
Net cash provided by operating activities	1,223	382	279
Cash flows from investing activities:			
Capital expenditures	(103)	(68)	(82)
Purchases of investments	(1,015)	(790)	(696)
Sales and maturities of investments	406	579	590
Investments in acquisitions, net of cash acquired	(136)	(63)	—
Net cash used in investing activities	(848)	(342)	(188)
Cash flows from financing activities:			
Proceeds from exercise of stock options	8	9	16
Proceeds from borrowings	1,875	180	400
Proceeds from stock offering	—	15	—
Payment of long term debt	(1,674)	(41)	(218)
Excess tax benefits from stock compensation	19	6	11
Common stock repurchases	(29)	(19)	(13)
Contribution from noncontrolling interest	6	8	1
Purchase of noncontrolling interest	—	—	(14)
Debt issue costs	(7)	(4)	(4)
Net cash provided by financing activities	198	154	179
Effect of exchange rate changes on cash and cash equivalents	(1)	—	—
Net increase in cash and cash equivalents	572	194	270
Cash and cash equivalents, beginning of period	1,038	844	574
Cash and cash equivalents, end of period	$ 1,610	$ 1,038	$ 844
Supplemental disclosures of cash flow information:			
Interest paid	$ 40	$ 30	$ 22
Income taxes paid	$ 237	$ 85	$ 43
Equity issued in connection with acquisitions	$ 190	$ 75	$ —

The accompanying notes to the consolidated financial statements are an integral part of these statements.

1. Organization and Operations

Centene Corporation, or the Company, is a diversified, multi-national healthcare enterprise operating in two segments: Managed Care and Specialty Services. The Managed Care segment provides Medicaid and Medicaid-related health plan coverage to individuals through the government subsidized programs, including Medicaid, the State Children's Health Insurance Program (CHIP), Long Term Care (LTC), Foster Care, dual-eligible individuals (Duals) in Medicare Special Needs Plans and the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program, or collectively ABD and the Health Insurance Marketplace. The Specialty Services segment consists of our specialty companies offering auxiliary healthcare services and products to state programs, healthcare organizations, employer groups and other commercial organizations, as well as to our own subsidiaries.

On February 2, 2015, the Board of Directors declared a two-for-one split of Centene's common stock in the form of a 100% stock dividend distributed February 19, 2015 to stockholders of record on February 12, 2015. All share, per share and stock price information presented in this Form 10-K has been adjusted for the two-for-one stock split.

2. Summary of Significant Accounting Policies

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of Centene Corporation and all majority owned subsidiaries and subsidiaries over which the Company exercises the power and control to direct activities significantly impacting financial performance. All material intercompany balances and transactions have been eliminated. The assets, liabilities and results of operations of Kentucky Spirit Health Plan are classified as discontinued operations for all periods presented.

Certain amounts in the consolidated financial statements have been reclassified to conform to the 2014 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles in the United States, or GAAP, requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Future events and their effects cannot be predicted with certainty; accordingly, the accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of the consolidated financial statements will change as new events occur, as more experience is acquired, as additional information is obtained and as the operating environment changes. The Company evaluates and updates its assumptions and estimates on an ongoing basis and may employ outside experts to assist in our evaluation, as considered necessary. Actual results could differ from those estimates.

Cash and Cash Equivalents

Investments with original maturities of three months or less are considered to be cash equivalents. Cash equivalents consist of money market funds and bank certificates of deposit and savings accounts.

The Company maintains amounts on deposit with various financial institutions, which may exceed federally insured limits. However, management periodically evaluates the credit-worthiness of those institutions, and the Company has not experienced any losses on such deposits.

Investments

Short term investments include securities with maturities greater than three months to one year. Long term investments include securities with maturities greater than one year.

Short term and long term investments are generally classified as available for sale and are carried at fair value. Certain equity investments are recorded using the cost or equity method. Unrealized gains and losses on investments available for sale are excluded from earnings and reported in accumulated other comprehensive income, a separate component of stockholders' equity, net of income tax effects. Premiums and discounts are amortized or accreted over the life of the related security using the effective interest method. The Company monitors the difference between the cost and fair value of investments. Investments that experience a decline in value that is judged to be other than temporary are written down to fair value and a realized loss is recorded in investment and other income. To calculate realized gains and losses on the sale of investments, the Company uses the specific amortized cost of each investment sold. Realized gains and losses are recorded in investment and other income.

The Company uses the equity method to account for certain of its investment in entities that it does not control and for which it does not have the ability to exercise significant influence over operating and financial policies. These investments are recorded at the lower of their cost or fair value adjusted for the Company's proportionate share of their undistributed earnings or losses.

Restricted Deposits

Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. These investments are classified as long term, regardless of the contractual maturity date, due to the nature of the states' requirements. The Company is required to annually adjust the amount of the deposit pledged to certain states.

Fair Value Measurements

In the normal course of business, the Company invests in various financial assets and incurs various financial liabilities. Fair values are disclosed for all financial instruments, whether or not such values are recognized in the Consolidated Balance Sheets. Management obtains quoted market prices and other observable inputs for these disclosures. The carrying amounts reported in the Consolidated Balance Sheets for cash and cash equivalents, premium and related receivables, unearned revenue, accounts payable and accrued expenses, and certain other current liabilities are carried at cost, which approximates fair value because of their short term nature.

The following methods and assumptions were used to estimate the fair value of each financial instrument:

- Available for sale investments and restricted deposits: The carrying amount is stated at fair value, based on quoted market prices, where available. For securities not actively traded, fair values were estimated using values obtained from independent pricing services or quoted market prices of comparable instruments.
- Senior unsecured notes: Estimated based on third-party quoted market prices for the same or similar issues.
- Variable rate debt: The carrying amount of our floating rate debt approximates fair value since the interest rates adjust based on market rate adjustments.
- Interest rate swap: Estimated based on third-party market prices based on the forward 3-month LIBOR curve.
- Contingent consideration: Estimate based on expected membership retained at contract commencement and per member purchase price in the acquisition agreement.

Property, Software and Equipment

Property, software and equipment are stated at cost less accumulated depreciation. Capitalized software includes 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. Depreciation is calculated principally by the straight-line method over estimated useful lives. Leasehold improvements are depreciated using the straight-line method over the shorter of the expected useful life or the remaining term of the lease. Property, software and equipment are depreciated over the following periods:

Fixed Asset	Depreciation Period
Buildings and land improvements	3 – 40 years
Computer hardware and software	2 – 7 years
Furniture and equipment	3 – 10 years
Leasehold improvements	1 – 20 years

The carrying amounts of all long-lived assets are evaluated to determine if adjustment to the depreciation and amortization period or to the unamortized balance is warranted. Such evaluation is based principally on the expected utilization of the long-lived assets.

The Company retains fully depreciated assets in property and accumulated depreciation accounts until it removes them from service. In the case of sale, retirement, or disposal, the asset cost and related accumulated depreciation balance is removed from the respective account, and the resulting net amount, less any proceeds, is included as a component of earnings from operations in the consolidated statements of operations.

Goodwill and Intangible Assets

Intangible assets represent assets acquired in purchase transactions and consist primarily of customer relationships, purchased contract rights, provider contracts, trade names and goodwill. Intangible assets are amortized using the straight-line method over the following periods:

Intangible Asset	Amortization Period
Purchased contract rights	5 – 15 years
Provider contracts	4 – 15 years
Customer relationships	3 – 15 years
Trade names	7 – 20 years

The Company tests for impairment of intangible assets as well as long-lived assets whenever events or changes in circumstances indicate that the carrying value of an asset or asset group (hereinafter referred to as "asset group") may not be recoverable by comparing the sum of the estimated undiscounted future cash flows expected to result from use of the asset group and its eventual disposition to the carrying value. Such factors include, but are not limited to, significant changes in membership, state funding, state contracts and provider networks and contracts. If the sum of the estimated undiscounted future cash flows is less than the carrying value, an impairment determination is required. The amount of impairment is calculated by subtracting the fair value of the asset group from the carrying value of the asset group. An impairment charge, if any, is recognized within earnings from operations.

The Company tests goodwill for impairment using a fair value approach. The Company is required to test for impairment at least annually, absent a triggering event including a significant decline in operating performance that would require an impairment assessment. Absent any impairment indicators, the Company performs its goodwill impairment testing during the fourth quarter of each year. The Company recognizes an impairment charge for any amount by which the carrying amount of goodwill exceeds its implied fair value.

The Company first assesses qualitative factors to determine whether it is necessary to perform the two-step quantitative goodwill impairment test. The Company generally does not calculate the fair value of a reporting unit unless it determines, based on a qualitative assessment, that it is more likely than not that its fair value is less than its carrying amount. However, in certain circumstances, such as recent acquisitions, the Company may elect to perform a quantitative assessment without first assessing qualitative factors.

If the two-step quantitative test is deemed necessary, the Company determines an appropriate valuation technique to estimate a reporting unit's fair value as of the testing date. The Company utilizes either the income approach or the market approach, whichever is most appropriate for the respective reporting unit. The income approach is based on an internally developed discounted cash flow model that includes many assumptions related to future growth rates, discount factors, future tax rates, etc. The market approach is based on financial multiples of comparable companies derived from current market data. Changes in economic and operating conditions impacting assumptions used in our analyses could result in goodwill impairment in future periods.

Medical Claims Liability

Medical claims liability includes claims reported but not yet paid, or inventory, estimates for claims incurred but not reported, or IBNR, and estimates for the costs necessary to process unpaid claims at the end of each period. The Company estimates its medical claims liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors.

Actuarial Standards of Practice generally require that the medical claims liability estimates be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate. In many situations, the claims amounts ultimately settled will be different than the estimate that satisfies the Actuarial Standards of Practice. The Company includes in its IBNR an estimate for medical claims liability under moderately adverse conditions which represents the risk of adverse deviation of the estimates in its actuarial method of reserving.

The Company uses its judgment to determine the assumptions to be used in the calculation of the required estimates. The assumptions it considers when estimating IBNR include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to fee schedules, and the incidence of high dollar or catastrophic claims.

The Company's development of the medical claims liability estimate is a continuous process which it monitors and refines on a monthly basis as additional claims receipts and payment information becomes available. As more complete claims information becomes available, the Company adjusts the amount of the estimates, and includes the changes in estimates in medical costs in the period in which the changes are identified. In every reporting period, the operating results include the effects of more completely developed medical claims liability estimates associated with previously reported periods. The Company consistently applies its reserving methodology from period to period. As additional information becomes known, it adjusts the actuarial model accordingly to establish medical claims liability estimates.

The Company periodically reviews actual and anticipated experience compared to the assumptions used to establish medical costs. The Company establishes premium deficiency reserves if actual and anticipated experience indicates that existing policy liabilities together with the present value of future gross premiums will not be sufficient to cover the present value of future benefits, settlement and maintenance costs.

Revenue Recognition

The Company's health plans generate revenues primarily from premiums received from the states in which it operates health plans. The Company receives a fixed premium per member per month pursuant to its state contracts. The Company generally receives premium payments during the month it provides services and recognizes premium revenue during the period in which it is obligated to provide services to its members. In some instances, the Company's base premiums are subject to an adjustment, or risk score, based on the acuity of its membership. Generally, the risk score is determined by the State analyzing submissions of processed claims data to determine the acuity of the Company's membership relative to the entire state's Medicaid membership.

Some states enact premium taxes, similar assessments and provider pass-through payments, collectively premium taxes, and these taxes are recorded as a separate component of both revenues and operating expenses. Some contracts allow for additional premiums related to certain supplemental services provided such as maternity deliveries.

Revenues are recorded based on membership and eligibility data provided by the states, which is adjusted on a monthly basis by the states for retroactive additions or deletions to membership data. These eligibility adjustments are estimated monthly and subsequent adjustments are made in the period known. We continuously review and update those estimates as new information becomes available. It is possible that new information could require us to make additional adjustments, which could be significant, to these estimates.

The Company's specialty companies generate revenues under contracts with state programs, individuals, healthcare organizations and other commercial organizations, as well as from the Company's own subsidiaries. Revenues are recognized when the related services are provided or as ratably earned over the covered period of service.

Health Insurance Marketplace

The Affordable Care Act (ACA) established risk spreading premium stabilization programs effective January 1, 2014 for the Health Insurance Marketplace product. These programs, commonly referred to as the "three Rs," include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. The Company's accounting policies for the programs are as follows:

Risk Adjustment

The permanent risk adjustment program established by the ACA transfers funds from qualified individual and small group insurance plans with below average risk scores to those plans with above average risk scores within each state. The Company estimates the receivable or payable under the risk adjustment program based on its estimated risk score compared to the state average risk score. The Company may record a receivable or payable as an adjustment to Premium revenue to reflect the year to date impact of the risk adjustment based on its best estimate. The Company expects to refine its estimate as new information becomes available. As of December 31, 2014, the Company recorded a payable of $44 million associated with risk adjustment.

Reinsurance

The ACA established a transitional three-year reinsurance program whereby the Company's claims costs incurred for qualified members will be reimbursed when they exceed a specific threshold ($45,000 with 80% coinsurance). When qualified member claims costs exceed the threshold, the Company is entitled to certain reimbursements from this program. The Company accounts for reinsurance recoveries as a reduction of Medical Costs based on each individual case that exceeds the reinsurance threshold established by the program. As of December 31, 2014, the Company recorded a receivable of $11 million associated with reinsurance.

Risk Corridor

The temporary, three-year risk corridor program established by the ACA applies to qualified individual and small group health plans operating both inside and outside of the Health Insurance Marketplace. The risk corridor program limits the Company's gains and losses in the Health Insurance Marketplace by comparing certain medical and administrative costs to a target amount and sharing the risk for allowable costs with the federal government. Allowable medical costs are adjusted for risk adjustment settlements, transitional reinsurance recoveries, and cost sharing reductions received from the federal government. The Company records a risk corridor receivable or payable as an adjustment to Premium Revenue on a year to date basis based on where its estimated annual costs fall within the risk corridor range. As of December 31, 2014, the Company recorded a payable of $9 million associated with risk corridor.

Minimum Medical Loss Ratio

Additionally, the ACA established a minimum annual medical loss ratio for the Health Insurance Marketplace. Each of the three R programs described above are taken into consideration to determine if the

Company's estimated annual medical costs are less than the minimum loss ratio and require an adjustment to Premium revenue to meet the minimum medical loss ratio. As of December 31, 2014, the Company recorded a payable of $6 million associated with minimum medical loss ratio.

Premium and Related Receivables and Unearned Revenue

Premium and service revenues collected in advance are recorded as unearned revenue. For performance-based contracts the Company does not recognize revenue subject to refund until data is sufficient to measure performance. Premiums and service revenues due to the Company are recorded as premium and related receivables and are recorded net of an allowance based on historical trends and management's judgment on the collectibility of these accounts. As the Company generally receives payments during the month in which services are provided, the allowance is typically not significant in comparison to total revenues and does not have a material impact on the presentation of the financial condition or results of operations. Activity in the allowance for uncollectible accounts for the years ended December 31, is summarized below ($ in millions):

	2014	2013	2012
Allowances, beginning of year	$ 1	$ 1	$ 1
Amounts charged to expense	8	3	1
Write-offs of uncollectible receivables	(4)	(3)	(1)
Allowances, end of year	$ 5	$ 1	$ 1

Significant Customers

Centene receives the majority of its revenues under contracts or subcontracts with state Medicaid managed care programs. The current contracts expire on various dates between January 31, 2015 and June 30, 2019. States where the aggregate annual contract value exceeded 10% of total annual revenues included Texas, where the percentage of the Company's total revenue was 25%, 37% and 40% for the years ended December 31, 2014, 2013, and 2012, respectively, and Florida where the percentage of the Company's total revenue was 14% for the year ended December 31, 2014.

Other Income (Expense)

Other income (expense) consists principally of investment income, interest expense and equity method earnings from investments. Investment income is derived from the Company's cash, cash equivalents, restricted deposits and investments. Interest expense relates to borrowings under the senior notes, interest rate swap, credit facilities, interest on capital leases and credit facility fees.

Income Taxes

Deferred tax assets and liabilities are recorded for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax law or tax rates is recognized in income in the period that includes the enactment date.

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. In determining if a deductible temporary difference or net operating loss can be realized, the Company considers future reversals of existing taxable temporary differences, future taxable income, taxable income in prior carryback periods and tax planning strategies.

Contingencies

The Company accrues for loss contingencies associated with outstanding litigation, claims and assessments for which it has determined it is probable that a loss contingency exists and the amount of loss can be reasonably

estimated. The Company expenses professional fees associated with litigation claims and assessments as incurred.

Stock Based Compensation

The fair value of the Company's employee share options and similar instruments are estimated using the Black-Scholes option-pricing model. That cost is recognized over the period during which an employee is required to provide service in exchange for the award. Excess tax benefits related to stock compensation are presented as a cash inflow from financing activities.

Foreign Currency Translation

The Company is exposed to foreign currency exchange risk through its equity method investment in Ribera Salud S.A. (Ribera Salud), a Spanish health management group whose functional currency is the Euro. The assets and liabilities of the Company's investment are translated into United States dollars at the balance sheet date. The Company translates its proportionate share of earnings using average rates during the year. The resulting foreign currency translation adjustments are recorded as a separate component of accumulated other comprehensive income.

Recent Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standard Update (ASU) 2014-09 "Revenue from Contracts with Customers." ASU 2014-09 will supersede existing revenue recognition standards with a single model unless those contracts are within the scope of other standards (e.g., an insurance entity's insurance contracts). Under the new standard, recognition of revenue occurs when a customer obtains control of promised goods or services in an amount that reflects the consideration which the entity expects to receive in exchange for those goods or services. In addition, the standard requires disclosure of the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers. ASU 2014-09 will become effective for annual and interim reporting periods beginning after December 15, 2016. The Company is currently evaluating the effect of the new revenue recognition guidance.

In April 2014, the FASB issued ASU 2014-08 "Presentation of Financial Statements (Topic 205) and Property, Plant, and Equipment (Topic 360): Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity." ASU 2014-08 raises the threshold for reporting discontinued operations to a strategic business shift having a major effect on an entity's operations and financial results. The updates also added disclosures for disposals of business units qualifying for discontinued presentation, and for some dispositions that do not qualify as discontinued operations but are still considered individually significant components of the entity. ASU 2014-08 is effective prospectively for all disposals (except disposals classified as held for sale before the adoption date) or components initially classified as held for sale in periods beginning on or after December 15, 2014. Early adoption is permitted.

The Company has determined that there are no other recently issued accounting pronouncements that will have a material impact on its consolidated financial position, results of operations and cash flows.

3. Acquisitions and Noncontrolling Interest

Acquisitions

AcariaHealth. In April 2013, the Company acquired 100% of AcariaHealth, a specialty pharmacy company, for $142 million in total consideration. The transaction consideration was financed through a combination of $75 million of Centene common stock and $67 million of cash. The Company also sold 685,280 shares of common stock for $15 million related to funding the escrow account for the acquisition. The Company's allocation of fair value resulted in goodwill of $92 million and other identifiable intangible assets of $35 million. The goodwill is not deductible for income tax purposes. The acquisition is recorded in the Specialty Services segment.

Community Health Solutions of America, Inc. In July 2014, the Company completed a transaction whereby Community Health Solutions of America, Inc. assigned its contract with the Louisiana Department of Health and Hospitals under the Bayou Health Shared Savings Program to the Company's subsidiary, Louisiana Healthcare Connections (LHC).

The fair value of consideration of $134 million consists of the following: cash consideration of $56 million; Centene common stock (1,492,738 shares) issued at closing of $58 million, and; the present value of the estimated contingent consideration subject to membership retained by LHC in the first quarter of 2015 of $20 million. The estimated contingent consideration is a Level III fair value measurement. The contingent consideration will not exceed $28 million.

The Company's allocation of fair value resulted in goodwill of $125 million and other identifiable intangible assets of $9 million. Approximately 100% of the goodwill is deductible for income tax purposes. The acquisition is recorded in the Managed Care segment.

Ribera Salud, S.A. In July 2014, the Company purchased a noncontrolling interest in Ribera Salud S.A. (Ribera Salud), a Spanish health management group for $17 million. Centene is a 50% joint shareholder with Ribera Salud's remaining investor, Banco Sabadell S.A. The Company is accounting for its investment using the equity method of accounting. Any basis difference between the Company's share of underlying net assets and the purchase price will be attributable to certain intangible assets and will be accreted into earnings over their useful lives.

Upon closing, the Company executed letters of credit for $58 million (valued at the December 31, 2014 conversion rate), or €48 million, representing its proportional share of the letters of credit issued to support Ribera Salud's outstanding debt.

U.S. Medical Management. In January 2014, the Company acquired 68% of U.S. Medical Management, LLC (USMM), a management services organization and provider of in-home health services for high acuity populations, for $213 million in total consideration. The transaction consideration consisted of $133 million of Centene common stock and $80 million of cash.

The total fair value of 100% of USMM on the date of acquisition was $352 million ($213 million for the Company's interest and $139 million for the redeemable noncontrolling interest). The Company's allocation of fair value resulted in goodwill of $280 million and other identifiable intangible assets of $78 million. Approximately 45% of the goodwill is deductible for income tax purposes. The acquisition is recorded in the Specialty Services segment.

In connection with the acquisition, the Company entered into call and put agreements with the noncontrolling interest holder to purchase the noncontrolling interest at a later date. Under these agreements, the Company may purchase or be required to purchase up to the total remaining interests in USMM over a period beginning in 2015 and continuing through 2017. Under certain circumstances, the agreements may be extended through 2020. At the Company's sole option, up to 50% of the consideration to be issued for the purchase of the additional interests under these agreements may be funded with shares of the Company's common stock.

Noncontrolling Interest

The Company has consolidated subsidiaries where it maintains less than 100% ownership. The Company's ownership interest for each subsidiary as of December 31, are as follows:

	2014	2013	2012
Centurion	51%	51%	51%
Home State Health Plan	95%	95%	95%
U.S. Medical Management	68%	—	—

Net income attributable to Centene Corporation and transfers from (to) noncontrolling interest entities are as follows ($ in millions):

	Year Ended December 31,		
	2014	2013	2012
Net earnings attributable to Centene Corporation	$268	$161	$ 89
Transfers from (to) the noncontrolling interest:			
Decrease in equity for purchase of, distribution to and redemption of noncontrolling interest	—	—	(12)
Increase in equity for distributions from and consolidation of noncontrolling interest	—	7	1
Reclassification to redeemable noncontrolling interest	(9)	—	—
Net transfers from (to) noncontrolling interest	(9)	7	(11)
Changes from net earnings attributable to Centene Corporation and net transfers from (to) the noncontrolling interest	$259	$168	$ 78

Ownership changes are described in more detail below.

Home State Health Plan. In July 2012, the Company began operations as a 95% joint venture partner, operating under a new contract with the Office of Administration for Missouri to serve Medicaid beneficiaries in the Eastern, Central, and Western Managed Care Regions of the state. The operating results of Home State Health Plan are included in the Company's Managed Care segment.

Louisiana Healthcare Connections. In February 2012, the Company began operations under a new contract in Louisiana through a joint venture subsidiary, Louisiana Healthcare Connections. The Company initially owned a 51% interest in the subsidiary and in October 2012, acquired the remaining noncontrolling interest for $10 million. The purchase price in excess of the noncontrolling interest was recorded to additional paid in capital. The operating results of Louisiana Healthcare Connections are included in the Company's Managed Care segment.

Redeemable Noncontrolling Interest

As a result of put option agreements, noncontrolling interest is considered redeemable and is classified in the Redeemable Noncontrolling Interest section of the consolidated balance sheets. Noncontrolling interest is initially measured at fair value using the binomial lattice model as of the acquisition date. The Company has elected to accrete changes in the redemption value through additional paid-in capital over the period from the date of issuance to the earliest redemption date following the effective interest method.

A reconciliation of the changes in the Redeemable Noncontrolling Interest is as follows ($ in millions):

Balance, December 31, 2013	$ —
Fair value of noncontrolling interest at acquisition	139
Contribution from noncontrolling interest	6
Reclassification to redeemable noncontrolling interest	9
Net losses attributable to noncontrolling interest	(6)
Balance, December 31, 2014	$148

Pro forma disclosures related to the acquisitions have been excluded as immaterial.

4. Discontinued Operations: Kentucky Spirit Health Plan

In October 2012, the Company notified the Kentucky Cabinet for Health and Family Services (Cabinet) that it was exercising a contractual right that it believes allowed the Company to terminate its Medicaid managed care contract with the Commonwealth of Kentucky (Commonwealth) effective July 5, 2013. As of July 6, 2013, our subsidiary, Kentucky Spirit Health Plan (KSHP), ceased serving Medicaid members in Kentucky. Refer to Note 17, *Contingencies*, in the Notes to the Consolidated Financial Statements for further information regarding litigation between the Company and the Cabinet.

Accordingly, the results of operations of KSHP are presented as discontinued operations for all periods presented. The assets, liabilities and results of operations of KSHP are classified as discontinued operations for all periods presented beginning in 2011. KSHP was previously reported in the Managed Care segment.

During the year ended December 31, 2014, the Company received $8 million of dividends from KSHP. KSHP had remaining statutory capital of approximately $80 million at December 31, 2014, which, subject to future dividends, will be transferred to unregulated cash upon regulatory approval.

Operating results for the discontinued operations are as follows ($ in millions):

	Year Ended December 31,		
	2014	2013	2012
Revenues	$ —	$ 248	$ 557
Earnings (loss) before income taxes	$ 4	$ 6	$ (134)
Net earnings (loss)	$ 3	$ 4	$ (87)

Assets and liabilities of the discontinued operations are as follows ($ in millions):

	December 31, 2014	December 31, 2013
Current assets	$ 75	$ 78
Long term investments and restricted deposits	25	38
Other assets	—	—
Assets of discontinued operations	$ 100	$ 116
Medical claims liability	$ 10	$ 27
Accounts payable and accrued expenses	7	3
Other liabilities	1	1
Liabilities of discontinued operations	$ 18	$ 31

5. Short term and Long term Investments, Restricted Deposits

Short term and long term investments and restricted deposits by investment type consist of the following ($ in millions):

	December 31, 2014				December 31, 2013			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 393	$ 1	$ (2)	$ 392	$246	$—	$ (7)	$239
Corporate securities	556	2	(2)	556	294	3	(1)	296
Restricted certificates of deposit	6	—	—	6	6	—	—	6
Restricted cash equivalents	79	—	—	79	27	—	—	27
Municipal securities:								
General obligation	54	—	—	54	54	—	—	54
Pre-refunded	5	—	—	5	11	—	—	11
Revenue	101	1	—	102	69	—	—	69
Variable rate demand notes	14	—	—	14	29	—	—	29
Asset backed securities	180	—	—	180	139	—	—	139
Mortgage backed securities	84	1	—	85	34	—	—	34
Cost and equity method investments	68	—	—	68	22	—	—	22
Life insurance contracts	16	—	—	16	15	—	—	15
Total	$1,556	$ 5	$ (4)	$1,557	$946	$ 3	$ (8)	$941

The Company's investments are classified as available-for-sale with the exception of life insurance contracts and certain cost and equity method investments. The Company's investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets with the focus on high credit quality securities. The Company limits the size of investment in any single issuer other than U.S. treasury securities and obligations of U.S. government corporations and agencies. The Company's mortgage backed securities are issued by the Federal National Mortgage Association and carry guarantees by the U.S. government. As of December 31, 2014, 50% of the Company's investments in securities recorded at fair value that carry a rating by S&P or Moody's were rated AAA/Aaa, 62% were rated AA-/Aa3 or higher, and 90% were rated A-/A3 or higher. At December 31, 2014, the Company held certificates of deposit, life insurance contracts and cost and equity method investments which did not carry a credit rating.

The fair value of available-for-sale investments with gross unrealized losses by investment type and length of time that individual securities have been in a continuous unrealized loss position were as follows ($ in millions):

	December 31, 2014				December 31, 2013			
	Less Than 12 Months		12 Months or More		Less Than 12 Months		12 Months or More	
	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$—	$ 72	$(2)	$180	$(7)	$172	$(1)	$27
Corporate securities	(2)	311	—	1	—	53	—	5
Municipal securities:								
General obligation	—	4	—	3	—	4	—	2
Revenue	—	16	—	3	—	28	—	—
Pre-refunded	—	—	—	1	—	—	—	—
Asset backed securities	—	70	—	10	—	38	—	—
Mortgage backed securities	—	18	—	—	—	34	—	—
Total	$(2)	$491	$(2)	$198	$(7)	$329	$(1)	$34

As of December 31, 2014, the gross unrealized losses were generated from 116 positions out of a total of 341 positions. The change in fair value of fixed income securities is a result of movement in interest rates subsequent to the purchase of the security.

For each security in an unrealized loss position, the Company assesses whether it intends to sell the security or if it is more likely than not the Company will be required to sell the security before recovery of the amortized cost basis for reasons such as liquidity, contractual or regulatory purposes. If the security meets this criterion, the decline in fair value is other-than-temporary and is recorded in earnings. The Company does not intend to sell these securities prior to maturity and it is not likely that the Company will be required to sell these securities prior to maturity; therefore, there is no indication of other than temporary impairment for these securities.

During the year ended December 31, 2014, the company recognized $6 million of income from equity method investments.

The contractual maturities of short term and long term investments and restricted deposits are as follows ($ in millions):

	December 31, 2014				December 31, 2013			
	Investments		Restricted Deposits		Investments		Restricted Deposits	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value
One year or less	$ 176	$ 177	$ 92	$ 92	$102	$102	$41	$41
One year through five years	1,121	1,121	8	8	610	611	6	6
Five years through ten years	121	120	—	—	157	151	—	—
Greater than ten years	38	39	—	—	30	30	—	—
Total	$1,456	$1,457	$100	$100	$899	$894	$47	$47

Actual maturities may differ from contractual maturities due to call or prepayment options. Asset backed and mortgage backed securities are included in the one year through five years category, while cost and equity method investments and life insurance contracts are included in the five years through ten years category. The Company has an option to redeem at amortized cost substantially all of the securities included in the greater than ten years category listed above.

The Company continuously monitors investments for other-than-temporary impairment. Certain investments have experienced a decline in fair value due to changes in credit quality, market interest rates and/or general economic conditions. The Company recognizes an impairment loss for cost and equity method investments when evidence demonstrates that it is other-than-temporarily impaired. Evidence of a loss in value that is other than temporary may include the absence of an ability to recover the carrying amount of the investment or the inability of the investee to sustain a level of earnings that would justify the carrying amount of the investment.

6. Fair Value Measurements

Assets and liabilities recorded at fair value in the consolidated balance sheets are categorized based upon observable or unobservable inputs used to estimate the fair value. Level inputs are as follows:

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

The following table summarizes fair value measurements by level at December 31, 2014, for assets and liabilities measured at fair value on a recurring basis ($ in millions):

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$1,546	$ —	$—	$1,546
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 360	$ 17	$—	$ 377
Corporate securities	—	556	—	556
Municipal securities:				
General obligation	—	54	—	54
Pre-refunded	—	5	—	5
Revenue	—	102	—	102
Variable rate demand notes	—	14	—	14
Asset backed securities	—	180	—	180
Mortgage backed securities	—	85	—	85
Total investments	$ 360	$1,013	$—	$1,373
Restricted deposits available for sale:				
Cash and cash equivalents	$ 79	$ —	$—	$ 79
Certificates of deposit	6	—	—	6
U.S. Treasury securities and obligations of U.S. government corporations and agencies	15	—	—	15
Total restricted deposits	$ 100	$ —	$—	$ 100
Other long term assets:				
Interest rate swap agreements	$ —	$ 11	$—	$ 11
Total assets at fair value	$2,006	$1,024	$—	$3,030

The following table summarizes fair value measurements by level at December 31, 2013, for assets and liabilities measured at fair value on a recurring basis ($ in millions):

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$ 974	$ —	$—	$ 974
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 213	$ 12	$—	$ 225
Corporate securities	—	296	—	296
Municipal securities:				
General obligation	—	54	—	54
Pre-refunded	—	11	—	11
Revenue	—	69	—	69
Variable rate demand notes	—	29	—	29
Asset backed securities	—	139	—	139
Mortgage backed securities	—	34	—	34
Total investments	$ 213	$644	$—	$ 857
Restricted deposits available for sale:				
Cash and cash equivalents	$ 27	$ —	$—	$ 27
Certificates of deposit	6	—	—	6
U.S. Treasury securities and obligations of U.S. government corporations and agencies	14	—	—	14
Total restricted deposits	$ 47	$ —	$—	$ 47
Other long term assets:				
Interest rate swap agreements	$ —	$ 10	$—	$ 10
Total assets at fair value	$1,234	$654	$—	$1,888

The Company periodically transfers U.S. Treasury securities and obligations of U.S. government corporations and agencies between Level I and Level II fair value measurements dependent upon the level of trading activity for the specific securities at the measurement date. The Company's policy regarding the timing of transfers between Level I and Level II is to measure and record the transfers at the end of the reporting period. At December 31, 2014, there were $14 million of transfers from Level I to Level II and $1 million of transfers from Level II to Level I. The Company utilizes matrix pricing services to estimate fair value for securities which are not actively traded on the measurement date. The Company designates these securities as Level II fair value measurements. The aggregate carrying amount of the Company's life insurance contracts and other non-majority owned investments, which approximates fair value, was $84 million and $37 million as of December 31, 2014 and December 31, 2013, respectively.

7. Property, Software and Equipment

Property, software and equipment consist of the following as of December 31 ($ in millions):

	2014	2013
Computer software	$ 198	$ 185
Building	208	206
Land	87	69
Computer hardware	88	69
Furniture and office equipment	70	53
Leasehold improvements	82	57
	733	639
Less accumulated depreciation	(288)	(244)
Property, software and equipment, net	$ 445	$ 395

As of December 31, 2014 and 2013, the Company had assets acquired under capital leases included above of $7 million and $6 million, net of accumulated amortization of $3 million and $2 million, respectively. Amortization on assets under capital leases charged to expense is included in depreciation expense. Depreciation expense for the years ended December 31, 2014, 2013 and 2012 was $65 million, $52 million and $49 million, respectively.

8. Goodwill and Intangible Assets

The following table summarizes the changes in goodwill by operating segment ($ in millions):

	Managed Care	Specialty Services	Total
Balance as of December 31, 2012	$151	$105	$256
Acquisition	—	92	92
Balance as of December 31, 2013	151	197	348
Acquisition	125	281	406
Balance as of December 31, 2014	$276	$478	$754

Goodwill acquisitions were related to the acquisitions and finalization of fair value allocations discussed in Note 3, *Acquisitions and Noncontrolling Interest*. During 2012, an impairment analysis of our subsidiary, Celtic Insurance Company, resulted in goodwill and intangible asset impairments of $28 million. The impaired identifiable intangible assets of $2 million and goodwill of $26 million were reported under the Specialty Services segment; $27 million of the impairment loss was not deductible for income tax purposes.

Intangible assets at December 31, consist of the following ($ in millions):

	2014	2013	Weighted Average Life in Years 2014	2013
Purchased contract rights	$ 28	$ 22	7.5	7.5
Provider contracts	103	36	11.1	13.2
Customer relationships	15	13	7.1	8.0
Trade names	17	9	13.1	18.9
Intangible assets	163	80	10.3	11.1
Less accumulated amortization:				
Purchased contract rights	(14)	(14)		
Provider contracts	(14)	(4)		
Customer relationships	(12)	(11)		
Trade names	(3)	(2)		
Total accumulated amortization	(43)	(31)		
Intangible assets, net	$120	$ 49		

Amortization expense was $16 million, $6 million and $5 million for the years ended December 31, 2014, 2013 and 2012, respectively. Estimated total amortization expense related to intangible assets for each of the five succeeding fiscal years is as follows ($ in millions):

Year	Expense
2015	$16
2016	16
2017	13
2018	11
2019	11

9. Medical Claims Liability

The change in medical claims liability is summarized as follows ($ in millions):

	Year Ended December 31, 2014	2013	2012
Balance, January 1,	$ 1,112	$ 815	$ 519
Incurred related to:			
Current year	12,820	9,073	6,836
Prior years	(142)	(78)	(55)
Total incurred	12,678	8,995	6,781
Paid related to:			
Current year	11,122	7,975	6,025
Prior years	945	723	460
Total paid	12,067	8,698	6,485
Balance, December 31,	$ 1,723	$1,112	$ 815

Changes in estimates of incurred claims for prior years are primarily attributable to reserving under moderately adverse conditions. In addition, claims processing initiatives yielded increased claim payment recoveries and coordination of benefits related to prior year dates of service. Changes in medical utilization and cost trends and the effect of medical management initiatives may also contribute to changes in medical claim

liability estimates. While the Company has evidence that medical management initiatives are effective on a case by case basis, medical management initiatives primarily focus on events and behaviors prior to the incurrence of the medical event and generation of a claim. Accordingly, any change in behavior, leveling of care, or coordination of treatment occurs prior to claim generation and as a result, the costs prior to the medical management initiative are not known by the Company. Additionally, certain medical management initiatives are focused on member and provider education with the intent of influencing behavior to appropriately align the medical services provided with the member's acuity. In these cases, determining whether the medical management initiative changed the behavior cannot be determined. Because of the complexity of its business, the number of states in which it operates, and the volume of claims that it processes, the Company is unable to practically quantify the impact of these initiatives on its changes in estimates of IBNR.

The Company had reinsurance recoverables related to medical claims liability of $22 million and $10 million at December 31, 2014 and 2013, respectively, included in premium and related receivables.

The Company periodically reviews actual and anticipated experience compared to the assumptions used to establish medical costs. The Company establishes premium deficiency reserves if actual and anticipated experience indicates that existing policy liabilities together with the present value of future gross premiums will not be sufficient to cover the present value of future benefits, settlement and maintenance costs.

10. Debt

Debt consists of the following ($ in millions):

	December 31, 2014	December 31, 2013
$425 million 5.75% Senior notes, due June 1, 2017	$429	$431
$300 million 4.75% Senior notes, due May 15, 2022	300	—
Fair value of interest rate swap agreements	11	10
Senior notes	740	441
Revolving credit agreement	75	150
Mortgage notes payable	70	73
Capital leases	8	5
Total debt	893	669
Less current portion	(5)	(3)
Long term debt	$888	$666

Senior Notes

In April 2014, the Company issued $300 million of 4.75% Senior Notes due May 15, 2022 ($300 Million Notes) at par. In connection with the April 2014 issuance, the Company entered into interest rate swap agreements for a notional amount of $300 million. Gains and losses due to changes in the fair value of the interest rate swap agreements completely offset changes in the fair value of the hedged portion of the underlying debt and are recorded as an adjustment to the $300 Million Notes.

The indentures governing both the $425 million and the $300 million notes contain non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio.

Interest Rate Swaps

The Company uses interest rate swap agreements to convert a portion of its interest rate exposure from fixed rates to floating rates to more closely align interest expense with interest income received on its cash equivalent and variable rate investment balances. The Company has $550 million of notional amount of interest rate swap agreements consisting of $250 million which are scheduled to expire on June 1, 2017 and $300 million that are

scheduled to expire May 15, 2022. Under the Swap Agreements, the Company receives a fixed rate of interest and pays an average variable rate of the three month LIBOR plus 2.83% adjusted quarterly. At December 31, 2014, the weighted average rate was 3.06%.

The Swap Agreements are formally designated and qualify as fair value hedges and are recorded at fair value in the Consolidated Balance Sheet in other assets or other liabilities. Gains and losses due to changes in fair value of the interest rate swap agreements completely offset changes in the fair value of the hedged portion of the underlying debt. Therefore, no gain or loss has been recognized due to hedge ineffectiveness. Offsetting changes in fair value of both the interest rate swaps and the hedged portion of the underlying debt both were recognized in interest expense in the Consolidated Statement of Operations. The Company does not hold or issue any derivative instrument for trading or speculative purposes.

The fair values of the Swap Agreements as of December 31, 2014 were assets of approximately $11 million and are included in other long term assets in the Consolidated Balance Sheet. The fair value of the Swap Agreements excludes accrued interest and takes into consideration current interest rates and current likelihood of the swap counterparties' compliance with its contractual obligations.

Revolving Credit Agreement

In May 2013, the Company entered into an unsecured $500 million revolving credit facility. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. The agreement has a maturity date of June 1, 2018, provided it will mature 90 days prior to the maturity date of the Company's 5.75% Senior Notes due 2017 if such notes are not refinanced (or extended), certain financial conditions are not met, or the Company does not carry $100 million of unrestricted cash. As of December 31, 2014, the Company had $75 million of borrowings outstanding under the agreement with a weighted average interest rate of 1.91%.

The agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt-to-EBITDA ratios and minimum tangible net worth. The Company is required to not exceed a maximum debt-to-EBITDA ratio of 3.0 to 1.0. As of December 31, 2014, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

Mortgage Notes Payable

The Company has a non-recourse mortgage note of $70 million at December 31, 2014 collateralized by its corporate headquarters building. The mortgage note is due January 1, 2021 and bears a 5.14% interest rate. The collateralized property had a net book value of $159 million at December 31, 2014.

Letters of Credit & Surety Bonds

The Company had outstanding letters of credit of $30 million as of December 31, 2014, which were not part of the revolving credit facility. As discussed in Note 3 *Acquisitions and Noncontrolling Interest*, the Company also had letters of credit for $58 million (valued at December 31, 2014 conversion rate), or €48 million, representing its proportional share of the letters of credit issued to support Ribera Salud's outstanding debt which are a part of the revolving credit facility. Collectively, the letters of credit bore interest at 1.73% as of December 31, 2014. The Company had outstanding surety bonds of $142 million as of December 31, 2014.

Aggregate maturities for the Company's debt are as follows ($ in millions):

2015	$ 5
2016	4
2017	429
2018	79
2019	4
Thereafter	357
Total	$878

The fair value of outstanding debt was approximately $901 million and $673 million at December 31, 2014 and 2013, respectively

11. Stockholders' Equity

The Company has 10,000,000 authorized shares of preferred stock at $.001 par value. At December 31, 2014, there were no preferred shares outstanding.

The Company's Board of Directors has authorized a stock repurchase program for up to 8,000,000 shares of the Company's common stock from time to time on the open market or through privately negotiated transactions. No duration has been placed on the repurchase program. The Company has 3,335,448 available shares remaining under the program for repurchases as of December 31, 2014. The Company reserves the right to discontinue the repurchase program at any time. During the year ended December 31, 2014, the Company did not repurchase any shares through this publicly announced program.

As a component of the employee stock compensation plan, employees can use shares of stock which have vested to satisfy minimum statutory tax withholding obligations. As part of this plan, the Company repurchased 626,234 shares at an aggregate cost of $29 million in 2014 and 688,128 shares at an aggregate cost of $19 million in 2013. These shares are included in the Company's treasury stock.

In January 2014, the Company completed the acquisition of 68% of USMM and as a result, issued 4,486,434 shares of Centene common stock to the selling stockholders. Additionally, in July 2014, the Company completed a transaction whereby CHS assigned its contract with the Louisiana Department of Health and Hospitals to Centene's wholly owned subsidiary, LHC. The closing resulted in the issuance of 1,492,738 shares of Centene common stock.

In April 2013, the Company completed the acquisition of AcariaHealth and as a result, issued 3,433,380 shares of Centene common stock to the selling stockholders. Additionally, the Company filed an equity shelf registration statement related to funding the escrow account for the acquisition and sold 685,280 shares of Centene common stock for $15 million.

12. Statutory Capital Requirements and Dividend Restrictions

Various state laws require Centene's regulated subsidiaries to maintain minimum capital levels specified by each state and restrict the amount of dividends that may be paid without prior regulatory approval. At December 31, 2014 and 2013, Centene's subsidiaries, including Kentucky Spirit Health Plan, had aggregate statutory capital and surplus of $1,699 million and $1,280 million, respectively, compared with the required minimum aggregate statutory capital and surplus of $851 million and $686 million, respectively.

13. Income Taxes

The consolidated income tax expense consists of the following for the years ended December 31 ($ in millions):

	2014	2013	2012
Current provision:			
Federal	$ 225	$ 121	$ 47
State and local	13	6	(4)
Total current provision	238	127	43
Deferred provision	(42)	(20)	4
Total provision for income taxes	$ 196	$ 107	$ 47

The reconciliation of the tax provision at the U.S. Federal Statutory Rate to the provision for income taxes for the years ended December 31 is as follows ($ in millions):

	2014	2013	2012
Earnings from continuing operations, before income tax expense	$457	$269	$123
(Earnings) loss attributable to flow through noncontrolling interest	4	(1)	2
Earnings from continuing operations, less noncontrolling interest, before income tax expense	461	268	125
Tax provision at the U.S. federal statutory rate	162	94	44
State income taxes, net of federal income tax benefit	6	3	(2)
Nondeductible compensation	1	12	1
Benefit from reversal of prior years impact of 162(m)(6) regulations	(14)	—	—
ACA Health Insurer Fee	44	—	—
Nondeductible goodwill impairment	—	—	8
Other, net	(3)	(2)	(4)
Income tax expense	$196	$107	$ 47

The tax effects of temporary differences which give rise to deferred tax assets and liabilities are presented below for the years ended December 31 ($ in millions):

	2014	2013
Deferred tax assets:		
Medical claims liability	$ 27	$ 20
Accrued expenses	11	5
Net operating loss carryforward	21	16
Compensation accruals	53	31
Premium and related receivables	35	20
Other	9	16
Deferred tax assets	156	108
Valuation allowance	(12)	(8)
Net deferred tax assets	$144	$100
Deferred tax liabilities:		
Intangible assets	$ 25	$ 18
Prepaid assets	6	6
Depreciation and amortization	26	30
Other	4	2
Deferred tax liabilities	61	56
Net deferred tax assets	$ 83	$ 44

The Company's deferred tax assets include federal and state net operating losses, or NOLs. Accordingly, the total and annual deduction for those NOLs is limited by tax law. The federal NOLs of $5 million were all acquired in business combinations. The Company's federal NOLs expire between the years 2020 and 2033 and the state NOLs expire between the years 2015 and 2035. Valuation allowances are recorded for those NOLs the Company believes are more likely than not to expire unused. During 2014 and 2013, the Company recorded valuation allowance additions in the tax provision of $5 million and $1 million, respectively. The Company recorded valuation allowance reductions of $1 million during the years ended December 31, 2014 and 2013.

As of December 31, 2014 and 2013, the Company maintained reserves for uncertain tax positions of $4 million and $3 million, respectively, that may be challenged by a tax authority. The unrecognized federal tax benefits are related to returns open from 2012 to 2014. The Company files in numerous state jurisdictions with varying statutes of limitation. The unrecognized state tax benefits are related to returns open from 2009 to 2014.

In September 2014, the Internal Revenue Service issued final regulations related to the compensation deduction limitation applicable to certain health insurance issuers. The new regulations provided additional information regarding the definition of a health insurance issuer. Based on the final regulations, the Company no longer believes it is subject to the compensation deduction limitation in 2013 and 2014. As a result of this change in regulation, tax benefits of $14 million related to prior years were recorded during 2014.

14. Stock Incentive Plans

The Company's stock incentive plans allow for the granting of restricted stock or restricted stock unit awards and options to purchase common stock. Both incentive stock options and nonqualified stock options can be awarded under the plans. No option will be exercisable for longer than ten years after the date of grant. The plans have 4,208,558 shares available for future awards. Compensation expense for stock options and restricted stock unit awards is recognized on a straight-line basis over the vesting period, generally three to five years for stock options and 1 to 10 years for restricted stock or restricted stock unit awards. Certain restricted stock unit awards contain performance-based as well as service-based provisions. Certain awards provide for accelerated vesting if there is a change in control as defined in the plans. The total compensation cost that has been charged against income for the stock incentive plans was $48 million, $36 million and $25 million for the years ended December 31, 2014, 2013 and 2012, respectively. The total income tax benefit recognized in the income statement for stock-based compensation arrangements was $17 million, $8 million and $9 million for the years ended December 31, 2014, 2013 and 2012, respectively.

Option activity for the year ended December 31, 2014 is summarized below:

	Shares	Weighted Average Exercise Price	Aggregate Intrinsic Value ($ in millions)	Weighted Average Remaining Contractual Term
Outstanding as of December 31, 2013	1,894,390	$11.71		
Granted	—	—		
Exercised	(619,324)	10.77		
Forfeited	(8,000)	9.23	—	—
Outstanding as of December 31, 2014	1,267,066	$12.18	$50	2.2
Exercisable as of December 31, 2014	1,249,734	$12.08	$50	2.1

The fair value of each option grant is estimated on the date of the grant using the Black-Scholes option-pricing model with the following weighted-average assumptions:

	Year Ended December 31,		
	2014[1]	2013	2012[1]
Expected life (in years)	—	5.1	—
Risk-free interest rate	—	0.8%	—
Expected volatility	—	48.1%	—
Expected dividend yield	—	—	—

[1] No options were awarded in the years ended December 31, 2014 and 2012.

For the year ended December 31, 2013, the Company used a projected expected life for each award granted based on historical experience of employees' exercise behavior. The expected volatility is primarily based on historical volatility levels. The risk-free interest rates are based on the implied yield currently available on U.S. Treasury instruments with a remaining term equal to the expected life.

Other information pertaining to option activity is as follows:

	Year Ended December 31,		
	2014[1]	2013	2012[1]
Weighted-average fair value of options granted	$ —	$ 9.52	$ —
Total intrinsic value of stock options exercised ($ in millions)	$ 17	$ 13	$ 24

[1] No options were awarded in the years ended December 31, 2014 and 2012.

A summary of the Company's non-vested restricted stock and restricted stock unit shares as of December 31, 2014, and changes during the year ended December 31, 2014, is presented below:

	Shares	Weighted Average Grant Date Fair Value
Non-vested balance as of December 31, 2013	4,179,186	$23.95
Granted	2,238,194	46.85
Vested	(1,953,094)	21.62
Forfeited	(114,272)	23.77
Non-vested balance as of December 31, 2014	4,350,014	$36.86

The total fair value of restricted stock and restricted stock units vested during the years ended December 31, 2014, 2013 and 2012, was $82 million, $49 million and $39 million, respectively.

As of December 31, 2014, there was $145 million of total unrecognized compensation cost related to non-vested share-based compensation arrangements granted under the plans; that cost is expected to be recognized over a weighted-average period of 1.9 years.

The Company maintains an employee stock purchase plan and has issued 76,088 shares, 84,168 shares, and 95,226 shares in 2014, 2013 and 2012, respectively.

15. Retirement Plan

Centene has a defined contribution plan which covers substantially all employees who are at least twenty-one years of age. Under the plan, eligible employees may contribute a percentage of their base salary, subject to certain limitations. Centene may elect to match a portion of the employee's contribution. Company expense related to matching contributions to the plan was $12 million, $9 million and $7 million during the years ended December 31, 2014, 2013 and 2012, respectively.

16. Commitments

Centene and its subsidiaries lease office facilities and various equipment under non-cancelable operating leases which may contain escalation provisions. The rental expense related to these leases is recorded on a straight-line basis over the lease term, including rent holidays. Tenant improvement allowances are recorded as a liability and amortized against rent expense over the term of the lease. Rent expense was $46 million, $31 million

and $28 million for the years ended December 31, 2014, 2013 and 2012, respectively. Annual non-cancelable minimum lease payments over the next five years and thereafter are as follows ($ in millions):

2015	$ 45
2016	49
2017	40
2018	30
2019	26
Thereafter	62
	$252

17. Contingencies

On July 5, 2013, the Company's subsidiary, Kentucky Spirit Health Plan, Inc. (Kentucky Spirit), terminated its contract with the Commonwealth of Kentucky (the Commonwealth). Kentucky Spirit believes it had a contractual right to terminate the contract and filed a lawsuit in Franklin Circuit Court seeking a declaration of this right. The Commonwealth has alleged that Kentucky Spirit's exit constitutes a material breach of contract. The Commonwealth seeks to recover substantial damages and to enforce its rights under Kentucky Spirit's $25 million performance bond. On July 3, 2014, the Commonwealth's attorneys asserted in a letter to the Cabinet for Health and Family Services that the Commonwealth's expenditures due to Kentucky Spirit's departure range from $28 million to $40 million plus interest, and that the associated CMS expenditures range from $92 million to $134 million. Kentucky Spirit disputes the Commonwealth's alleged damages, and is pursuing its own litigation claims for damages against the Commonwealth.

On February 6, 2015, the Kentucky Court of Appeals affirmed a Franklin Circuit Court ruling that Kentucky Spirit does not have a contractual right to terminate the contract early. The Court of Appeals also found that the contract's liquidated damages provision "is applicable in the event of a premature termination of the Contract term." Kentucky Spirit intends to seek Kentucky Supreme Court review of the finding that its departure constituted a breach of contract. The Commonwealth may seek review of the ruling that the liquidated damages provision is applicable in the event of a premature termination.

Kentucky Spirit also filed a lawsuit in April 2013, amended in October 2014, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches. On December 9, 2014, the Franklin Circuit Court denied the Commonwealth's motion for partial summary judgment on Kentucky Spirit's damages claims. Discovery is proceeding on those claims.

The resolution of the Kentucky litigation matters may result in a range of possible outcomes. If Kentucky Spirit prevails on its claims, it would be entitled to damages. If the Commonwealth prevails, a liability to the Commonwealth could be recorded. The Company is unable to estimate the ultimate outcome resulting from the Kentucky litigation. As a result, the Company has not recorded any receivable or any liability for potential damages under the contract as of December 31, 2014. While uncertain, the ultimate resolution of the pending litigation could have a material effect on the financial position, cash flow or results of operations of the Company in the period it is resolved or becomes known.

Excluding the Kentucky matters discussed above, the Company is also routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters in the normal course of business is uncertain, the Company does not expect the results of any of these matters individually, or in the aggregate, to have a material effect on its financial position, results of operations or cash flows.

18. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings per common share for the years ended December 31 ($ in millions, except per share data):

	2014	2013	2012
Earnings attributable to Centene Corporation:			
Earnings from continuing operations, net of tax	$ 268	$ 161	$ 89
Discontinued operations, net of tax	3	4	(87)
Net earnings	$ 271	$ 165	$ 2
Shares used in computing per share amounts:			
Weighted average number of common shares outstanding	116,345,764	108,253,090	103,018,732
Common stock equivalents (as determined by applying the treasury stock method)	4,014,448	4,241,256	4,410,018
Weighted average number of common shares and potential dilutive common shares outstanding	120,360,212	112,494,346	107,428,750
Net earnings per common share attributable to Centene Corporation:			
Basic:			
Continuing operations	$ 2.30	$ 1.49	$ 0.86
Discontinued operations	0.03	0.03	(0.84)
Basic earnings per common share	$ 2.33	$ 1.52	$ 0.02
Diluted:			
Continuing operations	$ 2.23	$ 1.43	$ 0.83
Discontinued operations	0.02	0.04	(0.81)
Diluted earnings per common share	$ 2.25	$ 1.47	$ 0.02

The calculation of diluted earnings per common share for 2014, 2013 and 2012 excludes the impact of 207,980 shares, 187,078 shares and 284,850 shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

19. Segment Information

Centene operates in two segments: Managed Care and Specialty Services. The Managed Care segment consists of Centene's health plans including all of the functions needed to operate them. The Specialty Services segment consists of Centene's specialty companies offering auxiliary healthcare services and products.

Factors used in determining the reportable business segments include the nature of operating activities, existence of separate senior management teams, and the type of information presented to the Company's chief operating decision maker to evaluate all results of operations.

In January 2013, the Company reclassified the health plan in Arizona, which is primarily a LTC operation, to the Managed Care segment. As a result, the financial results of the Arizona health plan have been reclassified from the Specialty Services segment to the Managed Care segment for all periods presented.

Segment information as of and for the year ended December 31, 2014, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$13,886	$1,781	$ —	$15,667
Premium and service revenues from internal customers	60	3,019	(3,079)	—
Total premium and service revenues	13,946	4,800	(3,079)	15,667
Earnings from operations	353	111	—	464
Total assets	4,620	1,118	—	5,738

Segment information as of and for the year ended December 31, 2013, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$9,741	$ 785	$ —	$10,526
Premium and service revenues from internal customers	41	2,147	(2,188)	—
Total premium and service revenues	9,782	2,932	(2,188)	10,526
Earnings from operations	198	79	—	277
Total assets	2,817	596	—	3,413

Segment information as of and for the year ended December 31, 2012, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$7,125	$ 557	$ —	$7,682
Premium and service revenues from internal customers	87	1,550	(1,637)	—
Total premium and service revenues	7,212	2,107	(1,637)	7,682
Earnings from operations	63	45	—	108
Total assets	2,164	371	—	2,535

20. Quarterly Selected Financial Information

(In millions, except share data)
(Unaudited)

	For the Quarter Ended			
	March 31, 2014	June 30, 2014	September 30, 2014	December 31, 2014
Total revenues	$ 3,460	$ 4,023	$ 4,352	$ 4,725
Amounts attributable to Centene Corporation common shareholders:				
Earnings from continuing operations, net of income tax expense	$ 34	$ 47	$ 81	$ 106
Discontinued operations, net of income tax expense (benefit)	(1)	2	1	1
Net earnings	$ 33	$ 49	$ 82	$ 107
Net earnings per common share attributable to Centene Corporation:				
Basic:				
Continuing operations	$ 0.30	$ 0.41	$ 0.69	$ 0.90
Discontinued operations	(0.01)	0.01	0.01	0.01
Basic earnings per common share	$ 0.29	$ 0.42	$ 0.70	$ 0.91
Diluted:				
Continuing operations	$ 0.29	$ 0.39	$ 0.67	$ 0.87
Discontinued operations	(0.01)	0.02	0.01	0.01
Diluted earnings per common share	$ 0.28	$ 0.41	$ 0.68	$ 0.88

	For the Quarter Ended			
	March 31, 2013	June 30, 2013	September 30, 2013	December 31, 2013
Total revenues	$ 2,525	$ 2,611	$ 2,795	$ 2,932
Amounts attributable to Centene Corporation common shareholders:				
Earnings from continuing operations, net of income tax expense	$ 23	$ 41	$ 50	$ 48
Discontinued operations, net of income tax expense (benefit)	—	(1)	(1)	5
Net earnings	$ 23	$ 40	$ 49	$ 53
Net earnings (loss) per common share attributable to Centene Corporation:				
Basic:				
Continuing operations	$ 0.22	$ 0.38	$ 0.46	$ 0.43
Discontinued operations	—	(0.01)	(0.01)	0.05
Basic earnings per common share	$ 0.22	$ 0.37	$ 0.45	$ 0.48
Diluted:				
Continuing operations	$ 0.21	$ 0.36	$ 0.44	$ 0.42
Discontinued operations	—	(0.01)	(0.01)	0.04
Diluted earnings per common share	$ 0.21	$ 0.35	$ 0.43	$ 0.46

21. Condensed Financial Information of Registrant

Centene Corporation (Parent Company Only)
Condensed Balance Sheets
(In millions, except share data)

	December 31, 2014	December 31, 2013
ASSETS		
Current assets:		
Cash and cash equivalents	$ 3	$ 3
Short term investments, at fair value (amortized cost $8 and $6, respectively)	8	6
Other current assets	378	125
Total current assets	389	134
Long term investments, at fair value (amortized cost $10 and $8, respectively)	10	8
Investment in subsidiaries	2,296	1,667
Other long term assets	38	32
Total assets	$ 2,733	$ 1,841
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities	$ 24	$ 5
Long term debt	815	591
Other long term liabilities	3	2
Total liabilities	842	598
Redeemable noncontrolling interest	148	—
Stockholders' equity:		
Common stock, $.001 par value; authorized 200,000,000 shares; 124,274,864 issued and 118,433,416 outstanding at December 31, 2014, and 117,346,430 issued and 110,638,478 outstanding at December 31, 2013	—	—
Additional paid-in capital	840	594
Accumulated other comprehensive loss	(1)	(3)
Retained earnings	1,003	732
Treasury stock, at cost (5,841,448 and 6,707,952 shares, respectively)	(98)	(89)
Total Centene stockholders' equity	1,744	1,234
Noncontrolling interest	(1)	9
Total stockholders' equity	1,743	1,243
Total liabilities and stockholders' equity	$ 2,733	$ 1,841

See notes to condensed financial information of registrant.

Centene Corporation (Parent Company Only)
Condensed Statements of Operations
(In millions, except share data)

	Year Ended December 31,		
	2014	2013	2012
Expenses:			
General and administrative expenses	$ 3	$ 4	$ 4
Other income (expense):			
Investment and other income	1	1	20
Interest expense	(30)	(23)	(16)
Earnings (loss) before income taxes	(32)	(26)	—
Income tax benefit	(8)	(15)	(10)
Net earnings (loss) before equity in subsidiaries	(24)	(11)	10
Equity in earnings from subsidiaries	285	173	66
Net earnings	261	162	76
(Earnings) loss attributable to noncontrolling interests	7	(1)	13
Net earnings attributable to Centene	268	161	89
Net earnings per share from continuing operations:			
Basic earnings per common share	$ 2.30	$ 1.49	$ 0.86
Diluted earnings per common share	$ 2.23	$ 1.43	$ 0.83
Weighted average number of shares outstanding:			
Basic	116,345,764	108,253,090	103,018,732
Diluted	120,360,212	112,494,346	107,428,750

See notes to condensed financial information of registrant.

Centene Corporation (Parent Company Only)
Condensed Statements of Cash Flows
(In millions)

	Year Ended December 31,		
	2014	2013	2012
Cash flows from operating activities:			
Cash provided by operating activities	$ 317	$ 302	$ 328
Cash flows from investing activities:			
Net dividends from and capital contributions to subsidiaries	(384)	(417)	(540)
Purchase of investments	(32)	(12)	(7)
Sales and maturities of investments	14	10	30
Acquisitions	(137)	(67)	—
Net cash used in investing activities	(539)	(486)	(517)
Cash flows from financing activities:			
Proceeds from borrowings	1,875	180	400
Payment of long term debt	(1,650)	(30)	(215)
Proceeds from exercise of stock options	8	9	16
Proceeds from stock offering	—	15	—
Common stock repurchases	(29)	(20)	(13)
Debt issue costs	(7)	(3)	(4)
Contributions from noncontrolling interest	6	8	1
Purchase of noncontrolling interest	—	—	(14)
Excess tax benefits from stock compensation	19	6	11
Net cash provided by financing activities	222	165	182
Net increase (decrease) in cash and cash equivalents	—	(19)	(7)
Cash and cash equivalents, beginning of period	3	22	29
Cash and cash equivalents, end of period	$ 3	$ 3	$ 22

See notes to condensed financial information of registrant.

Notes to Condensed Financial Information of Registrant

Note A – Basis of Presentation and Significant Accounting Policies

The parent company only financial statements should be read in conjunction with Centene Corporation's audited consolidated financial statements and the notes to consolidated financial statements included in this Form 10-K.

The parent company's investment in subsidiaries is stated at cost plus equity in undistributed earnings of the subsidiaries. The parent company's share of net income of its unconsolidated subsidiaries is included in income using the equity method of accounting. Certain unrestricted subsidiaries receive monthly management fees from our restricted subsidiaries. The management and service fees received by our unrestricted subsidiaries are associated with all of the functions required to manage the restricted subsidiaries including but not limited to salaries and wages for all personnel, rent, utilities, medical management, provider contracting, compliance, member services, claims processing, information technology, cash management, finance and accounting, and other services. The management fees are based on a percentage of the restricted subsidiaries revenue.

Due to our centralized cash management function, all cash flows generated by our unrestricted subsidiaries, including management fees, are transferred to the parent company, primarily to repay borrowings on the parent company's revolving credit facility. The parent company may also utilize the cash flow to make acquisitions, fund capital contributions to subsidiaries and fund its operations. During the years ended December 31, 2014, 2013 and 2012, cash flows received by the parent from unrestricted subsidiaries was $341 million, $313 million, and $318 million and was included in cash flows from operating activities.

Certain amounts presented in the parent company only financial statements are eliminated in the consolidated financial statements of Centene Corporation.

Note B – Dividends

During 2014, 2013 and 2012, the Registrant received dividends from its subsidiaries totaling $54 million, $21 million and $29 million, respectively.

Note C – Other Current Assets

The parent company's other current assets include $359 million and $113 million of federal and state income tax receivables as of December 31, 2014 and 2013, respectively, primarily due to tax sharing agreements with its subsidiaries.

22. Subsequent Events

In January 2015, the Company issued an additional $200 million of 4.75% Senior Notes ($200 million Add-on Notes) at par. The $200 million Add-on Notes were offered as additional debt securities under an indenture dated as of April 29, 2014, pursuant to which the Company previously issued $300 million aggregate principal amount of 4.75% Senior Notes due 2022. In connection with the January 2015 issuance, the Company entered into interest rate swap agreements for a notional amount of $200 million at a floating rate of interest based on the three month LIBOR plus 2.88%. Gains and losses due to changes in the fair value of the interest rate swap will completely offset changes in the fair value of the hedged portion of the underlying debt and will be recorded as an adjustment to the $200 million Add-on Notes.

In January 2015, the Company sold 25% of our ownership in Celtic Insurance Company. No gain or loss was recognized on the sale of the ownership interest. Celtic Insurance Company is included in the Specialty Services segment. Under the terms of the agreement, the Company entered into a put agreement with the noncontrolling interest holder to purchase the noncontrolling interest at a later date.

Item 9. ***Changes in and Disagreements With Accountants on Accounting and Financial Disclosure***

None.

Item 9A. ***Controls and Procedures.***

Evaluation of Disclosure Controls and Procedures — Our management, with the participation of our Chief Executive Officer and Chief Financial Officer, evaluated the effectiveness of our disclosure controls and procedures as of December 31, 2014. The term "disclosure controls and procedures," as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act, means controls and other procedures of a company that are designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is accumulated and communicated to the company's management, including its principal executive and principal financial officers, as appropriate to allow timely decisions regarding required disclosure. Management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving their objectives and management necessarily applies its judgment in evaluating the cost-benefit relationship of possible controls and procedures. Based on the evaluation of our disclosure controls and procedures as of December 31, 2014, our Chief Executive Officer and Chief Financial Officer concluded that, as of such date, our disclosure controls and procedures were effective at the reasonable assurance level.

Management's Report on Internal Control Over Financial Reporting — Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Exchange Act Rules 13a-15(f) and 15d-15(f). Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control — Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on our evaluation under the framework in *Internal Control — Integrated Framework (2013)*, our management concluded that our internal control over financial reporting was effective at the reasonable assurance level as of December 31, 2014. Our management's assessment of the effectiveness of our internal control over financial reporting as of December 31, 2014 has been audited by KPMG LLP, an independent registered public accounting firm, as stated in their report which is included herein.

Changes in Internal Control Over Financial Reporting — No change in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) occurred during the year ended December 31, 2014 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
Centene Corporation:

We have audited Centene Corporation's internal control over financial reporting 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 (COSO). Centene Corporation'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, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included 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 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 its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that 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, Centene Corporation maintained, in all material respects, effective internal control over financial reporting 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 (COSO).

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Centene Corporation and subsidiaries as of December 31, 2014 and 2013, and the related consolidated statements of operations, comprehensive earnings, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2014, and our report dated February 23, 2015 expressed an unqualified opinion on those consolidated financial statements.

KPMG LLP

St. Louis, Missouri
February 23, 2015

Item 9B. ***Other Information***

None.

PART III

Item 10. ***Directors, Executive Officers and Corporate Governance***

(a) Directors of the Registrant

Information concerning our directors will appear in our Proxy Statement for our 2015 annual meeting of stockholders under "Proposal One: Election of Directors". This portion of the Proxy Statement is incorporated herein by reference.

(b) Executive Officers of the Registrant

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant."

Information concerning our executive officers' compliance with Section 16(a) of the Exchange Act will appear in our Proxy Statement for our 2015 annual meeting of stockholders under "Section 16(a) Beneficial Ownership Reporting Compliance." Information concerning our audit committee financial expert and identification of our audit committee will appear in our Proxy Statement for our 2015 annual meeting of stockholders under "Board of Directors Committees." Information concerning our code of ethics will appear in our Proxy Statement for our 2015 annual meeting of stockholders under "Corporate Governance and Risk Management." These portions of our Proxy Statement are incorporated herein by reference.

(c) Corporate Governance

Information concerning certain corporate governance matters will appear in our Proxy Statement for our 2015 annual meeting of stockholders under "Corporate Governance and Risk Management." These portions of our Proxy Statement are incorporated herein by reference.

Item 11. ***Executive Compensation***

Information concerning executive compensation will appear in our Proxy Statement for our 2015 Annual Meeting of Stockholders under "Information About Executive Compensation." Information concerning Compensation Committee interlocks and insider participation will appear in the Proxy Statement for our 2015 Annual Meeting of Stockholders under "Compensation Committee Interlocks and Insider Participation." These portions of the Proxy Statement are incorporated herein by reference.

Item 12. ***Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters***

Information concerning the security ownership of certain beneficial owners and management and our equity compensation plans will appear in our Proxy Statement for our 2015 annual meeting of stockholders under "Information About Stock Ownership" and "Equity Compensation Plan Information." These portions of the Proxy Statement are incorporated herein by reference.

Item 13. ***Certain Relationships and Related Transactions, and Director Independence***

Information concerning director independence, certain relationships and related transactions will appear in our Proxy Statement for our 2015 annual meeting of stockholders under "Corporate Governance and Risk Management" and "Related Party Transactions." These portions of our Proxy Statement are incorporated herein by reference.

Item 14. ***Principal Accountant Fees and Services***

Information concerning principal accountant fees and services will appear in our Proxy Statement for our 2015 annual meeting of stockholders under "Proposal Two: Ratification of Appointment of Independent Registered Public Accounting Firm." This portion of our Proxy Statement is incorporated herein by reference.

PART IV

Item 15. ***Exhibits and Financial Statement Schedules***

(a) **Financial Statements and Schedules**

The following documents are filed under Item 8 of this report:

1. Financial Statements:

   Report of Independent Registered Public Accounting Firm
   Consolidated Balance Sheets as of December 31, 2014 and 2013
   Consolidated Statements of Operations for the years ended December 31, 2014, 2013 and 2012
   Consolidated Statements of Comprehensive Earnings for the years ended December 31, 2014, 2013 and 2012
   Consolidated Statements of Stockholders' Equity for the years ended December 31, 2014, 2013 and 2012
   Consolidated Statements of Cash Flows for the years ended December 31, 2014, 2013 and 2012
   Notes to Consolidated Financial Statements

2. Financial Statement Schedules:

   None.

3. The exhibits listed in the accompanying Exhibit Index are filed or incorporated by reference as part of this filing.

EXHIBIT INDEX

EXHIBIT NUMBER	DESCRIPTION	FILED WITH THIS FORM 10-K	INCORPORATED BY REFERENCE [1]		
			FORM	FILING DATE WITH SEC	EXHIBIT NUMBER
3.1	Certificate of Incorporation of Centene Corporation		S-1	October 9, 2001	3.2
3.1a	Certificate of Amendment to Certificate of Incorporation of Centene Corporation, dated November 8, 2001		S-1/A	November 13, 2001	3.2a
3.1b	Certificate of Amendment to Certificate of Incorporation of Centene Corporation as filed with the Secretary of State of the State of Delaware		10-Q	July 26, 2004	3.1b
3.1c	Certificate of Amendment to Certificate of Incorporation of Centene Corporation as filed with the Secretary of State of the State of Delaware		S-3ASR	May 16, 2014	3.1c
3.2	By-laws of Centene Corporation, as amended effective as of February 2, 2015	X			
4.1	Indenture, dated May 27, 2011, among the Company and The Bank of New York Mellon Trust Company, N.A., relating to the Company's 5.75% Senior Notes due 2017 (including Form of Global Note as Exhibit A thereto)		8-K	May 27, 2011	4.1
4.2	Indenture, dated April 29, 2014, among the Company and The Bank of New York Mellon Trust Company, N.A., relating to the Company's 4.75% Senior Notes due 2022 (including Form of Global Note as Exhibit A thereto).		8-K	April 29, 2014	4.1
10.1*	1998 Stock Plan of Centene Corporation, shares which are registered on Form S-8 – File number 333-83190		S-1	October 9, 2001	10.10
10.2*	1999 Stock Plan of Centene Corporation, shares which are registered on Form S-8 – File Number 333-83190		S-1	October 9, 2001	10.11
10.3*	2000 Stock Plan of Centene Corporation, shares which are registered on Form S-8 – File Number 333-83190		S-1	October 9, 2001	10.12
10.4*	2002 Employee Stock Purchase Plan of Centene Corporation, shares which are registered on Form S-8 – File Number 333-90976		10-Q	April 29, 2002	10.5
10.4a*	First Amendment to the 2002 Employee Stock Purchase Plan		10-K	February 24, 2005	10.9a

EXHIBIT NUMBER	DESCRIPTION	FILED WITH THIS FORM 10-K	INCORPORATED BY REFERENCE [1]		
			FORM	FILING DATE WITH SEC	EXHIBIT NUMBER
10.4b*	Second Amendment to the 2002 Employee Stock Purchase Plan		10-K	February 24, 2006	10.10b
10.5*	Centene Corporation Amended and Restated 2003 Stock Incentive Plan, shares which are registered on Form S-8 – File Number 333-108467		8-K	April 30, 2010	10.1
10.6*	2012 Stock Plan of Centene Corporation, shares which are registered on Form S-8 – File Number 333-180976		DEF 14A	March 9, 2012	4
10.6a*	Amended and Restated 2012 Stock Incentive Plan, shares which are registered on Form S-8 – File Number 333-197737		8-K	April 22, 2014	10.1
10.7*	Centene Corporation Non-Employee Directors Deferred Stock Compensation Plan		10-Q	October 25, 2004	10.1
10.7a*	First Amendment to the Non-Employee Directors Deferred Stock Compensation Plan		10-K	February 24, 2006	10.12a
10.8*	Centene Corporation Employee Deferred Compensation Plan		10-K	February 22, 2010	10.10
10.09*	Centene Corporation 2007 Long-Term Incentive Plan		8-K	April 26, 2007	10.2
10.10*	Centene Corporation Short-Term Executive Compensation Plan		10-K	February 22, 2011	10.12
10.11*	Executive Employment Agreement between Centene Corporation and Michael F. Neidorff, dated November 8, 2004		8-K	November 9, 2004	10.1
10.11a*	Amendment No. 1 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	October 28, 2008	10.2
10.11b*	Amendment No. 2 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	April 28, 2009	10.2
10.11c*	Amendment No. 3 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	October 23, 2012	10.2
10.11d*	Amendment No. 4 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		8-K	May 16, 2013	10.1

EXHIBIT NUMBER	DESCRIPTION	FILED WITH THIS FORM 10-K	INCORPORATED BY REFERENCE [1]		
			FORM	FILING DATE WITH SEC	EXHIBIT NUMBER
10.12*	Form of Executive Severance and Change in Control Agreement		10-Q	October 28, 2008	10.3
10.12a*	Amendment No. 1 to Form of Executive Severance and Change in Control Agreement		10-Q	October 23, 2012	10.3
10.13*	Form of Restricted Stock Unit Agreement		10-Q	October 28, 2008	10.4
10.14*	Form of Non-statutory Stock Option Agreement (Non-Employees)		8-K	July 28, 2005	10.3
10.15*	Form of Non-statutory Stock Option Agreement (Employees)		10-Q	October 28, 2008	10.5
10.16*	Form of Non-statutory Stock Option Agreement (Directors)		10-K	February 23, 2009	10.18
10.17*	Form of Incentive Stock Option Agreement		10-Q	October 28, 2008	10.6
10.18*	Form of Stock Appreciation Right Agreement		8-K	July 28, 2005	10.6
10.19*	Form of Restricted Stock Agreement		10-Q	October 25, 2005	10.8
10.20*	Form of Performance Based Restricted Stock Unit Agreement #1		10-Q	October 28, 2008	10.7
10.21*	Form of Performance Based Restricted Stock Unit Agreement #2		10-K	February 23, 2009	10.23
10.22*	Form of Long-Term Incentive Plan Agreement		8-K	February 7, 2008	10.1
10.23	Credit Agreement dated as of May 21, 2013 among Centene Corporation, the various financial institutions party hereto and Barclays Bank PLC		8-K	May 22, 2013	10.1
10.23a	Amended No. 1 to Amended and Restated Credit Agreement dated as of July 15, 2014 among Centene Corporation, the various financial institutions party hereto and Barclays Bank PLC.		10-Q	October 28, 2014	10.3
12.1	Computation of ratio of earnings to fixed charges	X			
21	List of subsidiaries	X			
23	Consent of Independent Registered Public Accounting Firm incorporated by reference in each prospectus constituting part of the Registration Statements on Form S-3 (File Numbers 333-197213, 333-196037, 333-193205, 333-187741, and 333-187652) and on Form S-8 (File Numbers 333-197737, 333-180976, 333-108467, 333-90976, and 333-83190)	X			

EXHIBIT NUMBER	DESCRIPTION	FILED WITH THIS FORM 10-K	INCORPORATED BY REFERENCE [1]		
			FORM	FILING DATE WITH SEC	EXHIBIT NUMBER
31.1	Certification Pursuant to Rule 13a-14(a) and 15d-14(a) of the Exchange Act, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 (Chief Executive Officer)	X			
31.2	Certification Pursuant to Rule 13a-14(a) and 15d-14(a) of the Exchange Act, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 (Chief Financial Officer)	X			
32.1	Certification Pursuant to 18 U.S.C. Section 1350 (Chief Executive Officer)	X			
32.2	Certification Pursuant to 18 U.S.C. Section 1350 (Chief Financial Officer)	X			
101.1	XBRL Taxonomy Instance Document.	X			
101.2	XBRL Taxonomy Extension Schema Document.	X			
101.3	XBRL Taxonomy Extension Calculation Linkbase Document.	X			
101.4	XBRL Taxonomy Extension Definition Linkbase Document.	X			
101.5	XBRL Taxonomy Extension Label Linkbase Document.	X			
101.6	XBRL Taxonomy Extension Presentation Linkbase Document.	X			

[1] SEC File No. 001-31826 (for filings prior to October 14, 2003, the Registrant's SEC File No. was 000-33395).

* Indicates a management contract or compensatory plan or arrangement.

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, as of February 23, 2015.

CENTENE CORPORATION

By: /s/ MICHAEL F. NEIDORFF
Michael F. Neidorff
Chairman and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities as indicated, as of February 23, 2015.

Signature	Title
/s/ MICHAEL F. NEIDORFF **Michael F. Neidorff**	Chairman and Chief Executive Officer (principal executive officer)
/s/ WILLIAM N. SCHEFFEL **William N. Scheffel**	Executive Vice President and Chief Financial Officer (principal financial officer)
/s/ JEFFREY A. SCHWANEKE **Jeffrey A. Schwaneke**	Senior Vice President, Corporate Controller and Chief Accounting Officer (principal accounting officer)
/s/ ORLANDO AYALA **Orlando Ayala**	Director
/s/ ROBERT K. DITMORE **Robert K. Ditmore**	Director
/s/ FRED H. EPPINGER **Fred H. Eppinger**	Director
/s/ RICHARD A. GEPHARDT **Richard A. Gephardt**	Director
/s/ PAMELA A. JOSEPH **Pamela A. Joseph**	Director
/s/ JOHN R. ROBERTS **John R. Roberts**	Director
/s/ DAVID L. STEWARD **David L. Steward**	Director
/s/ TOMMY G. THOMPSON **Tommy G. Thompson**	Director

EXHIBIT 31.1

CERTIFICATION

I, Michael F. Neidorff, certify that:

1. I have reviewed this Annual Report on Form 10-K of Centene Corporation;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
    a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
    b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, 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;
    c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
    d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
    a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
    b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: February 23, 2015

/s/ MICHAEL F. NEIDORFF

Chairman, President and Chief Executive Officer
(principal executive officer)

EXHIBIT 31.2

CERTIFICATION

I, William N. Scheffel, certify that:

1. I have reviewed this Annual Report on Form 10-K of Centene Corporation;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
    a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
    b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, 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;
    c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
    d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting;
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
    a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
    b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: February 23, 2015

/s/ WILLIAM N. SCHEFFEL

Executive Vice President and Chief Financial Officer
(principal financial officer)

EXHIBIT 32.1

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report on Form 10-K of Centene Corporation (the Company) for the period ended December 31, 2014, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, Michael F. Neidorff, Chairman, President and Chief Executive Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: February 23, 2015

/s/ MICHAEL F. NEIDORFF

Chairman, President and Chief Executive Officer
(principal executive officer)

EXHIBIT 32.2

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report on Form 10-K of Centene Corporation (the Company) for the period ended December 31, 2014, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, William N. Scheffel, Executive Vice President and Chief Financial Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: February 23, 2015

/s/ WILLIAM N. SCHEFFEL

Executive Vice President and Chief Financial Officer
(principal financial officer)

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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2013

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: 001-31826

Centene Corporation

(Exact name of registrant as specified in its charter)

Delaware	**42-1406317**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification Number)**
7700 Forsyth Boulevard St. Louis, Missouri	**63105**
(Address of principal executive offices)	**(Zip Code)**

Registrant's telephone number, including area code: (314) 725-4477

Securities registered pursuant to Section 12(b) of the Act:

Common Stock, $0.001 Par Value	**New York Stock Exchange**
Title of Each Class	**Name of Each Exchange on Which Registered**

Securities registered pursuant to Section 12(g) of the Act:

None

(Title of Each Class)

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 or 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 Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was require 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 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 "small reporting company" in Rule 12b-2 of the Exchange Act. 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 Act). Yes ☐ No ☒

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 28, 2013, was $2.9 billion.

As of February 14, 2014, the registrant had 57,615,380 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2014 annual meeting of stockholders are incorporated by reference in Part III, Items 10, 11, 12, 13 and 14.

CENTENE CORPORATION
ANNUAL REPORT ON FORM 10-K
TABLE OF CONTENTS

		PAGE
	Part I	
Item 1.	Business	1
Item 1A.	Risk Factors	19
Item 1B.	Unresolved Staff Comments	28
Item 2.	Properties	28
Item 3.	Legal Proceedings	28
Item 4.	Mine Safety Disclosures	29
	Part II	
Item 5.	Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities	30
Item 6.	Selected Financial Data	32
Item 7.	Management's Discussion and Analysis of Financial Condition and Results of Operations	34
Item 7A.	Quantitative and Qualitative Disclosures About Market Risk	54
Item 8.	Financial Statements and Supplementary Data	55
Item 9.	Changes in and Disagreements with Accountants on Accounting and Financial Disclosure	90
Item 9A.	Controls and Procedures	90
Item 9B.	Other Information	92
	Part III	
Item 10.	Directors, Executive Officers and Corporate Governance	92
Item 11.	Executive Compensation	92
Item 12.	Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters	92
Item 13.	Certain Relationships and Related Transactions, and Director Independence	92
Item 14.	Principal Accountant Fees and Services	92
	Part IV	
Item 15.	Exhibits and Financial Statement Schedules	93
Signatures		99
Certifications		100

CAUTIONARY STATEMENT ON FORWARD-LOOKING STATEMENTS

All statements, other than statements of current or historical fact, contained in this filing are forward-looking statements. We have attempted to identify these statements by terminology including "believe," "anticipate," "plan," "expect," "estimate," "intend," "seek," "target," "goal," "may," "will," "should," "can," "continue" and other similar words or expressions in connection with, among other things, any discussion of future operating or financial performance. In particular, these statements include statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions, investments and the adequacy of our available cash resources. These statements may be found in the various sections of this filing, including those entitled "Management's Discussion and Analysis of Financial Condition and Results of Operations," Part I, Item 1A. "Risk Factors," and Part I, Item 3 "Legal Proceedings." Readers are cautioned that matters subject to forward-looking statements involve known and unknown risks and uncertainties, including economic, regulatory, competitive and other factors that may cause our or our industry's actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

All forward-looking statements included in this filing are based on information available to us on the date of this filing and we undertake no obligation to update or revise the forward-looking statements included in this filing, whether as a result of new information, future events or otherwise, after the date of this filing. Actual results may differ from projections or estimates due to a variety of important factors, including:

- our ability to accurately predict and effectively manage health benefits and other operating expenses;
- competition;
- membership and revenue projections;
- timing of regulatory contract approval;
- changes in healthcare practices;
- changes in federal or state laws or regulations, including the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act and any regulations enacted thereunder;
- changes in expected contract start dates;
- changes in expected closing dates and accretion for acquisitions;
- inflation;
- provider and state contract changes;
- new technologies;
- advances in medicine;
- reduction in provider payments by governmental payors;
- major epidemics;
- disasters and numerous other factors affecting the delivery and cost of healthcare;
- the expiration, cancellation or suspension of our Medicare or Medicaid managed care contracts by federal or state governments;
- the outcome of pending legal proceedings;
- availability of debt and equity financing, on terms that are favorable to us; and
- general economic and market conditions.

Item 1A "Risk Factors" of Part I of this filing contains a further discussion of these and other important factors that could cause actual results to differ from expectations. We disclaim any current intention or obligation to update or revise any forward-looking statements, whether as a result of new information, future events or otherwise. Due to these important factors and risks, we cannot give assurances with respect to our future premium levels or our ability to control our future medical costs.

Other Information

The discussion in Part 2, Item 7. *"Management's Discussion and Analysis of Financial Condition and Results of Operations"* under the heading "Results of Operations" contains financial information for new and existing businesses. Existing businesses are primarily state markets, significant geographic expansion in an existing state or product that we have managed for four complete quarters. New businesses are primarily new state markets, significant geographic expansion in an existing state or product that conversely, we have not managed for four complete quarters.

PART I

ITEM 1. ***Business.***

OVERVIEW

We are a diversified, multi-line healthcare enterprise that provides programs and services to government sponsored healthcare programs, focusing on under-insured and uninsured individuals. We provide member-focused services through locally based staff by assisting in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions. We also provide education and outreach programs to inform and assist members in accessing quality, appropriate healthcare services. We believe our local approach, including member and provider services, enables us to provide accessible, quality, culturally-sensitive healthcare coverage to our communities. Our health management, educational and other initiatives are designed to help members best utilize the healthcare system to ensure they receive appropriate, medically necessary services and effective management of routine, severe and chronic health problems, resulting in better health outcomes. We combine our decentralized local approach for care with a centralized infrastructure of support functions such as finance, information systems and claims processing.

We operate in two segments: Managed Care and Specialty Services. Our Managed Care segment provides health plan coverage to individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program (CHIP), Long Term Care (LTC), Foster Care, dual-eligible individuals in Medicare Special Needs Plans and the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program, or collectively ABD. Beginning in 2014, our Managed Care segment also provides health plan coverage to individuals covered through federally-facilitated and state-based Marketplaces. Our Specialty Services segment consists of our specialty companies offering diversified healthcare services and products to state programs, correctional facilities, healthcare organizations, employer groups and other commercial organizations, as well as to our own subsidiaries. As of December 31, 2013, Medicaid accounted for 75% of our at-risk membership, while CHIP (also including Foster Care) and ABD (also including Medicare) accounted for 10% and 11%, respectively. Hybrid programs, LTC and correctional services represent the remaining 4% at-risk membership.

Our subsidiary, Kentucky Spirit Health Plan (KSHP), ceased serving Medicaid members in Kentucky as of July 6, 2013. Accordingly, the results of operations for KSHP are classified as discontinued operations for all periods presented in our consolidated financial statements. The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise identified.

Our at-risk managed care membership totaled 2.7 million as of December 31, 2013. For the year ended December 31, 2013, our premium and service revenues and net earnings from continuing operations attributable to Centene were $10.5 billion and $161.2 million, respectively, and our total cash flow from operations was $382.5 million.

Our initial health plan commenced operations in Wisconsin in 1984. We were organized in Wisconsin in 1993 as a holding company for our initial health plan and reincorporated in Delaware in 2001. Our corporate office is located at 7700 Forsyth Boulevard, St. Louis, Missouri 63105, and our telephone number is (314) 725-4477. Our stock is publicly traded on the New York Stock Exchange under the ticker symbol "CNC."

INDUSTRY

We provide our services primarily through Medicaid, CHIP, LTC, Foster Care, ABD, Medicare and other state and federal programs for the uninsured. The federal Centers for Medicare and Medicaid Services, or CMS, estimated the total Medicaid and CHIP market was approximately $408 billion in 2011, and estimate the market will grow to $839 billion by 2022. According to the most recent information provided by the Kaiser Commission on Medicaid and the Uninsured, Medicaid spending increased by 3.8% in fiscal 2013 and states appropriated an increase of 10.3% for Medicaid in fiscal 2014 budgets.

Established in 1965, Medicaid is the largest publicly funded program in the United States, and provides health insurance to low-income families and individuals with disabilities. Authorized by Title XIX of the Social Security Act, Medicaid is an entitlement program funded jointly by the federal and state governments and administered by the states. The majority of funding is provided at the federal level. Each state establishes its own eligibility standards, benefit packages, payment rates and program administration within federal standards. As a result, there are 56 Medicaid programs—one for each U.S. state, each U.S. territory and the District of Columbia. Eligibility is based on a combination of household income and assets, often determined by an income level relative to the federal poverty level. Historically, children have represented the largest eligibility group. Many states have selected Medicaid managed care as a means of delivering quality healthcare and controlling costs. We refer to these states as mandated managed care states.

Established in 1972, and authorized by Title XVI of the Social Security Act, ABD covers low-income persons with chronic physical disabilities or behavioral health impairments. ABD beneficiaries represent a growing portion of all Medicaid recipients. In addition, ABD recipients typically utilize more services because of their critical health issues.

The Balanced Budget Act of 1997 created CHIP to help states expand coverage primarily to children whose families earned too much to qualify for Medicaid, yet not enough to afford private health insurance. Some states include the parents of these children in their CHIP programs. Costs related to the largest eligibility group, children, are primarily composed of pediatrics and family care. These costs tend to be more predictable than those associated with other healthcare issues which predominantly affect the adult population.

A portion of Medicaid beneficiaries are dual-eligible, low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare. According to the Kaiser Commission on Medicaid and the Uninsured, there were approximately 9 million dual-eligible enrollees in 2013. These dual-eligible members may receive assistance from Medicaid for Medicaid benefits, such as nursing home care and/or assistance with Medicare premiums and cost sharing. Dual-eligibles also use more services due to their tendency to have more chronic health issues. We serve dual-eligibles through our ABD and LTC programs and through Medicare Special Needs Plans.

While Medicaid programs have directed funds to many individuals who cannot afford or otherwise maintain health insurance coverage, they did not initially address the inefficient and costly manner in which the Medicaid population tends to access healthcare. Medicaid recipients in non-managed care programs typically have not sought preventive care or routine treatment for chronic conditions, such as asthma and diabetes. Rather, they have sought healthcare in hospital emergency rooms, which tends to be more expensive. As a result, many states have found that the costs of providing Medicaid benefits have increased while the medical outcomes for the recipients remained unsatisfactory.

We expect that continued pressure on state Medicaid budgets will cause public policy to recognize the value of managed care as a means of delivering improved health outcomes for Medicaid beneficiaries and effectively controlling costs. A growing number of states have mandated that their Medicaid recipients enroll in managed care plans. Other states are considering moving to a mandated managed care approach. As a result, we believe a significant market opportunity exists for managed care organizations with operations and programs focused on the distinct socio-economic, cultural and healthcare needs of the uninsured population and the Medicaid, CHIP, LTC, Foster Care and ABD populations.

In March 2010, the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act collectively referred to as the Affordable Care Act (ACA), were enacted. While the constitutionality of the ACA was subsequently challenged in a number of legal actions, in June 2012, the Supreme Court upheld the constitutionality of the ACA, with one limited exception relating to the Medicaid expansion provision. The Supreme Court held that states could not be required to expand Medicaid and risk losing all federal money for their existing Medicaid programs. Under the ACA, Medicaid coverage was expanded to all individuals under age 65 with incomes up to 138% of the federal poverty level beginning January 1, 2014, subject to the states' elections. The federal government will pay the entire costs for Medicaid coverage for newly eligible beneficiaries for 3 years, from 2014 through 2016. In 2017, the federal share declines

to 95%; in 2018 it is 94%; in 2019 it is 93%; and it will be 90% in 2020 and subsequent years. States may delay Medicaid expansion after 2014.

Health Insurance Marketplaces are a key component of the ACA and provide an opportunity for individuals and small businesses to obtain health insurance. States have the option of operating their own Marketplace or partnering with the federal government. States choosing neither option will default to a federally-facilitated Marketplace. Premium and cost-sharing subsidies are available to make coverage more affordable and access to Marketplaces is limited to U.S. citizens and legal immigrants. Insurers are required to offer a minimum level of benefits with three levels of coverage that vary based on premiums and out-of-pocket costs. Premium subsidies will be provided to families without access to other coverage and with incomes between 100-400% of the federal poverty level to help them purchase insurance through the Marketplaces. These subsidies are offered on a sliding scale basis. In May 2013, the Congressional Budget Office (CBO) estimated approximately 7 million individuals would enroll through Marketplaces by 2014 with the number increasing to 25 million by 2025. However, recent reports have indicated lower than anticipated enrollment for 2014.

OUR COMPETITIVE STRENGTHS

Our multi-line managed care approach is based on the following key attributes:

- *Strong Historic Operating Performance.* We have increased revenues as we have grown in existing markets, expanded into new markets and broadened our product offerings. We entered the Wisconsin market in 1984 as a single health plan and have grown to serve 20 states with at-risk membership totaling 2.7 million in 2013. For the year ended December 31, 2013, we had premium and service revenues from continuing operations of $10.5 billion, representing a five year Compound Annual Growth Rate, of 26.3% and generated total cash flow from operations of $382.5 million.
- *Innovative Technology and Scalable Systems.* The ability to access data and translate it into meaningful information is essential to operating across a multi-state service area in a cost-effective manner. Our centralized information systems support our core processing functions under a set of integrated databases and are designed to be both replicable and scalable to accommodate organic growth and growth from acquisitions. We continue to enhance our systems in order to leverage the platform we have developed for our existing states for configuration into new states or health plan acquisitions. Our predictive modeling technology enables our medical management operations to proactively case and disease manage specific high risk members. It can recommend medical care opportunities using a mix of company defined algorithms and evidence based medical guidelines. Interventions are determined by the clinical indicators, the ability to improve health outcomes, and the risk profile of members. Our integrated approach helps to assure that consistent sources of claim and member information are provided across all of our health plans. Our membership and claims processing system is capable of expanding to support additional members in an efficient manner.
- *Medicaid Expertise.* For more than 25 years, we have developed a specialized Medicaid expertise that has helped us establish and maintain relationships with members, providers and state governments. We have implemented programs developed to achieve savings for state governments and improve medical outcomes for members by reducing inappropriate emergency room use, inpatient days and high cost interventions, as well as by managing care of chronic illnesses. We work with state agencies in order to maximize the effectiveness of their programs. Our approach is to accomplish this while maintaining adequate levels of provider compensation and protecting our profitability.
- *Diversified Business Lines.* We continue to broaden our service offerings to address areas that we believe have been traditionally under-served by Medicaid managed care organizations. In addition to our Medicaid and Medicaid-related managed care services, our service offerings include behavioral health, care management software, correctional services managed care, Health Insurance Marketplaces, in-home health services, individual health insurance, life and health management, managed vision, telehealth services, pharmacy benefits management and specialty pharmacy. Through the utilization of a multi-

business line approach, we are able to improve the quality of care, improve outcomes, diversify our revenues and help control our medical costs.

- *Localized Approach with Centralized Support Infrastructure.* We take a localized approach to managing our subsidiaries, including provider and member services. This approach enables us to facilitate access by our members to high quality, culturally sensitive healthcare services. Our systems and procedures have been designed to address these community-specific challenges through outreach, education, transportation and other member support activities. For example, our community outreach programs work with our members and their communities to promote health and self-improvement through employment and education on how best to access care. We complement this localized approach with a centralized infrastructure of support functions such as finance, information systems and claims processing, which allows us to minimize general and administrative expenses and to integrate and realize synergies from acquisitions. We believe this combined approach allows us to efficiently integrate new business opportunities in both Medicaid and specialty services while maintaining our local accountability and improved access.

OUR BUSINESS STRATEGY

Our objective is to become the leading multi-line healthcare enterprise focusing on the uninsured and under-insured population through government sponsored healthcare initiatives. We intend to achieve this objective by implementing the following key components of our strategy:

- *Increase Penetration of Existing State Markets.* We seek to continue to increase our Medicaid membership in states in which we currently operate through alliances with key providers, outreach efforts, development and implementation of community-specific products and acquisitions. For example, in 2013, we expanded our health plan in Florida with an expanded Medicaid managed care LTC contract.
- *Diversify Business Lines.* We seek to broaden our business lines into areas that complement our existing business to enable us to grow and diversify our revenue. We are constantly evaluating new opportunities for expansion both domestically and abroad. For instance, in 2013, we began operating through a joint venture subsidiary, Centurion, to provide managed care in correctional facilities and also acquired AcariaHealth, an independent, comprehensive specialty pharmacy company. In 2014, we acquired U.S. Medical Management, a management services organization and provider of in-home health services for high acuity populations. We employ a disciplined acquisition strategy that is based on defined criteria including internal rate of return, accretion to earnings per share, market leadership and compatibility with our information systems. We engage our executives in the relevant operational units or functional areas to ensure consistency between the diligence and integration process.
- *Address Emerging State Needs.* We work to assist the states in which we operate in addressing the operating challenges they face. We seek to assist the states in balancing premium rates, benefit levels, member eligibility, policies and practices, provider compensation and minimizing fraud and abuse. By helping states structure an appropriate level and range of Medicaid, CHIP and specialty services, we seek to ensure that we are able to continue to provide those services on terms that achieve targeted gross margins, provide an acceptable return and grow our business.
- *Develop and Acquire Additional State Markets.* We continue to leverage our experience to identify and develop new markets by seeking both to acquire existing business and to build our own operations. We focus expansion in states where Medicaid recipients are mandated to enroll in managed care organizations because we believe member enrollment levels are more predictable in these states. In addition, we focus on states where managed care programs can help address states' financial needs. For example, in 2013, we began managing care for Medicaid members in California, Kansas and New Hampshire.
- *Leverage Established Infrastructure to Enhance Operating Efficiencies.* We intend to continue to invest in infrastructure to further drive efficiencies in operations and to add functionality to improve the service provided to members and other organizations at a low cost. Information technology, or IT, investments

complement our overall efficiency goals by increasing the automated processing of transactions and growing the base of decision-making analytical tools. Our centralized functions and common systems enable us to add members and markets quickly and economically.

- *Maintain Operational Discipline.* We seek to operate in markets that allow us to meet our internal metrics including membership growth, plan size, market leadership and operating efficiency. We use multiple techniques to monitor and reduce our medical costs, including on-site hospital review by staff nurses and involvement of medical management in significant cases. Our executive dashboard is utilized to quickly identify cost drivers and medical trends. Our management team regularly evaluates the financial impact of proposed changes in provider relationships, contracts, changes in membership and mix of members, potential state rate changes and cost reduction initiatives. We may divest contracts or health plans in markets where the state's Medicaid environment, over a long term basis, does not allow us to meet our targeted performance levels. For example, as a result of lower than anticipated financial performance, in July 2013, we terminated our Kentucky Medicaid managed care contract with the Commonwealth of Kentucky.

We have subsidiaries offering healthcare services in each state we serve. The table below provides summary data for the state markets we currently serve:

State	Local Plan Name	First Year of Operations Under the Company	Counties Served at December 31, 2013	Market Share[1]	At-risk Managed Care Membership at December 31, 2013
Arizona	Bridgeway Health Solutions	2006	6	11.2%	7,100
Arizona	Cenpatico Behavioral Health of Arizona	2005	8	13.3%	(2)
Arkansas	Arkansas Health and Wellness Solutions	2014	—	—%	—
California	California Health and Wellness	2013	19	56.2%	97,200
Florida	Sunshine Health	2009	53	13.3%[3]	222,000
Georgia	Peach State Health Plan	2006	159	27.6%	318,700
Illinois	IlliniCare Health Plan	2011	12	51.3%	22,300
Indiana	Managed Health Services	1995	92	27.3%	195,500
Kansas	Sunflower State Health Plan	2013	105	36.3%	139,900
Louisiana	Louisiana Healthcare Connections	2012	64	17.0%	152,300
Massachusetts	CeltiCare Health Plan	2009	14	5.2%	12,000
Massachusetts	Massachusetts Partnership for Correctional Healthcare	2013	N/A	N/A	10,600
Minnesota	Centurion of Minnesota	2014	—	—%	—
Mississippi	Magnolia Health Plan	2011	82	54.7%	78,300
Missouri	Home State Health Plan	2012	54	14.6%	59,200
New Hampshire	New Hampshire Healthy Families	2013	10	33.5%	33,600
Ohio	Buckeye Community Health Plan	2004	88	10.0%	173,200
South Carolina	Absolute Total Care	2007	39	14.0%	91,900
Tennessee	Centurion of Tennessee	2013	N/A	N/A	20,700
Texas	Superior HealthPlan	1999	254	26.0%	935,100
Washington	Coordinated Care	2012	39	10.2%	82,100
Wisconsin	Managed Health Services	1984	46	10.2%	71,500
					2,723,200

[1] Market share represents our % of the total at-risk members that are included in managed care programs in which we participate.
[2] Cenpatico Behavioral Health of Arizona provided behavioral health services for 156,600 members at December 31, 2013.
[3] Reflects Medicaid, ABD and CHIP programs. The Sunshine Health LTC program has a market share of 28.9%.

Substantially all of our revenue is derived from operations within the United States and its territories, and all of the Company's long lived assets are based in the United States and its territories. We generally receive a fixed premium per member per month pursuant to our state contracts. Our medical costs have a seasonality component due to cyclical illness, for example cold and flu season, resulting in higher medical expenses beginning in the fourth quarter and continuing throughout the first quarter of the following year. Our managed care subsidiaries in Texas had revenues from the state government that represent 37% of our consolidated total revenues from continuing operations in 2013.

MANAGED CARE

Benefits to States

Our ability to establish and maintain a leadership position in the markets we serve results primarily from our demonstrated success in providing quality care while reducing and managing costs, and from our specialized programs in working with state governments. Among the benefits we are able to provide to the states with which we contract are:

- *Significant cost savings and budget predictability compared to state paid reimbursement for services.* We bring bottom-line management experience to our health plans. On the administrative and management side, we bring experience including quality of care improvement methods, utilization management procedures, an efficient claims payment system, and provider performance reporting, as well as managers and staff experienced in using these key elements to improve the quality of and access to care. We generally receive a contracted premium on a per member basis and are responsible for the medical costs and as a result, provide budget predictability.
- *Data-driven approaches to balance cost and verify eligibility.* We seek to ensure effective outreach procedures for new members, then educate them and ensure they receive needed services as quickly as possible. Our IT department has created mapping/translation programs for loading membership and linking membership eligibility status to all of Centene's subsystems. We utilize predictive modeling technology to proactively case and disease manage specific high risk members. In addition, we have developed Centelligence, our enterprise data warehouse system to provide a seamless flow of data across our organization, enabling providers and case managers to access information, apply analytical insight and make informed decisions.
- *Establishment of realistic and meaningful expectations for quality deliverables.* We have collaborated with state agencies in redefining benefits, eligibility requirements and provider fee schedules with the goal of maximizing the number of individuals covered through Medicaid.
- *Managed care expertise in government subsidized programs.* Our expertise in Medicaid has helped us establish and maintain strong relationships with our constituent communities of members, providers and state governments. We provide access to services through local providers and staff that focus on the cultural norms of their individual communities. To that end, systems and procedures have been designed to address community-specific challenges through outreach, education, transportation and other member support activities.
- *Improved quality and medical outcomes.* We have implemented programs developed to improve the quality of healthcare delivered to our members including Smart Start for your Baby, Living Well With Sickle Cell and The CentAccount Program.
- *Timely payment of provider claims.* We are committed to ensuring that our information systems and claims payment systems meet or exceed state requirements. We continuously endeavor to update our systems and processes to improve the timeliness of our provider payments.
- *Provider outreach and programs.* Our health plans have adopted a physician-driven approach where network providers are actively engaged in developing and implementing healthcare delivery policies and strategies. We prepare provider comparisons on a severity adjusted basis. This approach is designed to

eliminate unnecessary costs, improve services to members and simplify the administrative burdens placed on providers.

- *Responsible collection and dissemination of utilization data.* We gather utilization data from multiple sources, allowing for an integrated view of our members' utilization of services. These sources include medical, vision and behavioral health claims and encounter data, pharmacy data, dental vendor claims and authorization data from the authorization and case management system utilized by us to coordinate care.
- *Timely and accurate reporting.* Our information systems have reporting capabilities which have been instrumental in identifying the need for new and/or improved healthcare and specialty programs. For state agencies, our reporting capability is important in demonstrating an auditable program.
- *Fraud and abuse prevention.* We have several systems in place to help identify, detect and investigate potential waste, abuse and fraud including pre and post payment review software. We collaborate with state and federal agencies and assist with investigation requests. We use nationally recognized standards to benchmark our processes.

Member Programs and Services

We recognize the importance of member-focused delivery of quality managed care services. Our locally-based staff assists members in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions. While covered healthcare benefits vary from state to state, our health plans generally provide the following services:

- primary and specialty physician care
- inpatient and outpatient hospital care
- emergency and urgent care
- prenatal care
- laboratory and x-ray services
- home health and durable medical equipment
- behavioral health and substance abuse services
- 24-hour nurse advice line
- transportation assistance
- vision care
- dental care
- immunizations
- prescriptions and limited over-the-counter drugs
- therapies
- social work services
- care coordination

We also provide the following education and outreach programs to inform, assist and incentivize members in accessing quality, appropriate healthcare services in an efficient manner. Many of these programs have been recognized with awards for their excellence in education, outreach and/or case management techniques including Case In Point, Hermes Awards, and National Health Information Awards.

- *Start Smart For Your Baby,* or Smart Start, is our award winning prenatal and infant health program designed to increase the percentage of pregnant women receiving early prenatal care, reduce the incidence of low birth weight babies, identify high-risk pregnancies, increase participation in the federal Women, Infant and Children program, prevent hospital admissions in the first year of life and increase well-child visits.
- *Connections Plus* is a cell phone program developed for high-risk members who have limited or no access to a safe, reliable telephone. This program seeks to eliminate lack of safe, reliable access to a telephone as a barrier to coordinating care, thus reducing avoidable adverse events such as inappropriate emergency room utilization, hospital admissions and premature birth.
- *MemberConnections* is a community face-to-face outreach and education program designed to create a link between the member and the provider and help identify potential challenges or risk elements to a member's health, such as nutritional challenges and health education shortcomings.
- *Health Initiatives for Children* is aimed at educating child members on a variety of health topics. In order to empower and educate children, we have partnered with a nationally recognized children's

author to develop our own children's book series on topics such as obesity prevention and healthy eating, asthma, diabetes, foster care, the ills of smoking, anti-bullying and heart healthy.

- *Health Initiatives for Teens* is aimed at empowering, educating and reinforcing life skills with our teenage members. We have developed an educational series that addresses health issues, dealing with chronic diseases including diabetes and asthma, as well as teen pregnancy.
- *Living Well with Sickle Cell* is our innovative program that assists with coordination of care for our sickle cell members. Our program ensures that sickle cell members have established a medical home and work on strategies to reduce unnecessary emergency department (ED) visits through proper treatment to control symptoms and chronic complications, as well as promote self-management.
- *My Route for Health* is our adult educational series used with our case management and disease management programs. The topics of this series include how to manage asthma, COPD, diabetes, heart disease and HIV.
- *Nurtur Diabetes Program* is an innovative program that is a collaboration with our life and health management subsidiary, Nurtur Health, Inc., and our health plans that targets diabetic patients and educates them on their disease state.
- *Community Health Record,* our patient-centric electronic database, collects patient demographic data, clinician visit records, dispensed medications, vital sign history, lab results, allergy charts, and immunization data. Providers can directly input additional or updated patient data and documentation into the database. All information is accessible anywhere, anytime to all authorized users, including health plan staff, greatly facilitating coordinated care among providers.
- *The CentAccount Program* offers members financial incentives for performing certain healthy behaviors. The incentives are delivered through a restricted-use prepaid debit card redeemable for health-related items only. This incentive-based approach effectively increases the utilization of preventive services while strengthening the relationships between members and their primary care providers.
- *The Asthma Management Program* integrates a hands-on approach with a flexible outreach methodology that can be customized to suit different age groups and populations affected by asthma. Working through Nurtur, we provide proactive identification of members, stratification into appropriate levels of intervention including home visits, culturally sensitive education, and robust outcome reporting. The program also includes aggressive care coordination to ensure patients have basic services such as transportation to the doctor, electricity to power the nebulizer, and a clean, safe home environment.
- *Fluvention* is an outreach program aimed at educating members on preventing the transmission of the influenza virus by encouraging members to get the seasonal influenza vaccines and take everyday precautions to prevent illness.
- *Preventive Care Programs* are designed to educate our members on the benefits of Early and Periodic Screening, Diagnosis and Treatment, or EPSDT, services. We have a systematic program of communicating, tracking, outreach, reporting and follow-through that promotes state EPSDT programs.
- *Life and Health Management Programs* are designed to help members understand their disease and treatment plans and improve their wellness in a cost effective manner. These programs address medical conditions that are common within the Medicaid population such as asthma, diabetes and pregnancy.

Providers

For each of our service areas, we establish a provider network consisting of primary and specialty care physicians, hospitals and ancillary providers. As of December 31, 2013, we contracted with over 50,000 primary care physicians, 165,000 specialty care physicians and 2,000 hospitals.

Our network of primary care physicians is a critical component in care delivery, management of costs and the attraction and retention of new members. Primary care physicians include family and general practitioners, pediatricians, internal medicine physicians and obstetricians and gynecologists. Specialty care physicians provide medical care to members generally upon referral by the primary care physicians. Specialty care physicians include, but are not limited to, orthopedic surgeons, cardiologists and otolaryngologists. We also provide education and outreach programs to inform and assist members in accessing quality, appropriate healthcare services.

Our health plans facilitate access to healthcare services for our members primarily through contracts with our providers. Our contracts with primary and specialty care physicians and hospitals usually are for one to two-year periods and renew automatically for successive one-year terms, but generally are subject to termination by either party upon 90 to 120 days prior written notice. In the absence of a contract, we typically pay providers at state Medicaid reimbursement levels. We pay hospitals under a variety of methods, including fee-for-service, capitation arrangements, per diems, diagnostic related grouping and case rates. We pay physicians under a fee-for-service, capitation arrangement, or risk-sharing arrangement. In addition, we are governed by state prompt payment policies.

- Under our fee-for-service contracts with physicians, particularly specialty care physicians, we pay a negotiated fee for covered services. This model is characterized as having no financial risk for the physician. In addition, this model requires management oversight because our total cost may increase as the units of services increase or as more expensive services replace less expensive services. We have prior authorization procedures in place that are intended to make sure that certain high cost diagnostic and other services are medically appropriate.
- Under our capitated contracts, primary care physicians are paid a monthly fee for each of our members assigned to his or her practice for all ambulatory care. In return for this payment, these physicians provide all primary care and preventive services, including primary care office visits and EPSDT services, and are at risk for all costs associated with such services. If these physicians also provide non-capitated services to their assigned members, they may receive payment under fee-for-service arrangements at standard Medicaid rates.
- Under risk-sharing arrangements, physicians are paid under a capitated or fee-for-service arrangement. The arrangement, however, contains provisions for additional bonus to the physicians or reimbursement from the physicians based upon cost and quality measures.

We work with physicians to help them operate efficiently by providing financial and utilization information, physician and patient educational programs and disease and medical management programs. Our programs are also designed to help the physicians coordinate care outside of their offices.

We believe our collaborative approach with physicians gives us a competitive advantage in entering new markets. Our physicians serve on local committees that assist us in implementing preventive care programs, managing costs and improving the overall quality of care delivered to our members, while also simplifying the administrative burdens on our providers. This approach has enabled us to strengthen our provider networks through improved physician recruitment and retention that, in turn, have helped to increase our membership base. The following are among the services we provide to support physicians:

- *Customized Utilization Reports* provide certain of our contracted physicians with information that enables them to run their practices more efficiently and focuses them on specific patient needs. For example, quarterly detail reports update physicians on their status within their risk pools. Equivalency reports provide physicians with financial comparisons of capitated versus fee-for-service arrangements.
- *Case Management Support* helps the physician coordinate specialty care and ancillary services for patients with complex conditions and direct members to appropriate community resources to address both their health and socio-economic needs.
- *Web-based Claims and Eligibility Resources* have been implemented to provide physicians with on-line access to perform claims and eligibility inquiries.

Our contracted physicians also benefit from several of the services offered to our members, including the MemberConnections, EPSDT case management and health management programs. For example, the MemberConnections staff facilitates doctor/patient relationships by connecting members with physicians, the EPSDT programs encourage routine checkups for children with their physicians and the health management programs assist physicians in managing their patients with chronic disease.

Where appropriate, our health plans contract with our specialty services organizations to provide services and programs such as behavioral health, life and health management, managed vision, telehealth services, pharmacy benefits management and specialty pharmacy. When necessary, we also contract with third-party providers on a negotiated fee arrangement for physical therapy, home healthcare, dental, diagnostic laboratory tests, x-ray examinations, transportation, ambulance services and durable medical equipment.

Quality Management

Our medical management programs focus on improving quality of care in areas that have the greatest impact on our members. We employ strategies, including health management and complex case management, that are adjusted for implementation in our individual markets by a system of physician committees chaired by local physician leaders. This process promotes physician participation and support, both critical factors in the success of any clinical quality improvement program.

We have implemented specialized information systems to support our medical quality management activities. Information is drawn from our data warehouse, clinical databases and our membership and claims processing system to identify opportunities to improve care and to track the outcomes of the interventions implemented to achieve those improvements. Some examples of these intervention programs include:

- appropriate leveling of care for neonatal intensive care unit hospital admissions, other inpatient hospital admissions, and observation admissions, in accordance with Interqual criteria
- tightening of our pre-authorization list and more stringent review of durable medical equipment and injectibles
- emergency department, or ED, program designed to collaboratively work with hospitals to steer non-emergency care away from the costly ED setting (through patient education, on-site alternative urgent care settings, etc.)
- increase emphasis on case management and clinical rounding where case managers are nurses or social workers who are employed by the health plan to assist selected members with the coordination of healthcare services in order to meet a member's specific healthcare needs
- incorporation of disease management, which is a comprehensive, multidisciplinary, collaborative approach to chronic illnesses such as asthma and diabetes
- Start Smart For Your Baby, a prenatal case management program aimed at helping women with high-risk pregnancies deliver full-term, healthy infants

We provide reporting on a regular basis using our data warehouse. State and Health Employer Data and Information Set, or HEDIS, reporting constitutes the core of the information base that drives our clinical quality performance efforts. This reporting is monitored by Plan Quality Improvement Committees and our corporate medical management team.

In an effort to ensure the quality of our provider networks, we undertake to verify the credentials and background of our providers using standards that are supported by the National Committee for Quality Assurance, or NCQA.

It is our objective to provide access to the highest quality of care for our members. As a validation of that objective, we often pursue accreditation by independent organizations that have been established to promote healthcare quality. The NCQA Health Plan Accreditation and URAC Health Plan Accreditation programs provide unbiased, third party reviews to verify and publicly report results on specific quality care metrics. While we have achieved or are pursuing accreditation for all of our plans, accreditation is only one measure of our ability to provide access to quality care for our members. We currently have nine health plans and three specialty companies with NCQA accreditation.

SPECIALTY SERVICES

Our specialty services are a key component of our healthcare enterprise and complement our core Managed Care business. Specialty services diversify our revenue stream, provide higher quality health outcomes to our membership and others, and assist in controlling costs. Our specialty services are provided primarily through the following businesses:

- *Behavioral Health.* Cenpatico Behavioral Health, or Cenpatico, manages behavioral healthcare for members via a contracted network of providers. Cenpatico works with providers to determine the best services to help people overcome mental illness and lead productive lives. Our networks feature a full range of services and levels of care to help people with mental illness reach their recovery and wellness goals. In addition, we operate school-based programs in Arizona that focus on students with special needs and also provide speech and other therapy services.
- *Correctional Services.* Centurion, our joint venture subsidiary with MHM Services Inc., provides comprehensive healthcare services to individuals incarcerated in Massachusetts and Tennessee state correctional facilities. Beginning in January 2014, Centurion also began operating under a new contract with the Minnesota Department of Corrections.
- *In-Home Health Services.* U.S. Medical Management, our majority owned subsidiary acquired in January 2014, provides in-home health services for high acuity populations.
- *Individual Insurance.* Celtic Insurance Company, or Celtic, is a nationwide healthcare provider licensed in 49 states offering high-quality, affordable health insurance to individual customers and their families. Sold online and through independent insurance agents nationwide, Celtic's portfolio of major medical plans is designed to meet the diverse needs of the uninsured at all budget and benefit levels. Celtic also offers a standalone guaranteed-issue medical conversion program to self-funded employer groups, stop-loss and fully-insured group carriers, managed care plans, and HMO reinsurers.
- *Life and Health Management.* Nurtur specializes in implementing life and health management programs that encourage healthy behaviors, promote healthier workplaces, improve workforce and societal productivity and reduce healthcare costs. Health risk appraisals, biometric screenings, online and telephonic wellness programs, disease management and work-life/employee assistance services are areas of focus. Nurtur uses telephonic health and work/life balance coaching, in-home and online interaction and informatics processes to deliver effective clinical outcomes, enhanced patient-provider satisfaction and lower overall healthcare cost.
- *Managed Vision.* OptiCare Managed Vision, Inc., or OptiCare, administers routine and medical surgical eye care benefits via its own contracted national network of eye care providers. OptiCare clients include Medicaid, Medicare, and commercial health plans, as well as employer groups. OptiCare has been providing vision network services for over 25 years and offers a variety of plan designs to meet the individual needs of its clients and members.
- *Telehealth Services.* NurseWise LP provides a toll-free nurse triage line 24 hours per day, 7 days per week, 52 weeks per year. Our members call one number and reach bilingual customer service representatives and nursing staff who provide health education, triage advice and offer continuous access to health plan functions. Additionally, our representatives verify eligibility, confirm primary care provider assignments and provide benefit and network referral coordination for members and providers after business hours. Our staff can arrange for urgent pharmacy refills, transportation and qualified behavioral health professionals for crisis stabilization assessments.
- *Pharmacy Benefits Management & Specialty Pharmacy.* US Script, Inc., or US Script, offers progressive pharmacy benefits management services that are specifically designed to improve quality of care while containing costs. This is achieved through a lowest net cost strategy that helps optimize clients' pharmacy benefit. Services include claims processing, pharmacy network management, benefit design consultation, drug utilization review, formulary and rebate management, specialty and mail order pharmacy services, and patient and physician intervention.

In April 2013, we acquired AcariaHealth, a comprehensive specialty pharmacy company. With this transaction, we expanded our specialized pharmacy benefit services for complex diseases, including Hepatitis C, Hemophilia, Multiple Sclerosis, Rheumatoid Arthritis and Oncology.

- *Care Management Software.* Casenet, LLC, or Casenet, is a software provider of innovative care management solutions that automate the clinical, administrative and technical components of care management programs. During 2012, we acquired the remaining minority interest in Casenet and implemented this new software platform, which is available for sale to third parties and used by our health plans.

CORPORATE COMPLIANCE

Our Corporate Ethics and Compliance Program provides controls by which we assure that our values are reflected in everything we do, further enhance operations, improve access to quality care and safeguard against fraud and abuse.

The two primary standards by which corporate compliance programs in the healthcare industry are measured are the Federal Organizational Sentencing Guidelines and Compliance Program Guidance series issued by the Department of Health and Human Services' Office of the Inspector General, or OIG. Our program contains each of the seven elements suggested by the Sentencing Guidelines and the OIG guidance. These key components are:

- written standards of conduct
- designation of a corporate compliance officer and compliance committee
- effective training and education
- effective lines for reporting and communication
- enforcement of standards through disciplinary guidelines and actions
- internal monitoring and auditing
- prompt response to detected offenses and development of corrective action plans

The goal of the program is to build a culture of ethics and compliance, which is assessed periodically using a diagnostic survey to measure the integrity of the organization. Our internal Corporate Compliance intranet site, accessible to all employees, contains our Business Ethics and Conduct Policy (Code of Conduct), Compliance Program description and various resources for employees to report concerns or ask questions. If needed, employees have access to the contact information for the members of our Board of Directors' Audit Committee to report concerns. Our Ethics and Compliance Helpline is a toll-free number and web-based reporting tool operated by a third party independent of the Company and allows employees or other persons to report suspected incidents of misconduct, fraud, abuse or other compliance violations. Furthermore, the Board of Directors reviews an ethics and compliance report on a quarterly basis.

COMPETITION

We continue to face varying and increasing levels of competition as we expand in our existing service areas or enter new markets. Federal regulations require at least two competitors in each service area. Healthcare reform may cause a number of commercial managed care organizations to decide to enter or exit the Medicaid market.

In our business, our principal competitors for state contracts, members and providers consist of the following types of organizations:

- *Medicaid Managed Care Organizations* focus on providing healthcare services to Medicaid recipients. These organizations consist of national and regional organizations, as well as not-for-profits and smaller organizations that operate in one city or state and are owned by providers, primarily hospitals.
- *National and Regional Commercial Managed Care Organizations* have Medicaid members in addition to members in private commercial plans. Some of these organizations offer a range of specialty services including pharmacy benefits management, behavioral health management, health management, and nurse triage call support centers.
- *Primary Care Case Management Programs* are programs established by the states through contracts with primary care providers. Under these programs, physicians provide primary care services to Medicaid recipients, as well as limited medical management oversight.

We compete with other managed care organizations and specialty companies for state contracts. In order to grant a contract, state governments consider many factors. These factors include quality of care, financial requirements, an ability to deliver services and establish provider networks and infrastructure. In addition, our specialty companies also compete with other providers, such as disease management companies, individual health insurance companies, and pharmacy benefits managers for non-governmental contracts.

We also compete to enroll new members and retain existing members. People who wish to enroll in a managed healthcare plan or to change healthcare plans typically choose a plan based on the quality of care and services offered, ease of access to services, a specific provider being part of the network and the availability of supplemental benefits.

We also compete with other managed care organizations to enter into contracts with physicians, physician groups and other providers. We believe the factors that providers consider in deciding whether to contract with us include existing and potential member volume, reimbursement rates, medical management programs, speed of reimbursement and administrative service capabilities. See "Risk Factors—Competition may limit our ability to increase penetration of the markets that we serve."

REGULATION

Our operations are regulated at both state and federal levels. Government regulation of the provision of healthcare products and services is a changing 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 and rules also may occur periodically.

Our regulated subsidiaries are licensed to operate as health maintenance organizations, third party administrators, utilization review and/or insurance companies in their respective states. In each of the jurisdictions in which we operate, we are regulated by the relevant insurance, health and/or human services departments that oversee the activities of managed care organizations providing or arranging to provide services to Medicaid, Medicare and Health Insurance Marketplace enrollees.

The process for obtaining authorization to operate as a managed care organization is complex and requires us to demonstrate to the regulators the adequacy of the health plan's organizational structure, financial resources, utilization review, quality assurance programs, complaint procedures, provider network and procedures for covering emergency medical conditions. Under both state managed care organization statutes and insurance laws, our health plan subsidiaries, as well as our applicable specialty companies, must comply with minimum statutory capital and other financial solvency requirements, such as deposit and surplus requirements. Insurance regulations may also require prior state approval of acquisitions of other managed care organization businesses and the payment of dividends, as well as notice for loans or the transfer of funds. Our subsidiaries are also subject to periodic state and federal reporting requirements. In addition, each health plan and individual health insurance provider must meet criteria to secure the approval of state regulatory authorities before implementing operational changes, including the development of new product offerings and, in some states, the expansion of service areas.

States have adopted a number of regulations that may affect our business and results of operations. These regulations in certain states include:

- premium taxes or similar assessments
- stringent prompt payment laws
- disclosure requirements regarding provider fee schedules and coding procedures
- programs to monitor and supervise the activities and financial solvency of provider groups

We are regulated as an insurance holding company and are subject to the insurance holding company acts of the states in which our insurance company and HMO subsidiaries are domiciled. These acts contain certain reporting requirements as well as restrictions on transactions between an insurer or HMO and its affiliates. These holding company laws and regulations generally require insurance companies and HMOs within an insurance

holding company system to register with the insurance department of each state where they are domiciled and to file with those states' insurance departments reports describing capital structure, ownership, financial condition, intercompany transactions and general business operations. In addition, depending on the size and nature of the transaction, there are various notice and reporting requirements that generally apply to transactions between insurance companies and HMOs and their affiliates within an insurance holding company structure. Some insurance holding company laws and regulations require prior regulatory approval or, in certain circumstances, prior notice of certain material intercompany transfers of assets as well as certain transactions between insurance companies, HMOs, their parent holding companies and affiliates. Among other provisions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends.

Additionally, the holding company acts of the states in which our subsidiaries are domiciled restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval or an exemption, no person may acquire any voting security of an insurance holding company, which controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would "control" the insurance holding company. "Control" is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a company and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of a company.

Our mail order pharmacies must be licensed to do business as pharmacies in the states in which they are located. Our mail order pharmacies must also register with the U.S. Drug Enforcement Administration and individual state controlled substance authorities to dispense controlled substances. In many of the states where our mail order pharmacies deliver pharmaceuticals, there are laws and regulations that require out-of-state mail order pharmacies to register with that state's board of pharmacy or similar regulatory body. These states generally permit the pharmacy to follow the laws of the state in which the mail order pharmacy is located, although some states require that we also comply with certain laws in that state.

State Contracts

In addition to being a licensed insurance company or health maintenance organization, in order to be a Medicaid managed care organization in each of the states in which we operate, we must operate under a contract with the state's Medicaid agency. States generally use either a formal proposal process, reviewing a number of bidders, or award individual contracts to qualified applicants that apply for entry to the program. We receive monthly payments based on specified capitation rates determined on an actuarial basis. These rates differ by membership category and by state depending on the specific benefits and policies adopted by each state.

Our state contracts and the regulatory provisions applicable to us generally set forth the requirements for operating in the Medicaid sector, including provisions relating to:

- eligibility, enrollment and dis-enrollment processes
- covered services
- eligible providers
- subcontractors
- record-keeping and record retention
- periodic financial and informational reporting
- quality assurance
- accreditation
- health education and wellness and prevention programs
- timeliness of claims payment
- financial standards
- safeguarding of member information
- fraud and abuse detection and reporting
- grievance procedures
- organization and administrative systems

A health plan or individual health insurance provider's compliance with these requirements is subject to monitoring by state regulators and by CMS. A health plan is also subject to periodic comprehensive quality assurance evaluations by a third-party reviewing organization and generally by the insurance department of the jurisdiction that licenses the health plan. A health plan or individual health insurance provider must also submit reports to various regulatory agencies, including quarterly and annual statutory financial statements and utilization reports.

The table below sets forth the terms of our contracts and provides details regarding related renewal or extension and termination provisions. The contracts are subject to termination for cause, an event of default or lack of funding.

Contract	Expiration Date	Renewal or Extension
Arizona – Behavioral Health	June 30, 2014	Renewable for one additional one-year term.
Arizona – LTC	September 30, 2014	May be extended for up to two additional one-year terms.
Arizona – Special Needs Plan (Medicare)	December 31, 2014	Renewable annually for successive 12-month periods.
California – Medicaid, ABD & CHIP	October 31, 2018	Renewable up to three additional one-year terms.
Florida – CHIP	September 30, 2014	May be extended for up to two additional one-year terms.
Florida – Foster Care	(1)	(1)
Florida – LTC	August 31, 2018	Renewable through the state's recertification process.
Florida – Medicaid & ABD[2]	August 31, 2015	Renewable through the state's recertification process.
Florida – Special Needs Plan (Medicare)	December 31, 2014	Renewable annually for successive 12-month periods.
Georgia – Medicaid & CHIP	June 30, 2014	Renewable for two additional one-year terms.
Georgia – Special Needs Plan (Medicare)	December 31, 2014	Renewable annually for successive 12-month periods.
Illinois – ABD & LTC	April 30, 2016	May be extended for up to five additional years.
Illinois – Duals	December 31, 2015	Renewable for two additional one-year terms.
Indiana – Medicaid, CHIP & Hybrid (Healthy Indiana Plan)	December 31, 2014	Renewable for two additional one-year terms.
Kansas – Medicaid, ABD, CHIP, LTC & Foster Care	December 31, 2015	Renewable for two additional one-year terms.
Louisiana – Medicaid, CHIP, ABD & Foster Care	January 31, 2015	Renewable for an additional two-year period through the state's recertification process.
Massachusetts – Correctional Services	June 30, 2018	Renewable for two additional one-year terms.
Massachusetts – Medicaid	September 30, 2015	May be extended for five additional one-year terms.
Massachusetts – Hybrid (Commonwealth Care)	March 31, 2014	Program ending March 31, 2014.
Minnesota – Correctional Services	June 30, 2016	May be extended for up to two and a half additional years.
Mississippi – Medicaid, ABD & Foster Care	June 30, 2014	Renewable through the state's reprocurement process.[3]
Missouri – Medicaid, CHIP & Foster Care	June 30, 2014	Renewable for one additional one-year term.
New Hampshire – Medicaid, CHIP, Foster Care & ABD	June 30, 2015	Renewable for one additional two-year term.
Ohio – Duals	(1)	(1)
Ohio – Medicaid, CHIP & ABD	June 30, 2014	Renewable annually for successive 12-month periods.
Ohio – Special Needs Plan (Medicare)	December 31, 2014	Renewable annually for successive 12-month periods.
South Carolina – Medicaid, CHIP & ABD	June 30, 2014	Renewable through the state's recertification process.
South Carolina – Duals	(1)	(1)

(1) The Company has received notice of intent to award a contract, however a final contract has not yet been executed.

(2) The current contract expires in August 2015. In September 2013, the Florida Agency for Health Care Administration provided notice of intent to award a contract to our Florida subsidiary, Sunshine Health, in 9 of 11 regions of the Managed Medical Assistance (MMA) program. The MMA program includes TANF recipients as well as ABD and dual-eligible members. The award is subject to challenge and contract readiness periods, with enrollment expected to begin in the second quarter of 2014 and continue through October 2014.

(3) The current contract expires June 30, 2014. In February 2014, the State of Mississippi Department of Medicaid provided notice of intent to award a contract to our Mississippi subsidiary, Magnolia Health, to continue serving Medicaid, ABD and Foster Care members effective July 1, 2014 for a three-year period, renewable for up to two additional years.

Contract	Expiration Date	Renewal or Extension
Tennessee – Correctional Services	August 31, 2016	Renewable through the state's reprocurement process.
Texas – ABD Dallas Expansion	August 31, 2015	May be extended for up to three additional years.
Texas – ABD MRSA	August 31, 2017	May be extended for up to five additional years.
Texas – CHIP Rural Service Area	August 31, 2015	May be extended for up to three additional years.
Texas – Foster Care	February 22, 2015	Renewable through the state's reprocurement process.
Texas – Hybrid (Healthy Texas)	August 31, 2015	(4)
Texas – Medicaid, CHIP &ABD	August 31, 2015	May be extended for up to four and a half additional years.
Texas – Special Needs Plan (Medicare)	December 31, 2014	Renewable annually for successive 12-month periods.
Washington – Medicaid, CHIP, Foster Care & ABD	December 31, 2014	Renewable through the state's recertification process.
Wisconsin – Medicaid, CHIP & ABD	December 31, 2015	Renewable through the state's recertification process every two years.
Wisconsin – Network Health Plan Subcontract	December 31, 2015	(5)
Wisconsin – Special Needs Plan (Medicare)	December 31, 2014	Renewable annually for successive 12-month periods.

(4) The Texas Health and Human Services Commission (HHSC) has communicated that the Healthy Texas program is expected to end in December 2014.

(5) The Company and NHP are currently in negotiation regarding any future extensions.

Marketplace Contracts

Beginning in 2014, we began operating under federally facilitated Marketplace contracts with CMS in seven states: Arkansas, Florida, Georgia, Indiana, Mississippi, Ohio and Texas. These contracts expire annually and are renewable upon mutual consent.

In 2014, we also began operating under two state based Marketplaces in Massachusetts and Washington that expire annually. The Massachusetts contract may be extended for up to two additional one-year terms. The Washington contract is renewable annually through the state's recertification process.

In addition, we began operating under a contract with the Arkansas division of Medical Services and the Arkansas Insurance Department to participate in the Medicaid expansion model that Arkansas has adopted (referred to as the "private option") in January 2014. This contract expires December 31, 2014 and may be extended for subsequent and consecutive one year terms.

HIPAA Omnibus Rule and HITECH

In 1996, Congress enacted the Health Insurance Portability and Accountability Act, or HIPAA. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including HIPAA and the Gramm-Leach-Bliley Act. HIPAA is designed to improve the portability and continuity of health insurance coverage, simplify the administration of health insurance through standard transactions and ensure the privacy and security of individual health information. Among the main requirements of HIPAA are the Administrative Simplification provisions which include: standards for processing health insurance claims and related transactions (Transactions Standards); requirements for protecting the privacy and limiting the use and disclosure of medical records and other personal health information (Privacy Rule); and standards and specifications for safeguarding personal health information which is maintained, stored or transmitted in electronic format (Security Rule). The Health Information Technology for Economic and Clinical Health (HITECH) Act amended certain provisions of HIPAA and introduced new data security obligations for covered entities and their business associates. HITECH also mandated individual notifications in instances of a data breach, provided enhanced penalties for HIPAA violations, and granted enforcement authority to states' Attorneys General in addition to the HHS Office of Civil Rights. The HIPAA Omnibus Rule is based on the changes under the HITECH Acts and the Genetic Information Nondiscrimination Act of 2008 (GINA) which

clarifies that genetic information is protected under the HIPAA Privacy Rule and prohibits most health plans from using or disclosing genetic information for underwriting purposes. This Omnibus rule enhances the privacy protections and strengthens the government's ability to enforce the law. The preemption provisions of HIPAA provide that the federal standards will not preempt state laws that are more stringent than the related federal requirements.

The Privacy and Security Rules and HITECH/Omnibus enhancements establish requirements to protect the privacy of medical records and safeguard personal health information maintained and used by healthcare providers, health plans, healthcare clearinghouses, and their business associates.

The Security Rule requires healthcare providers, health plans, healthcare clearinghouses, and their business associates to implement administrative, physical and technical safeguards to ensure the privacy and confidentiality of health information when it is electronically stored, maintained or transmitted. The HITECH Act and Omnibus Rule established a federal requirement for notification when the security of protected health information is breached. In addition, there are state laws that have been adopted to provide for, among other things, private rights of action for breaches of data security and mandatory notification to persons whose identifiable information is obtained without authorization.

The requirements of the Transactions Standards apply to certain healthcare related transactions conducted using "electronic media." Since "electronic media" is defined broadly to include "transmissions that are physically moved from one location to another using magnetic tape, disk or compact disk media," many communications are considered to be electronically transmitted. Under HIPAA, health plans are required to have the capacity to accept and send all covered transactions in a standardized electronic format. Penalties can be imposed for failure to comply with these requirements. The transaction standards have been modified to version 5010 to prepare for the implementation of the ICD-10 coding system. We are planning for an expected transition to ICD-10 in October 2014.

We have implemented processes, policies and procedures to comply with HIPAA, HITECH and the Omnibus Rule, including administrative, technical and physical safeguards to prevent against electronic data breach. We provide education and training for employees specifically designed to help prevent any unauthorized use or access to health information and enhance the reporting of suspected breaches. In addition, our corporate privacy officer and health plan privacy officials handle privacy complaints and serve as resources to employees to address questions or concerns they may have.

Other Fraud and Abuse Laws

Investigating and prosecuting healthcare fraud and abuse continues to be a top priority for state and federal law enforcement entities. The focus of these efforts has been directed at participants in public government healthcare programs such as Medicare and Medicaid. The laws and regulations relating to fraud and abuse and the contractual requirements applicable to health plans participating in these programs are complex and regularly changing and compliance with them may require substantial resources. We are constantly looking for ways to improve our waste, fraud and abuse detection methods. While we have both prospective and retrospective processes to identify abusive patterns and fraudulent billing, we continue to increase our capabilities to proactively detect inappropriate billing prior to payment.

EMPLOYEES

As of December 31, 2013, we had approximately 8,800 employees. None of our employees are represented by a union. We believe our relationships with our employees are positive.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following table sets forth information regarding our executive officers, including their ages, at February 8, 2014:

Name	Age	Position
Michael F. Neidorff	71	Chairman, President and Chief Executive Officer
K. Rone Baldwin	55	Executive Vice President, Insurance Group Business Unit
Carol E. Goldman	56	Executive Vice President and Chief Administrative Officer
Jason M. Harrold	44	Executive Vice President, Specialty Company Business Unit
Robert T. Hitchcock	47	Executive Vice President, Health Plan Business Unit
Jesse N. Hunter	38	Executive Vice President, Chief Business Development Officer
Donald G. Imholz	61	Executive Vice President, Operations and Chief Information Officer
Edmund E. Kroll	54	Senior Vice President, Finance and Investor Relations
C. David Minifie	43	Executive Vice President, Business Integration & Chief Marketing Officer
William N. Scheffel	60	Executive Vice President, Chief Financial Officer and Treasurer
Jeffrey A. Schwaneke	38	Senior Vice President, Corporate Controller and Chief Accounting Officer
Keith H. Williamson	61	Executive Vice President, General Counsel and Secretary

Michael F. Neidorff. Mr. Neidorff has served as our Chairman and Chief Executive Officer since May 2004. From May 1996 to May 2004, Mr. Neidorff served as President, Chief Executive Officer and as a member of our Board of Directors. Mr. Neidorff also serves as a director of Brown Shoe Company, Inc., a publicly-traded footwear company with global operations.

K. Rone Baldwin. Mr. Baldwin has served as our Executive Vice President, Insurance Group Business Unit since December 2012. Prior to joining Centene, he served as Executive Vice President and Business Leader of Group Insurance Business, which included both group health and ancillary product lines, for Guardian Life Insurance Company, which he joined in 2006.

Carol E. Goldman. Ms. Goldman has served as Executive Vice President and Chief Administrative Officer since June 2007. Prior to this position, Ms. Goldman has held various positions of increasing responsibility since joining Centene in 2001.

Jason M. Harrold. Mr. Harrold has served as our Executive Vice President, Specialty Company Business Unit since April 2012. From August 2009 to April 2012, he served as our Senior Vice President, Specialty Business Unit. He served as President of OptiCare from July 2000 to August 2009.

Robert T. Hitchcock. Mr. Hitchcock has served as our Executive Vice President, Health Plan Business Unit, since October 2012. From March 1997 to October 2012, Mr. Hitchcock held various positions of increasing responsibility at Humana including Divisional Vice President, Western Division Medicare Operations.

Jesse N. Hunter. Mr. Hunter has served as our Executive Vice President, Chief Business Development Officer since December 2012. From February 2012 to December 2012, he served as our Executive Vice President, Operations. He previously served as our Executive Vice President, Corporate Development from April 2008 to February 2012. He served as our Senior Vice President, Corporate Development from April 2007 to April 2008.

Donald G. Imholz. Mr. Imholz has served as our Executive Vice President, Operations and Chief Information Officer since December 2009. Mr. Imholz served as our Senior Vice President and Chief Information Officer from September 2008 to December 2009.

Edmund E. Kroll. Mr. Kroll has served as our Senior Vice President, Finance and Investor Relations since May 2007.

C. David Minifie. Mr. Minifie has served as our Executive Vice President, Business Integration & Chief Marketing Officer since December 2012. He previously served as our Vice President, Chief Marketing Officer from April 2012 to December 2012. From 1999 to April 2012, Mr. Minifie held various positions of increasing responsibility at Procter & Gamble including Global Eukanuba Associate Marketing Director.

William N. Scheffel. Mr. Scheffel has served as our Executive Vice President, Chief Financial Officer and Treasurer since May 2009. He served as our Executive Vice President, Specialty Business Unit from June 2007 to May 2009.

Jeffrey A. Schwaneke. Mr. Schwaneke has served as our Senior Vice President, Corporate Controller since December 2011 and our Chief Accounting Officer since September 2008. He served as our Vice President, Corporate Controller from July 2008 to December 2011. He previously served as Vice President, Controller and Chief Accounting Officer at Novelis Inc. from October 2007 to July 2008.

Keith H. Williamson. Mr. Williamson has served as our Executive Vice President, General Counsel and Secretary since November 2012. He served as Senior Vice President and General Counsel from November 2006 to November 2012. Mr. Williamson also serves as a director of PPL Corporation, a publicly-traded utility holding company.

Available Information

We are subject to the reporting and information requirements of the Securities Exchange Act of 1934, as amended (Exchange Act) and, as a result, we file periodic reports and other information with the Securities and Exchange Commission, or SEC. We make these filings available on our website free of charge, the URL of which is http://www.centene.com, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. The SEC maintains a website (http://www.sec.gov) that contains our annual, quarterly and current reports and other information we file electronically with the SEC. You can read and copy any materials we file with the SEC at the SEC's Public Reference Room at 100 F Street, N.E., Room 1850, Washington, D.C. 20549. You may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. Information on our website does not constitute part of this Annual Report on Form 10-K.

ITEM 1A. ***Risk Factors.***

FACTORS THAT MAY AFFECT FUTURE RESULTS AND THE TRADING PRICE OF OUR COMMON STOCK

You should carefully consider the risks described below before making an investment decision. The trading price of our common stock could decline due to any of these risks, in which case you could lose all or part of your investment. You should also refer to the other information in this filing, including our consolidated financial statements and related notes. The risks and uncertainties described below are those that we currently believe may materially affect our Company. Additional risks and uncertainties that we are unaware of or that we currently deem immaterial also may become important factors that affect our Company.

Reductions in funding or changes to eligibility requirements for government sponsored healthcare programs in which we participate could substantially affect our financial position, results of operations and cash flows.

The majority of our revenues come from government subsidized healthcare programs including Medicaid, Medicare, CHIP, LTC, ABD, Foster Care and Health Insurance Marketplace premiums. The base premium rate paid for each program differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region and benefit mix. Since Medicaid was created in 1965, the federal government and the states have shared the costs, with the federal share currently averaging around 57%.

Future levels of funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints. Governments periodically

consider reducing or reallocating the amount of money they spend for Medicaid, Medicare, CHIP, LTC, ABD and Foster Care. Adverse economic conditions may continue to put pressures on state budgets as tax and other state revenues decrease while the population that is eligible to participate in these programs increases, creating more need for funding. We anticipate this will require government agencies to find funding alternatives, which may result in reductions in funding for programs, contraction of covered benefits, and limited or no premium rate increases or premium rate decreases. A reduction (or less than expected increase), a protracted delay, or a change in allocation methodology in government funding for these programs, as well as termination of the contract for the convenience of the government, may materially and adversely affect our results of operations, financial position and cash flows.

Additionally, changes in these programs could reduce the number of persons enrolled in or eligible for these programs or increase our administrative or healthcare costs under these programs. Recent legislation generally requires that eligibility levels be maintained, but this could cause states to reduce reimbursement or reduce benefits in order for states to afford to maintain eligibility levels. If any state in which we operate were to decrease premiums paid to us or pay us less than the amount necessary to keep pace with our cost trends, it could have a material adverse effect on our results of operations, financial position and cash flows.

Lastly, if a federal government shutdown were to occur for a prolonged period of time, federal government payment obligations, including its obligations under Medicaid, Medicare, CHIP, LTC, ABD, Foster Care and the new Health Insurance Marketplaces, may be delayed. If the federal government fails to make payments under these programs on a timely basis, our business could suffer, and our financial position, results of operations or cash flows may be materially affected.

Failure to accurately estimate and price our medical expenses or effectively manage our medical costs or related administrative costs could negatively affect our financial position, results of operations or cash flows.

Our profitability depends, to a significant degree, on our ability to estimate and effectively manage expenses related to health benefits through our ability to contract favorably with hospitals, physicians and other healthcare providers. For example, our Medicaid revenue is often based on bids submitted before the start of the initial contract year. If our actual medical expense exceeds our estimates, our health benefits ratio, or our expenses related to medical services as a percentage of premium revenue, would increase and our profits would decline. Because of the narrow margins of our health plan business, relatively small changes in our health benefits ratio can create significant changes in our financial results. Changes in healthcare regulations and practices, the level of utilization of healthcare services, hospital and pharmaceutical costs, major epidemics or pandemics, new medical technologies, pharmaceutical compounds and other external factors, including general economic conditions such as inflation and unemployment levels, are beyond our control and could reduce our ability to accurately predict and effectively control the costs of providing health benefits.

Our medical expense includes claims reported but not paid, estimates for claims incurred but not reported, and estimates for the costs necessary to process unpaid claims at the end of each period. Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as claims receipts and payment information as well as inpatient acuity information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expense in the period in which the changes are identified. However, we still cannot be sure that our medical claims liability estimate is adequate or that adjustments to the estimate will not unfavorably impact our results of operations.

Additionally, when we commence operations in a new state, region or product, we have limited information with which to estimate our medical claims liability. For a period of time after the inception of the new business, we base our estimates on state-provided historical actuarial data and limited actual incurred and received claims and inpatient acuity information. The addition of new categories of individuals who are eligible under new legislation may pose the same difficulty in estimating our medical claims liability. Similarly, we may face difficulty in estimating our medical claims liability beginning in January 2014 when we begin providing coverage for the first time under the newly created Health Insurance Marketplaces.

From time to time in the past, our actual results have varied from our estimates, particularly in times of significant changes in the number of our members. If it is determined that our estimates are significantly different than actual results, our results of operations and financial position could be adversely affected. In addition, if there is a significant delay in our receipt of premiums, our business operations, cash flows, or earnings could be negatively impacted.

The implementation of the Health Reform Legislation and other reforms could materially and adversely affect our results of operations, financial position and cash flows.

In March 2010, the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act, collectively referred to as the Affordable Care Act (ACA), were enacted. While the constitutionality of the ACA was generally upheld by the Supreme Court in 2012, the Court determined that states could not be required to expand Medicaid and risk losing all federal money for their existing Medicaid programs.

Under the ACA, Medicaid coverage was expanded to all individuals under age 65 with incomes up to 138% of the federal poverty level beginning January 1, 2014, subject to each states' election. The federal government will pay the entire costs for Medicaid coverage for newly eligible beneficiaries for 3 years (2014 through 2016). Beginning in 2017, the federal share begins to decline to 90% by 2020 and subsequent years. To date, 25 states have expanded Medicaid eligibility, and the remaining states are involved in a variety of legislative proposals. The ACA also extended CHIP through September 30, 2019.

The ACA required the establishment of Health Insurance Marketplaces for individuals and small employers to purchase health insurance coverage commencing in January 2014. Open enrollment began on October 1, 2013 and continues until March 31, 2014. The ACA required insurers participating on the Health Insurance Marketplaces to offer a minimum level of benefits and included guidelines on setting premium rates and coverage limitations.

Our ability to adequately price products offered in the Health Insurance Marketplaces may have a negative impact on our results of operations, financial position and cash flow. We may be adversely selected by individuals who will have a higher acuity level than the anticipated pool of participants. In addition, the risk corridor, reinsurance and risk adjustment ("three Rs") provisions of the ACA established to reduce risk for insurers may not be effective in appropriately mitigating the financial risks related to the Marketplace product. Further, the reinsurance component may not be adequately funded. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, the three Rs, or other assumptions utilized in setting adequate premium rates could have a material adverse effect on our results of operations, financial position and cash flows.

The U.S. Department of Health and Human Services (HHS) has stated that it will consider a limited number of premium assistance demonstration proposals from States that want to privatize Medicaid expansion. States must provide a choice between at least two qualified health plans and offer very similar benefits as those available in the newly created Health Insurance Marketplaces. Arkansas became the first state to obtain federal approval to use Medicaid funding to purchase private insurance for low-income residents and we began operations under the program beginning January 1, 2014.

The ACA imposes an annual insurance industry assessment of $8 billion starting in 2014, with increasing annual amounts thereafter. Such assessments are not deductible for income tax purposes. The fee will be allocated based on health insurers' premium revenues in the previous year. Each health insurer's fee is calculated by multiplying its market share by the annual fee. Market share is based on commercial, Medicare, and Medicaid premium revenue. Not-for-profit insurers may have a competitive advantage since they are exempt from paying the fee if they receive at least 80% of their premium revenue from Medicare, Medicaid, and CHIP, and other not-for-profit insurers are allowed to exclude 50% of their premium revenue from the fee calculation. If this federal premium assessment is imposed as enacted, and if we are not reimbursed by the states for the cost of the federal premium assessment (including the associated tax impact), or if we are unable to otherwise adjust our business model to address this new assessment, our results of operations, financial position and cash flows may be materially adversely affected.

There are numerous steps required to implement the legislation, including the promulgation of a substantial number of new and potentially more onerous federal regulations. Further, various health insurance reform proposals are also emerging at the state level. Because of the unsettled nature of these reforms and numerous steps required to implement them, we cannot predict what additional health insurance requirements will be implemented at the federal or state level, or the effect that any future legislation or regulation will have on our business or our growth opportunities. Although we believe the legislation may provide us with significant opportunities to grow our business, the enacted reforms, as well as future regulations and legislative changes, may in fact have a material adverse effect on our results of operations, financial position or liquidity. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of healthcare reform, or do not do so as effectively as our competitors, our results of operations may be materially adversely affected.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could force us to change how we operate and could harm our business.

Our business is extensively regulated by the states in which we operate and by the federal government. In addition, the managed care industry has received negative publicity that has led to increased legislation, regulation, review of industry practices and private litigation in the commercial sector. In each of the jurisdictions in which we operate, we are regulated by the relevant insurance, health and/or human services departments that oversee the activities of managed care organizations providing or arranging to provide services to Medicaid, Medicare and Health Insurance Marketplace enrollees. For example, our health plan subsidiaries, as well as our applicable specialty companies, must comply with minimum statutory capital and other financial solvency requirements, such as deposit and surplus requirements.

The frequent enactment of, changes to, or interpretations of laws and regulations could, among other things: force us to restructure our relationships with providers within our network; require us to implement additional or different programs and systems; restrict revenue and enrollment growth; increase our healthcare and administrative costs; impose additional capital and surplus requirements; and increase or change our liability to members in the event of malpractice by our contracted providers. In addition, changes in political party or administrations at the federal or state level may change the attitude towards healthcare programs.

Our contracts with states may require us to maintain a minimum health benefits ratio or may require us to share profits in excess of certain levels. In certain circumstances, our plans may be required to rebate premium back to the state in the event profits exceed established levels or HBR does not meet the minimum requirement. Other states may require us to meet certain performance and quality metrics in order to maintain our contract or receive additional or full contractual revenue.

The governmental healthcare programs in which we participate are subject to the satisfaction of certain regulations and performance standards. For example, under Health Reform Legislation, Congress authorized CMS and the states to implement managed care demonstration programs to serve dually eligible beneficiaries to improve the coordination of their care. Participation in these demonstration programs is subject to CMS approval and the satisfaction of conditions to participation, including meeting certain performance requirements. Our inability to improve or maintain adequate quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs. Specifically, several of our Medicaid contracts require us to maintain a Medicare health plan. Although we strive to comply with all existing regulations and to meet performance standards applicable to our business, failure to meet these requirements could result in financial fines and penalties. Also, states may not allow us to continue to participate in their government programs, or we may fail to win procurements to participate in such programs which could materially and adversely affect our results of operations, financial position and cash flows.

Our businesses providing pharmacy benefit management (PBM) and specialty pharmacy services face regulatory and other risks and uncertainties which could materially and adversely affect our results of operations, financial position and cash flows.

We provide PBM and specialty pharmacy services through our US Script and AcariaHealth businesses. Each business is subject to federal and state laws that govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. They also conduct business as a mail order pharmacy and specialty pharmacy, which subjects them to extensive federal, state and local laws and regulations. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially and adversely affect current industry practices, including the receipt or disclosure of rebates from pharmaceutical companies, the development and use of formularies, and the use of average wholesale prices.

Our PBM businesses would be materially and adversely affected by an inability to contract on favorable terms with pharmaceutical manufacturers and other suppliers, and could face potential claims in connection with purported errors by our mail order or specialty pharmacies, including in connection with the risks inherent in the authorization, compounding, packaging and distribution of pharmaceuticals and other healthcare products. Disruptions at any of our mail order or specialty pharmacies due to an event that is beyond our control could affect our ability to process and dispense prescriptions in a timely manner and could materially and adversely affect our results of operations, financial position and cash flows.

If any of our government contracts are terminated or are not renewed or we receive an adverse review, audit or investigation, our business will suffer.

We provide managed care programs and selected services to individuals receiving benefits under governmental assistance programs. We provide those healthcare services under contracts with regulatory entities in the areas in which we operate. Our government contracts are generally intended to run for three years and may be extended for additional years if the contracting entity or its agent elects to do so. When our contracts expire, they may be opened for bidding by competing healthcare providers, and there is no guarantee that our contracts will be renewed or extended. Competitors may buy their way into the market by submitting bids with lower pricing. Further, our government contracts contain certain provisions regarding eligibility, enrollment and dis-enrollment processes for covered services, eligible providers, periodic financial and informational reporting, quality assurance, timeliness of claims payment, agreement to maintain a Medicare plan in the state and financial standards and are subject to cancellation if we fail to perform in accordance with the standards set by regulatory agencies.

We are also subject to various reviews, audits and investigations to verify our compliance with the terms of our contracts with various governmental agencies and applicable laws and regulations. Any adverse review, audit or investigation could result in: cancellation of our contracts; refunding of amounts we have been paid pursuant to our contracts; imposition of fines, penalties and other sanctions on us; loss of our right to participate in various programs; increased difficulty in selling our products and services; or loss of one or more of our licenses.

If any of our government contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, or we have an adverse review, audit or investigation, our business will suffer, our goodwill could be impaired and our financial position, results of operations or cash flows may be materially affected.

Ineffectiveness of state-operated systems and subcontractors could adversely affect our business.

Our health plans rely on other state-operated systems or sub-contractors to qualify, solicit, educate and assign eligible members into managed care plans. The effectiveness of these state operations and sub-contractors can have a material effect on a health plan's enrollment in a particular month or over an extended period. When a state implements new programs to determine eligibility, new processes to assign or enroll eligible members into health plans, or chooses new subcontractors, there is an increased potential for an unanticipated impact on the overall number of members assigned to managed care plans.

Our investment portfolio may suffer losses which could materially and adversely affect our results of operations or liquidity.

We maintain a significant investment portfolio of cash equivalents and short-term and long-term investments in a variety of securities, which are subject to general credit, liquidity, market and interest rate risks and will decline in value if interest rates increase or one of the issuers' credit ratings is reduced. As a result, we may experience a reduction in value or loss of liquidity of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition.

Execution of our growth strategy may increase costs or liabilities, or create disruptions in our business.

Our growth strategy includes the acquisition of health plans participating in government sponsored healthcare programs and specialty services businesses, contract rights and related assets of other health plans both in our existing service areas and in new markets and start-up operations in new markets or new products in existing markets. Although we review the records of companies or businesses we plan to acquire, it is possible that we could assume unanticipated liabilities or adverse operating conditions, or an acquisition may not perform as well as expected or may not achieve timely profitability. We also face the risk that we will not be able to effectively integrate acquisitions into our existing operations effectively without substantial expense, delay or other operational or financial problems and we may need to divert more management resources to integration than we planned.

In connection with start-up operations, we may incur significant expenses prior to commencement of operations and the receipt of revenue. For example, in order to obtain a certificate of authority in most jurisdictions, we must first establish a provider network, have systems in place and demonstrate our ability to administer a state contract and process claims. We may experience delays in operational start dates. As a result of these factors, start-up operations may decrease our profitability. In the event we pursue any opportunity to diversify our business internationally, we would become subject to additional risks, including, but not limited to, political risk, an unfamiliar regulatory regime, currency exchange risk and exchange controls, cultural and language differences, foreign tax issues, and different labor laws and practices.

If we are unable to effectively execute our growth strategy, our future growth will suffer and our results of operations could be harmed.

If competing managed care programs are unwilling to purchase specialty services from us, we may not be able to successfully implement our strategy of diversifying our business lines.

We are seeking to diversify our business lines into areas that complement our government sponsored health plan business in order to grow our revenue stream and balance our dependence on risk reimbursement. In order to diversify our business, we must succeed in selling the services of our specialty subsidiaries not only to our managed care plans, but to programs operated by third-parties. Some of these third-party programs may compete with us in some markets, and they therefore may be unwilling to purchase specialty services from us. In any event, the offering of these services will require marketing activities that differ significantly from the manner in which we seek to increase revenues from our government sponsored programs. Our ineffectiveness in marketing specialty services to third-parties may impair our ability to execute our business strategy.

Adverse credit market conditions may have a material adverse effect on our liquidity or our ability to obtain credit on acceptable terms.

The securities and credit markets have been experiencing extreme volatility and disruption over the past several years. The availability of credit, from virtually all types of lenders, has at times been restricted. In the event we need access to additional capital to pay our operating expenses, fund subsidiary surplus requirements, make payments on or refinance our indebtedness, pay capital expenditures, or fund acquisitions, our ability to obtain such capital may be limited and the cost of any such capital may be significant, particularly if we are unable to access our existing credit facility.

Our access to additional financing will depend on a variety of factors such as prevailing economic and credit market conditions, the general availability of credit, the overall availability of credit to our industry, our credit

ratings and credit capacity, and perceptions of our financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain additional financing on favorable terms or at all.

If state regulators do not approve payments of dividends and distributions by our subsidiaries to us, we may not have sufficient funds to implement our business strategy.

We principally operate through our health plan subsidiaries. As part of normal operations, we may make requests for dividends and distributions from our subsidiaries to fund our operations. These subsidiaries are subject to regulations that limit the amount of dividends and distributions that can be paid to us without prior approval of, or notification to, state regulators. If these regulators were to deny our subsidiaries' request to pay dividends, the funds available to us would be limited, which could harm our ability to implement our business strategy.

We derive a majority of our premium revenues from operations in a limited number of states, and our financial position, results of operations or cash flows would be materially affected by a decrease in premium revenues or profitability in any one of those states.

Operations in a limited number of states have accounted for most of our premium revenues to date. If we were unable to continue to operate in any of our current states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly depending on legislative or other governmental or regulatory actions and decisions, economic conditions and similar factors in those states. For example, states we currently serve may bid out their Medicaid program through a request for proposal process. Our inability to continue to operate in any of the states in which we operate could harm our business.

Competition may limit our ability to increase penetration of the markets that we serve.

We compete for members principally on the basis of size and quality of provider networks, benefits provided and quality of service. We compete with numerous types of competitors, including other health plans and traditional state Medicaid programs that reimburse providers as care is provided. In addition, the impact of healthcare reform legislation and potential growth in our segment may attract new competitors.

Some of the health plans with which we compete have greater financial and other resources and offer a broader scope of products than we do. In addition, significant merger and acquisition activity has occurred in the managed care industry, as well as complementary industries, such as the hospital, physician, pharmaceutical, medical device and health information systems businesses. To the extent that competition intensifies in any market that we serve, our ability to retain or increase members and providers, or maintain or increase our revenue growth, pricing flexibility and control over medical cost trends may be adversely affected.

If we are unable to maintain relationships with our provider networks, our profitability may be harmed.

Our profitability depends, in large part, upon our ability to contract at competitive prices with hospitals, physicians and other healthcare providers. Our provider arrangements with our primary care physicians, specialists and hospitals generally may be canceled by either party without cause upon 90 to 120 days prior written notice. We cannot provide any assurance that we will be able to continue to renew our existing contracts or enter into new contracts on a timely basis or under favorable terms enabling us to service our members profitably. Healthcare providers with whom we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

In any particular market, physicians and healthcare providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical costs or difficulty in meeting regulatory or accreditation requirements. In some markets, certain healthcare providers, particularly hospitals, physician/ hospital organizations or multi-specialty physician groups, may have significant market positions or near

monopolies that could result in diminished bargaining power on our part. In addition, accountable care organizations, practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, and other organizational structures that physicians, hospitals and other care providers choose may change the way in which these providers interact with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which could adversely affect our operations, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way that we price our products and estimate our costs, which might require us to incur costs to change our operations. Provider networks may consolidate, resulting in a reduction in the competitive environment. In addition, if these providers refuse to contract with us, use their market position to negotiate contracts unfavorable to us or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

From time to time providers assert or threaten to assert claims seeking to terminate non-cancelable agreements due to alleged actions or inactions by us. In addition, we are aware that other managed care organizations have been subject to class action suits by physicians with respect to claim payment procedures, and we may be subject to similar suits. Regardless of whether any suits brought against us are successful or have merit, they will still be time-consuming and costly and could distract our management's attention. As a result, we may incur significant expenses and may be unable to operate our business effectively. If we are unable to retain our current provider contract terms or enter into new provider contracts timely or on favorable terms, our profitability may be harmed.

We may be unable to attract and retain key personnel.

We are highly dependent on our ability to attract and retain qualified personnel to operate and expand our business. If we lose one or more members of our senior management team, including our chief executive officer, Michael F. Neidorff, who has been instrumental in developing our business strategy and forging our business relationships, our business and financial position, results of operations or cash flows could be harmed. Our ability to replace any departed members of our senior management or other key employees may be difficult and may take an extended period of time because of the limited number of individuals in the managed care and specialty services industry with the breadth of skills and experience required to operate and successfully expand a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain or motivate these personnel.

If we are unable to integrate and manage our information systems effectively, our operations could be disrupted.

Our operations depend significantly on effective information systems. The information gathered and processed by our information systems assists us in, among other things, monitoring utilization and other cost factors, processing provider claims, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status and other information. Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs and regulatory requirements. We regularly upgrade and expand our information systems' capabilities. If we experience difficulties with the transition to or from information systems or are unable to properly maintain or expand our information systems, we could suffer, among other things, operational disruptions, loss of existing members and difficulty in attracting new members, regulatory problems and increases in administrative expenses. In addition, our ability to integrate and manage our information systems may be impaired as the result of events outside our control, including acts of nature, such as earthquakes or fires, or acts of terrorists.

From time to time, we may become involved in costly and time-consuming litigation and other regulatory proceedings, which require significant attention from our management.

We are a defendant from time to time in lawsuits and regulatory actions relating to our business, including, without limitation, medical malpractice claims. Due to the inherent uncertainties of litigation and regulatory proceedings, we cannot accurately predict the ultimate outcome of any such proceedings. An unfavorable outcome could have a material adverse impact on our business and financial position, results of operations or

cash flows. In addition, regardless of the outcome of any litigation or regulatory proceedings, such proceedings are costly and time consuming and require significant attention from our management, and could therefore harm our business and financial position, results of operations or cash flows.

An impairment charge with respect to our recorded goodwill and intangible assets could have a material impact on our results of operations.

We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. Changes in business strategy, government regulations or economic or market conditions have resulted and may result in impairments of our goodwill and other intangible assets at any time in the future. Our judgments regarding the existence of impairment indicators are based on, among other things, legal factors, market conditions, and operational performance. For example, the non-renewal of our health plan contracts with the state in which they operate may be an indicator of impairment. If an event or events occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill and other intangible assets, such revision could result in a non-cash impairment charge that could have a material impact on our results of operations in the period in which the impairment occurs.

If we fail to comply with applicable privacy, security, and data laws, regulations and standards, including with respect to third-party service providers that utilize sensitive personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

As part of our normal operations, we collect, process and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including HIPAA and the Gramm-Leach-Bliley Act, which require us to protect the privacy of medical records and safeguard personal health information we maintain and use. Despite our best attempts to maintain adherence to information security best practices as well as compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers, may be vulnerable to security breaches, acts of vandalism or theft, malware, misplaced or lost data including paper or electronic media, programming and/or human errors or other similar events. In the past, we have had data breaches resulting in disclosure of confidential or protected health information that have not resulted in any material financial loss or penalty to date. However, future data breaches could require us to expend significant resources to remediate any damage, interrupt our operations and damage our reputation, subject us to state or federal agency review and could also result in enforcement actions, material fines and penalties, litigation or other actions which could have a material adverse effect on our business, reputation and results of operations, financial position and cash flows.

Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities.

HIPAA broadened the scope of fraud and abuse laws applicable to healthcare companies. HIPAA created civil penalties for, among other things, billing for medically unnecessary goods or services. HIPAA established new enforcement mechanisms to combat fraud and abuse, including civil and, in some instances, criminal penalties for failure to comply with specific standards relating to the privacy, security and electronic transmission of protected health information. The HITECH Act expanded the scope of these provisions by mandating individual notification in instances of breaches of protected health information, providing enhanced penalties for HIPAA violations, and granting enforcement authority to states' Attorneys General in addition to the HHS Office of Civil Rights. It is possible that Congress may enact additional legislation in the future to increase penalties and to create a private right of action under HIPAA, which could entitle patients to seek monetary damages for violations of the privacy rules. In addition, HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities. Although we are not aware of HHS plans to audit any of our covered entities, an audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Under HIPAA, health plans are required to have the capacity to accept and send all covered transactions in a standardized electronic format. Penalties can be imposed for failure to comply with these requirements. The transaction standards have been modified to version 5010 to prepare for the implementation of the ICD-10 coding system. While we have prepared for the transition to ICD-10 in October 2014, if unforeseen circumstances arise, it is possible that we could be exposed to investigations and allegations of noncompliance. In addition, if some providers continue to use ICD-9 codes on claims after October 1, 2014, we may have to reject such claims, which may lead to claim resubmissions, increased call volume and provider and customer dissatisfaction. Further, providers may use ICD-10 codes differently than they used ICD-9 codes in the past, which could result in higher costs and reimbursement levels, or lost revenues under risk adjustment. During the transition to ICD-10, certain claims processing and payment information we have historically used to establish our reserves may not be reliable or available in a timely manner. As a result, implementation of ICD 10 may have a material adverse effect on our results of operations, financial position and cash flows.

A failure in or breach of our operational or security systems or infrastructure, or those of third parties with which we do business, including as a result of cyber attacks, could have an adverse effect on our business.

Information security risks have significantly increased in recent years in part because of the proliferation of new technologies, the use of the internet and telecommunications technologies to conduct our operations, and the increased sophistication and activities of organized crime, hackers, terrorists and other external parties, including foreign state agents. Our operations rely on the secure processing, transmission and storage of confidential, proprietary and other information in our computer systems and networks.

Security breaches may arise from external or internal threats. External breaches include hacking personal information for financial gain, attempting to cause harm to our operations, or intending to obtain competitive information. We experience attempted external hacking attacks on a regular basis. We maintain a rigorous system of preventive and detective controls through our security programs; however, our prevention and detection controls may not prevent or identify all such attacks. Internal breaches may result from inappropriate security access to confidential information by rogue employees, consultants or third party service providers. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, financial data, competitively sensitive information, or other proprietary data, whether by us or a third party, could have a material adverse effect on our business reputation, financial condition, cash flows, or results of operations.

Item 1B. ***Unresolved Staff Comments***

None.

Item 2. ***Properties***

We own our corporate office headquarters buildings and land located in St. Louis, Missouri. We generally lease space in the states where our health plans, specialty companies and claims processing facilities operate. We are required by various insurance and regulatory authorities to have offices in the service areas where we provide benefits. We believe our current facilities are adequate to meet our operational needs for the foreseeable future.

Item 3. ***Legal Proceedings.***

In October 2012, the Company notified the Kentucky Cabinet for Health and Family Services (Cabinet) that it was exercising a contractual right that it believes allows the Company to terminate its Medicaid managed care contract with the Commonwealth of Kentucky (Commonwealth) effective July 5, 2013. The Company also filed a lawsuit in Franklin Circuit Court against the Commonwealth seeking a declaration of the Company's right to terminate the contract on July 5, 2013. In April 2013, the Commonwealth answered that lawsuit and filed counterclaims against the Company seeking declaratory relief and damages. In May 2013, the Franklin Circuit Court ruled that Kentucky Spirit does not have a contractual right to terminate the contract early. Kentucky Spirit has appealed that ruling to the Kentucky Court of Appeals.

The Company also filed a formal dispute with the Cabinet for damages incurred under the contract, which was later appealed to and denied by the Finance and Administration Cabinet. In response, the Company filed a lawsuit in April 2013, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches. This lawsuit was subsequently consolidated with the original lawsuit for declaratory relief and continues to proceed.

Kentucky Spirit's efforts to resolve issues with the Commonwealth were unsuccessful and on July 5, 2013, Kentucky Spirit proceeded with its previously announced exit. The Commonwealth has alleged that Kentucky Spirit's exit constitutes a material breach of contract. The Commonwealth seeks to recover substantial damages and to enforce its rights under Kentucky Spirit's $25.0 million performance bond. Any claim for damages by the Commonwealth may include the costs of transition and the additional costs to the Commonwealth to cover Kentucky Spirit's former members through July 5, 2014. Kentucky Spirit is pursuing its litigation claims for damages against the Commonwealth and will vigorously defend against any allegations that it has breached the contract.

The resolution of the Kentucky litigation matters may result in a range of possible outcomes. If the Company prevails on its claims, Kentucky Spirit would be entitled to damages under its lawsuit. If the Commonwealth prevails, a liability to the Commonwealth could be recorded. The Company is unable to estimate the ultimate outcome resulting from the Kentucky litigation. As a result, the Company has not recorded any receivable or any liability for potential damages under the contract as of December 31, 2013. While uncertain, the ultimate resolution of the pending litigation could have a material effect on the financial position, cash flow or results of operations of the Company in the period it is resolved or becomes known.

Excluding the Kentucky matters discussed above, the Company is also routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters in the normal course of business is uncertain, the Company does not expect the results of any of these matters individually, or in the aggregate, to have a material effect on its financial position, cash flow or results of operations.

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; Dividends

Our common stock has been traded and quoted on the New York Stock Exchange under the symbol "CNC" since October 16, 2003. The high and low prices, as reported by the NYSE, are set forth below for the periods indicated.

	2014 Stock Price (through February 12, 2014)		2013 Stock Price		2012 Stock Price	
	High	Low	High	Low	High	Low
First Quarter	$63.09	$56.88	$48.55	$40.57	$50.36	$38.97
Second Quarter			52.74	42.14	50.98	24.26
Third Quarter			65.04	52.82	42.46	28.86
Fourth Quarter			67.84	54.12	46.44	34.73

As of February 14, 2014, there were 56 holders of record of our common stock.

We have never declared any cash dividends on our capital stock and currently anticipate that we will retain any future earnings for the development, operation and expansion of our business.

Issuer Purchases of Equity Securities

On October 26, 2009, the Company's Board of Directors extended the Company's stock repurchase program. The program authorizes the repurchase of up to 4,000,000 shares of the Company's common stock from time to time on the open market or through privately negotiated transactions. We have 1,667,724 available shares remaining under the program for repurchases as of December 31, 2013. No duration has been placed on the repurchase program. The Company reserves the right to discontinue the repurchase program at any time. During the year ended December 31, 2013, we did not repurchase any shares through this publicly announced program.

Issuer Purchases of Equity Securities
Fourth Quarter 2013

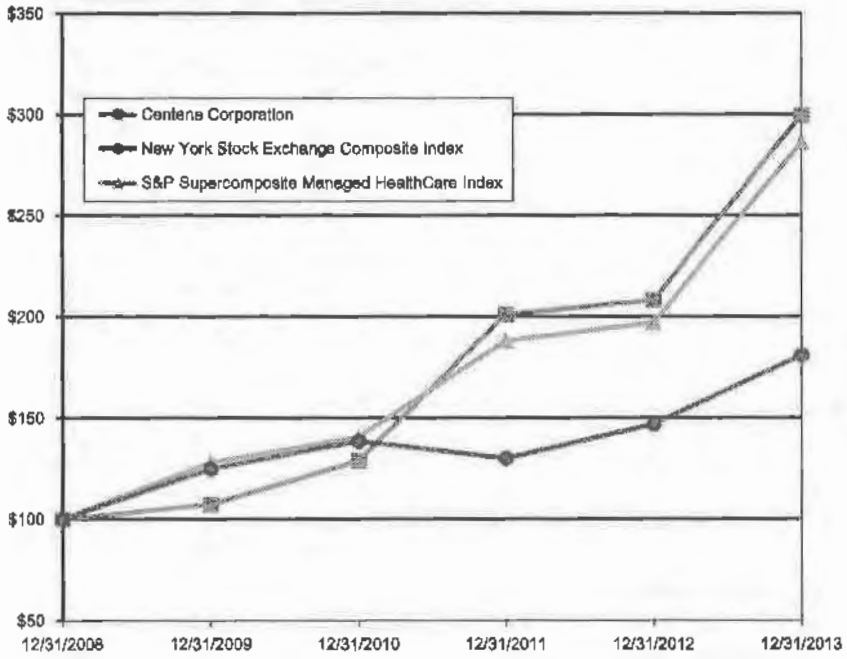
Period	Total Number of Shares Purchased[1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs[2]
October 1 – October 31, 2013	9,311	$62.37	—	1,667,724
November 1 – November 30, 2013	5,363	57.82	—	1,667,724
December 1 – December 31, 2013	234,055	56.44	—	1,667,724
Total	248,729	$56.69	—	1,667,724

(1) Shares acquired represent shares relinquished to the Company by certain employees for payment of taxes or option cost upon vesting of restricted stock units or option exercise.

(2) Our Board of Directors adopted a stock repurchase program which allows for repurchases of up to a remaining amount of 1,667,724 shares. No duration has been placed on the repurchase program.

Stock Performance Graph

The graph below compares the cumulative total stockholder return on our common stock for the period from December 31, 2008 to December 31, 2013 with the cumulative total return of the New York Stock Exchange Composite Index and the Standard & Poor's Supercomposite Managed Healthcare Index over the same period. The graph assumes an investment of $100 on December 31, 2008 in our common stock (at the last reported sale price on such day), the New York Stock Exchange Composite Index and the Standard & Poor's Supercomposite Managed Healthcare Index and assumes the reinvestment of any dividends. In prior years, the Company used the Morgan Stanley Healthcare Payor Index, which was discontinued in October 2013.



	December 31,					
	2008	2009	2010	2011	2012	2013
Centene Corporation	$100.00	$107.41	$128.56	$200.86	$208.02	$299.09
New York Stock Exchange Composite Index	100.00	124.80	138.34	129.88	146.66	180.65
S&P Supercomposite Managed Healthcare Index	100.00	128.05	140.22	187.84	196.95	285.81
Centene Corporation closing stock price	$ 19.71	$ 21.17	$ 25.34	$ 39.59	$ 41.00	$ 58.95
Centene Corporation annual shareholder return		7.4%	19.7%	56.2%	3.6%	43.8%

In accordance with the rules of the SEC, the information contained in the Stock Performance Graph on this page shall not be deemed to be "soliciting material," or to be "filed" with the SEC or subject to the SEC's Regulation 14A, or to the liabilities of Section 18 of the Exchange Act, except to the extent that Centene specifically requests that the information be treated as soliciting material or specifically incorporates it by reference into a document filed under the Securities Act, or the Exchange Act.

Item 6. *Selected Financial Data*

The following selected consolidated financial data should be read in conjunction with the consolidated financial statements and related notes and "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" included in our Annual Report on Form 10-K. The assets, liabilities and results of operations of Kentucky Spirit Health Plan, FirstGuard and University Health Plans have been classified as discontinued operations for all periods presented.

	Year Ended December 31,				
	2013	2012	2011	2010	2009
	(In thousands, except share data)				
Revenues:					
Premium	$10,153,460	$ 7,568,889	$ 4,948,137	$ 4,192,172	$ 3,786,525
Service	372,580	112,742	103,765	91,661	91,758
Premium and service revenues	10,526,040	7,681,631	5,051,902	4,283,833	3,878,283
Premium tax	337,289	428,665	159,575	164,490	224,581
Total revenues	10,863,329	8,110,296	5,211,477	4,448,323	4,102,864
Expenses:					
Medical costs	8,994,641	6,781,081	4,191,268	3,584,452	3,230,131
Cost of services	326,924	87,705	78,114	63,919	60,789
General and administrative expenses	931,137	677,157	577,898	477,765	447,921
Premium tax expense	333,210	428,354	160,394	165,118	225,888
Impairment loss	—	28,033	—	—	—
Total operating expenses	10,585,912	8,002,330	5,007,674	4,291,254	3,964,729
Earnings from operations	277,417	107,966	203,803	157,069	138,135
Other income (expense):					
Investment and other income	18,457	35,285	13,355	15,205	15,691
Debt extinguishment costs	—	—	(8,488)	—	—
Interest expense	(26,957)	(20,460)	(20,320)	(17,992)	(16,318)
Earnings from continuing operations, before income tax expense	268,917	122,791	188,350	154,282	137,508
Income tax expense	107,080	47,412	70,687	59,900	48,841
Earnings from continuing operations, net of income tax expense	161,837	75,379	117,663	94,382	88,667
Discontinued operations, net of income tax expense (benefit) of $2,284, $(47,741), $(4,165), $4,388, and $(1,204), respectively	3,881	(86,674)	(9,300)	3,889	(2,422)
Net earnings (loss)	165,718	(11,295)	108,363	98,271	86,245
Noncontrolling interest	619	(13,154)	(2,855)	3,435	2,574
Net earnings attributable to Centene Corporation	$ 165,099	$ 1,859	$ 111,218	$ 94,836	$ 83,671
Amounts attributable to Centene Corporation common shareholders:					
Earnings from continuing operations, net of income tax expense	$ 161,218	$ 88,533	$ 120,518	$ 90,947	$ 86,093
Discontinued operations, net of income tax expense (benefit)	3,881	(86,674)	(9,300)	3,889	(2,422)
Net earnings	$ 165,099	$ 1,859	$ 111,218	$ 94,836	$ 83,671
Net earnings (loss) per common share attributable to Centene Corporation:					
Basic:					
Continuing operations	$ 2.98	$ 1.72	$ 2.40	$ 1.87	$ 2.00
Discontinued operations	0.07	(1.68)	(0.18)	0.08	(0.06)
Basic earnings per common share	$ 3.05	$ 0.04	$ 2.22	$ 1.95	$ 1.94
Diluted:					
Continuing operations	$ 2.87	$ 1.65	$ 2.30	$ 1.80	$ 1.94
Discontinued operations	0.07	(1.62)	(0.18)	0.08	(0.05)
Diluted earnings per common share	$ 2.94	$ 0.03	$ 2.12	$ 1.88	$ 1.89
Weighted average number of common shares outstanding:					
Basic	54,126,545	51,509,366	50,198,954	48,754,947	43,034,791
Diluted	56,247,173	53,714,375	52,474,238	50,447,888	44,316,467

	December 31,				
	2013	2012	2011	2010	2009
	(In thousands)				
Consolidated Balance Sheet Data From Continuing Operations:					
Cash and cash equivalents	$ 974,304	$ 745,933	$ 493,532	$ 433,914	$ 400,951
Investments and restricted deposits	940,972	727,157	652,992	639,983	585,183
Total assets	3,413,483	2,534,612	2,092,530	1,937,852	1,668,772
Medical claims liability	1,111,709	815,161	518,840	456,765	470,932
Long term debt	665,697	535,481	348,344	327,824	307,085
Total stockholders' equity	1,243,439	953,767	936,419	797,055	619,427

ITEM 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations.*

The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes included elsewhere in this filing. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under Part I, Item 1A. "Risk Factors" of this Form 10-K.

OVERVIEW

Our subsidiary, Kentucky Spirit Health Plan (KSHP), ceased serving Medicaid members in Kentucky as of July 6, 2013. Accordingly, the results of operations for KSHP are classified as discontinued operations for all periods presented in our consolidated financial statements. The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise identified.

Our financial performance for 2013 is summarized as follows:

- Year-end at-risk managed care membership of 2,723,200, an increase of 298,700 members, or 12.3% over 2012.
- Premium and service revenues of $10.5 billion, representing 37.0% growth year over year.
- Health Benefits Ratio of 88.6%, compared to 89.6% in 2012.
- General and Administrative expense ratio of 8.8%, compared to 8.8% in 2012.
- Total operating cash flows of $382.5 million, or 2.3 times net earnings.
- Diluted net earnings per share of $2.87, compared to $1.65 in 2012.

The following items contributed to our revenue and membership growth over the last two years:

- *AcariaHealth.* In April 2013, we completed the acquisition of AcariaHealth, a specialty pharmacy company, for $142.5 million. The transaction consideration was financed through a combination of Centene common stock and cash on hand.
- *California.* In November 2013, our California subsidiary, California Health and Wellness Plan (CHWP), began operating under a new contract with the California Department of Health Care Services to serve Medicaid beneficiaries in 18 rural counties under the state's Medi-Cal Managed Care Rural Expansion program. Also in November 2013, CHWP began operating under a new contract to serve Medi-Cal beneficiaries in Imperial County.
- *Florida.* In August 2013, our Florida subsidiary, Sunshine Health, began operating under a contract with the Florida Agency for Health Care Administration to serve members of the Medicaid managed care LTC program. Enrollment began in August 2013 and will be implemented by region and continue through March 2014.
- *Kansas.* In January 2013, our subsidiary, Sunflower State Health Plan, began operating under a statewide contract to serve members in the state's KanCare program, which includes TANF, ABD (dual and non-dual), foster care, LTC and CHIP beneficiaries.
- *Louisiana.* In February 2012, Louisiana Healthcare Connections (LHC), began operating through a joint venture under a new contract in Louisiana to provide healthcare services to Medicaid enrollees participating in the Bayou Health program. LHC completed its three-phase membership roll-out for the three geographical service areas during the second quarter of 2012. In November 2012, the covered services provided by LHC expanded to include pharmacy benefits. During the fourth quarter of 2012, we acquired the ownership interest of our joint venture partner, bringing our ownership to 100%.
- *Massachusetts.* In July 2013, our joint venture subsidiary, Centurion, began operating under a new contract with the Department of Corrections in Massachusetts to provide comprehensive healthcare services to individuals incarcerated in Massachusetts state correctional facilities. Centurion is a joint venture between Centene and MHM Services Inc.

- *Mississippi.* In December 2012, our subsidiary, Magnolia Health Plan, began operating under an expanded contract to provide managed care services statewide to Medicaid members as well as providing behavioral health services.
- *Missouri.* In July 2012, our majority owned subsidiary, Home State Health Plan, began operating under a new contract with the Office of Administration for Missouri to serve Medicaid beneficiaries in the Eastern, Central, and Western Managed Care Regions of the state.
- *New Hampshire.* In December 2013, our subsidiary, New Hampshire Healthy Families, began operating under a new contract with the Department of Health and Human Services to serve Medicaid beneficiaries.
- *Ohio.* In July 2013, our Ohio subsidiary, Buckeye Community Health Plan (Buckeye), began operating under a new and expanded contract with Ohio Department of Job and Family Services (ODJFS) to serve Medicaid members statewide through Ohio's three newly aligned regions (West, Central/Southeast, and Northeast). Buckeye also began serving members under the ABD Children program in July 2013.
- *Tennessee.* In September 2013, our joint venture subsidiary, Centurion, began operating under a new contract to provide comprehensive healthcare services to individuals incarcerated in Tennessee state correctional facilities.
- *Texas.* In March 2012, we began operating under contracts in Texas that expanded its operations through new service areas including the 10 county Hidalgo Service Area and the Medicaid Rural Service Areas of West Texas, Central Texas and North-East Texas, as well as the addition of STAR+PLUS in the Lubbock Service Area. The expansion also added the management of outpatient pharmacy benefits in all service areas and products, as well as inpatient facility services for the STAR+PLUS program.
- *Washington.* In July 2012, we began operating under a new contract with the Washington Health Care Authority to serve Medicaid beneficiaries in the state, operating as Coordinated Care.

We expect the following items to contribute to our future growth potential:

- We expect to realize the full year benefit in 2014 of business commenced during 2013 in California, Florida, Massachusetts, New Hampshire, Ohio, and Tennessee as discussed above.
- In February 2014, our Mississippi subsidiary, Magnolia Health Plan, was awarded a statewide managed care contract to continue serving members enrolled in the Mississippi Coordinated Access Network (MississippiCAN) program, as one of two contractors. Under the new contract, Magnolia will continue providing outpatient, behavioral health, pharmacy, vision and dental services, and will also begin providing non-emergency transportation as of July 1, 2014.
- In January 2014, we acquired a majority interest in U.S. Medical Management, LLC, a management services organization and provider of in-home health services for high acuity populations, for approximately $200.0 million. The transaction consideration was financed through a combination of cash on hand and 2,243,217 shares of Centene common stock
- In January 2014, we began serving members enrolled in Health Insurance Marketplaces in certain regions of 9 states: Arkansas, Florida, Georgia, Indiana, Massachusetts, Mississippi, Ohio, Texas and Washington.
- In January 2014, our CeltiCare subsidiary began operating under a new contract with the Massachusetts Executive Office of Health and Human Services to participate in the MassHealth CarePlus program in all five regions.
- In January 2014, Centurion began operating under a new agreement with the Minnesota Department of Corrections to provide managed healthcare services to offenders in the state's correctional facilities.
- In December 2013, we signed a definitive agreement to purchase a majority stake in Fidelis SecureCare of Michigan, Inc. (Fidelis), a subsidiary of Fidelis SeniorCare, Inc. The transaction is expected to close in the fourth quarter of 2014, subject to certain closing conditions including regulatory approvals, and will involve cash purchase price payments contingent on the performance of the plan over the course of 2015. Fidelis was recently selected by the Michigan Department of Community Health to provide

integrated healthcare services to members who are dually eligible for Medicare and Medicaid in Macomb and Wayne counties. Enrollment is expected to commence in the fourth quarter of 2014.

- In November 2013, our South Carolina subsidiary, Absolute Total Care, was selected by the South Carolina Department of Health and Human Services to serve dual-eligible members as part of the state's pilot program to provide integrated and coordinated care for individuals who are eligible for both Medicare and Medicaid. Operations are expected to commence in the second half of 2014.
- In September 2013, the Florida Agency for Health Care Administration provided notice of intent to award a contract to our subsidiary, Sunshine Health, in 9 of 11 regions of the Managed Medical Assistance (MMA) program. The MMA program includes TANF recipients as well as ABD and dual-eligible members. The award is subject to challenge and contract readiness periods, with enrollment expected to begin in the second quarter of 2014 and continue through October 2014. In addition, we were recommended as the sole provider under a contract award for the Child Welfare Specialty Plan (Foster Care), which is expected to commence in the second quarter of 2014.
- In September 2013, we were awarded a contract in Texas from the Texas Health and Human Services Commission to expand our operations and serve STAR+PLUS members in two Medicaid Rural Service Areas. Enrollment is expected to begin in the second half of 2014.
- In November 2012, our Illinois subsidiary, IlliniCare Health Plan, was selected, contingent upon successful completion of contract negotiations, to serve dual-eligible members in Cook, DuPage, Lake, Kane, Kankakee and Will counties (Greater Chicago region) as part of the Illinois Medicare-Medicaid Alignment Initiative. Upon execution of a contract and regulatory approval, enrollment is expected to begin in 2014.
- In August 2012, we were notified by the ODJFS that Buckeye, our Ohio subsidiary, was selected to serve Medicaid members in a dual-eligible demonstration program in three of Ohio's pre-determined seven regions: Northeast (Cleveland), Northwest (Toledo) and West Central (Dayton). This three-year program, which is part of the state of Ohio's Integrated Care Delivery System (ICDS) expansion, will serve those who have both Medicare and Medicaid eligibility. Enrollment is expected to begin in 2014.

In March 2013, we were notified by the Arizona Health Care Cost Containment System (AHCCCS) that our Bridgeway Health Solutions of Arizona, LLC acute care contract was not renewed. As a result, our contract terminated on September 30, 2013. Bridgeway served 16,700 Medicaid acute care members in Yavapai County at September 30, 2013.

MEMBERSHIP

From December 31, 2011 to December 31, 2013, we increased our at-risk managed care membership by 1,087,900, or 66.5%. The following table sets forth our membership by state for our managed care organizations:

	December 31,		
	2013	2012	2011
Arizona	7,100	23,500	23,700
California	97,200	—	—
Florida	222,000	214,000	198,300
Georgia	318,700	313,700	298,200
Illinois	22,300	18,000	16,300
Indiana	195,500	204,000	206,900
Kansas	139,900	—	—
Louisiana	152,300	165,600	—
Massachusetts	22,600	21,500	35,700
Mississippi	78,300	77,200	31,600
Missouri	59,200	59,600	—
New Hampshire	33,600	—	—
Ohio	173,200	157,800	159,900
South Carolina	91,900	90,100	82,900
Tennessee	20,700	—	—
Texas	935,100	949,900	503,800
Washington	82,100	57,200	—
Wisconsin	71,500	72,400	78,000
Total	2,723,200	2,424,500	1,635,300

The following table sets forth our membership by line of business:

	December 31,		
	2013	2012	2011
Medicaid	2,054,700	1,877,100	1,202,300
CHIP & Foster Care	275,100	235,200	210,600
ABD & Medicare	305,300	274,600	175,100
Hybrid Programs	19,000	29,100	40,500
LTC	37,800	8,500	6,800
Correctional Services	31,300	—	—
Total	2,723,200	2,424,500	1,635,300

The following table identifies the Company's dual-eligible membership by line of business. The membership tables above include these members.

	December 31,		
	2013	2012	2011
ABD	71,700	62,600	34,400
LTC	28,800	7,700	6,200
Medicare	6,500	5,100	3,200
Total	107,000	75,400	43,800

At December 31, 2013, we also served 156,600 members under our behavioral health contract in Arizona, compared to 157,900 members at December 31, 2012.

From December 31, 2012 to December 31, 2013 our membership increased as a result of:

- operations commencing in California, Kansas and New Hampshire;
- geographic expansion in Ohio;
- growth in Washington; and,
- the commencement of correctional services contracts in Massachusetts and Tennessee.

From December 31, 2011 to December 31, 2012 our membership increased as a result of the commencement of operations in Louisiana, Missouri and Washington as well as the geographic expansion in Texas.

RESULTS OF OPERATIONS

The following discussion and analysis is based on our consolidated statements of operations, which reflect our results of operations for each of the three years ended December 31, 2013, prepared in accordance with generally accepted accounting principles in the United States ($ in millions):

	2013	2012	2011	% Change 2012-2013	% Change 2011-2012
Premium	$10,153.4	$7,568.9	$4,948.1	34.1%	53.0%
Service	372.6	112.7	103.8	230.5%	8.7%
Premium and service revenues	10,526.0	7,681.6	5,051.9	37.0%	52.1%
Premium tax	337.3	428.7	159.6	(21.3)%	168.6%
Total revenues	10,863.3	8,110.3	5,211.5	33.9%	55.6%
Medical costs	8,994.7	6,781.1	4,191.3	32.6%	61.8%
Cost of services	326.9	87.7	78.1	272.8%	12.3%
General and administrative expenses	931.1	677.2	577.9	37.5%	17.2%
Premium tax expense	333.2	428.4	160.4	(22.2)%	167.1%
Impairment loss	—	28.0	—	(100.0)%	n.m.
Earnings from operations	277.4	107.9	203.8	156.9%	(47.0)%
Investment and other income, net	(8.5)	14.8	(15.5)	(157.3)%	195.9%
Earnings from continuing operations, before income tax expense	268.9	122.7	188.3	119.0%	(34.8)%
Income tax expense	107.1	47.4	70.7	125.8%	(32.9)%
Earnings from continuing operations, net of income tax	161.8	75.3	117.6	114.7%	(35.9)%
Discontinued operations, net of income tax expense (benefit) of $2.3, $(47.7), and $(4.2) respectively	3.9	(86.7)	(9.3)	104.5%	n.m.
Net earnings (loss)	165.7	(11.4)	108.3	n.m.	(110.4)%
Noncontrolling interest	0.6	(13.2)	(2.9)	104.7%	(360.7)%
Net earnings attributable to Centene Corporation	$ 165.1	$ 1.8	$ 111.2	n.m.	(98.3)%
Amounts attributable to Centene Corporation common shareholders:					
Earnings from continuing operations, net of income tax expense	$ 161.2	$ 88.5	$ 120.5	82.1%	(26.5)%
Discontinued operations, net of income tax expense	3.9	(86.7)	(9.3)	104.5%	n.m.
Net earnings	$ 165.1	$ 1.8	$ 111.2	n.m.	(98.3)%
Diluted earnings (loss) per common share attributable to Centene Corporation:					
Continuing operations	$ 2.87	$ 1.65	$ 2.30	73.9%	(28.3)%
Discontinued operations	0.07	(1.62)	(0.18)	104.3%	n.m.
Total diluted earnings per common share	$ 2.94	$ 0.03	$ 2.12	n.m.	(98.6)%

n.m.: not meaningful.

Revenues and Revenue Recognition

Our health plans generate revenues primarily from premiums we receive from the states in which we operate. We generally receive a fixed premium per member per month pursuant to our state contracts. We generally receive premium payments and recognize premium revenue during the month in which we are obligated to provide services to our members. In some instances, our base premiums are subject to an adjustment, or risk score, based on the acuity of our membership. Generally, the risk score is determined by the state analyzing submissions of processed claims data to determine the acuity of our membership relative to the entire state's membership. Some contracts allow for additional premiums associated with certain supplemental services provided such as maternity deliveries.

Our contracts with states may require us to maintain a minimum health benefits ratio or may require us to share profits in excess of certain levels. In certain circumstances, our plans may be required to pay a rebate to the state in the event profits exceed established levels. We recognize reductions in revenue in the current period for these programs. Other states may require us to meet certain performance and quality metrics in order to receive additional or full contractual revenue. For performance-based contracts, we do not recognize revenue subject to refund until data is sufficient to measure performance.

Revenues are recorded based on membership and eligibility data provided by the states, which is adjusted on a monthly basis by the states for retroactive additions or deletions to membership data. These eligibility adjustments are estimated monthly and subsequently adjusted in the period known. We continuously review and update those estimates as new information becomes available. It is possible that new information could require us to make additional adjustments, which could be significant, to these estimates.

Our specialty services generate revenues under contracts with state programs, healthcare organizations, and other commercial organizations, as well as from our own subsidiaries. Revenues are recognized when the related services are provided or as ratably earned over the covered period of services.

Premium and service revenues collected in advance are recorded as unearned revenue. Premium and service revenues due to us are recorded as premium and related receivables and are recorded net of an allowance based on historical trends and our management's judgment on the collectibility of these accounts. As we generally receive payments during the month in which services are provided, the allowance is typically not significant in comparison to total revenues and does not have a material impact on the presentation of our financial condition or results of operations.

Some states enact premium taxes, similar assessments and provider and hospital pass-through payments, collectively, premium taxes, and these taxes are recorded as a component of revenues as well as operating expenses. We exclude premium taxes from our key ratios as we believe the premium tax is a pass-through of costs and not indicative of our operating performance.

The Centers for Medicare and Medicaid Services (CMS) deploys a risk adjustment model that retroactively apportions Medicare premiums paid according to health severity and certain demographic factors. The model pays more for members whose medical history indicates they have certain medical conditions. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient, physician treatment settings as well as prescription drug events. The Company estimates the amount of risk adjustment based upon the diagnosis and pharmacy data submitted and expected to be submitted to CMS and records revenues on a risk adjusted basis.

Operating Expenses

Medical Costs

Medical costs include payments to physicians, hospitals, and other providers for healthcare and specialty services claims. Medical costs also include estimates of medical expenses incurred but not yet reported, or IBNR, and estimates of the cost to process unpaid claims. We use our judgment to determine the assumptions to be used in the calculation of the required IBNR estimate. The assumptions we consider include, without limitation,

claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims.

Our development of the IBNR estimate is a continuous process which we monitor and refine on a monthly basis as claims receipts and payment information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expense in the period in which the changes are identified.

Additionally, we contract with independent actuaries to review our estimates on a quarterly basis. The independent actuaries provide us with a review letter that includes the results of their analysis of our medical claims liability. We do not solely rely on their report to adjust our claims liability. We utilize their calculation of our claims liability only as additional information, together with management's judgment, to determine the assumptions to be used in the calculation of our liability for medical costs.

While we believe our IBNR estimate is appropriate, it is possible future events could require us to make significant adjustments for revisions to these estimates. Accordingly, we cannot assure you that medical costs will not materially differ from our estimates.

Results of operations depend on our ability to manage expenses associated with health benefits and to accurately predict costs incurred. The health benefits ratio, or HBR, represents medical costs as a percentage of premium revenues (excluding premium taxes) and reflects the direct relationship between the premium received and the medical services provided.

Cost of Services

Cost of services expense includes the pharmaceutical costs associated with our pharmacy benefit manager and specialty pharmacy's external revenues and certain direct costs to support the functions responsible for generation of our service revenues. These expenses consist of the salaries and wages of the professionals who provide the services and associated expenses.

General and Administrative Expenses

General and administrative expenses, or G&A, primarily reflect wages and benefits, including stock compensation expense, and other administrative costs associated with our health plans, specialty companies and centralized functions that support all of our business units. Our major centralized functions are finance, information systems and claims processing. G&A expenses also include business expansion costs, such as wages and benefits for administrative personnel, contracting costs, and information technology buildouts, incurred prior to the commencement of a new contract or health plan.

The G&A expense ratio represents G&A expenses as a percentage of premium and service revenues, and reflects the relationship between revenues earned and the costs necessary to earn those revenues.

Other Income (Expense)

Other income (expense) consists principally of investment income from cash and investments, earnings in equity method investments, and interest expense on debt.

Discontinued Operations

Our subsidiary, Kentucky Spirit Health Plan (KSHP), ceased serving Medicaid members in Kentucky as of July 6, 2013. Accordingly, the results of operations for KSHP are classified as discontinued operations for all periods presented in our consolidated financial statements. The following discussion and analysis is presented primarily in the context of continuing operations unless otherwise identified.

Year Ended December 31, 2013 Compared to Year Ended December 31, 2012

Premium and Service Revenues

Premium and service revenues increased 37.0% in the year ended December 31, 2013 over the corresponding period in 2012 as a result of the Texas, Mississippi, Louisiana and Florida expansions, pharmacy carve-ins in Texas and Louisiana, the additions of the Kansas, Missouri, Washington, California and New Hampshire contracts, commencement of the correctional healthcare contracts in Massachusetts and Tennessee, rate increases in several of our markets and the acquisition of AcariaHealth. During the year ended December 31, 2013, we received premium rate adjustments which yielded a net 2.7% composite increase across all of our markets.

Premium Tax Revenue

Premium tax revenue decreased 21.3% in the year ended December 31, 2013 over the corresponding period in 2012. This is as a result of one of our states paying us approximately $180 million in 2012 to pay to specified providers.

Operating Expenses

Medical Costs

The table below depicts the HBR for our membership by member category for the year ended December 31,:

	2013	2012
Medicaid and CHIP	87.5%	88.8%
ABD and Medicare	90.4	90.7
Specialty Services	85.4	92.0
Total	88.6	89.6

The consolidated HBR for the year ended December 31, 2013, of 88.6% was a decrease of 100 basis points over the comparable period in 2012. The 2013 HBR reflects performance improvement in Texas and our individual insurance business from 2012.

Cost of Services

Cost of services increased by $239.2 million in the year ended December 31, 2013, compared to the corresponding period in 2012. This was primarily due to the additional volume resulting from the acquisition of AcariaHealth.

General & Administrative Expenses

General and administrative expenses, or G&A, increased by $254.0 million in the year ended December 31, 2013, compared to the corresponding period in 2012. This was primarily due to expenses for additional staff and facilities to support our membership growth, AcariaHealth transaction costs, as well as performance based compensation.

The consolidated G&A expense ratio for the years ended December 31, 2013 and 2012 was 8.8% and 8.8% respectively. The G&A expense ratio reflects an increase in performance based compensation expense in 2013 as well as AcariaHealth transaction costs, offset by the benefits of leveraging of expenses over higher revenue in 2013 and our efforts to control costs.

Other Income (Expense)

The following table summarizes the components of other income (expense) for the year ended December 31, ($ in millions):

	2013	2012
Investment income	$ 18.5	$ 15.9
Gain on sale of investments	—	1.5
Gain on sale of investment in convertible note	—	17.9
Interest expense	(27.0)	(20.5)
Other income (expense), net	$ (8.5)	$ 14.8

Investment income. The increase in investment income in 2013 primarily reflects an increase in investment balances over 2012.

Gain on sale of investments. During 2012, we recognized $1.5 million in net gains primarily as a result of the liquidation of $75.5 million of investments held by the Georgia health plan in order to meet short term liquidity needs due to delays in premium receipts from the state.

Gain on sale of investment in convertible note. During 2012, we executed an agreement with a third party borrower whereby the borrower agreed to pay us total consideration of $50.0 million for retirement of $30.0 million of outstanding notes and equity ownership conversion features in certain Medicaid and Medicare related businesses. As a result, we recorded a pre-tax gain of $17.9 million in other income representing the fair value of the total consideration in excess of the carrying value of the loans on the balance sheet.

Interest expense. Interest expense increased during the year ended December 31, 2013 by $6.5 million reflecting the addition of $175 million of Senior Notes in the fourth quarter of 2012.

Income Tax Expense

Excluding the effects of noncontrolling interests, our effective tax rate for the year ended December 31, 2013 was 39.9% compared to 34.9% in 2012. The increase in the income tax rate over 2012 resulted from a tax benefit in 2012 resulting from the clarification by a state taxing authority regarding a state income tax calculation, partially offset by a non-deductible goodwill impairment in 2012.

Segment Results

The following table summarizes our operating results by segment for the year ended December 31, (in millions):

	2013	2012	% Change 2012-2013
Premium and Service Revenues			
Managed Care	$ 9,781.8	$ 7,212.0	35.6%
Specialty Services	2,932.5	2,107.0	39.2%
Eliminations	(2,188.3)	(1,637.4)	(33.6)%
Consolidated Total	$10,526.0	$ 7,681.6	37.0%
Earnings from Operations			
Managed Care	$ 197.8	$ 62.9	214.7%
Specialty Services	79.6	45.1	76.4%
Consolidated Total	$ 277.4	$ 108.0	156.9%

Managed Care

Premium and service revenues increased 35.6% in the year ended December 31, 2013, due to the Texas, Mississippi, Louisiana and Florida expansions, pharmacy carve-ins in Texas and Louisiana, the additions of the California, Kansas, Missouri, New Hampshire and Washington contracts and rate increases in several of our markets. Earnings from operations increased $134.9 million in the year ended December 31, 2013, primarily due to improvements in the performance of the Texas business from 2012.

Specialty Services

Premium and service revenues increased 39.2% in the year ended December 31, 2013, due to the carve-in of pharmacy services in Texas and Louisiana, growth in our Medicaid segment and the associated services provided to this increased membership, the acquisition of AcariaHealth and the additions of the Centurion contracts in Massachusetts and Tennessee. Earnings from operations increased $34.5 million in the year ended December 31, 2013. This reflects improvement in our individual health insurance business in 2013 and the impact of a $28.0 million impairment loss in 2012 in our individual insurance business.

Year Ended December 31, 2012 Compared to Year Ended December 31, 2011

Revenues

Premium and service revenues increased 52.1% in the year ended December 31, 2012 over the corresponding period in 2011 as a result of the additional revenue from our Illinois, Louisiana, Mississippi, Missouri and Washington contracts, Texas and Arizona expansions, pharmacy carve-ins in Texas and Ohio, and organic membership growth. During the year ended December 31, 2012, we received premium rate adjustments which yielded a net 2.6% composite increase across all of our markets.

Operating Expenses

Medical Costs

The table below depicts the HBR for our membership by member category for the year ended December 31,:

	2012	2011
Medicaid and CHIP	88.8%	82.0%
ABD and Medicare	90.7	90.1
Specialty Services	92.0	86.2
Total	89.6	84.7

The consolidated HBR for the year ended December 31, 2012, of 89.6% was an increase of 490 basis points over the comparable period in 2011. The increase compared to last year primarily reflects (1) a high level of medical costs in the March 1, 2012 expansion areas in Texas, (2) a high level of medical costs in our individual health business, especially for policies issued to members who converted in the first quarter of 2012 and (3) a high level of flu costs during the fourth quarter of 2012.

General and Administrative Expenses

General and administrative expenses, or G&A, increased by $99.3 million in the year ended December 31, 2012, compared to the corresponding period in 2011. This was primarily due to expenses for additional staff and facilities to support our membership growth, partially offset by a reduction in performance based compensation expense in 2012.

The consolidated G&A expense ratio for the years ended December 31, 2012 and 2011 was 8.8% and 11.4% respectively. The year over year decrease in the G&A expense ratio reflects the leveraging of expenses over higher revenues in 2012 and a reduction in performance based compensation expense in 2012 which lowered the G&A expense ratio by approximately 60 basis points.

Impairment Loss

During 2011, the Company completed its annual goodwill and intangible asset impairment testing and concluded that the fair value of all reporting units with material amounts of goodwill was substantially in excess of the carrying value as of our impairment testing date. Specifically, the Company tested its Celtic reporting unit under a quantitative model which included anticipated financial performance for new business to be converted in 2012. Under the quantitative model, the testing revealed that the carrying value exceeded fair value of the Celtic reporting unit by approximately 190%.

During 2012, our subsidiary, Celtic Insurance Company, experienced a high level of medical costs for individual health policies, especially for recently issued policies related to members converted from another insurer during the first quarter of 2012. Additionally, in June 2012, the U.S. Supreme Court upheld the constitutionality of the Patient Protection and Affordable Care Act. The Affordable Care Act, among other things, limits the profitability of the individual health insurance business because of minimum medical loss ratios, guaranteed issue policies, and increased competition in the Marketplace product. As a result of these factors, our expectations for future growth and profitability were lower than previous estimates and we conducted an impairment analysis of the identifiable intangible assets and goodwill of the Celtic reporting unit. The impairment analysis resulted in goodwill and intangible asset impairments of $28.0 million, recorded as an impairment loss in the consolidated statement of operations. The impaired identifiable intangible assets of $2.3 million and goodwill of $25.7 million were reported under the Specialty Services segment; $26.6 million of the impairment loss is not deductible for income tax purposes.

Investment and Other Income, Net

The following table summarizes the components of other income (expense) for the year ended December 31, ($ in millions):

	2012	2011
Investment income	$ 15.9	$ 13.0
Gain on sale of investments	1.5	0.3
Gain on sale of investment in convertible note	17.9	—
Debt extinguishment costs	—	(8.5)
Interest expense	(20.5)	(20.3)
Other income (expense), net	$ 14.8	$(15.5)

Investment income. The increase in investment income in 2012 primarily reflects higher investment balances in 2012.

Gain on sale of investments. During the year ended December 31, 2012, we recognized $1.5 million in net gains primarily as a result of the liquidation of $75.5 million of investments held by the Georgia health plan in order to meet short term liquidity needs due to delays in premium receipts from the state.

Gain on sale of investment in convertible note. Between July 2008 and October 2011, we made an investment of $30.0 million in secured notes receivable to a third party as part of an investment in certain Medicaid and Medicare related businesses. The notes included a feature to convert the note balance into an equity ownership in the underlying businesses. In September 2012, we executed an agreement with the borrower whereby the borrower agreed to pay us total consideration of $50.0 million for retirement of the outstanding notes and equity ownership conversion feature. As a result, during the third quarter of 2012, we recorded a pre-tax gain of $17.9 million in other income representing the fair value of the total consideration in excess of the carrying value of the loans on the balance sheet.

Interest expense. Interest expense increased during the year ended December 31, 2012 by $0.2 million reflecting the issuance of an additional $175 million in Senior Notes in November 2012, partially offset by the refinancing of our $250 million Senior Notes and execution of the associated interest rate swap agreement in May 2011.

Income Tax Expense

Excluding the effects of noncontrolling interests, our effective tax rate for 2012 was 34.9% compared to 37.0% in 2011. The tax rate for the year ended December 31, 2012, reflects a tax benefit resulting from the clarification by a state taxing authority regarding a state income tax calculation, partially offset by Celtic's non-deductible goodwill impairment.

Segment Results

The following table summarizes our operating results by segment for the year ended December 31, (in millions):

	2012	2011	% Change 2011-2012
Premium and Service Revenues			
Managed Care	$ 7,212.0	$4,636.2	55.6%
Specialty Services	2,107.0	1,190.5	77.0%
Eliminations	(1,637.4)	(774.8)	(111.3)%
Consolidated Total	$ 7,681.6	$5,051.9	52.1%
Earnings from Operations			
Managed Care	$ 62.9	$ 161.9	(61.2)%
Specialty Services	45.1	41.9	7.6%
Consolidated Total	$ 108.0	$ 203.8	(47.0)%

Managed Care

Premium and service revenues increased 55.6% in the year ended December 31, 2012, due to the addition of our Illinois, Louisiana, Mississippi, Missouri and Washington contracts, Texas expansion, pharmacy carve-ins in Texas and Ohio, and organic membership growth. Earnings from operations decreased $99.0 million in the year ended December 31, 2012, primarily due to higher medical costs in our Texas health plan specifically in the expansion areas and increased flu costs during the fourth quarter of 2012.

Specialty Services

Premium and service revenues increased 77.0% in the year ended December 31, 2012, due to (1) the carve-in of pharmacy services in Texas and Ohio, (2) Specialty Company revenue related to the growth in our Medicaid segment and the associated specialty services provided to this increased membership and (3) the Arizona expansion. Earnings from operations increased $3.2 million in the year ended December 31, 2012, reflecting growth in our pharmacy business and the associated specialty services provided to our increased Medicaid membership, partially offset by the impairment loss of $28.0 million recorded in 2012 and a high level of medical costs in Celtic Insurance Company, especially for members converted in the first quarter of 2012.

LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows for the years ended December 31, 2013, 2012 and 2011, used in the discussion of liquidity and capital resources ($ in millions).

	Year Ended December 31,		
	2013	2012	2011
Net cash provided by operating activities	$ 382.5	$ 278.7	$ 261.7
Net cash used in investing activities	(342.1)	(187.9)	(129.1)
Net cash provided by financing activities	153.7	179.5	6.9
Net increase in cash and cash equivalents	$ 194.1	$ 270.3	$ 139.5

Cash Flows Provided by Operating Activities

Normal operations are funded primarily through operating cash flows and borrowings under our revolving credit facility.

Cash flows from operating activities for 2013 increased $103.8 million, or 37% compared to 2012 due to an increase in net earnings between years and growth in our business. Additionally, incentive compensation accruals increased from 2012 due to the performance of the Company. This accrual will be paid during the first and second quarter of 2014.

Cash flows from operating activities for 2012 increased $17.0 million, or 6% compared to 2011 driven by lower net earnings that were partially offset by the growth in medical claims liabilities associated with business expansions.

Cash flows from operations in each year were impacted by the timing of payments we receive from our states. States may prepay the following month premium payment, which we record as unearned revenue, or they may delay our premium payment, which we record as a receivable. We typically receive capitation payments monthly, however the states in which we operate may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period. The table below details the impact to cash flows from operations from the timing of payments from our states ($ in millions).

	Year Ended December 31,		
	2013	2012	2011
Premium and related receivables	$(143.0)	$(116.6)	$ (11.3)
Unearned revenue	2.7	24.7	(109.1)
Net decrease in operating cash flow	$(140.3)	$ (91.9)	$(120.4)

Net cash provided by operating activities in 2011 was negatively impacted by the timing of payments from our states by $120.4 million. As of December 31, 2011, we had received all December 2011 capitation payments from our states and had not received any prepayments of January 2012 capitation. This was offset by an increase in medical claims liabilities related to the start up of our Mississippi, Illinois and Kentucky health plans, as well as expansion of our Texas health plan in 2011.

Cash Flows Used in Investing Activities

Cash flows used in investing activities in 2013 primarily consisted of additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long term investments, the acquisition of AcariaHealth and capital expenditures. We completed the acquisition of AcariaHealth in April 2013 for $142.5 million in total consideration. The transaction was financed through a combination of Centene common stock as well as $67.1 million cash on hand. During 2012 and 2011, our investing activities primarily related to additions to the investment portfolio of our regulated subsidiaries and capital expenditures.

Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets within our guidelines. Net cash provided by and used in investing activities will fluctuate from year to year due to the timing of investment purchases, sales and maturities. As of December 31, 2013, our investment portfolio consisted primarily of fixed-income securities with an average duration of 2.9 years. These securities generally are actively traded in secondary markets and the reported fair market value is determined based on recent trading activity, recent trading activity in similar securities and other observable inputs. Our investment guidelines comply with the regulatory restrictions enacted in each state. We had unregulated cash and investments of $44.7 million at December 31, 2013, compared to $37.3 million at December 31, 2012.

We spent $67.8 million, $82.1 million and $73.7 million in 2013, 2012 and 2011 respectively, on capital expenditures for system enhancements, a new datacenter and market expansions including $20.9 million in 2012 for land in close proximity to our corporate headquarters to support future growth.

Cash Flows Provided by Financing Activities

Our financing activities provided cash of $153.7 million, $179.5 million and $6.9 million in 2013, 2012 and 2011 respectively. Financing activities in 2013, 2012 and 2011 are discussed below.

2013. During 2013, our financing activities primarily related to borrowings under our revolving credit facility, the sale of $15.2 million of common stock to fund the escrow account for the acquisition of AcariaHealth and the repayment of a mortgage note.

In May 2013, we entered into a new unsecured $500 million revolving credit facility and terminated our previous $350 million revolving credit facility. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. The agreement has a maturity date of June 1, 2018, provided it will mature 90 days prior to the maturity date of the 5.75% Senior Notes due 2017 if such notes are not refinanced (or extended) or certain financial conditions are not met, including carrying $100 million of unrestricted cash on deposit. As of December 31, 2013, we had $150.0 million in borrowings outstanding under our revolving credit facility, and we were in compliance with all covenants.

2012. In November 2012, pursuant to a shelf registration statement, we issued an additional $175 million of non-callable 5.75% Senior Notes due June 1, 2017 ($175 million Add-on Notes) at a premium to yield 4.29%. The indenture governing the $175 million Add-on Notes contains non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio. Interest is paid semi-annually in June and December. We used the net proceeds from the offering to make capital contributions to our regulated subsidiaries.

2011. In January 2011, we replaced our $300 million revolving credit agreement with a new $350 million revolving credit facility, or the revolver. The revolver was unsecured and had a five-year maturity with non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt to EBITDA ratios and minimum net worth. Borrowings under the revolver bore interest based upon LIBOR rates, the Federal funds rate, or the prime rate. There was a commitment fee on the unused portion of the agreement that ranges from 0.25% to 0.50% depending on the total debt to EBITDA ratio.

In May 2011, we exercised our option to redeem the $175 million 7.25% Senior Notes due April 1, 2014 ($175 million Notes). We redeemed the $175 million Notes at 103.625% and wrote off unamortized debt issuance costs, resulting in a pre-tax expense of $8.5 million.

In May 2011, pursuant to a shelf registration statement, we issued $250 million of non-callable 5.75% Senior Notes due June 1, 2017 ($250 million Notes) at a discount to yield 6%. The indenture governing the $250 million Notes contains non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio. Interest is paid semi-annually in June and December. We used a portion of the net proceeds from the offering to repay the $175 million Notes and call premium and to repay approximately $50 million outstanding on our revolving credit facility. The additional proceeds were used for general corporate purposes. In connection with the issuance, we entered into $250 million notional amount of interest rate swap agreements (Swap Agreements) that are scheduled to expire June 1, 2017. Under the Swap Agreements, we receive a fixed

rate of 5.75% and pay a variable rate of LIBOR plus 3.5% adjusted quarterly, which allows us to adjust the $250 million Notes to a floating rate. We do not hold or issue any derivative instrument for trading or speculative purposes.

Liquidity Metrics

The $500 million revolving credit agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt-to-EBITDA ratios and minimum tangible net worth. We are required not to exceed a maximum debt-to-EBITDA ratio of 3.0 to 1.0. As of December 31, 2013, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

We had outstanding letters of credit of $28.8 million as of December 31, 2013, which were not part of our revolving credit facility and bore interest at 0.51%. In addition, we had outstanding surety bonds of $102.6 million as of December 31, 2013.

At December 31, 2013, we had working capital, defined as current assets less current liabilities, of $241.1 million, as compared to $176.5 million at December 31, 2012. We manage our short term and long term investments with the goal of ensuring that a sufficient portion is held in investments that are highly liquid and can be sold to fund short term requirements as needed.

At December 31, 2013, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 35.0%, compared to 36.1% at December 31, 2012. Excluding the $72.8 million non-recourse mortgage note, our debt to capital ratio is 32.4%, compared to 32.7% at December 31, 2012. We utilize the debt to capital ratio as a measure, among others, of our leverage and financial flexibility.

We have a stock repurchase program authorizing us to repurchase up to four million shares of common stock from time to time on the open market or through privately negotiated transactions. We have 1.7 million available shares remaining under the program for repurchases as of December 31, 2013. No duration has been placed on the repurchase program. We reserve the right to discontinue the repurchase program at any time. We did not make any repurchases under this plan during 2013 or 2012.

During the year ended December 31, 2013, 2012 and 2011, we received dividends of $18.0 million, $29.0 million, and $69.1 million, respectively, from our regulated subsidiaries.

2014 Expectations

In January 2014, we acquired a majority interest in U.S. Medical Management, LLC, a leading management services organization and provider of in-home health services for high acuity populations, for approximately $200.0 million. The transaction consideration was financed through a combination of cash on hand and 2,243,217 shares of Centene common stock.

In December 2013, we signed a definitive agreement to purchase a majority stake in Fidelis SecureCare of Michigan, Inc., a subsidiary of Fidelis SeniorCare, Inc. The transaction is expected to close in the fourth quarter of 2014, subject to certain closing conditions including regulatory approvals, and will involve cash purchase price payments contingent on the performance of the plan over the course of 2015.

We expect to make capital contributions to our insurance subsidiaries of approximately $350 million during 2014 associated with our growth and spend approximately $95 million in additional capital expenditures primarily associated with system enhancements and market expansions. These capital contributions are expected to be funded by unregulated cash flow generation in 2014 and borrowings on our revolving credit facility.

Based on our operating plan, we expect that our available cash, cash equivalents and investments, cash from our operations and cash available under our credit facility, along with the issuance of shares of Centene common stock in connection with the acquisition of U.S. Medical Management, LLC discussed above will be sufficient to finance our general operations, planned acquisition of U.S. Medical Management, LLC and capital expenditures for at least 12 months from the date of this filing.

CONTRACTUAL OBLIGATIONS

The following table summarizes future contractual obligations. These obligations contain estimates and are subject to revision under a number of circumstances. Our debt consists of borrowings from our senior notes, credit facility, mortgages and capital leases. The purchase obligations consist primarily of software purchases and maintenance contracts. The contractual obligations and estimated period of payment over the next five years and beyond are as follows (in thousands):

	Payments Due by Period				
	Total	Less Than 1 Year	1-3 Years	3-5 Years	More Than 5 Years
Medical claims liability	$1,111,709	$1,111,709	$ —	$ —	$ —
Debt and interest	775,385	31,180	62,331	600,725	81,149
Operating lease obligations	126,186	25,350	50,073	31,963	18,800
Purchase obligations	51,549	28,404	19,424	2,732	989
Other long term liabilities[1]	—	—	—	—	—
Total	$2,064,829	$1,196,643	$131,828	$635,420	$100,938

[1] Our Consolidated Balance Sheet as of December 31, 2013, includes $60,015 of other long term liabilities. This consists primarily of long term deferred income taxes, liabilities under our deferred compensation plan, and reserves for uncertain tax positions. These liabilities have been excluded from the table above as the timing and/or amount of any cash payment is uncertain. As of December 31, 2013, reserves for uncertain tax positions totaled $3,274. See the "Income Taxes" footnote for additional information regarding our deferred tax positions and accruals for uncertain tax positions. Other long term liabilities also include $6,888 separate account liabilities from third party reinsurance that will not be settled in cash.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

Our operations are conducted through our subsidiaries. As managed care organizations, these subsidiaries are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us. Generally, the amount of dividend distributions that may be paid by a regulated subsidiary without prior approval by state regulatory authorities is limited based on the entity's level of statutory net income and statutory capital and surplus.

Our subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of December 31, 2013, our subsidiaries, including Kentucky Spirit Health Plan, had aggregate statutory capital and surplus of $1,279.7 million, compared with the required minimum aggregate statutory capital and surplus requirements of $686.4 million. During the year ended December 31, 2013, we contributed $426 million of statutory capital to our subsidiaries. We estimate our Risk Based Capital, or RBC, percentage to be in excess of 350% of the Authorized Control Level.

The National Association of Insurance Commissioners has adopted rules which set minimum risk-based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. As of December 31, 2013, each of our health plans was in compliance with the risk-based capital requirements enacted in those states.

RECENT ACCOUNTING PRONOUNCEMENTS

For this information, refer to Note 2, *Summary of Significant Accounting Policies*, in the Notes to the Consolidated Financial Statements, included herein.

CRITICAL ACCOUNTING POLICIES AND ESTIMATES

Our discussion and analysis of our results of operations and liquidity and capital resources are based on our consolidated financial statements which have been prepared in accordance with GAAP. Our significant

accounting policies are more fully described in Note 2, *Summary of Significant Accounting Policies,* to our consolidated financial statements included elsewhere herein. Our accounting policies regarding medical claims liability and intangible assets are particularly important to the portrayal of our financial position and results of operations and require the application of significant judgment by our management. As a result, they are subject to an inherent degree of uncertainty. We have reviewed these critical accounting policies and related disclosures with the Audit Committee of our Board of Directors.

Medical Claims Liability

Our medical claims liability includes claims reported but not yet paid, or inventory, estimates for claims incurred but not reported, or IBNR, and estimates for the costs necessary to process unpaid claims at the end of each period. We estimate our medical claims liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors.

Actuarial Standards of Practice generally require that the medical claims liability estimates be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate. In many situations, the claims amounts ultimately settled will be different than the estimate that satisfies the Actuarial Standards of Practice. We include in our IBNR an estimate for medical claims liability under moderately adverse conditions which represents the risk of adverse deviation of the estimates in our actuarial method of reserving.

We use our judgment to determine the assumptions to be used in the calculation of the required estimates. The assumptions we consider when estimating IBNR include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to fee schedules, and the incidence of high dollar or catastrophic claims.

We apply various estimation methods depending on the claim type and the period for which claims are being estimated. For more recent periods, incurred non-inpatient claims are estimated based on historical per member per month claims experience adjusted for known factors. Incurred hospital inpatient claims are estimated based on known inpatient utilization data and prior claims experience adjusted for known factors. For older periods, we utilize an estimated completion factor based on our historical experience to develop IBNR estimates. The completion factor is an actuarial estimate of the percentage of claims incurred during a given period that have been received or adjudicated as of the reporting period to the estimate of the total ultimate incurred costs. When we commence operations in a new state or region, we have limited information with which to estimate our medical claims liability. See "Risk Factors—Failure to accurately predict our medical expenses could negatively affect our financial position, results of operations or cash flows." These approaches are consistently applied to each period presented.

Additionally, we contract with independent actuaries to review our estimates on a quarterly basis. The independent actuaries provide us with a review letter that includes the results of their analysis of our medical claims liability. We do not solely rely on their report to adjust our claims liability. We utilize their calculation of our claims liability only as additional information, together with management's judgment, to determine the assumptions to be used in the calculation of our liability for claims.

Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as additional claims receipts and payment information becomes available. As more complete claims information becomes available, we adjust the amount of the estimates, and include the changes in estimates in medical costs in the period in which the changes are identified. In every reporting period, our operating results include the effects of more completely developed medical claims liability estimates associated with previously reported periods. We consistently apply our reserving methodology from period to period. As

additional information becomes known to us, we adjust our actuarial models accordingly to establish medical claims liability estimates.

The paid and received completion factors, claims per member per month and per diem cost trend factors are the most significant factors affecting the IBNR estimate. The following table illustrates the sensitivity of these factors and the estimated potential impact on our operating results caused by changes in these factors based on December 31, 2013 data:

Completion Factors[1]:		Cost Trend Factors[2]:	
(Decrease) Increase in Factors	Increase (Decrease) in Medical Claims Liabilities	(Decrease) Increase in Factors	Increase (Decrease) in Medical Claims Liabilities
	(in thousands)		(in thousands)
(2.0)%	$ 137,100	(2.0)%	$(36,800)
(1.5)	102,300	(1.5)	(27,700)
(1.0)	67,800	(1.0)	(18,500)
(0.5)	33,800	(0.5)	(9,200)
0.5	(33,500)	0.5	9,200
1.0	(66,500)	1.0	18,700
1.5	(99,100)	1.5	28,000
2.0	(131,600)	2.0	37,300

(1) Reflects estimated potential changes in medical claims liability caused by changes in completion factors.
(2) Reflects estimated potential changes in medical claims liability caused by changes in cost trend factors for the most recent periods.

While we believe our estimates are appropriate, it is possible future events could require us to make significant adjustments for revisions to these estimates. For example, a 1% increase or decrease in our estimated medical claims liability would have affected net earnings by $7.0 million for the year ended December 31, 2013. The estimates are based on our historical experience, terms of existing contracts, our observance of trends in the industry, information provided by our providers and information available from other outside sources.

The change in medical claims liability is summarized as follows (in thousands):

	Year Ended December 31,		
	2013	2012	2011
Balance, January 1,	$ 815,161	$ 518,840	$ 456,765
Incurred related to:			
Current year	9,072,867	6,836,177	4,256,645
Prior years	(78,226)	(55,096)	(65,377)
Total incurred	8,994,641	6,781,081	4,191,268
Paid related to:			
Current year	7,975,367	6,024,720	3,744,475
Prior years	722,726	460,040	384,718
Total paid	8,698,093	6,484,760	4,129,193
Balance, December 31,	$1,111,709	$ 815,161	$ 518,840
Claims inventory, December 31	622,200	619,200	432,200
Days in claims payable[1]	42.4	38.5	43.4

[1] Days in claims payable is a calculation of medical claims liability at the end of the period divided by average expense per calendar day for the fourth quarter of each year.

Medical claims are usually paid within a few months of the member receiving service from the physician or other healthcare provider. As a result, the liability generally is described as having a "short-tail," which causes less than 5% of our medical claims liability as of the end of any given year to be outstanding the following year. We believe that substantially all the development of the estimate of medical claims liability as of December 31, 2013 will be known by the end of 2014.

Changes in estimates of incurred claims for prior years are primarily attributable to reserving under moderately adverse conditions. In addition, claims processing initiatives yielded increased claim payment recoveries and coordination of benefits related to prior year dates of service. Changes in medical utilization and cost trends and the effect of medical management initiatives may also contribute to changes in medical claim liability estimates. While we have evidence that medical management initiatives are effective on a case by case basis, medical management initiatives primarily focus on events and behaviors prior to the incurrence of the medical event and generation of a claim. Accordingly, any change in behavior, leveling of care, or coordination of treatment occurs prior to claim generation and as a result, the costs prior to the medical management initiative are not known by us. Additionally, certain medical management initiatives are focused on member and provider education with the intent of influencing behavior to appropriately align the medical services provided with the member's acuity. In these cases, determining whether the medical management initiative changed the behavior cannot be determined. Because of the complexity of our business, the number of states in which we operate, and the volume of claims that we process, we are unable to practically quantify the impact of these initiatives on our changes in estimates of IBNR.

The following are examples of medical management initiatives that may have contributed to the favorable development through lower medical utilization and cost trends:

- Appropriate leveling of care for neonatal intensive care unit hospital admissions, other inpatient hospital admissions, and observation admissions, in accordance with Interqual or other criteria.
- Tightening of our pre-authorization list and more stringent review of durable medical equipment and injectibles.
- Emergency department, or ED, program designed to collaboratively work with hospitals to steer non-emergency care away from the costly ED setting (through patient education, on-site alternative urgent care settings, etc.)
- Increase emphasis on case management and clinical rounding where case managers are nurses or social workers who are employed by the health plan to assist selected patients with the coordination of healthcare services in order to meet a patient's specific healthcare needs.
- Incorporation of disease management which is a comprehensive, multidisciplinary, collaborative approach to chronic illnesses such as asthma.
- Prenatal and infant health programs utilized in our *Start Smart For Your Baby* outreach service.

Goodwill and Intangible Assets

We have made several acquisitions that have resulted in our recording of intangible assets. These intangible assets primarily consist of customer relationships, purchased contract rights, provider contracts, trade names and goodwill. At December 31, 2013, we had $348.4 million of goodwill and $48.8 million of other intangible assets.

Intangible assets are amortized using the straight-line method over the following periods:

Intangible Asset	Amortization Period
Purchased contract rights	5 – 15 years
Provider contracts	4 – 15 years
Customer relationships	5 – 15 years
Trade names	7 – 20 years

Our management evaluates whether events or circumstances have occurred that may affect the estimated useful life or the recoverability of the remaining balance of goodwill and other identifiable intangible assets. If the events or circumstances indicate that the remaining balance of the intangible asset or goodwill may be

impaired, the potential impairment will be measured based upon the difference between the carrying amount of the intangible asset or goodwill and the fair value of such asset. Our management must make assumptions and estimates, such as the discount factor, future utility and other internal and external factors, in determining the estimated fair values. While we believe these assumptions and estimates are appropriate, other assumptions and estimates could be applied and might produce significantly different results.

Goodwill is reviewed annually during the fourth quarter for impairment. In addition, an impairment analysis of intangible assets would be performed based on other factors. These factors include significant changes in membership, state funding, medical contracts and provider networks and contracts. The fair value of all reporting units with material amounts of goodwill was substantially in excess of the carrying value as of our annual impairment testing date.

ITEM 7A. ***Quantitative and Qualitative Disclosures About Market Risk.***

INVESTMENTS AND DEBT

As of December 31, 2013, we had short term investments of $102.1 million and long term investments of $838.8 million, including restricted deposits of $46.9 million. The short term investments generally consist of highly liquid securities with maturities between three and 12 months. The long term investments consist of municipal, corporate and U.S. Treasury securities, government sponsored obligations, life insurance contracts, asset backed securities and equity securities and have maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states' requirements, these investments are classified as long term regardless of the contractual maturity date. Substantially all of our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2013, the fair value of our fixed income investments would decrease by approximately $23.2 million. Declines in interest rates over time will reduce our investment income.

We entered into interest rate swap agreements with creditworthy financial institutions to manage the impact of market interest rates on interest expense. Our swap agreements convert a portion of our interest expense from fixed to variable rates to better match the impact of changes in market rates on our variable rate cash equivalent investments. As a result, the fair value of our $250 million Senior Note debt varies with market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2013, the fair value of our debt would decrease by approximately $8.3 million. An increase in interest rates decreases the fair value of the debt and conversely, a decrease in interest rates increases the value.

For a discussion of the interest rate risk that our investments are subject to, see "Risk Factors–Risks Related to Our Business–Our investment portfolio may suffer losses from reductions in market interest rates and changes in market conditions which could materially and adversely affect our results of operations or liquidity."

INFLATION

The inflation rate for medical care costs has been higher than the inflation rate for all items. We use various strategies to mitigate the negative effects of healthcare cost inflation. Specifically, our health plans try to control medical and hospital costs through our state savings initiatives and contracts with independent providers of healthcare services. Through these contracted care providers, our health plans emphasize preventive healthcare and appropriate use of specialty and hospital services. Additionally, our contracts with states require actuarially sound premiums that include healthcare cost trend.

While we currently believe our strategies to mitigate healthcare cost inflation will continue to be successful, competitive pressures, new healthcare and pharmaceutical product introductions, demands from healthcare providers and customers, applicable regulations or other factors may affect our ability to control the impact of healthcare cost increases.

Item 8. ***Financial Statements and Supplementary Data***

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
Centene Corporation:

We have audited the accompanying consolidated balance sheets of Centene Corporation and subsidiaries as of December 31, 2013 and 2012, and the related consolidated statements of operations, comprehensive earnings, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2013. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements 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 includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes 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, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Centene Corporation and subsidiaries as of December 31, 2013 and 2012, and the results of their operations and their cash flows for each of the years in the three-year period ended December 31, 2013, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Centene Corporation's internal control over financial reporting as of December 31, 2013, based on criteria established in *Internal Control—Integrated Framework (1992)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), and our report dated February 21, 2014 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

KPMG LLP

St. Louis, Missouri
February 21, 2014

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS
(In thousands, except share data)

	December 31, 2013	December 31, 2012
ASSETS		
Current assets:		
Cash and cash equivalents of continuing operations	$ 974,304	$ 745,933
Cash and cash equivalents of discontinued operations	63,769	98,019
Total cash and cash equivalents	1,038,073	843,952
Premium and related receivables	428,570	251,473
Short term investments	102,126	138,101
Other current assets	217,661	93,322
Other current assets of discontinued operations	13,743	78,977
Total current assets	1,800,173	1,405,825
Long term investments	791,900	554,770
Restricted deposits	46,946	34,286
Property, software and equipment, net	395,407	375,893
Goodwill	348,432	256,288
Intangible assets, net	48,780	20,268
Other long term assets	59,357	64,278
Long term assets of discontinued operations	38,305	62,297
Total assets	$3,529,300	$2,773,905
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$1,111,709	$ 815,161
Accounts payable and accrued expenses	375,862	219,066
Unearned revenue	38,191	34,597
Current portion of long term debt	3,065	3,373
Current liabilities of discontinued operations	30,294	157,116
Total current liabilities	1,559,121	1,229,313
Long term debt	665,697	535,481
Other long term liabilities	60,015	54,987
Long term liabilities of discontinued operations	1,028	357
Total liabilities	2,285,861	1,820,138
Commitments and contingencies		
Stockholders' equity:		
Common stock, $.001 par value; authorized 100,000,000 shares; 58,673,215 issued and 55,319,239 outstanding at December 31, 2013, and 55,339,160 issued and 52,329,248 outstanding at December 31, 2012	59	55
Additional paid-in capital	594,326	450,856
Accumulated other comprehensive income:		
Unrealized (loss) gain on investments, net of tax	(2,620)	5,189
Retained earnings	731,919	566,820
Treasury stock, at cost (3,353,976 and 3,009,912 shares, respectively)	(89,643)	(69,864)
Total Centene stockholders' equity	1,234,041	953,056
Noncontrolling interest	9,398	711
Total stockholders' equity	1,243,439	953,767
Total liabilities and stockholders' equity	$3,529,300	$2,773,905

The accompanying notes to the consolidated financial statements are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS
(In thousands, except share data)

	Year Ended December 31,		
	2013	2012	2011
Revenues:			
Premium	$10,153,460	$ 7,568,889	$ 4,948,137
Service	372,580	112,742	103,765
Premium and service revenues	10,526,040	7,681,631	5,051,902
Premium tax	337,289	428,665	159,575
Total revenues	10,863,329	8,110,296	5,211,477
Expenses:			
Medical costs	8,994,641	6,781,081	4,191,268
Cost of services	326,924	87,705	78,114
General and administrative expenses	931,137	677,157	577,898
Premium tax expense	333,210	428,354	160,394
Impairment loss	—	28,033	—
Total operating expenses	10,585,912	8,002,330	5,007,674
Earnings from operations	277,417	107,966	203,803
Other income (expense):			
Investment and other income	18,457	35,285	13,355
Debt extinguishment costs	—	—	(8,488)
Interest expense	(26,957)	(20,460)	(20,320)
Earnings from continuing operations, before income tax expense	268,917	122,791	188,350
Income tax expense	107,080	47,412	70,687
Earnings from continuing operations, net of income tax expense	161,837	75,379	117,663
Discontinued operations, net of income tax expense (benefit) of $2,284, $(47,741), and $(4,165), respectively	3,881	(86,674)	(9,300)
Net earnings (loss)	165,718	(11,295)	108,363
Noncontrolling interest	619	(13,154)	(2,855)
Net earnings attributable to Centene Corporation	$ 165,099	$ 1,859	$ 111,218
Amounts attributable to Centene Corporation common shareholders:			
Earnings from continuing operations, net of income tax expense	$ 161,218	$ 88,533	$ 120,518
Discontinued operations, net of income tax expense (benefit)	3,881	(86,674)	(9,300)
Net earnings	$ 165,099	$ 1,859	$ 111,218
Net earnings (loss) per common share attributable to Centene Corporation:			
Basic:			
Continuing operations	$ 2.98	$ 1.72	$ 2.40
Discontinued operations	0.07	(1.68)	(0.18)
Basic earnings per common share	$ 3.05	$ 0.04	$ 2.22
Diluted:			
Continuing operations	$ 2.87	$ 1.65	$ 2.30
Discontinued operations	0.07	(1.62)	(0.18)
Diluted earnings per common share	$ 2.94	$ 0.03	$ 2.12
Weighted average number of common shares outstanding:			
Basic	54,126,545	51,509,366	50,198,954
Diluted	56,247,173	53,714,375	52,474,238

The accompanying notes to the consolidated financial statements are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF COMPREHENSIVE EARNINGS
(In thousands)

	Year Ended December 31,		
	2013	2012	2011
Net earnings (loss)	$165,718	$(11,295)	$108,363
Reclassification adjustment, net of tax	(875)	(1,789)	(549)
Change in unrealized (loss) gain on investments, net of tax	(6,934)	1,217	(114)
Other comprehensive earnings (loss)	(7,809)	(572)	(663)
Comprehensive earnings (loss)	157,909	(11,867)	107,700
Comprehensive earnings (loss) attributable to the noncontrolling interest	619	(13,154)	(2,855)
Comprehensive earnings attributable to Centene Corporation	$157,290	$ 1,287	$110,555

The accompanying notes to the consolidated financial statements are an integral part of this statement.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(In thousands, except share data)

	Centene Stockholders' Equity								
	Common Stock					Treasury Stock			
	$.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Income	Retained Earnings	$.001 Par Value Shares	Amt	Non controlling Interest	Total
Balance, December 31, 2010	52,172,037	$52	$384,206	$ 6,424	$453,743	2,555,213	$(50,486)	$ 3,116	$ 797,055
Comprehensive Earnings:									
Net earnings	—	—	—	—	111,218	—	—	(2,855)	108,363
Change in unrealized investment gain, net of $(334) tax	—	—	—	(663)	—	—	—	—	(663)
Total comprehensive earnings									107,700
Common stock issued for employee benefit plans	1,414,689	2	15,435	—	—	—	—	—	15,437
Exercise of stock warrants	—	—	—	—	—	(50,000)	1,172	—	1,172
Common stock repurchases	—	—	—	—	—	216,895	(7,809)	—	(7,809)
Stock compensation expense	—	—	18,171	—	—	—	—	—	18,171
Excess tax benefits from stock compensation	—	—	4,169	—	—	—	—	—	4,169
Contributions from Noncontrolling interest	—	—	—	—	—	—	—	813	813
Deconsolidation of Noncontrolling interest	—	—	—	—	—	—	—	(289)	(289)
Balance, December 31, 2011	53,586,726	$54	$421,981	$ 5,761	$564,961	2,722,108	$(57,123)	$ 785	$ 936,419
Comprehensive Earnings:									
Net earnings (loss)	—	—	—	—	1,859	—	—	(13,154)	(11,295)
Change in unrealized investment gain, net of $(296) tax	—	—	—	(572)	—	—	—	—	(572)
Total comprehensive earnings (loss)									(11,867)
Common stock issued for employee benefit plans	1,752,434	1	16,725	—	—	—	—	—	16,726
Common stock repurchases	—	—	—	—	—	287,804	(12,741)	—	(12,741)
Stock compensation expense	—	—	25,332	—	—	—	—	—	25,332
Excess tax benefits from stock compensation	—	—	10,999	—	—	—	—	—	10,999
Purchase of noncontrolling interest	—	—	(24,181)	—	—	—	—	11,988	(12,193)
Contribution from noncontrolling interest	—	—	—	—	—	—	—	1,092	1,092
Balance, December 31, 2012	55,339,160	$55	$450,856	$ 5,189	$566,820	3,009,912	$(69,864)	$ 711	$ 953,767
Comprehensive Earnings:									
Net earnings (loss)	—	—	—	—	165,099	—	—	619	165,718
Change in unrealized investment loss, net of $(4,438) tax	—	—	—	(7,809)	—	—	—	—	(7,809)
Total comprehensive earnings									157,909
Common stock issued for acquisition	1,716,690	2	75,405	—	—	—	—	—	75,407
Common stock issued for stock offering	342,640	—	15,225	—	—	—	—	—	15,225
Common stock issued for employee benefit plans	1,274,725	2	9,796	—	—	—	—	—	9,798
Common stock repurchases	—	—	—	—	—	344,064	(19,779)	—	(19,779)
Stock compensation expense	—	—	36,656	—	—	—	—	—	36,656
Excess tax benefits from stock compensation	—	—	6,388	—	—	—	—	—	6,388
Contribution from noncontrolling interest	—	—	—	—	—	—	—	8,068	8,068
Balance, December 31, 2013	58,673,215	$59	$594,326	$(2,620)	$731,919	3,353,976	$(89,643)	$ 9,398	$1,243,439

The accompanying notes to the consolidated financial statements are an integral part of this statement.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)

	Year Ended December 31,		
	2013	2012	2011
Cash flows from operating activities:			
Net earnings (loss)	$ 165,718	$ (11,295)	$ 108,363
Adjustments to reconcile net earnings to net cash provided by operating activities			
Depreciation and amortization	67,420	65,866	58,327
Stock compensation expense	36,656	25,332	18,171
Impairment loss	—	28,033	
Gain on sale of investment in convertible note	—	(17,880)	—
Debt extinguishment costs	—	—	8,488
Deferred income taxes	(2,293)	(14,438)	2,031
Changes in assets and liabilities			
Premium and related receivables	(142,977)	(116,558)	(11,306)
Other current assets	(79,588)	(36,818)	(11,812)
Other assets	(736)	2,825	(2)
Medical claims liabilities	171,569	359,792	149,756
Unearned revenue	2,724	24,707	(109,082)
Accounts payable and accrued expenses	151,712	(21,474)	38,889
Other operating activities	12,321	(9,401)	9,873
Net cash provided by operating activities	382,526	278,691	261,696
Cash flows from investing activities:			
Capital expenditures	(67,835)	(82,144)	(73,708)
Purchases of investments	(790,653)	(695,687)	(318,397)
Sales and maturities of investments	579,161	589,921	267,404
Investments in acquisitions, net of cash acquired	(62,773)	—	(4,375)
Net cash used in investing activities	(342,100)	(187,910)	(129,076)
Cash flows from financing activities:			
Proceeds from exercise of stock options	8,983	15,912	15,815
Proceeds from borrowings	180,000	400,500	419,183
Proceeds from stock offering	15,225	—	—
Payment of long term debt	(41,593)	(218,234)	(416,283)
Excess tax benefits from stock compensation	6,380	10,996	4,435
Common stock repurchases	(19,779)	(12,741)	(7,809)
Contribution from noncontrolling interest	8,068	1,092	813
Purchase of noncontrolling interest	—	(14,429)	—
Debt issue costs	(3,589)	(3,623)	(9,242)
Net cash provided by financing activities	153,695	179,473	6,912
Net increase in cash and cash equivalents	194,121	270,254	139,532
Cash and cash equivalents, beginning of period	843,952	573,698	434,166
Cash and cash equivalents, end of period	$1,038,073	$ 843,952	$ 573,698
Supplemental disclosures of cash flow information:			
Interest paid	$ 30,009	$ 21,605	$ 27,383
Income taxes paid	$ 84,681	$ 42,877	$ 50,444
Equity issued in connection with acquisition	$ 75,425	$ —	$ —

The accompanying notes to the consolidated financial statements are an integral part of these statements.

1. Organization and Operations

Centene Corporation, or the Company, is a diversified, multi-line healthcare enterprise operating in two segments: Managed Care and Specialty Services. The Managed Care segment provides Medicaid and Medicaid-related health plan coverage to individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program, or CHIP, Long Term Care (LTC), Foster Care, Medicare Special Needs Plans and the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program, or collectively ABD. The Specialty Services segment consists of our specialty companies offering auxiliary healthcare services and products to state programs, healthcare organizations, employer groups and other commercial organizations, as well as to our own subsidiaries. The health plan in Massachusetts, operated by our individual health insurance business, is included in the Specialty Services segment.

2. Summary of Significant Accounting Policies

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of Centene Corporation and all majority owned subsidiaries and subsidiaries over which the Company exercises the power and control to direct activities significantly impacting financial performance. All material intercompany balances and transactions have been eliminated. The assets, liabilities and results of operations of Kentucky Spirit Health Plan are classified as discontinued operations for all periods presented.

Certain amounts in the consolidated financial statements have been reclassified to conform to the 2013 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles in the United States, or GAAP, requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Future events and their effects cannot be predicted with certainty; accordingly, the accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of the consolidated financial statements will change as new events occur, as more experience is acquired, as additional information is obtained and as the operating environment changes. The Company evaluates and updates its assumptions and estimates on an ongoing basis and may employ outside experts to assist in our evaluation, as considered necessary. Actual results could differ from those estimates.

Cash and Cash Equivalents

Investments with original maturities of three months or less are considered to be cash equivalents. Cash equivalents consist of money market funds and bank certificates of deposit and savings accounts.

The Company maintains amounts on deposit with various financial institutions, which may exceed federally insured limits. However, management periodically evaluates the credit-worthiness of those institutions, and the Company has not experienced any losses on such deposits.

Investments

Short term investments include securities with maturities greater than three months to one year. Long term investments include securities with maturities greater than one year.

Short term and long term investments are generally classified as available for sale and are carried at fair value. Certain equity investments are recorded using the cost or equity method. Unrealized gains and losses on investments available for sale are excluded from earnings and reported in accumulated other comprehensive income, a separate component of stockholders' equity, net of income tax effects. Premiums and discounts are amortized or accreted over the life of the related security using the effective interest method. The Company monitors the difference between the cost and fair value of investments. Investments that experience a decline in value that is judged to be other than temporary are written down to fair value and a realized loss is recorded in investment and other income. To calculate realized gains and losses on the sale of investments, the Company uses the specific amortized cost of each investment sold. Realized gains and losses are recorded in investment and other income.

The Company uses the equity method to account for certain of its investment in entities that it does not control and for which it does not have the ability to exercise significant influence over operating and financial policies. These investments are recorded at the lower of their cost or fair value.

Restricted Deposits

Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. These investments are classified as long term, regardless of the contractual maturity date, due to the nature of the states' requirements. The Company is required to annually adjust the amount of the deposit pledged to certain states.

Fair Value Measurements

In the normal course of business, the Company invests in various financial assets and incurs various financial liabilities. Fair values are disclosed for all financial instruments, whether or not such values are recognized in the Consolidated Balance Sheets. Management obtains quoted market prices and other observable inputs for these disclosures. The carrying amounts reported in the Consolidated Balance Sheets for cash and cash equivalents, premium and related receivables, unearned revenue, accounts payable and accrued expenses, and certain other current liabilities are carried at cost, which approximates fair value because of their short term nature.

The following methods and assumptions were used to estimate the fair value of each financial instrument:

- Available for sale investments and restricted deposits: The carrying amount is stated at fair value, based on quoted market prices, where available. For securities not actively traded, fair values were estimated using values obtained from independent pricing services or quoted market prices of comparable instruments.
- Senior unsecured notes: Estimated based on third-party quoted market prices for the same or similar issues.
- Variable rate debt: The carrying amount of our floating rate debt approximates fair value since the interest rates adjust based on market rate adjustments.
- Interest rate swap: Estimated based on third-party market prices based on the forward 3-month LIBOR curve.

Property, Software and Equipment

Property, software and equipment are stated at cost less accumulated depreciation. Capitalized software includes 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. Depreciation is calculated principally by the straight-line method over estimated useful lives. Leasehold improvements are

depreciated using the straight-line method over the shorter of the expected useful life or the remaining term of the lease. Property, software and equipment are depreciated over the following periods:

Fixed Asset	Depreciation Period
Buildings and land improvements	5 – 40 years
Computer hardware and software	2 – 7 years
Furniture and equipment	3 – 10 years
Leasehold improvements	1 – 20 years

The carrying amounts of all long-lived assets are evaluated to determine if adjustment to the depreciation and amortization period or to the unamortized balance is warranted. Such evaluation is based principally on the expected utilization of the long-lived assets.

The Company retains fully depreciated assets in property and accumulated depreciation accounts until it removes them from service. In the case of sale, retirement, or disposal, the asset cost and related accumulated depreciation balance is removed from the respective account, and the resulting net amount, less any proceeds, is included as a component of earnings from operations in the consolidated statements of operations.

Goodwill and Intangible Assets

Intangible assets represent assets acquired in purchase transactions and consist primarily of customer relationships, purchased contract rights, provider contracts, trade names and goodwill. Intangible assets are amortized using the straight-line method over the following periods:

Intangible Asset	Amortization Period
Purchased contract rights	5 – 15 years
Provider contracts	4 – 15 years
Customer relationships	5 – 15 years
Trade names	7 – 20 years

The Company tests for impairment of intangible assets as well as long-lived assets whenever events or changes in circumstances indicate that the carrying value of an asset or asset group (hereinafter referred to as "asset group") may not be recoverable by comparing the sum of the estimated undiscounted future cash flows expected to result from use of the asset group and its eventual disposition to the carrying value. Such factors include, but are not limited to, significant changes in membership, state funding, state contracts and provider networks and contracts. If the sum of the estimated undiscounted future cash flows is less than the carrying value, an impairment determination is required. The amount of impairment is calculated by subtracting the fair value of the asset group from the carrying value of the asset group. An impairment charge, if any, is recognized within earnings from operations.

The Company tests goodwill for impairment using a fair value approach. The Company is required to test for impairment at least annually, absent a triggering event including a significant decline in operating performance that would require an impairment assessment. Absent any impairment indicators, the Company performs its goodwill impairment testing during the fourth quarter of each year. The Company recognizes an impairment charge for any amount by which the carrying amount of goodwill exceeds its implied fair value.

The Company first assesses qualitative factors to determine whether it is necessary to perform the two-step quantitative goodwill impairment test. The Company does not calculate the fair value of a reporting unit unless it determines, based on a qualitative assessment, that it is more likely than not that its fair value is less than its carrying amount.

If the two-step quantitative test is deemed necessary, the Company uses discounted cash flows to establish the fair value as of the testing date. The discounted cash flow approach includes many assumptions related to future growth rates, discount factors, future tax rates, etc. Changes in economic and operating conditions

impacting these assumptions could result in goodwill impairment in future periods. When available and as appropriate, the Company uses comparative market multiples to corroborate discounted cash flow results.

Medical Claims Liability

Medical claims liability includes claims reported but not yet paid, or inventory, estimates for claims incurred but not reported, or IBNR, and estimates for the costs necessary to process unpaid claims at the end of each period. The Company estimates its medical claims liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors.

Actuarial Standards of Practice generally require that the medical claims liability estimates be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate. In many situations, the claims amounts ultimately settled will be different than the estimate that satisfies the Actuarial Standards of Practice. The Company includes in its IBNR an estimate for medical claims liability under moderately adverse conditions which represents the risk of adverse deviation of the estimates in its actuarial method of reserving.

The Company uses its judgment to determine the assumptions to be used in the calculation of the required estimates. The assumptions it considers when estimating IBNR include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to fee schedules, and the incidence of high dollar or catastrophic claims.

The Company's development of the medical claims liability estimate is a continuous process which it monitors and refines on a monthly basis as additional claims receipts and payment information becomes available. As more complete claims information becomes available, the Company adjusts the amount of the estimates, and includes the changes in estimates in medical costs in the period in which the changes are identified. In every reporting period, the operating results include the effects of more completely developed medical claims liability estimates associated with previously reported periods. The Company consistently applies its reserving methodology from period to period. As additional information becomes known, it adjusts the actuarial model accordingly to establish medical claims liability estimates.

The Company periodically reviews actual and anticipated experience compared to the assumptions used to establish medical costs. The Company establishes premium deficiency reserves if actual and anticipated experience indicates that existing policy liabilities together with the present value of future gross premiums will not be sufficient to cover the present value of future benefits, settlement and maintenance costs.

Revenue Recognition

The Company's health plans generate revenues primarily from premiums received from the states in which it operates health plans. The Company receives a fixed premium per member per month pursuant to its state contracts. The Company generally receives premium payments during the month it provides services and recognizes premium revenue during the period in which it is obligated to provide services to its members. In some instances, the Company's base premiums are subject to an adjustment, or risk score, based on the acuity of its membership. Generally, the risk score is determined by the State analyzing submissions of processed claims data to determine the acuity of the Company's membership relative to the entire state's Medicaid membership. Some states enact premium taxes, similar assessments and provider pass-through payments, collectively premium taxes, and these taxes are recorded as a separate component of both revenues and operating expenses. Some contracts allow for additional premiums related to certain supplemental services provided such as maternity deliveries.

Revenues are recorded based on membership and eligibility data provided by the states, which is adjusted on a monthly basis by the states for retroactive additions or deletions to membership data. These eligibility adjustments are estimated monthly and subsequent adjustments are made in the period known. We continuously review and update those estimates as new information becomes available. It is possible that new information could require us to make additional adjustments, which could be significant, to these estimates.

The Company's specialty companies generate revenues under contracts with state programs, individuals, healthcare organizations and other commercial organizations, as well as from the Company's own subsidiaries. Revenues are recognized when the related services are provided or as ratably earned over the covered period of service.

Premium and Related Receivables and Unearned Revenue

Premium and service revenues collected in advance are recorded as unearned revenue. For performance-based contracts the Company does not recognize revenue subject to refund until data is sufficient to measure performance. Premiums and service revenues due to the Company are recorded as premium and related receivables and are recorded net of an allowance based on historical trends and management's judgment on the collectibility of these accounts. As the Company generally receives payments during the month in which services are provided, the allowance is typically not significant in comparison to total revenues and does not have a material impact on the presentation of the financial condition or results of operations. Activity in the allowance for uncollectible accounts for the years ended December 31, is summarized below:

	2013	2012	2011
Allowances, beginning of year	781	639	17
Amounts charged to expense	3,138	1,350	865
Write-offs of uncollectible receivables	(2,801)	(1,208)	(243)
Allowances, end of year	1,118	781	639

Significant Customers

Centene receives the majority of its revenues under contracts or subcontracts with state Medicaid managed care programs. The current contracts expire on various dates between March 31, 2014 and October 31, 2018. States whose aggregate annual contract value exceeded 10% of annual revenues and the respective percentage of the Company's total revenues for the years ended December 31, are as follows:

2013		2012		2011	
Texas	37%	Texas	40%	Georgia	15%
				Ohio	12%
				Texas	21%

Reinsurance

Centene's subsidiaries report reinsurance premiums as medical costs, while related reinsurance recoveries are reported as deductions from medical costs. The Company limits its risk of certain catastrophic losses by maintaining high deductible reinsurance coverage.

Other Income (Expense)

Other income (expense) consists principally of investment income, interest expense and equity method earnings from investments. Investment income is derived from the Company's cash, cash equivalents, restricted deposits and investments. Interest expense relates to borrowings under the senior notes, interest rate swap, credit facilities, interest on capital leases and credit facility fees.

Income Taxes

Deferred tax assets and liabilities are recorded for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax law or tax rates is recognized in income in the period that includes the enactment date.

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. In determining if a deductible temporary difference or net operating loss can be realized, the Company considers future reversals of existing taxable temporary differences, future taxable income, taxable income in prior carryback periods and tax planning strategies.

Contingencies

The Company accrues for loss contingencies associated with outstanding litigation, claims and assessments for which it has determined it is probable that a loss contingency exists and the amount of loss can be reasonably estimated. The Company expenses professional fees associated with litigation claims and assessments as incurred.

Stock Based Compensation

The fair value of the Company's employee share options and similar instruments are estimated using the Black-Scholes option-pricing model. That cost is recognized over the period during which an employee is required to provide service in exchange for the award. Excess tax benefits related to stock compensation are presented as a cash inflow from financing activities.

Recent Accounting Pronouncements

In 2011, the Financial Accounting Standards Board issued accounting guidance for the health insurance industry's annual fees mandated by the Patient Protection and Affordable Care Act. The fees will be imposed beginning in 2014 based on the Company's share of the industry's net premiums written during the preceding calendar year. In addition, these fees will not be tax deductible. Under the guidance, the liability for the fee will be estimated and recorded in full each year beginning in 2014 when health insurance is first provided. A corresponding deferred cost will be recorded and amortized to operating expense over the calendar year.

3. Noncontrolling Interest and Acquisition

Noncontrolling Interest

The Company has consolidated subsidiaries where it maintains less than 100% ownership. The Company's ownership interest for each subsidiary as of December 31, are as follows:

	2013	2012	2011
Casenet	100%	100%	81%
Centurion	51%	51%	51%
Louisiana Healthcare Connections	100%	100%	51%
Home State Health Plan	95%	95%	—%

Casenet. During 2011, the Company increased its ownership interest in Casenet to 81% and in December 2012, acquired the remaining ownership interest for $4,429. The excess purchase price over the noncontrolling interest was recorded to additional paid in capital, net of the related deferred tax asset. Casenet is recorded in the Specialty Services segment.

Centurion. During 2011, the Company began operations as a 51% joint venture partner with MHM Services Inc. as Centurion. In July 2013, Centurion began operating under a new contract with the Department of

Corrections in Massachusetts to provide comprehensive healthcare services to individuals incarcerated in Massachusetts state correctional facilities and in September 2013, began operating under a new contract to provide comprehensive healthcare services to individuals incarcerated in Tennessee state correctional facilities. Centurion is recorded in the Specialty Services segment.

Home State Health Plan. In July 2012, the Company began operations as a 95% joint venture partner, operating under a new contract with the Office of Administration for Missouri to serve Medicaid beneficiaries in the Eastern, Central, and Western Managed Care Regions of the state.

Louisiana Healthcare Connections. In February 2012, the Company began operations under a new contract in Louisiana through a joint venture subsidiary, Louisiana Healthcare Connections. The Company initially owned a 51% interest in the subsidiary and in October 2012, acquired the remaining noncontrolling interest for $10,000. The purchase price in excess of the noncontrolling interest was recorded to additional paid in capital. The operating results of Louisiana are included in the Company's Managed Care segment.

Net income attributable to Centene Corporation and transfers from (to) noncontrolling interest entities are as follows:

	Year Ended December 31,		
	2013	2012	2011
Net earnings attributable to Centene Corporation	$161,218	$ 88,533	$120,518
Transfers from (to) the noncontrolling interest:			
Decrease in equity for purchase of, distribution to and redemption of noncontrolling interest	—	(12,193)	(289)
Increase in equity for distributions from and consolidation of noncontrolling interest	8,068	1,092	813
Net transfers from (to) noncontrolling interest	8,068	(11,101)	524
Changes from net earnings attributable to Centene Corporation and net transfers from (to) the noncontrolling interest	$169,286	$ 77,432	$121,042

Acquisition

AcariaHealth. In April 2013, the Company acquired 100% of AcariaHealth, a specialty pharmacy company, for $142,495 in total consideration. The transaction consideration was financed through a combination of $75,425 of Centene common stock and $67,070 of cash on hand. The Company also sold 342,640 shares of common stock for $15,225 related to funding the escrow account for the acquisition. The Company's allocation of fair value resulted in goodwill of $92,144 and other identifiable intangible assets of $35,000. The goodwill is not deductible for income tax purposes. The acquisition is recorded in the Specialty Services segment.

Pro forma disclosures related to the acquisitions have been excluded as immaterial.

4. Discontinued Operations: Kentucky Spirit Health Plan

In October 2012, the Company notified the Kentucky Cabinet for Health and Family Services (Cabinet) that it was exercising a contractual right that it believes allows the Company to terminate its Medicaid managed care contract with the Commonwealth of Kentucky (Commonwealth) effective July 5, 2013. As of July 6, 2013, our subsidiary, Kentucky Spirit Health Plan (KSHP), ceased serving Medicaid members in Kentucky. Accordingly, the results of operations of KSHP are presented as discontinued operations for all periods presented. The assets, liabilities and results of operations of KSHP are classified as discontinued operations for all periods presented beginning in 2011. KSHP was previously reported in the Managed Care segment.

During the years ended December 31, 2013 and 2012, the Company incurred exit costs consisting primarily of lease termination fees and employee severance. The change in exit cost liability for KSHP is summarized as follows:

	Employee Benefits	Lease Termination	Total
Balance, December 31, 2011	$ —	$ —	$ —
Incurred	2,939	—	2,939
Balance, December 31, 2012	2,939	—	2,939
Incurred	434	735	1,169
Paid	(2,837)	—	(2,837)
Balance, December 31, 2013	$ 536	$735	$ 1,271

KSHP had remaining statutory capital of approximately $83,600 at December 31, 2013, which will be transferred to unregulated cash, subject to regulatory approval.

Operating results for the discontinued operations are as follows:

	Year Ended December 31,		
	2013	2012	2011
Revenues	$248,327	$ 557,316	$129,105
Earnings (loss) before income taxes	$ 6,165	$(134,415)	$ (13,465)
Net earnings (loss)	$ 3,881	$ (86,674)	$ (9,300)

Assets and liabilities of the discontinued operations are as follows:

	December 31, 2013	December 31, 2012
Current assets	$ 77,512	$176,996
Long term investments and restricted deposits	38,305	60,461
Other assets	—	1,836
Assets of discontinued operations	$115,817	$239,293
Medical claims liability	$ 27,637	$111,141
Accounts payable and accrued expenses	2,657	45,975
Other liabilities	1,028	357
Liabilities of discontinued operations	$ 31,322	$157,473

5. Short term and Long term Investments and Restricted Deposits

Short term and long term investments and restricted deposits by investment type consist of the following:

	December 31, 2013				December 31, 2012			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$246,085	$ 245	$(7,494)	$238,836	$110,941	$ 581	$(221)	$111,301
Corporate securities	293,912	2,782	(608)	296,086	290,691	4,615	(195)	295,111
Restricted certificates of deposit	5,891	—	—	5,891	5,890	—	—	5,890
Restricted cash equivalents	26,642	—	—	26,642	14,455	—	—	14,455
Municipal securities:								
General obligation	54,003	555	(136)	54,422	85,440	1,157	(26)	86,571
Pre-refunded	10,835	82	—	10,917	5,337	85	—	5,422
Revenue	68,801	545	(292)	69,054	82,781	1,313	(30)	84,064
Variable rate demand notes	28,575	—	—	28,575	23,385	—	—	23,385
Asset backed securities	138,803	579	(332)	139,050	73,570	1,082	(15)	74,637
Mortgage backed securities	33,974	—	(83)	33,891	—	—	—	—
Cost and equity method investments	22,239	—	—	22,239	11,298	—	—	11,298
Life insurance contracts	15,369	—	—	15,369	15,023	—	—	15,023
Total	$945,129	$4,788	$(8,945)	$940,972	$718,811	$8,833	$(487)	$727,157

The Company's investments are classified as available-for-sale with the exception of life insurance contracts and certain cost and equity method investments. The Company's investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets with the focus on high credit quality securities. The Company limits the size of investment in any single issuer other than U.S. treasury securities and obligations of U.S. government corporations and agencies. The Company's mortgage backed securities are issued by the Federal National Mortgage Association and carry guarantees by the U.S. government. As of December 31, 2013, 52% of the Company's investments in securities recorded at fair value that carry a rating by S&P or Moody's were rated AAA/Aaa, 68% were rated AA-/Aa3 or higher, and 94% were rated A-/A3 or higher. At December 31, 2013, the Company held certificates of deposit, life insurance contracts and cost and equity method investments which did not carry a credit rating.

The fair value of available-for-sale investments with gross unrealized losses by investment type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

	December 31, 2013				December 31, 2012			
	Less Than 12 Months		12 Months or More		Less Than 12 Months		12 Months or More	
	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$(6,188)	$172,365	$(1,307)	$26,454	$(219)	$ 56,033	$ (2)	$201
Corporate securities	(400)	52,725	(207)	5,020	(195)	44,208	—	—
Municipal securities:								
General obligation	(72)	3,480	(63)	2,426	(26)	7,930	—	—
Revenue	(292)	27,789	—	—	(30)	3,090	—	—
Asset backed securities	(333)	37,689	—	—	(15)	8,192	—	—
Mortgage backed securities	(83)	33,891	—	—	—	—	—	—
Total	$(7,368)	$327,939	$(1,577)	$33,900	$(485)	$119,453	$ (2)	$201

As of December 31, 2013, the gross unrealized losses were generated from 83 positions out of a total of 343 positions. The decline in fair value of fixed income securities is a result of movement in interest rates subsequent to the purchase of the security.

For each security in an unrealized loss position, the Company assesses whether it intends to sell the security or if it is more likely than not the Company will be required to sell the security before recovery of the amortized cost basis for reasons such as liquidity, contractual or regulatory purposes. If the security meets this criterion, the decline in fair value is other-than-temporary and is recorded in earnings. The Company does not intend to sell these securities prior to maturity and it is not likely that the Company will be required to sell these securities prior to maturity; therefore, there is no indication of other than temporary impairment for these securities.

The contractual maturities of short term and long term investments and restricted deposits are as follows:

	December 31, 2013				December 31, 2012			
	Investments		Restricted Deposits		Investments		Restricted Deposits	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value
One year or less	$101,537	$102,126	$40,633	$40,637	$136,997	$138,101	$33,897	$33,928
One year through five years	609,755	610,589	6,301	6,309	429,053	435,728	358	358
Five years through ten years	157,003	151,221	—	—	93,907	93,778	—	—
Greater than ten years	29,900	30,090	—	—	24,599	25,264	—	—
Total	$898,195	$894,026	$46,934	$46,946	$684,556	$692,871	$34,255	$34,286

Actual maturities may differ from contractual maturities due to call or prepayment options. Asset backed and mortgage backed securities are included in the one year through five years category, while cost and equity method investments and life insurance contracts are included in the five years through ten years category. The Company has an option to redeem at amortized cost substantially all of the securities included in the greater than ten years category listed above.

The Company continuously monitors investments for other-than-temporary impairment. Certain investments have experienced a decline in fair value due to changes in credit quality, market interest rates and/or general

economic conditions. The Company recognizes an impairment loss for cost and equity method investments when evidence demonstrates that it is other-than-temporarily impaired. Evidence of a loss in value that is other than temporary may include the absence of an ability to recover the carrying amount of the investment or the inability of the investee to sustain a level of earnings that would justify the carrying amount of the investment.

6. Fair Value Measurements

Assets and liabilities recorded at fair value in the consolidated balance sheets are categorized based upon the extent to which the fair value estimates are based upon observable or unobservable inputs. Level inputs are as follows:

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

The following table summarizes fair value measurements by level at December 31, 2013, for assets and liabilities measured at fair value on a recurring basis:

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$ 974,304	$ —	$—	$ 974,304
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 212,185	$ 12,238	$—	$ 224,423
Corporate securities	—	296,086	—	296,086
Municipal securities:				
General obligation	—	54,422	—	54,422
Pre-refunded	—	10,917	—	10,917
Revenue	—	69,054	—	69,054
Variable rate demand notes	—	28,575	—	28,575
Asset backed securities	—	139,050	—	139,050
Mortgage backed securities	—	33,891	—	33,891
Total investments	$ 212,185	$644,233	$—	$ 856,418
Restricted deposits available for sale:				
Cash and cash equivalents	$ 26,642	$ —	$—	$ 26,642
Certificates of deposit	5,891	—	—	5,891
U.S. Treasury securities and obligations of U.S. government corporations and agencies	14,413	—	—	14,413
Total restricted deposits	$ 46,946	$ —	$—	$ 46,946
Other long term assets:				
Interest rate swap contract	$ —	$ 9,576	$—	$ 9,576
Total assets at fair value	$1,233,435	$653,809	$—	$1,887,244

The following table summarizes fair value measurements by level at December 31, 2012, for assets and liabilities measured at fair value on a recurring basis:

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$745,933	$ —	$—	$ 745,933
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 57,114	$ 40,246	$—	$ 97,360
Corporate securities	—	295,111	—	295,111
Municipal securities:				
General obligation	—	86,571	—	86,571
Pre-refunded	—	5,422	—	5,422
Revenue	—	84,064	—	84,064
Variable rate demand notes	—	23,385	—	23,385
Asset backed securities	—	74,637	—	74,637
Mortgage backed securities	—	—	—	—
Total investments	$ 57,114	$609,436	$—	$ 666,550
Restricted deposits available for sale:				
Cash and cash equivalents	$ 14,455	$ —	$—	$ 14,455
Certificates of deposit	5,890	—	—	5,890
U.S. Treasury securities and obligations of U.S. government corporations and agencies	13,941	—	—	13,941
Total restricted deposits	$ 34,286	$ —	$—	$ 34,286
Other long term assets:				
Interest rate swap contract	$ —	$ 16,304	$—	$ 16,304
Total assets at fair value	$837,333	$625,740	$—	$1,463,073

The Company periodically transfers U.S. Treasury securities and obligations of U.S. government corporations and agencies between Level I and Level II fair value measurements dependent upon the level of trading activity for the specific securities at the measurement date. The Company's policy regarding the timing of transfers between Level I and Level II is to measure and record the transfers at the end of the reporting period. At December 31, 2013, there were $1,143 of transfers from Level I to Level II and $26,301 of transfers from Level II to Level I. The Company utilizes matrix pricing services to estimate fair value for securities which are not actively traded on the measurement date. The Company designates these securities as Level II fair value measurements. The aggregate carrying amount of the Company's life insurance contracts and other non-majority owned investments, which approximates fair value, was $37,608 and $26,321 as of December 31, 2013 and December 31, 2012, respectively.

7. Notes Receivable

Between July 2008 and October 2011, the Company made an investment of $30,000 in secured notes receivable to a third party as part of an investment in certain Medicaid and Medicare related businesses. The notes included a feature to convert the note balance into an equity ownership in the underlying businesses.

In September 2012, the Company executed an agreement with the borrower whereby the borrower agreed to pay the Company total consideration of $50,000 for retirement of the outstanding notes and equity ownership conversion feature. Under the terms of the agreement, the borrower paid the Company $30,000 in December 2012, and agreed to

pay the Company $10,000 by September 30, 2013 and $10,000 by September 30, 2014. All outstanding balances are secured by liens on certain underlying businesses as well as guaranteed personally by the principal owner of the businesses. The $10,000 notes to be paid on or before September 30, 2013 and September 30, 2014 are non-interest bearing and, as a result, total consideration was discounted by $2,120 to reflect imputation of interest. As a result, during the third quarter of 2012, the Company recorded a pre-tax gain of $17,880 in other income representing the fair value of the total consideration in excess of the carrying value of the loans on the Company's balance sheet. As of December 31, 2013, the Company has a remaining receivable of $9,483 associated with this transaction.

8. Property, Software and Equipment

Property, software and equipment consist of the following as of December 31:

	2013	2012
Computer software	$ 184,983	$ 164,755
Building	206,058	193,186
Land	69,705	70,276
Computer hardware	69,087	57,389
Furniture and office equipment	53,180	43,136
Leasehold improvements	56,816	49,808
	639,829	578,550
Less accumulated depreciation	(244,422)	(202,657)
Property, software and equipment, net	$ 395,407	$ 375,893

As of December 31, 2013 and 2012, the Company had assets acquired under capital leases included above of $5,815 and $6,133, net of accumulated amortization of $1,782 and $1,595, respectively. Amortization on assets under capital leases charged to expense is included in depreciation expense. Depreciation expense for the years ended December 31, 2013, 2012 and 2011 was $52,234, $48,942 and $42,098, respectively.

9. Goodwill and Intangible Assets

During the second quarter of 2012, the Company's subsidiary, Celtic Insurance Company, experienced a high level of medical costs for individual health policies, especially for recently issued policies related to members converted from another insurer during the first quarter of 2012. Additionally, in June 2012, the U.S. Supreme Court upheld the constitutionality of the Patient Protection and Affordable Care Act which limits the profitability of the individual health insurance business because of minimum medical loss ratios, guaranteed issue policies, and increased competition in the exchange market. As a result of these factors, the Company conducted an impairment analysis of the identifiable intangible assets and goodwill of the Celtic reporting unit. The impairment analysis resulted in goodwill and intangible asset impairments of $28,033, recorded as an impairment loss in the consolidated statement of operations. The impaired identifiable intangible assets of $2,340 and goodwill of $25,693 were reported under the Specialty Services segment; $26,589 of the impairment loss is not deductible for income tax purposes.

The following table summarizes the changes in goodwill by operating segment:

	Managed Care	Specialty Services	Total
Balance as of December 31, 2011	$151,402	$130,579	$281,981
Impairment	—	(25,693)	(25,693)
Balance as of December 31, 2012	151,402	104,886	256,288
Acquisition	—	92,144	92,144
Balance as of December 31, 2013	$151,402	$197,030	$348,432

Goodwill acquisitions and other adjustments were related to the acquisitions and finalization of fair value allocations discussed in Note 3, *Noncontrolling Interest and Acquisitions*.

Intangible assets at December 31, consist of the following:

			Weighted Average Life in Years	
	2013	2012	2013	2012
Purchased contract rights	$ 21,988	$ 21,988	7.5	7.5
Provider contracts	35,537	2,737	13.2	9.8
Customer relationships	13,396	13,396	8.0	8.0
Trade names	8,695	6,495	18.9	16.3
Intangible assets	79,616	44,616	11.1	9.1
Less accumulated amortization:				
Purchased contract rights	(13,459)	(11,010)		
Provider contracts	(3,767)	(1,241)		
Customer relationships	(11,425)	(10,214)		
Trade names	(2,185)	(1,883)		
Total accumulated amortization	(30,836)	(24,348)		
Intangible assets, net	$ 48,780	$ 20,268		

Amortization expense was $6,489, $4,822 and $5,561 for the years ended December 31, 2013, 2012 and 2011 respectively. Estimated total amortization expense related to intangible assets for each of the five succeeding fiscal years is as follows:

Year	Expense
2014	$6,800
2015	5,900
2016	5,900
2017	4,400
2018	2,600

10. Medical Claims Liability

The change in medical claims liability is summarized as follows:

	Year Ended December 31,		
	2013	2012	2011
Balance, January 1,	$ 815,161	$ 518,840	$ 456,765
Incurred related to:			
Current year	9,072,867	6,836,177	4,256,645
Prior years	(78,226)	(55,096)	(65,377)
Total incurred	8,994,641	6,781,081	4,191,268
Paid related to:			
Current year	7,975,367	6,024,720	3,744,475
Prior years	722,726	460,040	384,718
Total paid	8,698,093	6,484,760	4,129,193
Balance, December 31,	$1,111,709	$ 815,161	$ 518,840

Changes in estimates of incurred claims for prior years are primarily attributable to reserving under moderately adverse conditions. In addition, claims processing initiatives yielded increased claim payment recoveries and coordination of benefits related to prior year dates of service. Changes in medical utilization and cost trends and the effect of medical management initiatives may also contribute to changes in medical claim liability estimates. While the Company has evidence that medical management initiatives are effective on a case by case basis, medical management initiatives primarily focus on events and behaviors prior to the incurrence of the medical event and generation of a claim. Accordingly, any change in behavior, leveling of care, or coordination of treatment occurs prior to claim generation and as a result, the costs prior to the medical management initiative are not known by the Company. Additionally, certain medical management initiatives are focused on member and provider education with the intent of influencing behavior to appropriately align the medical services provided with the member's acuity. In these cases, determining whether the medical management initiative changed the behavior cannot be determined. Because of the complexity of its business, the number of states in which it operates, and the volume of claims that it processes, the Company is unable to practically quantify the impact of these initiatives on its changes in estimates of IBNR.

The Company had reinsurance recoverables related to medical claims liability of $10,427 and $9,094 at December 31, 2013 and 2012, respectively, included in premium and related receivables.

The Company periodically reviews actual and anticipated experience compared to the assumptions used to establish medical costs. The Company establishes premium deficiency reserves if actual and anticipated experience indicates that existing policy liabilities together with the present value of future gross premiums will not be sufficient to cover the present value of future benefits, settlement and maintenance costs.

11. Debt

Debt consists of the following:

	December 31, 2013	December 31, 2012
Senior notes, at par	$425,000	$425,000
Unamortized premium on senior notes	6,052	7,823
Interest rate swap fair value	9,576	16,304
Senior notes	440,628	449,127
Revolving credit agreement	150,000	—
Mortgage notes payable	72,785	84,081
Capital leases and other	5,349	5,646
Total debt	668,762	538,854
Less current portion	(3,065)	(3,373)
Long term debt	$665,697	$535,481

Senior Notes

In May 2011, the Company issued $250,000 non-callable 5.75% Senior Notes due June 1, 2017 (the $250,000 Notes) at a discount to yield 6%. In connection with the May 2011 issuance, the Company entered into an interest rate swap for a notional amount of $250,000. Gains and losses due to changes in the fair value of the interest rate swap completely offset changes in the fair value of the hedged portion of the underlying debt and are recorded as an adjustment to the $250,000 Notes. At December 31, 2013, the fair value of the interest rate swap increased the fair value of the notes by $9,576 and the variable interest rate of the swap was 3.74%.

In November 2012, the Company issued an additional $175,000 non-callable 5.75% Senior Notes due June 1, 2017 ($175,000 Add-on Notes) at a premium to yield 4.29%. The indenture governing the $250,000 Notes and the $175,000 Add-on Notes contains non-financial and financial covenants, including requirements of

a minimum fixed charge coverage ratio. Interest is paid semi-annually in June and December. At December 31, 2013, the total net unamortized debt premium on the $250,000 Notes and $175,000 Add-on Notes was $6,052.

Revolving Credit Agreement

In May 2013, the Company entered into a new unsecured $500,000 revolving credit facility and terminated its previous $350,000 revolving credit facility. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. The agreement has a maturity date of June 1, 2018, provided it will mature 90 days prior to the maturity date of the Company's 5.75% Senior Notes due 2017 if such notes are not refinanced (or extended) or certain financial conditions are not met, including carrying $100,000 of unrestricted cash on deposit. As of December 31, 2013, the Company had $150,000 of borrowings outstanding under the agreement with a weighted average interest rate of 3.31%.

The agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt-to-EBITDA ratios and minimum tangible net worth. The Company is required not to exceed a maximum debt-to-EBITDA ratio of 3.0 to 1.0. As of December 31, 2013, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

Mortgage Notes Payable

The Company has a non-recourse mortgage note of $72,785 at December 31, 2013 collateralized by its corporate headquarters building. The mortgage note is due January 1, 2021 and bears a 5.14% interest rate. The collateralized property had a net book value of $160,246 at December 31, 2013.

The Company also had a mortgage note of $8,700 at December 31, 2012 collateralized by another building and parking garage. In June 2013, the Company repaid this mortgage note.

Letters of Credit & Surety Bonds

The Company had outstanding letters of credit of $28,757 as of December 31, 2013, which were not part of the revolving credit facility. The letters of credit bore interest at 0.51% as of December 31, 2013. The Company had outstanding surety bonds of $102,568 as of December 31, 2013.

Aggregate maturities for the Company's debt are as follows:

2014	$ 3,065
2015	3,188
2016	3,353
2017	428,525
2018	153,702
Thereafter	61,301
Total	$653,134

The fair value of outstanding debt was approximately $672,529 and $543,611 at December 31, 2013 and 2012, respectively.

12. Interest Rate Swap

In May 2011, the Company entered into $250,000 notional amount of interest rate swap agreements (Swap Agreements) that are scheduled to expire June 1, 2017. Under the Swap Agreements, the Company receives a fixed rate of 5.75% and pays a variable rate of the three month LIBOR plus 3.5% adjusted quarterly, which allows the Company to adjust $250,000 of its senior notes to a floating rate. The Company does not hold or issue any derivative instrument for trading or speculative purposes. At December 31, 2013, the variable rate was 3.74%.

The Swap Agreements are formally designated and qualify as fair value hedges. The Swap Agreements are recorded at fair value in the Consolidated Balance Sheet in other assets or other liabilities. Gains and losses due to changes in fair value of the interest rate swaps completely offset changes in the fair value of the hedged portion of the underlying debt. Therefore, no gain or loss has been recognized due to hedge ineffectiveness. Offsetting changes in fair value of both the interest rate swaps and the hedged portion of the underlying debt both were recognized in interest expense in the Consolidated Statement of Operations.

The fair value of the Swap Agreements as of December 31, 2013 was an asset of approximately $9,576, and is included in other long term assets in the Consolidated Balance Sheet. The fair value of the Swap Agreements excludes accrued interest and takes into consideration current interest rates and current likelihood of the swap counterparties' compliance with its contractual obligations.

13. Stockholders' Equity

The Company has 10,000,000 authorized shares of preferred stock at $.001 par value. At December 31, 2013, there were no preferred shares outstanding.

The Company's Board of Directors has authorized a stock repurchase program for up to 4,000,000 shares of the Company's common stock from time to time on the open market or through privately negotiated transactions. No duration has been placed on the repurchase program. The Company has 1,667,724 available shares remaining under the program for repurchases as of December 31, 2013. The Company reserves the right to discontinue the repurchase program at any time. During the year ended December 31, 2013, the Company did not repurchase any shares through this publicly announced program.

As a component of the employee stock compensation plan, employees can use shares of stock which have vested to satisfy minimum statutory tax withholding obligations. As part of this plan, the Company repurchased 344,064 shares at an aggregate cost of $19,779 in 2013 and 287,804 shares at an aggregate cost of $12,741 in 2012. These shares are included in the Company's treasury stock.

In April 2013, the Company completed the acquisition of AcariaHealth and as a result, issued 1,716,690 shares of Centene common stock to the selling stockholders. Additionally, the Company filed an equity shelf registration statement related to funding the escrow account for the acquisition and sold 342,640 shares of Centene common stock for $15,225.

14. Statutory Capital Requirements and Dividend Restrictions

Various state laws require Centene's regulated subsidiaries to maintain minimum capital levels specified by each state and restrict the amount of dividends that may be paid without prior regulatory approval. At December 31, 2013 and 2012, Centene's subsidiaries, including Kentucky Spirit Health Plan, had aggregate statutory capital and surplus of $1,279,700 and $990,300, respectively, compared with the required minimum aggregate statutory capital and surplus of $686,400 and $617,000, respectively.

15. Income Taxes

The consolidated income tax expense consists of the following for the years ended December 31:

	2013	2012	2011
Current provision:			
Federal	$120,858	$47,528	$63,388
State and local	5,857	(4,368)	5,157
Total current provision	126,715	43,160	68,545
Deferred provision	(19,635)	4,252	2,142
Total provision for income taxes	$107,080	$47,412	$70,687

The reconciliation of the tax provision at the U.S. Federal Statutory Rate to the provision for income taxes is as follows:

	2013	2012	2011
Earnings from continuing operations, before income tax expense	$268,917	$122,791	$188,350
Less flow through noncontrolling interest	960	(2,539)	(2,855)
Earnings from continuing operations, less noncontrolling interest, before income tax expense	267,957	125,330	191,205
Tax provision at the U.S. federal statutory rate	93,785	43,866	66,922
State income taxes, net of federal income tax benefit	2,871	(2,288)	3,381
Nondeductible goodwill impairment	—	8,487	—
Nondeductible compensation	12,519	1,108	2,705
Other, net	(2,095)	(3,761)	(2,321)
Income tax expense	$107,080	$ 47,412	$ 70,687

The tax effects of temporary differences which give rise to deferred tax assets and liabilities are presented below for the years ended December 31:

	2013	2012
Deferred tax assets:		
Medical claims liability and other accruals	$ 53,943	$37,413
State net operating loss carry forward	9,530	9,055
Stock compensation	14,223	12,615
Other	30,199	20,573
Deferred tax assets	107,895	79,656
Valuation allowance	(8,119)	(8,180)
Net deferred tax assets	$ 99,776	$71,476
Deferred tax liabilities:		
Intangible assets	$ 18,278	$12,441
Prepaid assets	5,621	4,767
Depreciation and amortization	30,411	31,741
Other	1,615	5,624
Deferred tax liabilities	$ 55,925	$54,573
Net deferred tax assets	$ 43,851	$16,903

The Company's deferred tax assets include federal and state net operating losses, or NOLs, of which $6,547 were acquired in business combinations. Accordingly, the total and annual deduction for those NOLs is limited by tax law. The Company's federal NOLs expire between the years 2020 and 2032 and the state NOLs expire between the years 2014 and 2034. Valuation allowances are recorded for those NOLs the Company believes are more likely than not to expire unused. During 2013 and 2012, the Company recorded valuation allowance additions in the tax provision of $1,301 and $2,093, respectively. In 2013 and 2012, the Company recorded valuation allowance reductions of $1,362 and $2,289, respectively.

The Company maintains a reserve for uncertain tax positions that may be challenged by a tax authority. A roll-forward of the reserve is as follows:

	2013	2012
Gross unrecognized tax benefits, beginning of period	$ 7,870	$13,552
Gross increases:		
Current year tax positions	338	4,107
Prior year tax positions	164	451
Gross decreases:		
Prior year tax positions	—	(9,925)
Settlements	(4,390)	(53)
Statute of limitation lapses	(708)	(262)
Gross unrecognized tax benefits, end of period	$ 3,274	$ 7,870

Included in the balance of unrecognized tax benefits at December 31, 2013 and 2012 were reserve balances of $3,274 and $4,095, respectively, that, if recognized, would decrease the effective tax rate on income from continuing operations. Also included in the December 31, 2012 reserve balance were liabilities of $3,775 that, if recognized, would have been recorded as an adjustment to deferred taxes.

The Company recognizes interest accrued related to unrecognized tax benefits in the provision for income taxes. During the year ended December 31, 2013 and 2012, the Company recognized tax benefits generated from the net reduction in interest accrued of $310 and $170, respectively. Interest accrued, net of federal benefit, was $623, $933 and $1,157 as of December 31, 2013, 2012 and 2011, respectively. No penalties have been accrued.

During 2013, the IRS concluded its examination of the Company's 2010 and 2011 federal tax returns. The Company files in numerous state jurisdictions with varying statutes of limitation. The unrecognized state tax benefits are related to returns open from 2009 to 2013.

16. Stock Incentive Plans

The Company's stock incentive plans allow for the granting of restricted stock or restricted stock unit awards and options to purchase common stock. Both incentive stock options and nonqualified stock options can be awarded under the plans. No option will be exercisable for longer than ten years after the date of grant. The plans have 1,414,240 shares available for future awards. Compensation expense for stock options and restricted stock unit awards is recognized on a straight-line basis over the vesting period, generally three to five years for stock options and 1 to 10 years for restricted stock or restricted stock unit awards. Certain restricted stock unit awards contain performance-based as well as service-based provisions. Certain awards provide for accelerated vesting if there is a change in control as defined in the plans. The total compensation cost that has been charged against income for the stock incentive plans was $36,153, $25,001 and $18,141 for the years ended December 31, 2013, 2012 and 2011, respectively. The total income tax benefit recognized in the income statement for stock-based compensation arrangements was $7,575, $8,952 and $5,804 for the years ended December 31, 2013, 2012 and 2011, respectively.

Option activity for the year ended December 31, 2013 is summarized below:

	Shares	Weighted Average Exercise Price	Aggregate Intrinsic Value	Weighted Average Remaining Contractual Term
Outstanding as of December 31, 2012	1,299,396	$22.39		
Granted	10,000	44.58		
Exercised	(361,538)	20.32		
Forfeited	(663)	17.86		
Outstanding as of December 31, 2013	947,195	$23.41	$33,659	2.8
Exercisable as of December 31, 2013	921,462	$23.21	$32,937	2.7

The fair value of each option grant is estimated on the date of the grant using the Black-Scholes option-pricing model with the following weighted-average assumptions:

	Year Ended December 31,		
	2013	2012[1]	2011
Expected life (in years)	5.1	—	5.2
Risk-free interest rate	0.8%	—	0.9%
Expected volatility	48.1%	—	49.9%
Expected dividend yield	—	—	—

[1] No options were awarded in the year ended December 31, 2012.

For the years ended December 31, 2013, 2012 and 2011, the Company used a projected expected life for each award granted based on historical experience of employees' exercise behavior. The expected volatility is primarily based on historical volatility levels. The risk-free interest rates are based on the implied yield currently available on U.S. Treasury instruments with a remaining term equal to the expected life.

Other information pertaining to option activity is as follows:

	Year Ended December 31,		
	2013	2012[1]	2011
Weighted-average fair value of options granted	$ 19.04	$ —	$ 13.94
Total intrinsic value of stock options exercised	$12,845	$24,120	$11,744

[1] No options were awarded in the year ended December 31, 2012.

A summary of the Company's non-vested restricted stock and restricted stock unit shares as of December 31, 2013, and changes during the year ended December 31, 2013, is presented below:

	Shares	Weighted Average Grant Date Fair Value
Non-vested balance as of December 31, 2012	2,058,908	$37.25
Granted	1,037,542	55.36
Vested	(961,741)	33.57
Forfeited	(45,116)	38.91
Non-vested balance as of December 31, 2013	2,089,593	$47.90

The total fair value of restricted stock and restricted stock units vested during the years ended December 31, 2013, 2012 and 2011, was $49,032, $38,576 and $22,280, respectively.

As of December 31, 2013, there was $87,901 of total unrecognized compensation cost related to non-vested share-based compensation arrangements granted under the plans; that cost is expected to be recognized over a weighted-average period of 1.7 years. The actual tax benefit realized for the tax deductions from disqualified dispositions of stock option exercises totaled $508, $1,078 and $955 for the years ended December 31, 2013, 2012 and 2011, respectively.

The Company maintains an employee stock purchase plan and has issued 42,084 shares, 47,613 shares, and 34,966 shares in 2013, 2012 and 2011, respectively.

17. Retirement Plan

Centene has a defined contribution plan which covers substantially all employees who are at least twenty-one years of age. Under the plan, eligible employees may contribute a percentage of their base salary, subject to certain limitations. Centene may elect to match a portion of the employee's contribution. Company expense related to matching contributions to the plan was $9,422, $6,771 and $5,119 during the years ended December 31, 2013, 2012 and 2011, respectively.

18. Commitments

Centene and its subsidiaries lease office facilities and various equipment under non-cancelable operating leases which may contain escalation provisions. The rental expense related to these leases is recorded on a straight-line basis over the lease term, including rent holidays. Tenant improvement allowances are recorded as a liability and amortized against rent expense over the term of the lease. Rent expense was $30,562, $27,564 and $22,537 for the years ended December 31, 2013, 2012 and 2011, respectively. Annual non-cancelable minimum lease payments over the next five years and thereafter are as follows:

2014	$ 25,350
2015	25,871
2016	24,202
2017	19,336
2018	12,628
Thereafter	18,800
	$126,187

19. Contingencies

In October 2012, the Company notified the Kentucky Cabinet for Health and Family Services (Cabinet) that it was exercising a contractual right that it believes allows the Company to terminate its Medicaid managed care contract with the Commonwealth of Kentucky (Commonwealth) effective July 5, 2013. The Company also filed a lawsuit in Franklin Circuit Court against the Commonwealth seeking a declaration of the Company's right to terminate the contract on July 5, 2013. In April 2013, the Commonwealth answered that lawsuit and filed counterclaims against the Company seeking declaratory relief and damages. In May 2013, the Franklin Circuit Court ruled that Kentucky Spirit does not have a contractual right to terminate the contract early. Kentucky Spirit has appealed that ruling to the Kentucky Court of Appeals.

The Company also filed a formal dispute with the Cabinet for damages incurred under the contract, which was later appealed to and denied by the Finance and Administration Cabinet. In response, the Company filed a lawsuit in April 2013, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches. This lawsuit was subsequently consolidated with the original lawsuit for declaratory relief and continues to proceed.

Kentucky Spirit's efforts to resolve issues with the Commonwealth were unsuccessful and on July 5, 2013, Kentucky Spirit proceeded with its previously announced exit. The Commonwealth has alleged that Kentucky

Spirit's exit constitutes a material breach of contract. The Commonwealth seeks to recover substantial damages and to enforce its rights under Kentucky Spirit's $25,000 performance bond. Any claim for damages by the Commonwealth may include the costs of transition and the additional costs to the Commonwealth to cover Kentucky Spirit's former members through July 5, 2014. Kentucky Spirit is pursuing its litigation claims for damages against the Commonwealth and will vigorously defend against any allegations that it has breached the contract.

The resolution of the Kentucky litigation matters may result in a range of possible outcomes. If the Company prevails on its claims, Kentucky Spirit would be entitled to damages under its lawsuit. If the Commonwealth prevails, a liability to the Commonwealth could be recorded. The Company is unable to estimate the ultimate outcome resulting from the Kentucky litigation. As a result, the Company has not recorded any receivable or any liability for potential damages under the contract as of December 31, 2013. While uncertain, the ultimate resolution of the pending litigation could have a material effect on the financial position, cash flow or results of operations of the Company in the period it is resolved or becomes known.

Excluding the Kentucky matters discussed above, the Company is also routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters in the normal course of business is uncertain, the Company does not expect the results of any of these matters individually, or in the aggregate, to have a material effect on its financial position, results of operations or cash flows.

20. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings per common share for the years ended December 31:

	2013	2012	2011
Earnings attributable to Centene Corporation:			
Earnings from continuing operations, net of tax	$ 161,218	$ 88,533	$ 120,518
Discontinued operations, net of tax	3,881	(86,674)	(9,300)
Net earnings	$ 165,099	$ 1,859	$ 111,218
Shares used in computing per share amounts:			
Weighted average number of common shares outstanding	54,126,545	51,509,366	50,198,954
Common stock equivalents (as determined by applying the treasury stock method)	2,120,628	2,205,009	2,275,284
Weighted average number of common shares and potential dilutive common shares outstanding	56,247,173	53,714,375	52,474,238
Net earnings per common share attributable to Centene Corporation:			
Basic:			
Continuing operations	$ 2.98	$ 1.72	$ 2.40
Discontinued operations	0.07	(1.68)	(0.18)
Basic earnings per common share	$ 3.05	$ 0.04	$ 2.22
Diluted:			
Continuing operations	$ 2.87	$ 1.65	$ 2.30
Discontinued operations	0.07	(1.62)	(0.18)
Diluted earnings per common share	$ 2.94	$ 0.03	$ 2.12

The calculation of diluted earnings per common share for 2013, 2012 and 2011 excludes the impact of 93,539 shares, 142,425 shares and 106,219 shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

21. Segment Information

Centene operates in two segments: Managed Care and Specialty Services. The Managed Care segment consists of Centene's health plans including all of the functions needed to operate them. The Specialty Services segment consists of Centene's specialty companies offering auxiliary healthcare services and products. The health plan in Massachusetts, operated by our individual health insurance business, is included in the Specialty Services segment.

Factors used in determining the reportable business segments include the nature of operating activities, existence of separate senior management teams, and the type of information presented to the Company's chief operating decision maker to evaluate all results of operations.

In January 2013, the Company reclassified the health plan in Arizona, which is primarily a LTC operation, to the Managed Care segment. As a result, the financial results of the Arizona health plan have been reclassified from the Specialty Services segment to the Managed Care segment for all periods presented.

Segment information as of and for the year ended December 31, 2013, follows:

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$9,740,720	$ 785,320	$ —	$10,526,040
Premium and service revenues from internal customers	41,094	2,147,200	(2,188,294)	—
Total premium and service revenues	9,781,814	2,932,520	(2,188,294)	10,526,040
Earnings from operations	197,844	79,573	—	277,417
Total assets	2,817,519	595,964	—	3,413,483

Segment information as of and for the year ended December 31, 2012, follows:

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$7,124,720	$ 556,911	$ —	$7,681,631
Premium and service revenues from internal customers	87,319	1,550,096	(1,637,415)	—
Total premium and service revenues	7,212,039	2,107,007	(1,637,415)	7,681,631
Earnings from operations	62,867	45,099	—	107,966
Total assets	2,163,347	371,265	—	2,534,612

Segment information as of and for the year ended December 31, 2011, follows:

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$4,571,430	$ 480,472	$ —	$5,051,902
Premium and service revenues from internal customers	64,809	710,002	(774,811)	—
Total premium and service revenues	4,636,239	1,190,474	(774,811)	5,051,902
Earnings from operations	161,890	41,913	—	203,803
Total assets	1,709,271	383,259	—	2,092,530

22. Quarterly Selected Financial Information

(In thousands, except share data and membership data)
(Unaudited)

	For the Quarter Ended			
	March 31, 2013	June 30, 2013	September 30, 2013	December 31, 2013
Total revenues	$2,525,482	$2,610,538	$2,795,569	$2,931,740
Amounts attributable to Centene Corporation common shareholders:				
Earnings from continuing operations, net of income tax expense	$ 22,639	$ 40,289	$ 50,325	$ 47,965
Discontinued operations, net of income tax expense (benefit)	363	(805)	(952)	5,275
Net earnings	$ 23,002	$ 39,484	$ 49,373	$ 53,240
Net earnings (loss) per common share attributable to Centene Corporation:				
Basic:				
Continuing operations	$ 0.43	$ 0.74	$ 0.92	$ 0.87
Discontinued operations	0.01	(0.02)	(0.02)	0.10
Basic earnings per common share	$ 0.44	$ 0.72	$ 0.90	$ 0.97
Diluted:				
Continuing operations	$ 0.41	$ 0.71	$ 0.88	$ 0.84
Discontinued operations	0.01	0.01	(0.01)	0.09
Diluted earnings per common share	$ 0.42	$ 0.72	$ 0.87	$ 0.93
Health Benefits Ratio	90.2%	88.4%	87.8%	88.1%
General & Administrative Expense Ratio	8.4%	8.9%	9.1%	8.9%
Period end at-risk membership	2,553,400	2,563,400	2,612,500	2,723,200

	For the Quarter Ended			
	March 31, 2012	June 30, 2012	September 30, 2012	December 31, 2012
Total revenues	$1,562,809	$1,967,362	$2,308,075	$2,272,050
Amounts attributable to Centene Corporation common shareholders:				
Earnings (loss) from continuing operations, net of income tax expense (benefit)	$ 27,072	$ (16,656)	$ 59,438	$ 18,679
Discontinued operations, net of income tax benefit	(3,094)	(18,343)	(55,619)	(9,618)
Net earnings (loss)	$ 23,978	$ (34,999)	$ 3,819	$ 9,061
Net earnings (loss) per common share attributable to Centene Corporation:				
Basic:				
Continuing operations	$ 0.53	$ (0.32)	$ 1.15	$ 0.36
Discontinued operations	(0.06)	(0.36)	(1.08)	(0.19)
Basic earnings per common share	$ 0.47	$ (0.68)	$ 0.07	$ 0.17
Diluted:				
Continuing operations	$ 0.51	$ (0.32)	$ 1.10	$ 0.35
Discontinued operations	(0.06)	(0.36)	(1.03)	(0.18)
Diluted earnings per common share	$ 0.45	$ (0.68)	$ 0.07	$ 0.17
Health Benefits Ratio	87.1%	91.2%	88.7%	90.7%
General & Administrative Expense Ratio	10.4%	8.5%	8.4%	8.4%
Period end at-risk membership	2,003,800	2,254,000	2,357,600	2,424,500

23. Condensed Financial Information of Registrant

Centene Corporation (Parent Company Only)
Condensed Balance Sheets
(In thousands, except share data)

	December 31,	
	2013	2012
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,740	$ 22,279
Short term investments, at fair value (amortized cost $6,000 and $6,500, respectively)	6,000	6,500
Other current assets	124,903	42,230
Total current assets	133,643	71,009
Long term investments, at fair value (amortized cost $8,070 and $1,356, respectively)	8,070	1,356
Investment in subsidiaries	1,667,258	1,298,648
Other long term assets	31,876	42,523
Total assets	$1,840,847	$1,413,536
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities	$ 4,460	$ 4,333
Long term debt	590,628	449,127
Other long term liabilities	2,320	6,309
Total liabilities	597,408	459,769
Stockholders' equity:		
Common stock, $.001 par value; authorized 100,000,000 shares; 58,673,215 issued and 55,319,239 outstanding at December 31, 2013, and 55,339,160 issued and 52,329,248 outstanding at December 31, 2012	59	55
Additional paid-in capital	594,326	450,856
Accumulated other comprehensive income:		
Unrealized gain (loss) on investments, net of tax	(2,620)	5,189
Retained earnings	731,919	566,820
Treasury stock, at cost (3,353,976 and 3,009,912 shares, respectively)	(89,643)	(69,864)
Total Centene stockholders' equity	1,234,041	953,056
Noncontrolling interest	9,398	711
Total stockholders' equity	1,243,439	953,767
Total liabilities and stockholders' equity	$1,840,847	$1,413,536

See notes to condensed financial information of registrant.

Centene Corporation (Parent Company Only)
Condensed Statements of Operations
(In thousands, except share data)

	Year Ended December 31,		
	2013	2012	2011
Expenses:			
General and administrative expenses	$ 4,196	$ 4,090	$ 4,488
Other income (expense):			
Investment and other income	983	19,921	(8,790)
Interest expense	(22,623)	(15,757)	(15,494)
Earnings (loss) before income taxes	(25,836)	74	(28,772)
Income tax benefit	(15,191)	(9,668)	(12,825)
Net earnings (loss) before equity in subsidiaries	(10,645)	9,742	(15,947)
Equity in earnings from subsidiaries	171,863	78,791	136,465
Net earnings from continuing operations	$ 161,218	$ 88,533	$ 120,518
Net earnings per share from continuing operations:			
Basic earnings per common share	$ 2.98	$ 1.72	$ 2.40
Diluted earnings per common share	$ 2.87	$ 1.65	$ 2.30
Weighted average number of shares outstanding:			
Basic	54,126,545	51,509,366	50,198,954
Diluted	56,247,173	53,714,375	52,474,238

See notes to condensed financial information of registrant.

Centene Corporation (Parent Company Only)
Condensed Statements of Cash Flows
(In thousands)

	Year Ended December 31,		
	2013	2012	2011
Cash flows from operating activities:			
Cash provided by operating activities	$ 302,242	$ 327,940	$ 72,754
Cash flows from investing activities:			
Net dividends from and capital contributions to subsidiaries	(417,734)	(539,575)	(50,581)
Purchase of investments	(12,518)	(7,320)	(21,915)
Sales and maturities of investments	10,252	30,000	11,111
Acquisitions	(67,070)	—	(1,773)
Net cash used in investing activities	(487,070)	(516,895)	(63,158)
Cash flows from financing activities:			
Proceeds from borrowings	180,000	400,500	419,183
Payment of long term debt	(30,000)	(215,000)	(413,644)
Proceeds from exercise of stock options	8,983	15,912	15,815
Proceeds from stock offering	15,225	—	—
Common stock repurchases	(19,779)	(12,741)	(7,809)
Debt issue costs	(3,589)	(3,623)	(9,242)
Contributions from noncontrolling interest	8,069	1,092	813
Purchase of noncontrolling interest	—	(14,429)	—
Excess tax benefits from stock compensation	6,380	10,996	4,435
Net cash provided by financing activities	165,289	182,707	9,551
Net increase (decrease) in cash and cash equivalents	(19,539)	(6,248)	19,147
Cash and cash equivalents, beginning of period	22,279	28,527	9,380
Cash and cash equivalents, end of period	$ 2,740	$ 22,279	$ 28,527

See notes to condensed financial information of registrant.

Notes to Condensed Financial Information of Registrant

Note A – Basis of Presentation and Significant Accounting Policies

The parent company only financial statements should be read in conjunction with Centene Corporation's audited consolidated financial statements and the notes to consolidated financial statements included in this Form 10-K.

The parent company's investment in subsidiaries is stated at cost plus equity in undistributed earnings of the subsidiaries. The parent company's share of net income of its unconsolidated subsidiaries is included in income using the equity method of accounting. Certain unrestricted subsidiaries receive monthly management fees from our restricted subsidiaries. The management and service fees received by our unrestricted subsidiaries are associated with all of the functions required to manage the restricted subsidiaries including but not limited to salaries and wages for all personnel, rent, utilities, medical management, provider contracting, compliance, member services, claims processing, information technology, cash management, finance and accounting, and other services. The management fees are based on a percentage of the restricted subsidiaries revenue.

Due to our centralized cash management function, all cash flows generated by our unrestricted subsidiaries, including management fees, are transferred to the parent company, primarily to repay borrowings on the parent company's revolving credit facility. The parent company may also utilize the cash flow to make acquisitions, fund capital contributions to subsidiaries and fund its operations. During the years ended December 31, 2013, 2012 and 2011, cash flows received by the parent from unrestricted subsidiaries was $312,887, $318,198, and $88,701 and was included in cash flows from operating activities.

Certain amounts presented in the parent company only financial statements are eliminated in the consolidated financial statements of Centene Corporation.

Note B – Dividends

During 2013, 2012 and 2011, the Registrant received dividends from its subsidiaries totaling $20,500, $29,000 and $69,100, respectively.

24. Subsequent Events

In January 2014, the Company acquired a majority interest in U.S. Medical Management, LLC, a management services organization and provider of in-home health services for high acuity populations, for approximately $200,000. The transaction consideration was financed through a combination of cash on hand and 2,243,217 shares of Centene common stock.

Item 9. ***Changes in and Disagreements With Accountants on Accounting and Financial Disclosure***

None.

Item 9A. ***Controls and Procedures.***

Evaluation of Disclosure Controls and Procedures — Our management, with the participation of our Chief Executive Officer and Chief Financial Officer, evaluated the effectiveness of our disclosure controls and procedures as of December 31, 2013. The term "disclosure controls and procedures," as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act, means controls and other procedures of a company that are designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is accumulated and communicated to the company's management, including its principal executive and principal financial officers, as appropriate to allow timely decisions regarding required disclosure. Management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving their objectives and management necessarily applies its judgment in evaluating the cost-benefit relationship of possible controls and procedures. Based on the evaluation of our disclosure controls and procedures as of December 31, 2013, our Chief Executive Officer and Chief Financial Officer concluded that, as of such date, our disclosure controls and procedures were effective at the reasonable assurance level.

Management's Report on Internal Control Over Financial Reporting — Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Exchange Act Rules 13a-15(f) and 15d-15(f). Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control — Integrated Framework (1992)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on our evaluation under the framework in *Internal Control — Integrated Framework (1992)*, our management concluded that our internal control over financial reporting was effective at the reasonable assurance level as of December 31, 2013. Our management's assessment of the effectiveness of our internal control over financial reporting as of December 31, 2013 has been audited by KPMG LLP, an independent registered public accounting firm, as stated in their report which is included herein.

Changes in Internal Control Over Financial Reporting — No change in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) occurred during the year ended December 31, 2013 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
Centene Corporation:

We have audited Centene Corporation's internal control over financial reporting as of December 31, 2013, based on criteria established in *Internal Control — Integrated Framework (1992)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). Centene Corporation'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, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included 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 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 its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that 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, Centene Corporation maintained, in all material respects, effective internal control over financial reporting as of December 31, 2013, based on criteria established in *Internal Control — Integrated Framework (1992)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Centene Corporation and subsidiaries as of December 31, 2013 and 2012, and the related consolidated statements of operations, comprehensive earnings, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2013, and our report dated February 21, 2014 expressed an unqualified opinion on those consolidated financial statements.

KPMG LLP

St. Louis, Missouri
February 21, 2014

Item 9B. ***Other Information***

None.

PART III

Item 10. ***Directors, Executive Officers and Corporate Governance***

(a) Directors of the Registrant

Information concerning our directors will appear in our Proxy Statement for our 2014 annual meeting of stockholders under "Proposal One: Election of Directors". This portion of the Proxy Statement is incorporated herein by reference.

(b) Executive Officers of the Registrant

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant."

Information concerning our executive officers' compliance with Section 16(a) of the Exchange Act will appear in our Proxy Statement for our 2014 annual meeting of stockholders under "Section 16(a) Beneficial Ownership Reporting Compliance." Information concerning our audit committee financial expert and identification of our audit committee will appear in our Proxy Statement for our 2014 annual meeting of stockholders under "Board of Directors Committees." Information concerning our code of ethics will appear in our Proxy Statement for our 2014 annual meeting of stockholders under "Corporate Governance and Risk Management." These portions of our Proxy Statement are incorporated herein by reference.

(c) Corporate Governance

Information concerning certain corporate governance matters will appear in our Proxy Statement for our 2014 annual meeting of stockholders under "Corporate Governance and Risk Management." These portions of our Proxy Statement are incorporated herein by reference.

Item 11. ***Executive Compensation***

Information concerning executive compensation will appear in our Proxy Statement for our 2014 Annual Meeting of Stockholders under "Information About Executive Compensation." Information concerning Compensation Committee interlocks and insider participation will appear in the Proxy Statement for our 2014 Annual Meeting of Stockholders under "Compensation Committee Interlocks and Insider Participation." These portions of the Proxy Statement are incorporated herein by reference.

Item 12. ***Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters***

Information concerning the security ownership of certain beneficial owners and management and our equity compensation plans will appear in our Proxy Statement for our 2014 annual meeting of stockholders under "Information About Stock Ownership" and "Equity Compensation Plan Information." These portions of the Proxy Statement are incorporated herein by reference.

Item 13. ***Certain Relationships and Related Transactions, and Director Independence***

Information concerning director independence, certain relationships and related transactions will appear in our Proxy Statement for our 2014 annual meeting of stockholders under "Corporate Governance and Risk Management" and "Related Party Transactions." These portions of our Proxy Statement are incorporated herein by reference.

Item 14. ***Principal Accountant Fees and Services***

Information concerning principal accountant fees and services will appear in our Proxy Statement for our 2014 annual meeting of stockholders under "Proposal Two: Ratification of Appointment of Independent Registered Public Accounting Firm." This portion of our Proxy Statement is incorporated herein by reference.

PART IV

Item 15. ***Exhibits and Financial Statement Schedules***

(a) **Financial Statements and Schedules**

The following documents are filed under Item 8 of this report:

1. Financial Statements:

   Report of Independent Registered Public Accounting Firm
   Consolidated Balance Sheets as of December 31, 2013 and 2012
   Consolidated Statements of Operations for the years ended December 31, 2013, 2012 and 2011
   Consolidated Statements of Comprehensive Earnings for the years ended December 31, 2013, 2012 and 2011
   Consolidated Statements of Stockholders' Equity for the years ended December 31, 2013, 2012 and 2011
   Consolidated Statements of Cash Flows for the years ended December 31, 2013, 2012 and 2011
   Notes to Consolidated Financial Statements

2. Financial Statement Schedules:

   None.

3. The exhibits listed in the accompanying Exhibit Index are filed or incorporated by reference as part of this filing.

EXHIBIT INDEX

EXHIBIT NUMBER	DESCRIPTION	FILED WITH THIS FORM 10-K	INCORPORATED BY REFERENCE [1]		
			FORM	FILING DATE WITH SEC	EXHIBIT NUMBER
3.1	Certificate of Incorporation of Centene Corporation		S-1	October 9, 2001	3.2
3.1a	Certificate of Amendment to Certificate of Incorporation of Centene Corporation, dated November 8, 2001		S-1/A	November 13, 2001	3.2a
3.1b	Certificate of Amendment to Certificate of Incorporation of Centene Corporation as filed with the Secretary of State of the State of Delaware		10-Q	July 26, 2004	3.1b
3.2	By-laws of Centene Corporation, as amended effective as of February 3, 2014		8-K	February 6, 2014	3.1
4.1	Indenture, dated May 27, 2011, among the Company and The Bank of New York Mellon Trust Company, N.A., relating to the Company's 5.75% Senior Notes due 2017 (including Form of Global Note as Exhibit A thereto)		8-K	May 27, 2011	4.1
10.1*	1996 Stock Plan of Centene Corporation, shares which are registered on Form S-8 – File Number 333-83190		S-1	October 9, 2001	10.9
10.2*	1998 Stock Plan of Centene Corporation, shares which are registered on Form S-8 – File number 333-83190		S-1	October 9, 2001	10.10
10.3*	1999 Stock Plan of Centene Corporation, shares which are registered on Form S-8 –File Number 333-83190		S-1	October 9, 2001	10.11
10.4*	2000 Stock Plan of Centene Corporation, shares which are registered on Form S-8 – File Number 333-83190		S-1	October 9, 2001	10.12
10.5*	2002 Employee Stock Purchase Plan of Centene Corporation, shares which are registered on Form S-8 – File Number 333-90976		10-Q	April 29, 2002	10.5
10.5a*	First Amendment to the 2002 Employee Stock Purchase Plan		10-K	February 24, 2005	10.9a
10.5b*	Second Amendment to the 2002 Employee Stock Purchase Plan		10-K	February 24, 2006	10.10b

EXHIBIT NUMBER	DESCRIPTION	FILED WITH THIS FORM 10-K	INCORPORATED BY REFERENCE [1]		
			FORM	FILING DATE WITH SEC	EXHIBIT NUMBER
10.6*	Centene Corporation Amended and Restated 2003 Stock Incentive Plan, shares which are registered on Form S-8 – File Number 333-108467		8-K	April 30, 2010	10.1
10.7*	2012 Stock Plan of Centene Corporation, shares which are registered on Form S-8 – File Number 333-180976		DEF 14A	March 9, 2012	4
10.8*	Centene Corporation Non-Employee Directors Deferred Stock Compensation Plan		10-Q	October 25, 2004	10.1
10.8a*	First Amendment to the Non-Employee Directors Deferred Stock Compensation Plan		10-K	February 24, 2006	10.12a
10.9*	Centene Corporation Employee Deferred Compensation Plan		10-K	February 22, 2010	10.10
10.10*	Centene Corporation 2007 Long Term Incentive Plan		8-K	April 26, 2007	10.2
10.11*	Centene Corporation Short Term Executive Compensation Plan		10-K	February 22, 2011	10.12
10.12*	Executive Employment Agreement between Centene Corporation and Michael F. Neidorff, dated November 8, 2004		8-K	November 9, 2004	10.1
10.12a*	Amendment No. 1 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	October 28, 2008	10.2
10.12b*	Amendment No. 2 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	April 28, 2009	10.2
10.12c*	Amendment No. 3 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	October 23, 2012	10.2
10.12d*	Amendment No. 4 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		8-K	May 16, 2013	10.1
10.13*	Form of Executive Severance and Change in Control Agreement		10-Q	October 28, 2008	10.3
10.13a*	Amendment No. 1 to Form of Executive Severance and Change in Control Agreement		10-Q	October 23, 2012	10.3

EXHIBIT NUMBER	DESCRIPTION	FILED WITH THIS FORM 10-K	INCORPORATED BY REFERENCE [1]		
			FORM	FILING DATE WITH SEC	EXHIBIT NUMBER
10.14*	Form of Restricted Stock Unit Agreement		10-Q	October 28, 2008	10.4
10.15*	Form of Non-statutory Stock Option Agreement (Non-Employees)		8-K	July 28, 2005	10.3
10.16*	Form of Non-statutory Stock Option Agreement (Employees)		10-Q	October 28, 2008	10.5
10.17*	Form of Non-statutory Stock Option Agreement (Directors)		10-K	February 23, 2009	10.18
10.18*	Form of Incentive Stock Option Agreement		10-Q	October 28, 2008	10.6
10.19*	Form of Stock Appreciation Right Agreement		8-K	July 28, 2005	10.6
10.20*	Form of Restricted Stock Agreement		10-Q	October 25, 2005	10.8
10.21*	Form of Performance Based Restricted Stock Unit Agreement #1		10-Q	October 28, 2008	10.7
10.22*	Form of Performance Based Restricted Stock Unit Agreement #2		10-K	February 23, 2009	10.23
10.23*	Form of Long Term Incentive Plan Agreement		8-K	February 7, 2008	10.1
10.24	Credit Agreement dated as of May 21, 2013 among Centene Corporation, the various financial institutions party hereto and Barclays Bank PLC		8-K	May 22, 2013	10.1
10.25**	Contract between the Texas Health and Human Services Commission and Superior HealthPlan, Inc.		10-Q	October 25, 2011	10.2
10.25a**	Amendment A (Version 2.1) to Contract between the Texas Health and Human Services Commission and Superior HealthPlan, Inc.		10-Q	April 24, 2012	10.1
10.25b**	Amendment B (Version 2.2) to Contract between the Texas Health and Human Services Commission and Superior HealthPlan, Inc.		10-Q	July 24, 2012	10.1
10.25c**	Amendment C (Version 2.3) to Contract between the Texas Health and Human Services Commission and Superior HealthPlan, Inc.		10-Q	October 23, 2012	10.1
10.25d**	Amendment D (Version 2.4) to Contract between the Texas Health and Human Services Commission and Bankers Life Insurance Company of Wisconsin, Inc. d.b.a Superior HealthPlan Network		10-Q	April 23, 2013	10.1

EXHIBIT NUMBER	DESCRIPTION	FILED WITH THIS FORM 10-K	INCORPORATED BY REFERENCE [1]		
			FORM	FILING DATE WITH SEC	EXHIBIT NUMBER
10.25e**	Amendment E (Version 2.5) to Contract between the Texas Health and Human Services Commission and Bankers Life Insurance Company of Wisconsin, Inc. d.b.a Superior HealthPlan Network		10-Q	July 23, 2013	10.1
10.25f**	Amendment F (Version 2.6) to Contract between the Texas Health and Human Services Commission and Bankers Life Insurance Company of Wisconsin, Inc. d.b.a Superior HealthPlan Network		10-Q	October 22, 2013	10.1
10.25g**	Amendment G (Version 2.7) to Contract between the Texas Health and Human Services Commission and Bankers Life Insurance Company of Wisconsin, Inc. d.b.a Superior HealthPlan Network		10-Q	October 22, 2013	10.2
10.25h**	Amendment H (Version 2.8) to Contract between the Texas Health and Human Services Commission and Bankers Life Insurance Company of Wisconsin, Inc. d.b.a Superior HealthPlan Network	X			
10.25i**	Amendment I (Version 2.9) to Contract between the Texas Health and Human Services Commission and Bankers Life Insurance Company of Wisconsin, Inc. d.b.a Superior HealthPlan Network	X			
12.1	Computation of ratio of earnings to fixed charges	X			
21	List of subsidiaries	X			
23	Consent of Independent Registered Public Accounting Firm incorporated by reference in each prospectus constituting part of the Registration Statements on Form S-3 (File Numbers 333-174164, 333-187652, 333-187741, and 333-193205) and on Form S-8 (File Numbers 333-108467, 333-90976, 333-83190, and 333-180976)	X			
31.1	Certification Pursuant to Rule 13a-14(a) and 15d-14(a) of the Exchange Act, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 (Chief Executive Officer)	X			

EXHIBIT NUMBER	DESCRIPTION	FILED WITH THIS FORM 10-K	INCORPORATED BY REFERENCE [1]		
			FORM	FILING DATE WITH SEC	EXHIBIT NUMBER
31.2	Certification Pursuant to Rule 13a-14(a) and 15d-14(a) of the Exchange Act, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 (Chief Financial Officer)	X			
32.1	Certification Pursuant to 18 U.S.C. Section 1350 (Chief Executive Officer)	X			
32.2	Certification Pursuant to 18 U.S.C. Section 1350 (Chief Financial Officer)	X			
101.1	XBRL Taxonomy Instance Document.	X			
101.2	XBRL Taxonomy Extension Schema Document.	X			
101.3	XBRL Taxonomy Extension Calculation Linkbase Document.	X			
101.4	XBRL Taxonomy Extension Definition Linkbase Document.	X			
101.5	XBRL Taxonomy Extension Label Linkbase Document.	X			
101.6	XBRL Taxonomy Extension Presentation Linkbase Document.	X			

[1] SEC File No. 001-31826 (for filings prior to October 14, 2003, the Registrant's SEC File No. was 000-33395).

* Indicates a management contract or compensatory plan or arrangement.

** The Company has requested confidential treatment of the redacted portions of this exhibit pursuant to Rule 24b-2 under the Securities Exchange Act of 1934, as amended, and has separately filed a complete copy of this exhibit with the Securities and Exchange Commission.

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, as of February 21, 2014.

CENTENE CORPORATION

By: /s/ MICHAEL F. NEIDORFF
Michael F. Neidorff
Chairman and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities as indicated, as of February 21, 2014.

Signature	Title
/s/ MICHAEL F. NEIDORFF **Michael F. Neidorff**	Chairman and Chief Executive Officer (principal executive officer)
/s/ WILLIAM N. SCHEFFEL **William N. Scheffel**	Executive Vice President and Chief Financial Officer (principal financial officer)
/s/ JEFFREY A. SCHWANEKE **Jeffrey A. Schwaneke**	Senior Vice President, Corporate Controller and Chief Accounting Officer (principal accounting officer)
/s/ ORLANDO AYALA **Orlando Ayala**	Director
/s/ ROBERT K. DITMORE **Robert K. Ditmore**	Director
/s/ FRED H. EPPINGER **Fred H. Eppinger**	Director
/s/ RICHARD A. GEPHARDT **Richard A. Gephardt**	Director
/s/ PAMELA A. JOSEPH **Pamela A. Joseph**	Director
/s/ JOHN R. ROBERTS **John R. Roberts**	Director
/s/ DAVID L. STEWARD **David L. Steward**	Director
/s/ TOMMY G. THOMPSON **Tommy G. Thompson**	Director

EXHIBIT 31.1

CERTIFICATION

I, Michael F. Neidorff, certify that:

1. I have reviewed this Annual Report on Form 10-K of Centene Corporation;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
   a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
   b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, 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;
   c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
   d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
   a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: February 21, 2014

/s/ MICHAEL F. NEIDORFF

Chairman, President and Chief Executive Officer
(principal executive officer)

EXHIBIT 31.2

CERTIFICATION

I, William N. Scheffel, certify that:

1. I have reviewed this Annual Report on Form 10-K of Centene Corporation;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
    a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
    b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, 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;
    c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
    d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
    a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
    b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: February 21, 2014

/s/ William N. Scheffel

Executive Vice President and Chief Financial Officer
(principal financial officer)

EXHIBIT 32.1

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report on Form 10-K of Centene Corporation (the Company) for the period ended December 31, 2013, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, Michael F. Neidorff, Chairman, President and Chief Executive Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: February 21, 2014

/s/ MICHAEL F. NEIDORFF

Chairman, President and Chief Executive Officer
(principal executive officer)

EXHIBIT 32.2

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report on Form 10-K of Centene Corporation (the Company) for the period ended December 31, 2013, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, William N. Scheffel, Executive Vice President and Chief Financial Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: February 21, 2014

/s/ WILLIAM N. SCHEFFEL

Executive Vice President and Chief Financial Officer
(principal financial officer)

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

☒ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2012

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: 001-31826

Centene Corporation

(Exact name of registrant as specified in its charter)

Delaware	42-1406317
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification Number)
7700 Forsyth Boulevard St. Louis, Missouri	63105
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: (314) 725-4477

Securities registered pursuant to Section 12(b) of the Act:

Common Stock, $0.001 Par Value	New York Stock Exchange
Title of Each Class	Name of Each Exchange on Which Registered

Securities registered pursuant to Section 12(g) of the Act:

None

(Title of Each Class)

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 or 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 Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was require 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 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 "small reporting company" in Rule 12b-2 of the Exchange Act. 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 Act). Yes ☐ No ☒

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 29, 2012, was $1.6 billion.

As of February 1, 2013, the registrant had 52,333,516 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2013 annual meeting of stockholders are incorporated by reference in Part III, Items 10, 11, 12, 13 and 14.

CENTENE CORPORATION
ANNUAL REPORT ON FORM 10-K
TABLE OF CONTENTS

		PAGE
	Part I	
Item 1.	Business	1
Item 1A.	Risk Factors	22
Item 1B.	Unresolved Staff Comments	35
Item 2.	Properties	35
Item 3.	Legal Proceedings	35
Item 4.	Mine Safety Disclosures	35
	Part II	
Item 5.	Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities	36
Item 6.	Selected Financial Data	38
Item 7.	Management's Discussion and Analysis of Financial Condition and Results of Operations	40
Item 7A.	Quantitative and Qualitative Disclosures About Market Risk	59
Item 8.	Financial Statements and Supplementary Data	60
Item 9.	Changes in and Disagreements with Accountants on Accounting and Financial Disclosure	94
Item 9A.	Controls and Procedures	94
Item 9B.	Other Information	96
	Part III	
Item 10.	Directors, Executive Officers and Corporate Governance	96
Item 11.	Executive Compensation	96
Item 12.	Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters	96
Item 13.	Certain Relationships and Related Transactions, and Director Independence	96
Item 14.	Principal Accountant Fees and Services	96
	Part IV	
Item 15.	Exhibits and Financial Statement Schedules	97
Signatures		102
Certifications		103

CAUTIONARY STATEMENT ON FORWARD-LOOKING STATEMENTS

All statements, other than statements of current or historical fact, contained in this filing are forward-looking statements. We have attempted to identify these statements by terminology including "believe," "anticipate," "plan," "expect," "estimate," "intend," "seek," "target," "goal," "may," "will," "should," "can," "continue" and other similar words or expressions in connection with, among other things, any discussion of future operating or financial performance. In particular, these statements include statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions, investments and the adequacy of our available cash resources. These statements may be found in the various sections of this filing, including those entitled "Management's Discussion and Analysis of Financial Condition and Results of Operations," Part I, Item 1A. "Risk Factors," and Part I, Item 3 "Legal Proceedings." Readers are cautioned that matters subject to forward-looking statements involve known and unknown risks and uncertainties, including economic, regulatory, competitive and other factors that may cause our or our industry's actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

All forward-looking statements included in this filing are based on information available to us on the date of this filing and we undertake no obligation to update or revise the forward-looking statements included in this filing, whether as a result of new information, future events or otherwise, after the date of this filing. Actual results may differ from projections or estimates due to a variety of important factors, including:

- our ability to accurately predict and effectively manage health benefits and other operating expenses;
- competition;
- membership and revenue projections;
- timing of regulatory contract approval;
- changes in healthcare practices;
- changes in federal or state laws or regulations, including the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act and any regulations enacted thereunder;
- changes in expected contract start dates;
- changes in expected closing dates for acquisitions;
- inflation;
- provider and state contract changes;
- new technologies;
- reduction in provider payments by governmental payors;
- major epidemics;
- disasters and numerous other factors affecting the delivery and cost of healthcare;
- the expiration, cancellation or suspension of our Medicare or Medicaid managed care contracts by federal or state governments;
- availability of debt and equity financing, on terms that are favorable to us; and
- general economic and market conditions.

Item 1A "Risk Factors" of Part I of this filing contains a further discussion of these and other important factors that could cause actual results to differ from expectations. We disclaim any current intention or obligation to update or revise any forward-looking statements, whether as a result of new information, future events or otherwise. Due to these important factors and risks, we cannot give assurances with respect to our future premium levels or our ability to control our future medical costs.

PART I

ITEM 1. ***Business.***

OVERVIEW

We are a diversified, multi-line healthcare enterprise that provides programs and services to the rising number of under-insured and uninsured individuals. We provide member-focused services through locally based staff by assisting in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions. We also provide education and outreach programs to inform and assist members in accessing quality, appropriate healthcare services. We believe our local approach to managing our health plans, including member and provider services, enables us to provide accessible, quality, culturally-sensitive healthcare coverage to our communities. Our health management, educational and other initiatives are designed to help members best utilize the healthcare system to ensure they receive appropriate, medically necessary services and effective management of routine, severe and chronic health problems, resulting in better health outcomes. We combine our decentralized local approach for care with a centralized infrastructure of support functions such as finance, information systems and claims processing.

We operate in two segments: Medicaid Managed Care and Specialty Services. Our Medicaid Managed Care segment provides Medicaid and Medicaid-related health plan coverage to individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program (CHIP), long-term care (LTC), Foster Care, dual eligible individuals in Medicare Special Needs Plans and the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program, or collectively ABD. As of December 31, 2012, Medicaid accounted for 77% of our at-risk membership, while CHIP (also including Foster Care) and ABD (also including Medicare) accounted for 9% and 12%, respectively. Hybrid programs and long-term care represent the remaining 2% at-risk membership. Our Specialty Services segment offers products for behavioral health, care management software, health insurance exchanges, individual health insurance, life and health management, LTC programs, managed vision, telehealth services, and pharmacy benefits management to state programs, healthcare organizations, employer groups and other commercial organizations, as well as to our own subsidiaries. Our health plans in Arizona, operated by our long-term care company, and Massachusetts, operated by our individual health insurance provider, are included in the Specialty Services segment.

Our at-risk managed care membership totaled 2.6 million as of December 31, 2012. For the year ended December 31, 2012, our premium and service revenues and net earnings attributable to Centene were $8.2 billion and $1.9 million, respectively, and our total cash flow from operations was $278.7 million.

Our initial health plan commenced operations in Wisconsin in 1984. We were organized in Wisconsin in 1993 as a holding company for our initial health plan and reincorporated in Delaware in 2001. Our corporate office is located at 7700 Forsyth Boulevard, St. Louis, Missouri 63105, and our telephone number is (314) 725-4477. Our stock is publicly traded on the New York Stock Exchange under the ticker symbol "CNC."

INDUSTRY

We provide our services to the uninsured primarily through Medicaid, CHIP, LTC, Foster Care, ABD, Medicare and other state programs for the uninsured. The federal Centers for Medicare and Medicaid Services, or CMS, estimated the total Medicaid and CHIP market was approximately $401 billion in 2010, and estimate the market will grow to $957 billion by 2021. According to the most recent information provided by the Kaiser Commission on Medicaid and the Uninsured, Medicaid spending increased by 2.0% in fiscal 2012 and states appropriated an increase of 3.8% for Medicaid in fiscal 2013 budgets.

Established in 1965, Medicaid is the largest publicly funded program in the United States, and provides health insurance to low-income families and individuals with disabilities. Authorized by Title XIX of the Social Security Act, Medicaid is an entitlement program funded jointly by the federal and state governments and administered by the states. The majority of funding is provided at the federal level. Each state establishes its own eligibility standards, benefit packages, payment rates and program administration within federal standards. As a

result, there are 56 Medicaid programs—one for each U.S. state, each U.S. territory and the District of Columbia. Eligibility is based on a combination of household income and assets, often determined by an income level relative to the federal poverty level. Historically, children have represented the largest eligibility group. Many states have selected Medicaid managed care as a means of delivering quality healthcare and controlling costs. We refer to these states as mandated managed care states.

Established in 1972, and authorized by Title XVI of the Social Security Act, ABD covers low-income persons with chronic physical disabilities or behavioral health impairments. ABD beneficiaries represent a growing portion of all Medicaid recipients. In addition, ABD recipients typically utilize more services because of their critical health issues.

The Balanced Budget Act of 1997 created CHIP to help states expand coverage primarily to children whose families earned too much to qualify for Medicaid, yet not enough to afford private health insurance. Some states include the parents of these children in their CHIP programs. CHIP is the single largest expansion of health insurance coverage for children since the enactment of Medicaid. Costs related to the largest eligibility group, children, are primarily composed of pediatrics and family care. These costs tend to be more predictable than other healthcare issues which predominantly affect the adult population.

A portion of Medicaid beneficiaries are dual eligibles, low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare. According to the Kaiser Commission on Medicaid and the Uninsured, there were approximately 9 million dual eligible enrollees in 2012. These dual eligibles may receive assistance from Medicaid for Medicaid benefits, such as nursing home care and/or assistance with Medicare premiums and cost sharing. Dual eligibles also use more services due to their tendency to have more chronic health issues. We serve dual eligibles through our ABD and LTC programs and through Medicare Special Needs Plans.

While Medicaid programs have directed funds to many individuals who cannot afford or otherwise maintain health insurance coverage, they did not initially address the inefficient and costly manner in which the Medicaid population tends to access healthcare. Medicaid recipients in non-managed care programs typically have not sought preventive care or routine treatment for chronic conditions, such as asthma and diabetes. Rather, they have sought healthcare in hospital emergency rooms, which tends to be more expensive. As a result, many states have found that the costs of providing Medicaid benefits have increased while the medical outcomes for the recipients remained unsatisfactory.

Since the early 1980s, increasing healthcare costs, combined with significant growth in the number of Medicaid recipients, have led many states to establish Medicaid managed care initiatives. Additionally, a number of states are designing programs to cover the rising number of uninsured Americans. The Kaiser Commission on Medicaid and the Uninsured estimated that there were approximately 48 million non-elderly Americans in 2011 that lacked health insurance. We expect that continued pressure on state Medicaid budgets will cause public policy to recognize the value of managed care as a means of delivering improved health outcomes for Medicaid beneficiaries and effectively controlling costs. A growing number of states have mandated that their Medicaid recipients enroll in managed care plans. Other states are considering moving to a mandated managed care approach. As a result, a significant market opportunity exists for managed care organizations with operations and programs focused on the distinct socio-economic, cultural and healthcare needs of the uninsured population and the Medicaid, CHIP, LTC, Foster Care and ABD populations.

In March 2010, the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act collectively referred to as the Affordable Care Act (ACA), were enacted. While the constitutionality of the ACA was subsequently challenged in a number of legal actions, in June 2012, the Supreme Court upheld the constitutionality of the ACA, with one limited exception relating to the Medicaid expansion provision. The Supreme Court held that states could not be required to expand Medicaid and risk losing all federal money for their existing Medicaid programs. Under the ACA, Medicaid coverage will be expanded to all individuals under age 65 with incomes up to 133% of the federal poverty level beginning January 1, 2014, subject to the states' elections. The federal government will pay the entire costs for Medicaid coverage for newly eligible beneficiaries for 3 years, from 2014 through 2016. In 2017, the federal share declines

to 95%; in 2018 it is 94%; in 2019 it is 93%; and it will be 90% in 2020 and subsequent years. States may delay Medicaid expansion after 2014 but the federal payment rates will be less.

Health insurance exchanges are a key component of the ACA, and the marketplace where individuals and small businesses will be able to obtain health insurance. States have the option of operating their own exchange or partnering with the federal government. States choosing neither option will default to a federally-facilitated exchange. All exchanges, regardless of how they are administered, must be ready to begin enrolling consumers on October 1, 2013 and must be fully operational on January 1, 2014. Premium and cost-sharing subsidies will be available to make coverage more affordable and access to exchanges will be limited to U.S. citizens and legal immigrants. Insurers will be required to offer a minimum level of benefits with four levels of coverage that vary based on premiums, out-of-pocket costs, and benefits beyond the minimum required, plus a catastrophic coverage plan. Premium subsidies will be provided to families without access to other coverage and with incomes between 100-400% of the federal poverty level to help them purchase insurance through the exchanges. These subsidies will be offered on a sliding scale basis. Congressional Budget Office (CBO) estimates approximately 9 million individuals enrolling through exchanges by 2014 and the number increasing to 25 million by 2025.

OUR COMPETITIVE STRENGTHS

Our multi-line managed care approach is based on the following key attributes:

- *Strong Historic Operating Performance.* We have increased revenues as we have grown in existing markets, expanded into new markets and broadened our product offerings. We entered the Wisconsin market in 1984 as a single health plan and have grown to 15 health plans with at-risk membership totaling 2.6 million in 2012. For the year ended December 31, 2012, we had premium and service revenues of $8.2 billion, representing a five year Compound Annual Growth Rate, of 25.1% and generated total cash flow from operations of $278.7 million.
- *Innovative Technology and Scalable Systems.* The ability to access data and translate it into meaningful information is essential to operating across a multi-state service area in a cost-effective manner. Our centralized information systems support our core processing functions under a set of integrated databases and are designed to be both replicable and scalable to accommodate organic growth and growth from acquisitions. We continue to enhance our systems in order to leverage the platform we have developed for our existing states for configuration into new states or health plan acquisitions. Our predictive modeling technology enables our medical management operations to proactively case and disease manage specific high risk members. It can recommend medical care opportunities using a mix of company defined algorithms and evidence based medical guidelines. Interventions are determined by the clinical indicators, the ability to improve health outcomes, and the risk profile of members. Our integrated approach helps to assure that consistent sources of claim and member information are provided across all of our health plans. Our membership and claims processing system is capable of expanding to support additional members in an efficient manner.
- *Medicaid Expertise.* For more than 25 years, we have developed a specialized Medicaid expertise that has helped us establish and maintain relationships with members, providers and state governments. We have implemented programs developed to achieve savings for state governments and improve medical outcomes for members by reducing inappropriate emergency room use, inpatient days and high cost interventions, as well as by managing care of chronic illnesses. We work with state agencies on redefining benefits and eligibility requirements in order to maximize the number of uninsured individuals covered through Medicaid, CHIP, LTC, Foster Care, ABD and other state sponsored programs and expand the types of benefits offered. Our approach is to accomplish this while maintaining adequate levels of provider compensation and protecting our profitability.
- *Diversified Business Lines.* We continue to broaden our service offerings to address areas that we believe have been traditionally under-served by Medicaid managed care organizations. In addition to our Medicaid and Medicaid-related managed care services, our service offerings include behavioral health,

care management software, health insurance exchanges, individual health insurance, life and health management, LTC programs, managed vision, telehealth services and pharmacy benefits management. Through the utilization of a multi-business line approach, we are able to improve the quality of care, improve outcomes, diversify our revenues and help control our medical costs.

- *Localized Approach with Centralized Support Infrastructure.* We take a localized approach to managing our subsidiaries, including provider and member services. This approach enables us to facilitate access by our members to high quality, culturally sensitive healthcare services. Our systems and procedures have been designed to address these community-specific challenges through outreach, education, transportation and other member support activities. For example, our community outreach programs work with our members and their communities to promote health and self-improvement through employment and education on how best to access care. We complement this localized approach with a centralized infrastructure of support functions such as finance, information systems and claims processing, which allows us to minimize general and administrative expenses and to integrate and realize synergies from acquisitions. We believe this combined approach allows us to efficiently integrate new business opportunities in both Medicaid and specialty services while maintaining our local accountability and improved access.

OUR BUSINESS STRATEGY

Our objective is to become the leading multi-line healthcare enterprise focusing on the uninsured and under-insured population and state funded healthcare initiatives. We intend to achieve this objective by implementing the following key components of our strategy:

- *Increase Penetration of Existing State Markets.* We seek to continue to increase our Medicaid membership in states in which we currently operate through alliances with key providers, outreach efforts, development and implementation of community-specific products and acquisitions. For example, in 2010, we expanded our health plan in Florida into LTC through the acquisition of Citrus Health Care, Inc. In 2011, we expanded our health plan in Texas under an additional STAR+PLUS ABD contract in the Dallas service area and in 2012 under a new contract to serve additional members in several new service areas.
- *Diversify Business Lines.* We seek to broaden our business lines into areas that complement our existing business to enable us to grow and diversify our revenue. We are constantly evaluating new opportunities for expansion both domestically and abroad. For instance, in July 2008, we completed the acquisition of Celtic Insurance Company, a nationwide individual health insurance provider. In 2010, we acquired a controlling ownership interest in Casenet, LLC, or Casenet, a care management software provider and in 2012, we acquired the remaining minority ownership interest. In 2013, we announced a definitive agreement to acquire AcariaHealth, one of the nation's largest, independent, comprehensive specialty pharmacy companies. We employ a disciplined acquisition strategy that is based on defined criteria including internal rate of return, accretion to earnings per share, market leadership and compatibility with our information systems. We engage our executives in the relevant operational units or functional areas to ensure consistency between the diligence and integration process.
- *Address Emerging State Needs.* We work to assist the states in which we operate in addressing the operating challenges they face. We seek to assist the states in balancing premium rates, benefit levels, member eligibility, policies and practices, and provider compensation. For example, in 2008, we began operating under a new statewide program providing managed care services to participants in the Texas Foster Care program; in April 2010, we began offering an individual insurance product for residents of Massachusetts who do not qualify for other state funded insurance programs; in November 2010, we began operating under a new contract to provide affordable health plans for Texas small businesses under the new Healthy Texas initiative; and, in January 2011, we began operating under a new contract with the state of Indiana to provide affordable health plans for uninsured Indiana individuals under the new Healthy Indiana Plan. By helping states structure an appropriate level and range of Medicaid, CHIP

and specialty services, we seek to ensure that we are able to continue to provide those services on terms that achieve targeted gross margins, provide an acceptable return and grow our business.

- *Develop and Acquire Additional State Markets.* We continue to leverage our experience to identify and develop new markets by seeking both to acquire existing business and to build our own operations. We focus expansion in states where Medicaid recipients are mandated to enroll in managed care organizations because we believe member enrollment levels are more predictable in these states. In addition, we focus on states where managed care programs can help address states' financial needs. For example, in 2012, we began managing care for Medicaid members in Louisiana, Missouri and Washington and in 2013, began managing care for Medicaid members in Kansas.
- *Leverage Established Infrastructure to Enhance Operating Efficiencies.* We intend to continue to invest in infrastructure to further drive efficiencies in operations and to add functionality to improve the service provided to members and other organizations at a low cost. Information technology, or IT, investments complement our overall efficiency goals by increasing the automated processing of transactions and growing the base of decision-making analytical tools. Our centralized functions and common systems enable us to add members and markets quickly and economically.
- *Maintain Operational Discipline.* We seek to operate in markets that allow us to meet our internal metrics including membership growth, plan size, market leadership and operating efficiency. We use multiple techniques to monitor and reduce our medical costs, including on-site hospital review by staff nurses and involvement of medical management in significant cases. Our executive dashboard is utilized to quickly identify cost drivers and medical trends. Our management team regularly evaluates the financial impact of proposed changes in provider relationships, contracts, changes in membership and mix of members, potential state rate changes and cost reduction initiatives. We may divest contracts or health plans in markets where the state's Medicaid environment, over a long-term basis, does not allow us to meet our targeted performance levels. For example, as a result of lower than anticipated financial performance, in October 2012, we notified the Cabinet for Health and Family Services that we were terminating our Kentucky Medicaid managed care contract with the Commonwealth of Kentucky effective July 5, 2013.

We have regulated subsidiaries offering healthcare services in each state we serve. The table below provides summary data for the state markets we currently serve:

State	Local Health Plan Name	First Year of Operations Under the Company	Counties Served at December 31, 2012	Market Share[1]	At-risk Managed Care Membership at December 31, 2012
Arizona	Bridgeway Health Solutions	2006	9	11.9%[2]	23,500
Florida	Sunshine State Health Plan	2009	32	17.1%[3]	214,000
Georgia	Peach State Health Plan	2006	159	26.7%	313,700
Illinois	IlliniCare Health Plan	2011	7	50.0%	18,000
Indiana	Managed Health Services	1995	92	27.8%	204,000
Kentucky	Kentucky Spirit Health Plan	2011	104	24.9%	135,800
Louisiana	Louisiana Healthcare Connections	2012	64	19.0%	165,600
Massachusetts	CeltiCare Health Plan	2009	14	10.6%	21,500
Mississippi	Magnolia Health Plan	2011	82	55.7%	77,200
Missouri	Home State Health Plan	2012	54	14.3%	59,600
Ohio	Buckeye Community Health Plan	2004	88	10.1%	157,800
South Carolina	Absolute Total Care	2007	39	14.0%	90,100
Texas	Superior HealthPlan	1999	254	25.9%	949,900
Washington	Coordinated Care	2012	39	6.9%	57,200
Wisconsin	Managed Health Services	1984	46	13.1%	72,400
					2,560,300

[1] Market share represents the % of at-risk members in managed care.
[2] Reflects LTC membership. The Bridgeway Health Solutions Acute Care program has a market share of 1.5%.
[3] Reflects Medicaid, ABD and CHIP programs. The Sunshine State Health Plan LTC program has a market share of 10.9%.

Substantially all of our revenue is derived from operations within the United States and its territories, and all of the Company's long lived assets are based in the United States and its territories. We generally receive a fixed premium per member per month pursuant to our state contracts. Our medical costs have a seasonality component due to cyclical illness, for example cold and flu season, resulting in higher medical expenses beginning in the fourth quarter and continuing throughout the first quarter of the following year. Our managed care subsidiaries in Texas had revenues from the state government that represent 36% of our consolidated total revenues in 2012.

MEDICAID MANAGED CARE

Benefits to States

Our ability to establish and maintain a leadership position in the markets we serve results primarily from our demonstrated success in providing quality care while reducing and managing costs, and from our specialized programs in working with state governments. Among the benefits we are able to provide to the states with which we contract are:

- *Significant cost savings and budget predictability compared to state paid reimbursement for services.* We bring bottom-line management experience to our health plans. On the administrative and management side, we bring experience including quality of care improvement methods, utilization management procedures, an efficient claims payment system, and provider performance reporting, as well as managers and staff experienced in using these key elements to improve the quality of and access to care. We generally receive a contracted premium on a per member basis and are responsible for the medical costs and as a result, provide budget predictability.

- *Data-driven approaches to balance cost and verify eligibility.* We seek to ensure effective outreach procedures for new members, then educate them and ensure they receive needed services as quickly as possible. Our IT department has created mapping/translation programs for loading membership and linking membership eligibility status to all of Centene's subsystems. We utilize predictive modeling technology to proactively case and disease manage specific high risk members. In addition, we have developed Centelligence, our enterprise data warehouse system to provide a seamless flow of data across our organization, enabling providers and case managers to access information, apply analytical insight and make informed decisions.
- *Establishment of realistic and meaningful expectations for quality deliverables.* We have collaborated with state agencies in redefining benefits, eligibility requirements and provider fee schedules with the goal of maximizing the number of individuals covered through Medicaid, CHIP, LTC, Foster Care and ABD programs.
- *Managed care expertise in government subsidized programs.* Our expertise in Medicaid has helped us establish and maintain strong relationships with our constituent communities of members, providers and state governments. We provide access to services through local providers and staff that focus on the cultural norms of their individual communities. To that end, systems and procedures have been designed to address community-specific challenges through outreach, education, transportation and other member support activities.
- *Improved quality and medical outcomes.* We have implemented programs developed to improve the quality of healthcare delivered to our members including Smart Start for your Baby, Living Well With Sickle Cell and The CentAccount Program.
- *Timely payment of provider claims.* We are committed to ensuring that our information systems and claims payment systems meet or exceed state requirements. We continuously endeavor to update our systems and processes to improve the timeliness of our provider payments.
- *Provider outreach and programs.* Our health plans have adopted a physician-driven approach where network providers are actively engaged in developing and implementing healthcare delivery policies and strategies. We prepare provider comparisons on a severity adjusted basis. This approach is designed to eliminate unnecessary costs, improve services to members and simplify the administrative burdens placed on providers.
- *Responsible collection and dissemination of utilization data.* We gather utilization data from multiple sources, allowing for an integrated view of our members' utilization of services. These sources include medical, vision and behavioral health claims and encounter data, pharmacy data, dental vendor claims and authorization data from the authorization and case management system utilized by us to coordinate care.
- *Timely and accurate reporting.* Our information systems have reporting capabilities which have been instrumental in identifying the need for new and/or improved healthcare and specialty programs. For state agencies, our reporting capability is important in demonstrating an auditable program.
- *Fraud and abuse prevention.* We have several systems in place to help identify, detect and investigate potential waste, abuse and fraud including pre and post payment review software. We collaborate with state and federal agencies and assist with investigation requests. We use nationally recognized standards to benchmark our processes.

Member Programs and Services

We recognize the importance of member-focused delivery of quality managed care services. Our locally-based staff assists members in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions. While covered healthcare benefits vary from state to state, our health plans generally provide the following services:

- primary and specialty physician care
- inpatient and outpatient hospital care
- emergency and urgent care
- prenatal care
- laboratory and x-ray services
- home health and durable medical equipment
- behavioral health and substance abuse services
- 24-hour nurse advice line
- transportation assistance
- vision care
- dental care
- immunizations
- prescriptions and limited over-the-counter drugs
- therapies
- social work services
- care coordination

We also provide the following education and outreach programs to inform, assist and incentivize members in accessing quality, appropriate healthcare services in an efficient manner:

- *Start Smart For Your Baby,* or Smart Start, is our award winning prenatal and infant health program designed to increase the percentage of pregnant women receiving early prenatal care, reduce the incidence of low birth weight babies, identify high-risk pregnancies, increase participation in the federal Women, Infant and Children program, prevent hospital admissions in the first year of life and increase well-child visits. The program includes risk assessments, education through face-to-face meetings and materials, behavior modification plans, assistance in selecting a physician for the infant and scheduling newborn follow-up visits. These initiatives are supported by a statistically proven reduction in Neonatal Intensive Care Unit (NICU) days as well as increased gestational birth weights. The program includes a proprietary Notification of Pregnancy process to identify pregnant women more quickly and enables us to help them gain access to prenatal medical care, give them education on their healthcare needs, assist with social needs and concerns, and coordinate referrals to appropriate specialists and the obstetrics (OB) case management program as needed. The Notification of Pregnancy also identifies women eligible for our high-risk OB management program, or 17P program, which aims to reduce the rate of recurrent pre-term delivery and neonatal intensive care admissions through the use of Progesterone.

  Empowering members through educational materials specifically developed for our members is a key part of this program. Our "Your Pregnancy Guide" has received several awards including a National Health Information Awards Silver Medal in 2010, and The Web Health Awards Gold Medal in 2010 for the audio book. In addition, Start Smart has also co-written a book for the first year of life with the American Academy of Pediatrics, "A Guide to Your Baby's Care-The First Year." This book received a National Health Information Award Bronze Medal in 2011 as well as a Web Health Awards Merit Medical for the audio book.

  Start Smart continues to be recognized by multiple organizations. In 2010, Start Smart won the Platinum Award for Consumer Empowerment at the URAC Quality Summit and was awarded the 2010 URAC / GKEN International Health Promotion Award for Community Health. Start Smart was recognized in NCQA Quality Profiles: Focus on Patient Engagement as a featured program in 2011. Start Smart won the Case-in Point Platinum Awards Women's/ Children's category for the 17P program in 2010 and the Breastfeeding program in 2012. The program has been featured in several issues of the Medicaid Health Plans of America (MHPA) Best Practices Compendium, as well as a video feature on the MHPA website. The results of the Start Smart program have also been published in several peer reviewed articles. Our paper "Effects of a Pregnancy Management Program on Birth Outcomes in Managed Medicaid" published in Managed Care in April 2011 was presented at the Care Continuum Alliance as a finalist for the 2012 Population Health Award. In August 2012, the *American Journal of Perinatology* published the results of our 17P program, "Pregnancy Outcomes of Managed Medicaid Members Prescribed Home Administration of 17 Alpha- Hydroxyprogesterone Caproate."

- *Connections Plus* is a cell phone program developed for high-risk members who have limited or no access to a safe, reliable telephone. The program puts free, preprogrammed cell phones into the hands of eligible members. This program seeks to eliminate lack of safe, reliable access to a telephone as a barrier to coordinating care, thus reducing avoidable adverse events such as inappropriate emergency room utilization, hospital admissions and premature birth. Members are identified through case management activities or through a referral. Connections Plus is available to high-risk members in all our health plans. Originally designed for pregnant women and ABD populations, this program has now been expanded to service members with mental health issues, and specific diseases, including sickle cell. In 2011, Connections Plus received a MHPA Best Practice Award in the Technology Division and in 2012, it was presented at the TripleTree iAwards as a finalist for Consumer Innovation.
- *AT&T / WellDoc Program* is a pilot program introduced in Ohio in 2011 through a partnership with AT&T. This program provides smart phones to a limited group of high-risk members with diabetes, giving them access to DiabetesManager, the enterprise mHealth solution from AT&T and WellDoc. DiabetesManager enables patients to manage their diabetes by offering real-time tips and advice based on their individual data. It not only tracks food consumption and blood sugar levels, but also allows members to take better control of self-management of their Type 2 diabetes to support them in establishing long-term healthy habits and improved quality of life. This highly-secure technology also empowers our nurse case managers to monitor patients virtually, so they can more efficiently intervene when necessary.
- *MemberConnections* is a community face-to-face outreach and education program designed to create a link between the member and the provider and help identify potential challenges or risk elements to a member's health, such as nutritional challenges and health education shortcomings. MemberConnections representatives contact new members by phone or mail to discuss managed care, the Medicaid program and our services. Our MemberConnections representatives make home visits, conduct educational programs and represent our health plans at community events such as health fairs.
- *Health Initiatives for Children* is aimed at educating child members on a variety of health topics. In order to empower and educate children, we have partnered with a nationally recognized children's author to develop our own children's book series. Our character, Darby, focuses on obesity prevention and healthy eating, asthma, diabetes, foster care and the ills of smoking. Titles in development include bullying and healthy heart. In 2013, we are introducing our newly designed "Darby's Kids Club" which will include an interactive website, newsletters, school visits and contests. Our books have been recognized by the National Health Information Awards. Our asthma book for Children, "Adventures from Puffletown," received the National Health Information Award Silver Medal in 2010. Our children's cookbook, "Super Centeam 5 Cookbook," received the National Health Information Award Bronze Medal in 2011 and "Smokey Yuckpack!" which focuses on the dangers of smoking received the 2012 National Health Information Award Bronze Medal.
- *Health Initiatives for Teens* is aimed at empowering, educating and reinforcing life skills with our teenage members. We have developed an educational series "Off the Chain" that addresses health issues, dealing with chronic diseases such as asthma and teen pregnancy. We have partnered with the National Urban League on a Teen Pregnancy program, including a book we co-wrote with the National Urban League, and an educational course for which the participant can receive high school credits. An interactive website and online course for this program will be launched in 2013. Our "Off the Chain" book has received a 2012 Hermes Gold Medal and a 2011 National Health Information Award Bronze Medal.
- *Living Well with Sickle Cell* is our innovative program that assists with coordination of care for our sickle cell members. Our program targets adult members by ensuring that they have established a medical home and work on strategies to reduce unnecessary ER visits and prevent hospitalizations for pain crisis through proper treatment for control of symptoms and chronic complications and promoting self-management. Using our Centelligence systems, we have proactively identified candidates for the medication Hydroxyurea, which is used in certain subsets of sickle cell patients and has resulted in

significantly fewer episodes of acute chest syndrome as well as fewer emergency department (ED) and inpatient visits. Our proactive identification has led to doubling of the number of patients taking the medication over the last 3 years. We have also used our CentAccount program to remove barriers for noncompliance by offering incentives to the members. Additionally we have developed an educational book for our members, "Living Well with Sickle Cell" which received a 2012 Hermes Award Honorable Mention and the audio book received 2012 Web Health Awards Silver Medal.

- *My Route for Health* is our adult educational series used with our case management and disease management programs. Our Obesity Book has received a 2012 Gold Hermes Award and a 2011 National Health Information Award Gold Medal.
- *Nurtur Diabetes Program* is an innovative program that is a collaboration with Nurtur Health, Inc., or Nurtur, and our health plans that targets diabetic patients and educates them on their disease state. This program received the 2012 MHPA Best Practice Award for Outreach.
- *Health Passport* is a leading-edge, patient-centric electronic community health record for foster care children. Health Passport collects patient demographic data, clinician visit records, dispensed medications, vital sign history, lab results, allergy charts, and immunization data. Providers can directly input additional or updated patient data and documentation into the Passport. All information is accessible anywhere, anytime to all authorized users, including health plan staff, greatly facilitating coordinated care among providers. In 2010, we expanded the Health Passport to our behavioral health program in Arizona.
- *The CentAccount Program* encourages healthy behaviors by offering members financial incentives for performing certain healthy behaviors. The incentives are delivered through a restricted-use prepaid debit card redeemable for health-related items only. This incentive-based approach effectively increases the utilization of preventive services while strengthening the relationships between members and their primary care providers. In 2012, this program received the Case-in-Point Platinum Award for the Medicaid Case Management category.
- *The Asthma Management Program* integrates a hands-on approach with a flexible outreach methodology that can be customized to suit the different age groups and populations it serves that are affected by asthma. Working through Nurtur, we provide proactive identification of members, stratification into appropriate levels of intervention including home visits, culturally sensitive education, and robust outcome reporting. The program also includes aggressive care coordination to ensure patients have basic services such as transportation to the doctor, electricity to power the nebulizer, and a clean, safe home environment. During 2011, the Asthma Management Program was the recipient of the EPA National Environmental Leadership Award in Asthma Management. The program also received the Case-in-Point Platinum Award for the Disease Management/Population Health Category and the 2012 URAC Best Practice Platinum Award for Consumer Health.
- *Fluvention* is an outreach program aimed at educating members on preventing the transmission of the influenza virus by encouraging members to get the seasonal influenza vaccines and take everyday precautions to prevent illness. We use an integrated communications approach including direct mail, phone calls, providing information via health plan websites and posting information in provider offices. The health plans also conduct general community awareness through public service announcements on television and radio. We target education efforts related to health hygiene, preventative care and the benefits of obtaining appropriate care for those at higher-risk for contracting the influenza viruses, including pregnant women, children from six months old up to 24-year-old adults, as well as adults with chronic health conditions.
- *EPSDT Case Management* is a preventive care program designed to educate our members on the benefits of Early and Periodic Screening, Diagnosis and Treatment, or EPSDT, services. We have a systematic program of communicating, tracking, outreach, reporting and follow-through that promotes state EPSDT programs.
- *Life and Health Management Programs* are designed to help members understand their disease and treatment plan and improve their wellness in a cost effective manner. These programs address medical conditions that are common within the Medicaid population such as asthma, diabetes and pregnancy.

Our Specialty Services segment manages many of our life and health management programs. Our ABD program uses a proprietary assessment tool that effectively identifies barriers to care, unmet functional needs, available social supports and the existence of behavioral health conditions that impede a member's ability to maintain a proper health status. Care coordinators develop individual care plans with the member and healthcare providers ensuring the full integration of behavioral, social and acute care services. These care plans, while specific to an ABD member, incorporate "Condition Specific" practices in collaboration with physician partners and community resources.

Providers

For each of our service areas, we establish a provider network consisting of primary and specialty care physicians, hospitals and ancillary providers. As of December 31, 2012, the health plans we currently operate contracted with the following number of physicians and hospitals:

	Primary Care Physicians	Specialty Care Physicians	Hospitals
Arizona	1,026	4,844	26
Florida	2,746	8,675	157
Georgia	3,753	10,324	121
Illinois	2,373	5,467	62
Indiana	1,321	8,301	118
Kentucky	4,303	11,899	120
Louisiana	1,916	5,821	144
Massachusetts	2,348	9,021	41
Mississippi	1,497	4,159	91
Missouri	2,153	8,102	89
Ohio	3,470	18,077	198
South Carolina	1,935	5,565	35
Texas	10,207	30,333	492
Washington	3,352	8,514	120
Wisconsin	3,013	8,912	88
Total	45,413	148,014	1,902

Our network of primary care physicians is a critical component in care delivery, management of costs and the attraction and retention of new members. Primary care physicians include family and general practitioners, pediatricians, internal medicine physicians and obstetricians and gynecologists. Specialty care physicians provide medical care to members generally upon referral by the primary care physicians. Specialty care physicians include, but are not limited to, orthopedic surgeons, cardiologists and otolaryngologists. We also provide education and outreach programs to inform and assist members in accessing quality, appropriate healthcare services.

Our health plans facilitate access to healthcare services for our members primarily through contracts with our providers. Our contracts with primary and specialty care physicians and hospitals usually are for one to two-year periods and renew automatically for successive one-year terms, but generally are subject to termination by either party upon 90 to 120 days prior written notice. In the absence of a contract, we typically pay providers at state Medicaid reimbursement levels. We pay hospitals under a variety of methods, including fee-for-service, per diems, diagnostic related grouping and case rates. We pay physicians under a fee-for-service, capitation arrangement, or risk-sharing arrangement. In addition, we are governed by state prompt payment policies.

- Under our fee-for-service contracts with physicians, particularly specialty care physicians, we pay a negotiated fee for covered services. This model is characterized as having no financial risk for the physician. In addition, this model requires management oversight because our total cost may increase as

the units of services increase or as more expensive services replace less expensive services. We have prior authorization procedures in place that are intended to make sure that certain high cost diagnostic and other services are medically appropriate.

- Under our capitated contracts, primary care physicians are paid a monthly fee for each of our members assigned to his or her practice for all ambulatory care. In return for this payment, these physicians provide all primary care and preventive services, including primary care office visits and EPSDT services, and are at risk for all costs associated with such services. If these physicians also provide non-capitated services to their assigned members, they may receive payment under fee-for-service arrangements at standard Medicaid rates.
- Under risk-sharing arrangements, physicians are paid under a capitated or fee-for-service arrangement. The arrangement, however, contains provisions for additional bonus to the physicians or reimbursement from the physicians based upon cost and quality measures.

We work with physicians to help them operate efficiently by providing financial and utilization information, physician and patient educational programs and disease and medical management programs. Our programs are also designed to help the physicians coordinate care outside of their offices.

We believe our collaborative approach with physicians gives us a competitive advantage in entering new markets. Our physicians serve on local committees that assist us in implementing preventive care programs, managing costs and improving the overall quality of care delivered to our members, while also simplifying the administrative burdens on our providers. This approach has enabled us to strengthen our provider networks through improved physician recruitment and retention that, in turn, have helped to increase our membership base. The following are among the services we provide to support physicians:

- *Customized Utilization Reports* provide certain of our contracted physicians with information that enables them to run their practices more efficiently and focuses them on specific patient needs. For example, quarterly detail reports update physicians on their status within their risk pools. Equivalency reports provide physicians with financial comparisons of capitated versus fee-for-service arrangements.
- *Case Management Support* helps the physician coordinate specialty care and ancillary services for patients with complex conditions and direct members to appropriate community resources to address both their health and socio-economic needs.
- *Web-based Claims and Eligibility Resources* have been implemented to provide physicians with on-line access to perform claims and eligibility inquiries.

Our contracted physicians also benefit from several of the services offered to our members, including the MemberConnections, EPSDT case management and health management programs. For example, the MemberConnections staff facilitates doctor/patient relationships by connecting members with physicians, the EPSDT programs encourage routine checkups for children with their physicians and the health management programs assist physicians in managing their patients with chronic disease.

Where appropriate, our health plans contract with our specialty services organizations to provide services and programs such as behavioral health, life and health management, managed vision, telehealth services and pharmacy benefits management. When necessary, we also contract with third-party providers on a negotiated fee arrangement for physical therapy, home healthcare, diagnostic laboratory tests, x-ray examinations, ambulance services and durable medical equipment. Additionally, we contract with dental vendors in markets where dental care is a provided benefit.

Quality Management

Our medical management programs focus on improving quality of care in areas that have the greatest impact on our members. We employ strategies, including health management and complex case management, that are adjusted for implementation in our individual markets by a system of physician committees chaired by local physician leaders. This process promotes physician participation and support, both critical factors in the success of any clinical quality improvement program.

We have implemented specialized information systems to support our medical quality management activities. Information is drawn from our data warehouse, clinical databases and our membership and claims processing system to identify opportunities to improve care and to track the outcomes of the interventions implemented to achieve those improvements. Some examples of these intervention programs include:

- appropriate leveling of care for neonatal intensive care unit hospital admissions, other inpatient hospital admissions, and observation admissions, in accordance with Interqual criteria
- tightening of our pre-authorization list and more stringent review of durable medical equipment and injectibles
- emergency department, or ED, program designed to collaboratively work with hospitals to steer non-emergency care away from the costly ED setting (through patient education, on-site alternative urgent care settings, etc.)
- increase emphasis on case management and clinical rounding where case managers are nurses or social workers who are employed by the health plan to assist selected members with the coordination of healthcare services in order to meet a member's specific healthcare needs
- incorporation of disease management, which is a comprehensive, multidisciplinary, collaborative approach to chronic illnesses such as asthma and diabetes
- Start Smart For Your Baby, a prenatal case management program aimed at helping women with high-risk pregnancies deliver full-term, healthy infants

We provide reporting on a regular basis using our data warehouse. State and Health Employer Data and Information Set, or HEDIS, reporting constitutes the core of the information base that drives our clinical quality performance efforts. This reporting is monitored by Plan Quality Improvement Committees and our corporate medical management team.

In an effort to ensure the quality of our provider networks, we undertake to verify the credentials and background of our providers using standards that are supported by the National Committee for Quality Assurance, or NCQA.

It is our objective to provide access to the highest quality of care for our members. As a validation of that objective, we often pursue accreditation by independent organizations that have been established to promote health care quality. The NCQA Health Plan Accreditation and URAC Health Plan Accreditation programs provide unbiased, third party reviews to verify and publicly report results on specific quality care metrics. While we have achieved or are pursuing accreditation for all of our plans, accreditation is only one measure of our ability to provide access to quality care for our members. We currently have six health plans and three specialty companies with NCQA accreditation.

SPECIALTY SERVICES

Our specialty services are a key component of our healthcare enterprise and complement our core Medicaid Managed Care business. Specialty services diversify our revenue stream, provide higher quality health outcomes to our membership and others, and assist in controlling costs. Our specialty services are provided primarily through the following businesses:

- *Behavioral Health.* Cenpatico Behavioral Health, or Cenpatico, manages behavioral healthcare for members via a contracted network of providers. Cenpatico works with providers to determine the best services to help people overcome mental illness and lead productive lives. Our networks feature a full range of services and levels of care to help people with mental illness reach their recovery and wellness goals. In addition, we operate school-based programs in Arizona that focus on students with special needs and also provide speech and other therapy services.
- *Individual and State Sponsored Health Insurance Exchanges.* Celtic Insurance Company, or Celtic, is a nationwide healthcare provider licensed in 49 states offering high-quality, affordable health insurance to individual customers and their families. Sold online and through independent insurance agents nationwide, Celtic's portfolio of major medical plans is designed to meet the diverse needs of the

uninsured at all budget and benefit levels. Celtic also offers a standalone guaranteed-issue medical conversion program to self-funded employer groups, stop-loss and fully-insured group carriers, managed care plans, and HMO reinsurers.

- *Life and Health Management.* Nurtur specializes in implementing life and health management programs that encourage healthy behaviors, promote healthier workplaces, improve workforce and societal productivity and reduce healthcare costs. Health risk appraisals, biometric screenings, online and telephonic wellness programs, disease management and work-life/employee assistance services are areas of focus. Nurtur uses telephonic health and work/ life balance coaching, in-home and online interaction and informatics processes to deliver effective clinical outcomes, enhanced patient-provider satisfaction and lower overall healthcare cost.

- *LTC and Acute Care.* Bridgeway Health Solutions, or Bridgeway, provides LTC services to the elderly and people with disabilities that meet income and resources requirements who are at risk of being or are institutionalized. Bridgeway participates with community groups to address situations that might be barriers to quality care and independent living. Acute care services include emergency and physician and hospitalization services, limited dental and rehabilitative services and other maternal and child health services.

- *Managed Vision.* OptiCare Managed Vision, Inc., or OptiCare, administers routine and medical surgical eye care benefits via its own contracted national network of eye care providers. OptiCare clients include Medicaid, Medicare, and commercial health plans, as well as employer groups. OptiCare has been providing vision network services for over 25 years and offers a variety of plan designs to meet the individual needs of its clients and members.

- *Telehealth Services.* NurseWise LP and Nurse Response, Inc. provide a toll-free nurse triage line 24 hours per day, 7 days per week, 52 weeks per year. Our members call one number and reach bilingual customer service representatives and nursing staff who provide health education, triage advice and offer continuous access to health plan functions. Additionally, our representatives verify eligibility, confirm primary care provider assignments and provide benefit and network referral coordination for members and providers after business hours. Our staff can arrange for urgent pharmacy refills, transportation and qualified behavioral health professionals for crisis stabilization assessments.

- *Pharmacy Benefits Management.* US Script, Inc., or US Script, offers progressive pharmacy benefits management services that are specifically designed to improve quality of care while containing costs. This is achieved through a lowest net cost strategy that helps optimize clients' pharmacy benefit. Services include claims processing, pharmacy network management, benefit design consultation, drug utilization review, formulary and rebate management, specialty and mail order pharmacy services, and patient and physician intervention.

  In 2013, we announced a definitive agreement to acquire AcariaHealth, one of the nation's largest, independent, comprehensive specialty pharmacy companies. With this transaction, we will expand our specialized pharmacy benefit services for complex diseases, including Hepatitis C, Hemophilia, Multiple Sclerosis, Rheumatoid Arthritis and Oncology.

- *Care Management Software.* Casenet, LLC, or Casenet, is a software provider of innovative care management solutions that automate the clinical, administrative and technical components of care management programs. During 2012, we acquired the remaining minority interest in Casenet and implemented this new software platform, which is available for sale to third parties, in our health plans.

CORPORATE COMPLIANCE

Our Corporate Ethics and Compliance Program provides controls by which we further enhance operations, safeguard against fraud and abuse, improve access to quality care and help assure that our values are reflected in everything we do.

The two primary standards by which corporate compliance programs in the healthcare industry are measured are the Federal Organizational Sentencing Guidelines and Compliance Program Guidance series issued by the Department of Health and Human Services' Office of the Inspector General, or OIG. Our program contains each of the seven elements suggested by the Sentencing Guidelines and the OIG guidance. These key components are:

- written standards of conduct
- designation of a corporate compliance officer and compliance committee
- effective training and education
- effective lines for reporting and communication
- enforcement of standards through disciplinary guidelines and actions
- internal monitoring and auditing
- prompt response to detected offenses and development of corrective action plans

The goal of the program is to build a culture of ethics and compliance, which is assessed periodically using a diagnostic survey to measure the integrity of the organization. Our internal Corporate Compliance intranet site, accessible to all employees, contains our Business Ethics and Conduct Policy (Code of Conduct), Compliance Program description and various resources for employees to report concerns or ask questions. If needed, employees have access to the contact information for the members of our Board of Directors' Audit Committee to report concerns. Our Ethics and Compliance Helpline is a toll-free number and web-based reporting tool operated by a third party independent of the Company to allow employees or other persons to report suspected incidents of misconduct, fraud, abuse or other compliance violations. Furthermore, the Board of Directors reviews an ethics and compliance report on a quarterly basis.

COMPETITION

We continue to face varying and increasing levels of competition as we expand in our existing service areas or enter new markets, as federal regulations require at least two competitors in each service area. Healthcare reform may cause a number of commercial managed care organizations to decide to enter or exit the Medicaid market.

In our business, our principal competitors for state contracts, members and providers consist of the following types of organizations:

- *Medicaid Managed Care Organizations* focus on providing healthcare services to Medicaid recipients. These organizations consist of national and regional organizations, as well as not-for-profits and smaller organizations that operate in one city or state and are owned by providers, primarily hospitals.
- *National and Regional Commercial Managed Care Organizations* have Medicaid members in addition to members in private commercial plans. Some of these organizations offer a range of specialty services including pharmacy benefits management, behavioral health management, health management, and nurse triage call support centers.
- *Primary Care Case Management Programs* are programs established by the states through contracts with primary care providers. Under these programs, physicians provide primary care services to Medicaid recipients, as well as limited medical management oversight.

We compete with other managed care organizations and specialty companies for state contracts. In order to grant a contract, state governments consider many factors. These factors include quality of care, financial requirements, an ability to deliver services and establish provider networks and infrastructure. In addition, our specialty companies also compete with other providers, such as disease management companies, individual health insurance companies, and pharmacy benefits managers for non-governmental contracts.

We also compete to enroll new members and retain existing members. People who wish to enroll in a managed healthcare plan or to change healthcare plans typically choose a plan based on the quality of care and services offered, ease of access to services, a specific provider being part of the network and the availability of supplemental benefits.

We also compete with other managed care organizations to enter into contracts with physicians, physician groups and other providers. We believe the factors that providers consider in deciding whether to contract with us include existing and potential member volume, reimbursement rates, medical management programs, speed of reimbursement and administrative service capabilities. See "Risk Factors — Competition may limit our ability to increase penetration of the markets that we serve."

REGULATION

Our operations are regulated at both state and federal levels. Government regulation of the provision of healthcare products and services is a changing 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 and rules also may occur periodically.

Our regulated subsidiaries are licensed to operate as health maintenance organizations, third party administrators, utilization review and/or insurance companies in their respective states. In each of the jurisdictions in which we operate, we are regulated by the relevant insurance, health and/or human services departments that oversee the activities of managed care organizations providing or arranging to provide services to Medicaid or Medicare enrollees.

The process for obtaining authorization to operate as a managed care organization is complex and requires us to demonstrate to the regulators the adequacy of the health plan's organizational structure, financial resources, utilization review, quality assurance programs, complaint procedures, provider network and procedures for covering emergency medical conditions. Under both state managed care organization statutes and insurance laws, our health plan subsidiaries, as well as our applicable specialty companies, must comply with minimum statutory capital and other financial solvency requirements, such as deposit and surplus requirements. Insurance regulations may also require prior state approval of acquisitions of other managed care organization businesses and the payment of dividends, as well as notice for loans or the transfer of funds. Our subsidiaries are also subject to periodic state and federal reporting requirements. In addition, each health plan and individual health insurance provider must meet criteria to secure the approval of state regulatory authorities before implementing operational changes, including the development of new product offerings and, in some states, the expansion of service areas.

States have adopted a number of regulations that may affect our business and results of operations. These regulations in certain states include:

- premium taxes or similar assessments
- stringent prompt payment laws
- disclosure requirements regarding provider fee schedules and coding procedures
- programs to monitor and supervise the activities and financial solvency of provider groups

We are regulated as an insurance holding company and are subject to the insurance holding company acts of the states in which our insurance company and HMO subsidiaries are domiciled. These acts contain certain reporting requirements as well as restrictions on transactions between an insurer or HMO and its affiliates. These holding company laws and regulations generally require insurance companies and HMOs within an insurance holding company system to register with the insurance department of each state where they are domiciled and to file with those states' insurance departments reports describing capital structure, ownership, financial condition, intercompany transactions and general business operations. In addition, depending on the size and nature of the transaction, there are various notice and reporting requirements that generally apply to transactions between insurance companies and HMOs and their affiliates within an insurance holding company structure. Some insurance holding company laws and regulations require prior regulatory approval or, in certain circumstances, prior notice of certain material intercompany transfers of assets as well as certain transactions between insurance companies, HMOs, their parent holding companies and affiliates. Among other provisions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends.

Additionally, the holding company acts of the states in which our subsidiaries are domiciled restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval.

Under those statutes, without such approval (or an exemption), no person may acquire any voting security of an insurance holding company, which controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would "control" the insurance holding company. "Control" is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a company and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of a company.

State Contracts

In addition to being a licensed insurance company or health maintenance organization, in order to be a Medicaid Managed Care organization in each of the states in which we operate, we must operate under a contract with the state's Medicaid agency. States generally use either a formal proposal process, reviewing a number of bidders, or award individual contracts to qualified applicants that apply for entry to the program. We receive monthly payments based on specified capitation rates determined on an actuarial basis. These rates differ by membership category and by state depending on the specific benefits and policies adopted by each state.

Our state contracts and the regulatory provisions applicable to us generally set forth the requirements for operating in the Medicaid sector, including provisions relating to:

- eligibility, enrollment and dis-enrollment processes
- covered services
- eligible providers
- subcontractors
- record-keeping and record retention
- periodic financial and informational reporting
- quality assurance
- accreditation
- health education and wellness and prevention programs
- timeliness of claims payment
- financial standards
- safeguarding of member information
- fraud and abuse detection and reporting
- grievance procedures
- organization and administrative systems

A health plan or individual health insurance provider's compliance with these requirements is subject to monitoring by state regulators and by CMS. A health plan is also subject to periodic comprehensive quality assurance evaluations by a third-party reviewing organization and generally by the insurance department of the jurisdiction that licenses the health plan. A health plan or individual health insurance provider must also submit reports to various regulatory agencies, including quarterly and annual statutory financial statements and utilization reports.

The table below sets forth the terms of our contracts and provides details regarding related renewal or extension and termination provisions. The contracts are subject to termination for cause, an event of default or lack of funding.

Contract	Expiration Date	Renewal or Extension
Arizona – Acute Care	September 30, 2013	Subject to renewal under the state's reprocurement process effective September 30, 2013.
Arizona – Behavioral Health	September 30, 2013	Renewable for two additional one-year terms.
Arizona – LTC	September 30, 2014	May be extended for up to two additional one-year terms.
Arizona – Special Needs Plan (Medicare)	December 31, 2013	Renewable annually for successive 12-month periods.
Florida – LTC[1]	August 31, 2013	Renewable through the state's recertification process.
Florida – Medicaid & ABD	August 31, 2015	Renewable through the state's recertification process.
Florida – CHIP	September 30, 2014	May be extended for up to two additional one-year terms.
Florida – Special Needs Plan (Medicare)	December 31, 2013	Renewable annually for successive 12-month periods.
Georgia – Medicaid & CHIP	June 30, 2013	Renewable for one additional one-year term.
Georgia – Special Needs Plan (Medicare)	December 31, 2013	Renewable annually for successive 12-month periods.
Illinois – ABD	April 30, 2016	May be extended for up to five additional years.
Indiana – Medicaid, CHIP & Hybrid (Healthy Indiana Plan)	December 31, 2014	Renewable for two additional one-year terms.
Kansas – Medicaid, ABD, CHIP, LTC & Foster Care	December 31, 2015	Renewable for two additional one-year terms.
Kentucky – Medicaid, Foster Care, & ABD[2]	July 5, 2013	
Louisiana – Medicaid, CHIP & ABD	January 31, 2015	Renewable for an additional two-year period through the state's recertification process.
Massachusetts – Hybrid (Commonwealth Care)	June 30, 2013	Renewable through the state's recertification process.
Missouri – Medicaid, CHIP & Foster Care	June 30, 2013	Renewable for two additional one-year terms.
Mississippi – Medicaid, ABD & Foster Care	December 31, 2013	Renewable through the state's reprocurement process.
New Hampshire – Medicaid, CHIP, Foster Care & ABD	June 30, 2015	Renewable for one additional two-year term.
Ohio – Medicaid, CHIP & ABD[3]	June 30, 2013	Renewable annually for successive 12-month periods.
Ohio – Special Needs Plan (Medicare)	December 31, 2013	Renewable annually for successive 12-month periods.

[1] The current Florida LTC contract expires on August 31, 2013. In January 2013, our Florida subsidiary, Sunshine State Health Plan, was notified by the Florida Agency for Health Care Administration it has been recommended for a contract award in 10 regions of the Medicaid Managed Care LTC program. Upon execution of a contract and regulatory approval, enrollment will be implemented out by region, beginning in August 2013 and continuing through March 2014.

[2] In October 2012, we notified the Kentucky Cabinet for Health and Family Services that we were exercising a contractual right that we believe allows us to terminate our Medicaid managed care contract with the Commonwealth of Kentucky effective July 5, 2013. We have also filed a formal dispute with the Cabinet for damages incurred under the contract. In addition, we have filed a lawsuit in Franklin Circuit Court against the Commonwealth of Kentucky seeking declaratory relief as a result of the Commonwealth's failure to completely and accurately disclose material information.

[3] The current Ohio Medicaid, CHIP & ABD contract expires on June 30, 2013. The recently awarded statewide Ohio Medicaid, CHIP & ABD contract commences July 1, 2013.

Contract	Expiration Date	Renewal or Extension
South Carolina – Medicaid & ABD	December 31, 2013	Renewable through the state's recertification process.
Texas – ABD Dallas Expansion	August 31, 2013	May be extended for up to five additional years.
Texas – CHIP Rural Service Area	August 31, 2013	May be extended for up to five additional years.
Texas – Foster Care	August 31, 2015	May be extended for up to three and a half additional years.
Texas – Hybrid (Healthy Texas)	August 31, 2013	Renewable for two additional two-year terms.
Texas – Medicaid, CHIP &ABD	August 31, 2015	May be extended for up to four and a half additional years.
Texas – Special Needs Plan (Medicare)	December 31, 2013	Renewable annually for successive 12-month periods.
Washington – Medicaid, CHIP, ABD, Foster Care & Hybrid	December 31, 2013	Renewable through the state's recertification process.
Wisconsin – Medicaid, CHIP & ABD	December 31, 2013	Renewable through the state's recertification process every two years.
Wisconsin – Network Health Plan Subcontract	December 31, 2016	Renews automatically for successive five-year terms.
Wisconsin – Special Needs Plan (Medicare)	December 31, 2013	Renewable annually for successive 12-month periods.

HIPAA and HITECH

In 1996, Congress enacted the Health Insurance Portability and Accountability Act, or HIPAA. HIPAA is designed to improve the portability and continuity of health insurance coverage, simplify the administration of health insurance transactions and ensure the privacy and security of individual health information. Among the main requirements of HIPAA are the Administrative Simplification provisions which include: standards for processing health insurance claims and related transactions (Transactions Standards); requirements for protecting the privacy and limiting the disclosure of medical records and other personal health information (Privacy Rule); and standards and specifications for safeguarding personal health information which is maintained, stored or transmitted in electronic format (Security Rule). The Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Reinvestment and Recovery Act of 2009, amended certain provisions of HIPAA and introduced new data security obligations for covered entities and their business associates. HITECH also mandated individual notifications in instances of a data breach, provided enhanced penalties for HIPAA violations, and granted enforcement authority to states' Attorneys General in addition to the HHS Office of Civil Rights.

The Privacy and Security Rules and HITECH enhancements establish requirements to protect the privacy of medical records and safeguard personal health information maintained and used by healthcare providers, health plans, healthcare clearinghouses, and their business associates. Other requirements of the privacy regulations include:

- limit certain uses and disclosures of health information, and require individual authorizations for some uses and disclosures of protected health information
- guarantee individuals the right to access their health information and to know who else has accessed it
- limit most disclosure of health information to the minimum needed for the intended purpose
- establish procedures to ensure the protection of health information
- authorize access to records by researchers and others under certain circumstances
- establish requirements for information breach notifications
- impose criminal and civil sanctions for improper uses or disclosures of health information

The Security Rule requires healthcare providers, health plans, healthcare clearinghouses, and their business associates to implement administrative, physical and technical safeguards to ensure the privacy and confidentiality of health information when it is electronically stored, maintained or transmitted. The HITECH Act established a federal requirement for notification when the security of protected health information is breached. In addition, there is a patchwork of state laws that have been adopted to provide for, among other things, private rights of action for breaches of data security and mandatory notification to persons whose identifiable information is obtained without authorization.

The requirements of the Transactions Standards apply to certain healthcare related transactions conducted using "electronic media." Since "electronic media" is defined broadly to include "transmissions that are physically moved from one location to another using magnetic tape, disk or compact disk media," many communications are considered to be electronically transmitted. Under HIPAA, health plans are required to have the capacity to accept and send all covered transactions in a standardized electronic format. Penalties can be imposed for failure to comply with these requirements. The transaction standards have been modified to version 5010 to prepare for the implementation of the ICD10 coding system. We are planning for an expected transition to ICD10 in October 2014.

The preemption provisions of HIPAA provide that the federal standards will not preempt state laws that are more stringent than the related federal requirements. In addition, the Secretary of HHS may grant exceptions allowing state laws contrary to HIPAA to prevail if the Secretary determines that:

- the state law is necessary to prevent fraud and abuse associated with the provision of and payment for healthcare
- the state law is necessary to ensure appropriate state regulation of insurance and health plans
- the state law is necessary for state reporting on healthcare delivery or costs
- the state law addresses controlled substances

We have implemented processes, policies and procedures to comply with both HIPAA and HITECH, including administrative, technical and physical safeguards to prevent against electronic data breach. We provide education and training for employees specifically designed to help prevent any unauthorized use or access to health information and enhance the reporting of suspected breaches. In addition, our corporate privacy officer and health plan privacy officials handle privacy complaints and serve as resources to employees to address questions or concerns they may have.

Other Fraud and Abuse Laws

Investigating and prosecuting healthcare fraud and abuse continues to be a top priority for state and federal law enforcement entities. The focus of these efforts has been directed at participants in public government healthcare programs such as Medicare and Medicaid. The laws and regulations relating to fraud and abuse and the contractual requirements applicable to health plans participating in these programs are complex and regularly changing and compliance with them may require substantial resources. We are constantly looking for ways to improve our waste, fraud and abuse detection methods. While we have both prospective and retrospective processes to identify abusive patterns and fraudulent billing, we continue to increase our capabilities to proactively detect inappropriate billing prior to payment.

EMPLOYEES

As of December 31, 2012, we had approximately 6,800 employees. None of our employees are represented by a union. We believe our relationships with our employees are good.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following table sets forth information regarding our executive officers, including their ages, at February 8, 2013:

Name	Age	Position
Michael F. Neidorff	70	Chairman, President and Chief Executive Officer
K. Rone Baldwin	54	Executive Vice President, Insurance Group Business Unit
Carol E. Goldman	55	Executive Vice President and Chief Administrative Officer
Jason M. Harrold	43	Executive Vice President, Specialty Company Business Unit
Robert T. Hitchcock	46	Executive Vice President, Health Plan Business Unit
Jesse N. Hunter	37	Executive Vice President, Chief Business Development Officer
Donald G. Imholz	60	Executive Vice President and Chief Information Officer
Edmund E. Kroll	53	Senior Vice President, Finance and Investor Relations
C. David Minifie	42	Executive Vice President, Business Integration & Chief Marketing Officer
William N. Scheffel	59	Executive Vice President, Chief Financial Officer and Treasurer
Jeffrey A. Schwaneke	37	Senior Vice President, Corporate Controller and Chief Accounting Officer
Keith H. Williamson	60	Executive Vice President, General Counsel and Secretary

Michael F. Neidorff. Mr. Neidorff has served as our Chairman and Chief Executive Officer since May 2004. From May 1996 to May 2004, Mr. Neidorff served as President, Chief Executive Officer and as a member of our Board of Directors. Mr. Neidorff also serves as a director of Brown Shoe Company, Inc., a publicly-traded footwear company with global operations.

K. Rone Baldwin. Mr. Baldwin has served as our Executive Vice President, Insurance Group Business Unit since December 2012. Prior to joining Centene, he served as Executive Vice President and Business Leader of Group Insurance Business, which included both group health and ancillary product lines, for Guardian Life Insurance Company, which he joined in 2006.

Carol E. Goldman. Ms. Goldman has served as Executive Vice President and Chief Administrative Officer since June 2007. Prior to this position, Ms. Goldman has held various positions of increasing responsibility since joining Centene in 2001.

Jason M. Harrold. Mr. Harrold has served as our Executive Vice President, Specialty Company Business Unit since April 2012. From August 2009 to April 2012, he served as our Senior Vice President, Specialty Business Unit. He served as President of OptiCare from July 2000 to August 2009.

Robert T. Hitchcock. Mr. Hitchcock has served as our Executive Vice President, Health Plan Officer, since October 2012. From March 1997 to October 2012, Mr. Hitchcock held various positions of increasing responsibility at Humana including Divisional Vice President, Western Division Medicare Operations.

Jesse N. Hunter. Mr. Hunter has served as our Executive Vice President, Chief Business Development Officer since December 2012. From February 2012 to December 2012, he served as our Executive Vice President, Operations. He previously served as our Executive Vice President, Corporate Development from April 2008 to February 2012. He served as our Senior Vice President, Corporate Development from April 2007 to April 2008.

Donald G. Imholz. Mr. Imholz has served as our Executive Vice President and Chief Information Officer since December 2009. Mr. Imholz served as our Senior Vice President and Chief Information Officer from September 2008 to December 2009. From January 2008 to September 2008, Mr. Imholz was an independent consultant working for clients across a variety of industries.

Edmund E. Kroll. Mr. Kroll has served as our Senior Vice President, Finance and Investor Relations since May 2007.

C. David Minifie. Mr. Minifie has served as our Executive Vice President, Business Integration and Chief Marketing Officer since December 2012. He previously served as our Vice President, Chief Marketing Officer from April 2012 to December 2012. From 1999 to April 2012, Mr. Minifie held various positions of increasing responsibility at Procter & Gamble including Global Eukanuba Associate Marketing Director.

William N. Scheffel. Mr. Scheffel has served as our Executive Vice President, Chief Financial Officer and Treasurer since May 2009. He served as our Executive Vice President, Specialty Business Unit from June 2007 to May 2009.

Jeffrey A. Schwaneke. Mr. Schwaneke has served as our Senior Vice President, Corporate Controller since December 2011 and our Chief Accounting Officer since September 2008. He served as our Vice President, Corporate Controller from July 2008 to December 2011. He previously served as Vice President, Controller and Chief Accounting Officer at Novelis Inc. from October 2007 to July 2008.

Keith H. Williamson. Mr. Williamson has served as our Executive Vice President, General Counsel and Secretary since November 2012. He served as Senior Vice President and General Counsel from November 2006 to November 2012. Mr. Williamson also serves as a director of PPL Corporation, a publicly-traded utility holding company.

Available Information

We are subject to the reporting and information requirements of the Securities Exchange Act of 1934, as amended (Exchange Act) and, as a result, we file periodic reports and other information with the Securities and Exchange Commission, or SEC. We make these filings available on our website free of charge, the URL of which is http://www.centene.com, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. The SEC maintains a website (http://www.sec.gov) that contains our annual, quarterly and current reports and other information we file electronically with the SEC. You can read and copy any materials we file with the SEC at the SEC's Public Reference Room at 100 F Street, N.E., Room 1850, Washington, D.C. 20549. You may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. Information on our website does not constitute part of this Annual Report on Form 10-K.

ITEM 1A. ***Risk Factors.***

FACTORS THAT MAY AFFECT FUTURE RESULTS AND THE TRADING PRICE OF OUR COMMON STOCK

You should carefully consider the risks described below before making an investment decision. The trading price of our common stock could decline due to any of these risks, in which case you could lose all or part of your investment. You should also refer to the other information in this filing, including our consolidated financial statements and related notes. The risks and uncertainties described below are those that we currently believe may materially affect our Company. Additional risks and uncertainties that we are unaware of or that we currently deem immaterial also may become important factors that affect our Company.

Risks Related to Being a Regulated Entity

Reduction in Medicaid, CHIP and ABD funding could substantially reduce our profitability.

Most of our revenues come from Medicaid, CHIP and ABD premiums. The base premium rate paid by each state differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region, benefit mix and member eligibility categories. Since Medicaid was created in 1965, the federal government and the states have shared the costs, with the federal share currently averaging around 57%. Future levels of Medicaid, CHIP and ABD funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints.

In March 2010, the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act collectively referred to as the Affordable Care Act (ACA), were enacted. While the constitutionality of the ACA was subsequently challenged in a number of legal actions, in June 2012, the Supreme Court upheld the constitutionality of the ACA, with one limited exception relating to the Medicaid expansion provision. The Court held that states could not be required to expand Medicaid and risk losing all federal money for their existing Medicaid programs. Under the ACA, Medicaid coverage will be expanded to all individuals under age 65 with incomes up to 133% of the federal poverty level beginning January 1, 2014, subject to the states' elections. The federal government will pay the entire costs for Medicaid coverage for newly eligible beneficiaries for 3 years, from 2014 through 2016. In 2017, the federal share declines to 95%; in 2018 it is 94%; in 2019 it is 93%; and it will be 90% in 2020 and subsequent years. States may delay Medicaid expansion after 2014 but the federal payment rates will be less. It is unknown as to what states will expand their Medicaid programs although certain states, including Florida, Louisiana, and Texas, have indicated that they will not do so.

Although states are currently required by law to maintain current Medicaid eligibility standards until at least 2014, at least one state has filed a lawsuit challenging the constitutionality of the "maintenance of effort" (MOE) provision based on the Supreme Court's decision. States may also seek to reduce reimbursement or benefits to enable them to afford to maintain their eligibility levels.

States periodically consider reducing or reallocating the amount of money they spend for Medicaid, CHIP, LTC, Foster Care and ABD. The current adverse economic conditions have, and are expected to continue to, put pressures on state budgets as tax and other state revenues decrease while these eligible populations increase, creating more need for funding. We anticipate this will require government agencies with whom we contract to find funding alternatives, which may result in reductions in funding for current programs and program expansions, contraction of covered benefits, limited or no premium rate increases or premium decreases. In recent years, the majority of states have implemented measures to restrict Medicaid, CHIP, LTC, Foster Care and ABD costs and eligibility. If any state in which we operate were to decrease premiums paid to us, 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 operating results.

Changes to Medicaid, CHIP, LTC, Foster Care and ABD programs could reduce the number of persons enrolled in or eligible for these programs, reduce the amount of reimbursement or payment levels, or increase our administrative or healthcare costs under these programs, all of which could have a negative impact on our business. Recent legislation generally requires that eligibility levels be maintained, but this could cause states to reduce reimbursement or reduce benefits in order to afford to maintain eligibility levels. A number of states have requested waivers to the requirements to maintain eligibility levels and legislation has been introduced that would eliminate the requirement that eligibility levels be maintained. We believe that reductions in Medicaid, CHIP, LTC, Foster Care and ABD payments could substantially reduce our profitability. 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.

If we are unable to participate in CHIP programs, our growth rate may be limited.

CHIP is a federal initiative designed to provide coverage for low-income children not otherwise covered by Medicaid or other insurance programs. The programs vary significantly from state to state. Participation in CHIP programs is an important part of our growth strategy. If states do not allow us to participate or if we fail to win bids to participate, our growth strategy may be materially and adversely affected.

If CHIP is not reauthorized or states face shortfalls, our business could suffer.

Federal support for CHIP has been authorized through 2019, with funding authorized through 2015. We cannot be certain that funding for CHIP will be reauthorized when current funding expires in 2015. Thus, we cannot predict the impact that reauthorization will have on our business.

States receive matching funds from the federal government to pay for their CHIP programs which have a per state annual cap. Because of funding caps, there is a risk that states could experience shortfalls in future years, which could have an impact on our ability to receive amounts owed to us from states in which we have CHIP contracts.

If any of our state contracts are terminated or are not renewed, our business will suffer.

We provide managed care programs and selected services to individuals receiving benefits under federal assistance programs, including Medicaid, CHIP and ABD. We provide those healthcare services under contracts with regulatory entities in the areas in which we operate. Our contracts with various states are generally intended to run for one or two years and may be extended for one or two additional years if the state or its agent elects to do so. Our current contracts are set to expire or renew between June 30, 2013 and December 31, 2016. When our contracts expire, they may be opened for bidding by competing healthcare providers. There is no guarantee that our contracts will be renewed or extended. For example, on April 12, 2010, the Wisconsin Department of Health Services notified us that our Wisconsin subsidiary was not awarded a Southeast Wisconsin BadgerCare Plus Managed Care contract. While we will continue to serve other regions of the state, we transitioned the affected members to other plans by November 1, 2010. 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. For example, the Indiana contract under which we operate can be terminated by the State without cause. 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, renewed on less favorable terms, or not renewed on a timely basis, our business will suffer, and our financial position, results of operations or cash flows may be materially affected.

Changes in government regulations designed to protect the financial interests of providers and members rather than our investors could force us to change how we operate and could harm our business.

Our business is extensively regulated by the states in which we operate and by the federal government. The applicable laws and regulations are subject to frequent change and generally are intended to benefit and protect the financial interests of health plan providers and members rather than investors. The enactment of new laws and rules or changes to existing laws and rules or the interpretation of such laws and rules could, among other things:

- force us to restructure our relationships with providers within our network;
- require us to implement additional or different programs and systems;
- mandate minimum medical expense levels as a percentage of premium revenues;
- restrict revenue and enrollment growth;
- require us to develop plans to guard against the financial insolvency of our providers;
- increase our healthcare and administrative costs;
- impose additional capital and reserve requirements; and
- increase or change our liability to members in the event of malpractice by our providers.

The ACA also requires that proposed increases of 10% or more of premiums for most individual and small group insurance health insurance plans must be approved by state or federal officials (Rate Review Program).

Regulations may decrease the profitability of our health plans.

Certain states have enacted regulations which require us to maintain a minimum health benefits ratio, or establish limits on our profitability. Other states require us to meet certain performance and quality metrics in order to receive our full contractual revenue. In certain circumstances, our plans may be required to pay a rebate to the state in the event profits exceed established levels. These regulatory requirements, changes in these requirements or the adoption of similar requirements by other regulators may limit our ability to increase our overall profits as a percentage of revenues. Most states, including but not limited to Georgia, Indiana, Texas and Wisconsin have implemented prompt-payment laws and many states are enforcing penalty provisions for failure to pay claims in a timely manner. Failure to meet these requirements can result in financial fines and penalties. In addition, states may attempt to reduce their contract premium rates if regulators perceive our health benefits ratio as too low. Any of these regulatory actions could harm our financial position, results of operations or cash flows. Certain states also impose marketing restrictions on us which may constrain our membership growth and our ability to increase our revenues.

If we fail to comply with Medicare laws and regulation, our growth rate could be limited.

We feel there are potential growth opportunities in dual eligible markets to fully integrate care for dual eligible beneficiaries who are enrolled in both Medicaid and Medicare. The dual eligible population represents a

disproportionate amount of state and federal health care spending yet less than 15 percent of dual eligibles are in comprehensive, managed care. As a result, states and the federal government have put dual eligibles on the fast track to managed care and dual eligibles are an important part of our growth strategy.

Although we believe that we substantially comply with all existing Medicare statutes and regulations applicable to our business, different interpretations and enforcement policies of these laws and regulations could subject our current practices to allegations of impropriety or illegality or could require us to make significant changes to our operations. If we fail to comply with existing or future applicable Medicare laws and regulations, states may not allow us to continue to participate in dual eligible demonstration programs or we may fail to win bids to participate in such programs, and our growth strategy may be materially and adversely affected.

We face periodic reviews, audits and investigations under our contracts with state and federal government agencies, and these audits could have adverse findings, which may negatively impact our business.

We contract with various state and federal governmental agencies to provide managed healthcare services. Pursuant to these contracts, 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 or investigation could result in:

- cancellation of our contracts;
- refunding of amounts we have been paid pursuant to our contracts;
- imposition of fines, penalties and other sanctions on us;
- loss of our right to participate in various markets;
- increased difficulty in selling our products and services; or
- loss of one or more of our licenses.

Failure to comply with government regulations could subject us to civil and criminal penalties.

Federal and state governments have enacted fraud and abuse laws and other laws to protect patients' privacy and access to healthcare. In some states, we may be subject to regulation by more than one governmental authority, which may impose overlapping or inconsistent regulations. Violation of these and other laws or regulations governing our operations or the operations of our providers could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide services, the suspension or revocation of our licenses or our exclusion from participating in the Medicaid, CHIP, LTC, Foster Care and ABD programs. If we were to become subject to these penalties or exclusions as the result of our actions or omissions or our inability to monitor the compliance of our providers, it would negatively affect our ability to operate our business.

HIPAA broadened the scope of fraud and abuse laws applicable to healthcare companies. HIPAA created civil penalties for, among other things, billing for medically unnecessary goods or services. HIPAA established new enforcement mechanisms to combat fraud and abuse, including civil and, in some instances, criminal penalties for failure to comply with specific standards relating to the privacy, security and electronic transmission of protected health information. The HITECH Act expanded the scope of these provisions by mandating individual notification in instances of breaches of protected health information, providing enhanced penalties for HIPAA violations, and granting enforcement authority to states' Attorneys General in addition to the HHS Office of Civil Rights. It is possible that Congress may enact additional legislation in the future to increase penalties and to create a private right of action under HIPAA, which could entitle patients to seek monetary damages for violations of the privacy rules.

We may incur significant costs as a result of compliance with government regulations, and our management will be required to devote time to compliance.

Many aspects of our business are affected by government laws and regulations. The issuance of new regulations, or judicial or regulatory guidance regarding existing regulations, could require changes to many of the procedures we currently use to conduct our business, which may lead to additional costs that we have not yet identified. We do not know whether, or the extent to which, we will be able to recover from the states our costs of complying with these new regulations. The costs of any such future compliance efforts could have a material adverse effect on our business. We have already expended significant time, effort and financial resources to

comply with the privacy and security requirements of HIPAA and will have to expend additional time and financial resources to comply with the HIPAA provisions contained in the American Recovery and Reinvestment Act of 2009 and the Patient Protection and Affordable Care Act and Health Care and Education Affordability Reconciliation Act. We cannot predict whether states will enact stricter laws governing the privacy and security of electronic health information. If any new requirements are enacted at the state or federal level, compliance would likely require additional expenditures and management time.

Changes in healthcare law and benefits may reduce our profitability.

Changes in applicable laws and regulations are continually being considered, and interpretations of existing laws and rules may also change from time to time. We are unable to predict what regulatory changes may occur or what effect any particular change may have on our business. For example, these changes could reduce the number of persons enrolled or eligible to enroll in Medicaid, reduce the reimbursement or payment levels for medical services or reduce benefits included in Medicaid coverage. We are also unable to predict whether new laws or proposals will favor or hinder the growth of managed healthcare in general.

Beginning in 2014, the ACA requires that policies of health insurance offered in individual and small group markets as well as Medicaid benchmark plans provide coverage of designated items and services known as essential health benefits. These must include at least 10 legally defined benefit categories. HHS has granted states significant flexibility in establishing what constitutes essential health benefits in their states. The diversity of essential health benefits across states will increase the complexity in managing health plans and may affect payments.

Initiatives have begun in at least 26 states to more efficiently care for people who are dually eligible for Medicare and Medicaid. As a result, hospitals are seeking higher Medicare reimbursement rates for these patients from insurers which could negatively impact profits.

The health care reform law and the implementation of that law could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

The ACA provides comprehensive changes to the U.S. health care system, which are being phased in at various stages through 2018. The legislation imposes an annual insurance industry assessment of $8 billion starting in 2014, with increasing annual amounts thereafter. Such assessment may not be deductible for income tax purposes. If this federal premium tax is imposed as enacted, and if the cost of the federal premium tax is not included in the calculation of our rates, or if we are unable to otherwise adjust our business model to address this new tax, our results of operations, financial position and liquidity may be materially adversely affected.

There are numerous outstanding steps required to implement the legislation, including the promulgation of a substantial number of new and potentially more onerous federal regulations. Further, various health insurance reform proposals are also emerging at the state level. Because of the unsettled nature of these reforms and numerous steps required to implement them, we cannot predict what additional health insurance requirements will be implemented at the federal or state level, or the effect that any future legislation or regulation will have on our business or our growth opportunities.

Although we believe the legislation may provide us with significant opportunities to grow our business, the enacted reforms, as well as future regulations and legislative changes, may in fact have a material adverse affect on our results of operations, financial position or liquidity. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of health care reform, or do not do so as effectively as our competitors, our business may be materially adversely affected.

If a state fails to renew a required federal waiver for mandated Medicaid enrollment into managed care or such application is denied, our membership in that state will likely decrease.

States may administer Medicaid managed care programs pursuant to demonstration programs or required waivers of federal Medicaid standards. Waivers and demonstration programs are generally approved for two year periods and can be renewed on an ongoing basis if the state applies. We have no control over this renewal process. If a state does not renew such a waiver or demonstration program or the Federal government denies a state's application for renewal, membership in our health plan in the state could decrease and our business could suffer.

Changes in federal funding mechanisms may reduce our profitability.

Changes in funding for Medicaid may affect our business. For example, on May 29, 2007, CMS issued a final rule that would reduce states' use of intergovernmental transfers for the states' share of Medicaid program funding. By restricting the use of intergovernmental transfers, this rule may restrict some states' funding for Medicaid, which could adversely affect our growth, operations and financial performance. On May 23, 2008, the United States District Court for the District of Columbia vacated the final rule as improperly promulgated. On November 30, 2010, CMS issued final regulations that remove these provisions and restore the regulatory language that was in place before the 2007 regulations were issued. While this rule has been removed, we cannot predict whether another similar rule or any other rule that changes funding mechanisms will be promulgated, and if any are, what impact they will have on our business.

Legislative changes in the Medicare program may also affect our business. For example, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 revised cost-sharing requirements for some beneficiaries and required states to reimburse the federal Medicare program for costs of prescription drug coverage provided to beneficiaries who are enrolled simultaneously in both the Medicaid and Medicare programs.

Medicaid spending by the federal government could be decreased as part of the spending cuts associated with the debt ceiling.

The Sequestration Transparency Act of 2012 (P.L. 112-155) requires President Obama to submit to Congress a report on the potential sequestration triggered by the failure of the Joint Selective Committee on Deficit Reduction to propose, and Congress to enact, a plan to reduce the deficit by $1.2 trillion, as required by the Budget Control Act of 2011. Under the sequestration, automatic spending cuts would have become effective beginning January 2, 2013. This would result in cuts of 2% ($11.1 billion) to Medicare. Although Medicare is impacted, Medicaid programs are not subject to automatic spending cuts. However, on January 2, 2013, President Obama signed into law The American Taxpayer Relief Act of 2012, which among other things, delayed such automatic spending cuts until March 1, 2013.

We cannot predict whether Congress will take any action to change the automatic spending cuts. Further, we cannot predict how states will react to any changes that occur at the federal level.

If state regulatory agencies require a statutory capital level higher than the state regulations, we may be required to make additional capital contributions.

Our operations are conducted through our wholly owned subsidiaries, which include health maintenance organizations, or HMOs, and managed care organizations, or MCOs. HMOs and MCOs are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Additionally, state regulatory agencies may require, at their discretion, individual HMOs to maintain statutory capital levels higher than the state regulations. If this were to occur to one of our subsidiaries, we may be required to make additional capital contributions to the affected subsidiary. Any additional capital contribution made to one of the affected subsidiaries could have a material adverse effect on our liquidity and our ability to grow.

If state regulators do not approve payments of dividends and distributions by our subsidiaries to us, we may not have sufficient funds to implement our business strategy.

We principally operate through our health plan subsidiaries. If funds normally available to us become limited in the future, we may need to rely on dividends and distributions from our subsidiaries to fund our operations. These subsidiaries are subject to regulations that limit the amount of dividends and distributions that can be paid to us without prior approval of, or notification to, state regulators. If these regulators were to deny our subsidiaries' request to pay dividends to us, the funds available to us would be limited, which could harm our ability to implement our business strategy.

Risks Related to Our Business

Ineffectiveness of state-operated systems and subcontractors could adversely affect our business.

Our health plans rely on other state-operated systems or sub-contractors to qualify, solicit, educate and assign eligible members into the health plans. The effectiveness of these state operations and sub-contractors can

have a material effect on a health plan's enrollment in a particular month or over an extended period. When a state implements new programs to determine eligibility, new processes to assign or enroll eligible members into health plans, or chooses new contractors, there is an increased potential for an unanticipated impact on the overall number of members assigned into the health plans.

Failure to accurately predict our medical expenses could negatively affect our financial position, results of operations or cash flows.

Our medical expense includes claims reported but not yet paid, or inventory, estimates for claims incurred but not reported, or IBNR, and estimates for the costs necessary to process unpaid claims at the end of each period. Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as claims receipts and payment information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expense in the period in which the changes are identified.

While we utilize our predictive modeling technology and our executive dashboard, we still cannot be sure that our medical claims liability estimates are adequate or that adjustments to those estimates will not unfavorably impact our results of operations. For example, in the three months ended June 30, 2006 we adjusted medical expense by $9.7 million for adverse medical costs development from the first quarter of 2006.

Additionally, when we commence operations in a new state or region, we have limited information with which to estimate our medical claims liability. For example, we commenced operations in Kentucky in November 2011, in Louisiana in February 2012, in Missouri and Washington in July 2012 and expanded in Texas in March 2012. For a period of time after the inception of business in these states, we base our estimates on state-provided historical actuarial data and limited actual incurred and received claims. The addition of new categories of individuals who are eligible for Medicaid under new legislation may pose the same difficulty in estimating our medical claims liability and utilization patterns.

From time to time in the past, our actual results have varied from our estimates, particularly in times of significant changes in the number of our members. The accuracy of our medical claims liability estimate may also affect our ability to take timely corrective actions, further harming our results.

Assumptions and estimates are utilized in establishing premium deficiency reserves. In October 2012, we notified the Kentucky Cabinet for Health and Family Services that we were exercising a contractual right that we believe allows Kentucky Spirit to terminate its Medicaid managed care contract with the Commonwealth of Kentucky effective July 5, 2013. As a result, we recorded a premium deficiency reserve included in Medical costs expense of $41.5 million for the Kentucky contract in the year ended December 31, 2012. The premium deficiency reserve encompasses the contract period from January 1, 2013 through July 5, 2013. If our assumptions are inaccurate, our reserves may be inadequate to pay medical costs and there could be a material adverse effect on the results of operations and financial condition. In addition, if the contract is not terminated effective July 5, 2013, we may be required to increase our premium deficiency reserve and there could be a material adverse effect on the results of operations and financial condition.

Receipt of inadequate or significantly delayed premiums would negatively affect our revenues, profitability or cash flows.

Our premium revenues consist of fixed monthly payments per member and supplemental payments for other services such as maternity deliveries. These premiums are fixed by contract, and we are obligated during the contract periods to provide healthcare services as established by the state governments. We use a large portion of our revenues to pay the costs of healthcare services delivered to our members. If premiums do not increase when expenses related to medical services rise, our earnings will be affected negatively. In addition, our actual medical services costs may exceed our estimates, which would cause our health benefits ratio, or our expenses related to medical services as a percentage of premium revenue, to increase and our profits to decline. In addition, it is possible for a state to increase the rates payable to certain providers without granting a corresponding increase in premiums to us. If this were to occur in one or more of the states in which we operate, our profitability would be harmed. In addition, if there is a significant delay in our receipt of premiums to offset previously incurred health benefits costs, our cash flows or earnings could be negatively impacted.

In some instances, our base premiums are subject to an adjustment, or risk score, based on the acuity of our membership. Generally, the risk score is determined by the State analyzing encounter submissions of processed claims data to determine the acuity of our membership relative to the entire state's Medicaid membership. The risk score is dependent on several factors including our providers' completeness and quality of claims submission, our processing of the claim, submission of the processed claims in the form of encounters to the states' encounter systems and the states' acceptance and analysis of the encounter data. If the risk scores assigned to our premiums that are risk adjusted are not adequate or do not appropriately reflect the acuity of our membership, our earnings will be affected negatively.

Failure to effectively manage our medical costs or related administrative costs or uncontrollable epidemic or pandemic costs would reduce our profitability.

Our profitability depends, to a significant degree, on our ability to predict and effectively manage expenses related to health benefits. We have less control over the costs related to medical services than we do over our general and administrative expenses. Because of the narrow margins of our health plan business, relatively small changes in our health benefits ratio can create significant changes in our financial results. Changes in healthcare regulations and practices, the level of use of healthcare services, hospital costs, pharmaceutical costs, major epidemics or pandemics, new medical technologies and other external factors, including general economic conditions such as inflation levels, are beyond our control and could reduce our ability to predict and effectively control the costs of providing health benefits. In 2009, the H1N1 influenza pandemic resulted in heightened costs due to increased physician visits and increased utilization of hospital emergency rooms and pharmaceutical costs. We cannot predict what impact an epidemic or pandemic will have on our costs in the future. Additionally, we may not be able to manage costs effectively in the future. If our costs related to health benefits increase, our profits could be reduced or we may not remain profitable.

Our investment portfolio may suffer losses from changes in market interest rates and changes in market conditions which could materially and adversely affect our results of operations or liquidity.

As of December 31, 2012, we had $983.1 million in cash, cash equivalents and short-term investments and $649.5 million of long-term investments and restricted deposits. We maintain an investment portfolio of cash equivalents and short-term and long-term investments in a variety of securities which may include asset backed securities, bank deposits, commercial paper, certificates of deposit, money market funds, municipal bonds, corporate bonds, instruments of the U.S. Treasury and other government corporations and agencies, insurance contracts and equity securities. These investments are subject to general credit, liquidity, market and interest rate risks. Substantially all of these securities are subject to interest rate and credit risk and will decline in value if interest rates increase or one of the issuers' credit ratings is reduced. As a result, we may experience a reduction in value or loss of liquidity of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition.

Our investments in state, municipal and corporate securities are not guaranteed by the United States government which could materially and adversely affect our results of operation, liquidity or financial condition.

As of December 31, 2012, we had $539.7 million of investments in state, municipal and corporate securities. These securities are not guaranteed by the United States government. State and municipal securities are subject to additional credit risk based upon each local municipality's tax revenues and financial stability. As a result, we may experience a reduction in value or loss of liquidity of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition.

Difficulties in executing our acquisition strategy could adversely affect our business.

Historically, the acquisition of Medicaid and specialty services businesses, contract rights and related assets of other health plans both in our existing service areas and in new markets has accounted for a significant amount of our growth. Many of the other potential purchasers have greater financial resources than we have. In addition, many of the sellers are interested either in (a) selling, along with their Medicaid assets, other assets in which we do not have an interest or (b) selling their companies, including their liabilities, as opposed to the assets of their ongoing businesses.

We generally are required to obtain regulatory approval from one or more state agencies when making acquisitions. In the case of an acquisition of a business located in a state in which we do not currently operate, we would be required to obtain the necessary licenses to operate in that state. In addition, even if we already operate in a state in which we acquire a new business, we would be required to obtain additional regulatory approval if the acquisition would result in our operating in an area of the state in which we did not operate previously, and we could be required to renegotiate provider contracts of the acquired business. We cannot provide any assurance that we would be able to comply with these regulatory requirements for an acquisition in a timely manner, or at all. In deciding whether to approve a proposed acquisition, state regulators may consider a number of factors outside our control, including giving preference to competing offers made by locally owned entities or by not-for-profit entities.

We also may be unable to obtain sufficient additional capital resources for future acquisitions. If we are unable to effectively execute our acquisition strategy, our future growth will suffer and our results of operations could be harmed.

Execution of our growth strategy may increase costs or liabilities, or create disruptions in our business.

We pursue acquisitions of other companies or businesses from time to time. Although we review the records of companies or businesses we plan to acquire, even an in-depth review of records may not reveal existing or potential problems or permit us to become familiar enough with a business to assess fully its capabilities and deficiencies. As a result, we may assume unanticipated liabilities or adverse operating conditions, or an acquisition may not perform as well as expected. We face the risk that the returns on acquisitions will not support the expenditures or indebtedness incurred to acquire such businesses, or the capital expenditures needed to develop such businesses. We also face the risk that we will not be able to integrate acquisitions into our existing operations effectively without substantial expense, delay or other operational or financial problems. Integration may be hindered by, among other things, differing procedures, including internal controls, business practices and technology systems. We may need to divert more management resources to integration than we planned, which may adversely affect our ability to pursue other profitable activities.

In addition to the difficulties we may face in identifying and consummating acquisitions, we will also be required to integrate and consolidate any acquired business or assets with our existing operations. This may include the integration of:

- additional personnel who are not familiar with our operations and corporate culture;
- provider networks that may operate on different terms than our existing networks;
- existing members, who may decide to switch to another healthcare plan; or
- disparate administrative, accounting and finance, and information systems.

Additionally, our growth strategy includes start-up operations in new markets or new products in existing markets. We may incur significant expenses prior to commencement of operations and the receipt of revenue. As a result, these start-up operations may decrease our profitability. We also face the risk that we will not be able to integrate start-up operations into our existing operations effectively without substantial expense, delay or other operational or financial problems. In the event we pursue any opportunity to diversify our business internationally, we would become subject to additional risks, including, but not limited to, political risk, an unfamiliar regulatory regime, currency exchange risk and exchange controls, cultural and language differences, foreign tax issues, and different labor laws and practices.

Accordingly, we may be unable to identify, consummate and integrate future acquisitions or start-up operations successfully or operate acquired or new businesses profitably.

Acquisitions of unfamiliar new businesses could negatively impact our business.

We are subject to the expenditures and risks associated with entering into any new line of business. Our failure to properly manage these expenditures and risks could have a negative impact on our overall business. For example, effective July 2008, we completed the previously announced acquisition of Celtic Group, Inc., the parent company of Celtic Insurance Company, or Celtic. Celtic is a national individual health insurance provider that provides health insurance to individual customers and their families. While we believed that the addition of Celtic would be complementary to our business, we had not previously operated in the individual health care industry.

If competing managed care programs are unwilling to purchase specialty services from us, we may not be able to successfully implement our strategy of diversifying our business lines.

We are seeking to diversify our business lines into areas that complement our Medicaid business in order to grow our revenue stream and balance our dependence on Medicaid risk reimbursement. In order to diversify our business, we must succeed in selling the services of our specialty subsidiaries not only to our managed care plans, but to programs operated by third-parties. Some of these third-party programs may compete with us in some markets, and they therefore may be unwilling to purchase specialty services from us. In any event, the offering of these services will require marketing activities that differ significantly from the manner in which we seek to increase revenues from our Medicaid programs. Our inability to market specialty services to other programs may impair our ability to execute our business strategy.

Failure to achieve timely profitability in any business would negatively affect our results of operations.

Business expansion costs associated with a new business can be substantial. For example, in order to obtain a certificate of authority in most jurisdictions, we must first establish a provider network, have systems in place and demonstrate our ability to obtain a state contract and process claims. If we were unsuccessful in obtaining the necessary license, winning the bid to provide service or attracting members in numbers sufficient to cover our costs, any new business of ours would fail. We also could be obligated by the state to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or recover business expansion costs. The expenses associated with starting up a new business could have a significant impact on our results of operations if we are unable to achieve profitable operations in a timely fashion.

Adverse credit market conditions may have a material adverse affect on our liquidity or our ability to obtain credit on acceptable terms.

The securities and credit markets have been experiencing extreme volatility and disruption over the past several years. The availability of credit, from virtually all types of lenders, has been restricted. Such conditions may persist during 2013 and beyond. In the event we need access to additional capital to pay our operating expenses, make payments on our indebtedness, pay capital expenditures, or fund acquisitions, our ability to obtain such capital may be limited and the cost of any such capital may be significant, particularly if we are unable to access our existing credit facility.

Our access to additional financing will depend on a variety of factors such as prevailing economic and credit market conditions, the general availability of credit, the overall availability of credit to our industry, our credit ratings and credit capacity, and perceptions of our financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain additional financing on favorable terms or at all. We believe that if credit could be obtained, the terms and costs of such credit could be significantly less favorable to us than what was obtained in our most recent financings.

We derive a majority of our premium revenues from operations in a small number of states, and our financial position, results of operations or cash flows would be materially affected by a decrease in premium revenues or profitability in any one of those states.

Operations in a few states have accounted for most of our premium revenues to date. If we were unable to continue to operate in any of our current states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly depending on legislative or other governmental or regulatory actions and decisions, economic conditions and similar factors in those states. For example, states we currently serve may bid out their Medicaid program through a Request for Proposal, or RFP, process. Our inability to continue to operate in any of the states in which we operate would harm our business.

Competition may limit our ability to increase penetration of the markets that we serve.

We compete for members principally on the basis of size and quality of provider network, benefits provided and quality of service. We compete with numerous types of competitors, including other health plans and traditional state Medicaid programs that reimburse providers as care is provided. In addition, the impact of health care reform and potential growth in our segment may attract new competitors. Subject to limited exceptions by federally approved state applications, the federal government requires that there be choices for Medicaid recipients among managed care programs. Voluntary programs, increases in the number of competitors and mandated competition may limit our ability to increase our market share.

Some of the health plans with which we compete have greater financial and other resources and offer a broader scope of products than we do. In addition, significant merger and acquisition activity has occurred in the managed care industry, as well as in industries that act as suppliers to us, such as the hospital, physician, pharmaceutical, medical device and health information systems businesses. To the extent that competition intensifies in any market that we serve, our ability to retain or increase members and providers, or maintain or increase our revenue growth, pricing flexibility and control over medical cost trends may be adversely affected.

In addition, in order to increase our membership in the markets we currently serve, we believe that we must continue to develop and implement community-specific products, alliances with key providers and localized outreach and educational programs. If we are unable to develop and implement these initiatives, or if our competitors are more successful than we are in doing so, we may not be able to further penetrate our existing markets.

If we are unable to maintain relationships with our provider networks, our profitability may be harmed.

Our profitability depends, in large part, upon our ability to contract favorably with hospitals, physicians and other healthcare providers. Our provider arrangements with our primary care physicians, specialists and hospitals generally may be canceled by either party without cause upon 90 to 120 days prior written notice. We cannot provide any assurance that we will be able to continue to renew our existing contracts or enter into new contracts enabling us to service our members profitably.

From time to time providers assert or threaten to assert claims seeking to terminate non-cancelable agreements due to alleged actions or inactions by us. Even if these allegations represent attempts to avoid or renegotiate contractual terms that have become economically disadvantageous to the providers, it is possible that in the future a provider may pursue such a claim successfully. In addition, we are aware that other managed care organizations have been subject to class action suits by physicians with respect to claim payment procedures, and we may be subject to similar claims. Regardless of whether any claims brought against us are successful or have merit, they will still be time-consuming and costly and could distract our management's attention. As a result, we may incur significant expenses and may be unable to operate our business effectively.

We will be required to establish acceptable provider networks prior to entering new markets. We may be unable to enter into agreements with providers in new markets on a timely basis or under favorable terms. If we are unable to retain our current provider contracts or enter into new provider contracts timely or on favorable terms, our profitability will be harmed.

We may be unable to attract and retain key personnel.

We are highly dependent on our ability to attract and retain qualified personnel to operate and expand our business. If we lose one or more members of our senior management team, including our chief executive officer, Michael F. Neidorff, who has been instrumental in developing our business strategy and forging our business relationships, our business and financial position, results of operations or cash flows could be harmed. Our ability to replace any departed members of our senior management or other key employees may be difficult and may take an extended period of time because of the limited number of individuals in the Medicaid managed care and specialty services industry with the breadth of skills and experience required to operate and successfully expand a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain or motivate these personnel.

Negative publicity regarding the managed care industry may harm our business and financial position, results of operations or cash flows.

The managed care industry has received negative publicity. This publicity has led to increased legislation, regulation, review of industry practices and private litigation in the commercial sector. These factors may adversely affect our ability to market our services, require us to change our services, and increase the regulatory burdens under which we operate. Any of these factors may increase the costs of doing business and adversely affect our financial position, results of operations or cash flows.

Claims relating to medical malpractice could cause us to incur significant expenses.

Our providers and employees involved in medical care decisions may be subject to medical malpractice claims. In addition, some states have adopted legislation that permits managed care organizations to be held liable for negligent treatment decisions, credentialing or benefits coverage determinations. Claims of this nature, if successful, could result in substantial damage awards against us and our providers that could exceed the limits of any applicable insurance coverage. Therefore, successful malpractice or tort claims asserted against us, our providers or our employees could adversely affect our financial condition and profitability. Even if any claims brought against us are unsuccessful or without merit, they would still be time consuming and costly and could distract our management's attention. As a result, we may incur significant expenses and may be unable to operate our business effectively.

Loss of providers due to increased insurance costs could adversely affect our business.

Our providers routinely purchase insurance to help protect themselves against medical malpractice claims. In recent years, the costs of maintaining commercially reasonable levels of such insurance have increased dramatically, and these costs are expected to increase to even greater levels in the future. As a result of the level of these costs, providers may decide to leave the practice of medicine or to limit their practice to certain areas, which may not address the needs of Medicaid participants. We rely on retaining a sufficient number of providers in order to maintain a certain level of service. If a significant number of our providers exit our provider networks or the practice of medicine generally, we may be unable to replace them in a timely manner, if at all, and our business could be adversely affected.

Growth in the number of Medicaid-eligible persons could cause our financial position, results of operations or cash flows to suffer if state and federal budgets decrease or do not increase.

Less favorable economic conditions may cause our membership to increase as more people become eligible to receive Medicaid benefits. During such economic downturns, however, state and federal budgets could decrease, causing states to attempt to cut healthcare programs, benefits and rates. Additionally, the number of individuals eligible for Medicaid managed care will likely increase as a result of the health care reform legislation. We cannot predict the impact of changes in the United States economic environment or other economic or political events, including acts of terrorism or related military action, on federal or state funding of healthcare programs or on the size of the population eligible for the programs we operate. If federal or state funding decreases or remains unchanged while our membership increases, our results of operations will suffer.

Growth in the number of Medicaid-eligible persons may be countercyclical, which could cause our financial position, results of operations or cash flows to suffer when general economic conditions are improving.

Historically, the number of persons eligible to receive Medicaid benefits has increased more rapidly during periods of rising unemployment, corresponding to less favorable general economic conditions. Conversely, this number may grow more slowly or even decline if economic conditions improve. Therefore, improvements in general economic conditions may cause our membership levels to decrease, thereby causing our financial position, results of operations or cash flows to suffer, which could lead to decreases in our stock price during periods in which stock prices in general are increasing.

If we are unable to integrate and manage our information systems effectively, our operations could be disrupted.

Our operations depend significantly on effective information systems. The information gathered and processed by our information systems assists us in, among other things, monitoring utilization and other cost

factors, processing provider claims, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status and other information.

Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs and regulatory requirements. Moreover, our acquisition activity requires frequent transitions to or from, and the integration of, various information systems. We regularly upgrade and expand our information systems' capabilities. If we experience difficulties with the transition to or from information systems or are unable to properly maintain or expand our information systems, we could suffer, among other things, from operational disruptions, loss of existing members and difficulty in attracting new members, regulatory problems and increases in administrative expenses. In addition, our ability to integrate and manage our information systems may be impaired as the result of events outside our control, including acts of nature, such as earthquakes or fires, or acts of terrorists.

We rely on the accuracy of eligibility lists provided by state governments. Inaccuracies in those lists would negatively affect our results of operations.

Premium payments to us are based upon eligibility lists produced by state governments. From time to time, states require us to reimburse them for premiums paid to us based on an eligibility list that a state later discovers contains individuals who are not in fact eligible for a government sponsored program or are eligible for a different premium category or a different program. Alternatively, a state could fail to pay us for members for whom we are entitled to payment. Our results of operations would be adversely affected as a result of such reimbursement to the state if we had made related payments to providers and were unable to recoup such payments from the providers.

We may not be able to obtain or maintain adequate insurance.

We maintain liability insurance, subject to limits and deductibles, for claims that could result from providing or failing to provide managed care and related services. These claims could be substantial. We believe that our present insurance coverage and reserves are adequate to cover currently estimated exposures. We cannot provide any assurance that we will be able to obtain adequate insurance coverage in the future at acceptable costs or that we will not incur significant liabilities in excess of policy limits.

From time to time, we may become involved in costly and time-consuming litigation and other regulatory proceedings, which require significant attention from our management.

We are a defendant from time to time in lawsuits and regulatory actions relating to our business. Due to the inherent uncertainties of litigation and regulatory proceedings, we cannot accurately predict the ultimate outcome of any such proceedings. An unfavorable outcome could have a material adverse impact on our business and financial position, results of operations or cash flows. In addition, regardless of the outcome of any litigation or regulatory proceedings, such proceedings are costly and time consuming and require significant attention from our management. For example, we have been named in a recently-filed securities lawsuit seeking class action and we have in the past, or may be subject to in the future, IRS examinations, securities class action lawsuits or similar regulatory actions. Any such matters could harm our business and financial position, results of operations or cash flows.

An impairment charge with respect to our recorded goodwill and intangible assets could have a material impact on our results of operations.

Goodwill and other intangible assets were $276.6 million as of December 31, 2012. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. Changes in business strategy, government regulations or economic or market conditions have resulted and may result in impairments of our goodwill and other intangible assets at any time in the future. Our judgments regarding the existence of impairment indicators are based on, among other things, legal factors, market conditions, and operational performance. For example, the non-renewal of our health plan contracts with the state in which they operate may be an indicator of impairment.

If an event or events occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill and other intangible assets, such revision could result in a non-cash impairment charge that could have a material impact on our results of operations in the period in which the impairment occurs.

An unauthorized disclosure of sensitive or confidential member information could have an adverse effect on our business.

As part of our normal operations, we collect, process and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including HIPAA and the Gramm-Leach-Bliley Act. The American Recovery and Reinvestment Act of 2009 further expands the coverage of HIPAA by, among other things, extending the privacy and security provisions, requiring new disclosures if a data breach occurs, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions and increasing penalties for violations. Despite the security measures we have in place to ensure compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers, may be vulnerable to security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, whether by us or a third party, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Item 1B. ***Unresolved Staff Comments***

None.

Item 2. ***Properties***

We own our corporate office headquarters buildings and land located in St. Louis, Missouri. During 2010, our capital expenditures included costs for the construction of a new real estate development on our property, which has accommodated our growing business. During 2011, our capital expenditures also included costs for the construction of a new datacenter.

We generally lease space in the states where our health plans, specialty companies and claims processing facilities operate. We are required by various insurance and regulatory authorities to have offices in the service areas where we provide benefits. We believe our current facilities are adequate to meet our operational needs for the foreseeable future.

Item 3. ***Legal Proceedings.***

In October 2012, the Company notified the Kentucky Cabinet for Health and Family Services that it was exercising a contractual right that it believes allows the Company to terminate its Medicaid managed care contract with the Commonwealth of Kentucky effective July 5, 2013. The Company has also filed a formal dispute with the Cabinet for damages incurred under the contract. That dispute is currently on appeal to the Finance and Administration Cabinet. In addition, the Company has filed a lawsuit in Franklin Circuit Court against the Commonwealth of Kentucky seeking declaratory relief as a result of the Commonwealth's failure to completely and accurately disclose material information. On January 23, 2013, the Franklin Circuit Court denied the Commonwealth's Motion to Dismiss and retained jurisdiction of the lawsuit, but stayed the proceedings pending a formal, written determination by the Finance and Administration Cabinet.

The Company is routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters is uncertain, the Company does not expect the results of any of these matters individually, or in the aggregate, to have a material effect on its financial position or results of operations.

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; Dividends

Our common stock has been traded and quoted on the New York Stock Exchange under the symbol "CNC" since October 16, 2003. The high and low prices, as reported by the NYSE, are set forth below for the periods indicated.

	2013 Stock Price (through February 13, 2013)		2012 Stock Price		2011 Stock Price	
	High	Low	High	Low	High	Low
First Quarter	$47.28	$40.57	$50.36	$38.97	$32.99	$25.08
Second Quarter			50.98	24.26	39.25	31.34
Third Quarter			42.46	28.86	39.35	25.64
Fourth Quarter			46.44	34.73	40.81	25.28

As of February 1, 2013, there were 52 holders of record of our common stock.

We have never declared any cash dividends on our capital stock and currently anticipate that we will retain any future earnings for the development, operation and expansion of our business.

Issuer Purchases of Equity Securities

On October 26, 2009, the Company's Board of Directors extended the Company's stock repurchase program. The program authorizes the repurchase of up to 4,000,000 shares of the Company's common stock from time to time on the open market or through privately negotiated transactions. We have 1,667,724 available shares remaining under the program for repurchases as of December 31, 2012. No duration has been placed on the repurchase program. The Company reserves the right to discontinue the repurchase program at any time. During the year ended December 31, 2012, we did not repurchase any shares through this publicly announced program.

Issuer Purchases of Equity Securities
Fourth Quarter 2012

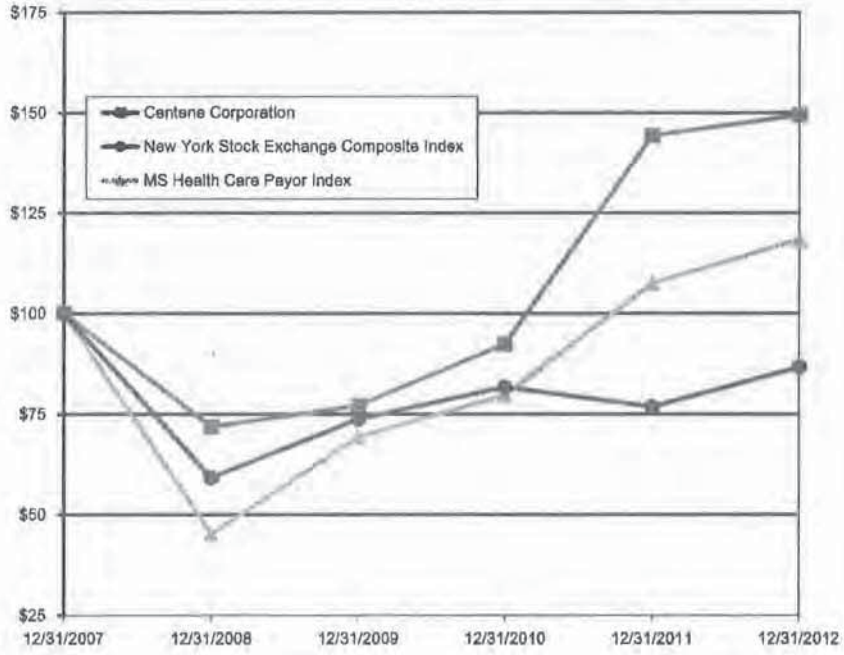
Period	Total Number of Shares Purchased[1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs[2]
October 1 – October 31, 2012	5,561	$38.35	—	1,667,724
November 1 – November 30, 2012	7,805	41.61	—	1,667,724
December 1 – December 31, 2012	223,639	44.88	—	1,667,724
Total	237,005	$44.62	—	1,667,724

(1) Shares acquired represent shares relinquished to the Company by certain employees for payment of taxes or option cost upon vesting of restricted stock units or option exercise.

(2) Our Board of Directors adopted a stock repurchase program of up to 4,000,000 shares. No duration has been placed on the repurchase program.

Stock Performance Graph

The graph below compares the cumulative total stockholder return on our common stock for the period from December 31, 2007 to December 31, 2012 with the cumulative total return of the New York Stock Exchange Composite Index and the Morgan Stanley Health Care Payor Index over the same period. The graph assumes an investment of $100 on December 31, 2007 in our common stock (at the last reported sale price on such day), the New York Stock Exchange Composite Index and the Morgan Stanley Health Care Payor Index and assumes the reinvestment of any dividends.



	December 31,					
	2007	2008	2009	2010	2011	2012
Centene Corporation	$100.00	$71.83	$77.15	$92.35	$144.28	$149.42
New York Stock Exchange Composite Index	100.00	59.11	73.77	81.76	76.76	86.69
MS Health Care Payor Index	100.00	45.19	69.33	79.64	107.39	118.34
Centene Corporation closing stock price	$27.44	$19.71	$21.17	$25.34	$39.59	$41.00
Centene Corporation annual shareholder return	11.7%	(28.2)%	7.4%	19.7%	56.2%	3.6%

Item 6. *Selected Financial Data*

The following selected consolidated financial data should be read in conjunction with the consolidated financial statements and related notes and "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" included in our Annual Report on Form 10-K. The assets, liabilities and results of operations of FirstGuard and University Health Plans have been classified as discontinued operations for all periods presented. The data for the years ended December 31, 2012, 2011 and 2010 and as of December 31, 2012 and 2011 are derived from consolidated financial statements included elsewhere in this filing. The data for the years ended December 31, 2009 and 2008 and as of December 31, 2010, 2009 and 2008 are derived from consolidated financial statements not included in this filing.

	Year Ended December 31,				
	2012	2011	2010	2009	2008
	(In thousands, except share data)				
Revenues:					
Premium	$ 8,126,205	$ 5,077,242	$ 4,192,172	$ 3,786,525	$ 3,199,360
Service	112,742	103,765	91,661	91,758	74,953
Premium and service revenues	8,238,947	5,181,007	4,283,833	3,878,283	3,274,313
Premium tax	428,665	159,575	164,490	224,581	90,202
Total revenues	8,667,612	5,340,582	4,448,323	4,102,864	3,364,515
Expenses:					
Medical costs	7,446,037	4,324,746	3,584,452	3,230,131	2,704,647
Cost of services	87,705	78,114	63,919	60,789	56,920
General and administrative expenses	704,604	587,004	477,765	447,921	380,421
Premium tax expense	428,354	160,394	165,118	225,888	90,966
Impairment loss	28,033	—	—	—	—
Total operating expenses	8,694,733	5,150,258	4,291,254	3,964,729	3,232,954
Earnings (loss) from operations	(27,121)	190,324	157,069	138,135	131,561
Other income (expense):					
Investment and other income	35,957	13,369	15,205	15,691	21,728
Debt extinguishment costs	—	(8,488)	—	—	—
Interest expense	(20,460)	(20,320)	(17,992)	(16,318)	(16,673)
Earnings (loss) from continuing operations, before income tax expense	(11,624)	174,885	154,282	137,508	136,616
Income tax expense (benefit)	(329)	66,522	59,900	48,841	52,435
Earnings (loss) from continuing operations, net of income tax expense	(11,295)	108,363	94,382	88,667	84,181
Discontinued operations, net of income tax expense (benefit) of $0, $0, $4,388, $(1,204), and $(281), respectively	—	—	3,889	(2,422)	(684)
Net earnings (loss)	(11,295)	108,363	98,271	86,245	83,497
Noncontrolling interest	(13,154)	(2,855)	3,435	2,574	—
Net earnings attributable to Centene Corporation	$ 1,859	$ 111,218	$ 94,836	$ 83,671	$ 83,497
Amounts attributable to Centene Corporation common shareholders:					
Earnings from continuing operations, net of income tax expense	$ 1,859	$ 111,218	$ 90,947	$ 86,093	$ 84,181
Discontinued operations, net of income tax expense (benefit)	—	—	3,889	(2,422)	(684)
Net earnings	$ 1,859	$ 111,218	$ 94,836	$ 83,671	$ 83,497
Net earnings (loss) per common share attributable to Centene Corporation:					
Basic:					
Continuing operations	$ 0.04	$ 2.22	$ 1.87	$ 2.00	$ 1.95
Discontinued operations	—	—	0.08	(0.06)	(0.02)
Basic earnings per common share	$ 0.04	$ 2.22	$ 1.95	$ 1.94	$ 1.93
Diluted:					
Continuing operations	$ 0.03	$ 2.12	$ 1.80	$ 1.94	$ 1.90
Discontinued operations	—	—	0.08	(0.05)	(0.02)
Diluted earnings per common share	$ 0.03	$ 2.12	$ 1.88	$ 1.89	$ 1.88
Weighted average number of common shares outstanding:					
Basic	51,509,366	50,198,954	48,754,947	43,034,791	43,275,187
Diluted	53,714,375	52,474,238	50,447,888	44,316,467	44,398,955

	December 31,				
	2012	2011	2010	2009	2008
	(In thousands)				
Consolidated Balance Sheet Data:					
Cash and cash equivalents	$ 843,952	$ 573,698	$ 434,166	$ 403,752	$ 379,099
Investments and restricted deposits	788,634	663,457	639,983	585,183	451,058
Total assets	2,741,682	2,190,336	1,943,882	1,702,364	1,451,152
Medical claims liability	926,302	607,985	456,765	470,932	384,360
Long-term debt	535,481	348,344	327,824	307,085	264,637
Total stockholders' equity	953,767	936,419	797,055	619,427	501,272

ITEM 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations.*

The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes included elsewhere in this filing. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under Part I, Item 1A. "Risk Factors" of this Form 10-K.

OVERVIEW

Our financial performance for 2012 is summarized as follows:

- Year-end at-risk managed care membership of 2,560,300, an increase of 744,300 members, or 41.0% year over year.
- Premium and service revenues of $8.2 billion, representing 59.0% growth year over year.
- Health Benefits Ratio of 91.6%, compared to 85.2% in 2011.
- General and Administrative expense ratio of 8.6%, compared to 11.3% in 2011.
- Total operating cash flows of $278.7 million.
- Diluted net earnings per share of $0.03.

Included in the year ended December 31, 2012, results are the following significant items: (1) a $142.2 million pre-tax operating loss in our Kentucky health plan, including a $41.5 million pre-tax premium deficiency reserve for our Kentucky health plan contract covering the period from January 1, 2013 through July 5, 2013; (2) a pre-tax impairment loss of $28.0 million for the write down of goodwill and intangible assets in the Celtic reporting unit; (3) a $19.4 million pre-tax gain on the sale of investments; and (4) a $5.8 million state income tax benefit. These items are discussed in further detail below.

The following items contributed to our revenue and membership growth over the last two years:

- *Arizona.* In October 2011, Bridgeway Health Solutions began operating under an expanded contract to deliver LTC services in three geographic service areas of Arizona.
- *Illinois.* In May 2011, our subsidiary, IlliniCare Health Plan, began providing managed care services for older adults and adults with disabilities under the Integrated Care Program in six counties.
- *Kentucky.* In November 2011, our subsidiary, Kentucky Spirit Health Plan, began providing managed care services under a contract with the Kentucky Finance and Administration Cabinet to serve Medicaid beneficiaries.
- *Louisiana.* In February 2012, our joint venture subsidiary, Louisiana Healthcare Connections (LHC), began operating under a new contract in Louisiana to provide healthcare services to Medicaid enrollees participating in the Bayou Health program. LHC completed its three-phase membership roll-out for the three geographical service areas during the second quarter of 2012. In November 2012, the covered services provided by LHC expanded to include pharmacy benefits. During the fourth quarter of 2012, we acquired the ownership interest of our joint venture partner, bringing our ownership to 100%.
- *Mississippi.* In December 2012, our subsidiary, Magnolia Health Plan, began operating under an expanded contract to provide managed care services statewide to Medicaid members as well as providing behavioral health services.
- *Missouri.* In July 2012, our joint venture subsidiary, Home State Health Plan, began operating under a new contract with the Office of Administration for Missouri to serve Medicaid beneficiaries in the Eastern, Central, and Western Managed Care Regions of the state.
- *Ohio.* In October 2011, Buckeye Community Health Plan, or Buckeye, began operating under an amended contract with the Ohio Department of Job and Family Services which included the management of the pharmacy benefits for Buckeye's members.
- *Texas.* In February 2011, we began operating under an additional STAR+PLUS ABD contract in the Dallas service area and in September 2011, we added additional membership through the contiguous

county expansion. In March 2012, the Company began operating under contracts in Texas that expanded its operations through new service areas including the 10 county Hidalgo Service Area and the Medicaid Rural Service Areas of West Texas, Central Texas and North-East Texas, as well as the addition of STAR+PLUS in the Lubbock Service Area. The expansion also added the management of outpatient pharmacy benefits in all service areas and products, as well as inpatient facility services for the STAR+PLUS program.

- *Washington.* In July 2012, we began operating under a new contract with the Washington Health Care Authority to serve Medicaid beneficiaries in the state, operating as Coordinated Care.

We expect the following items to contribute to our future growth potential:

- We expect to realize the full year benefit in 2013 of business commenced during 2012 in Louisiana, Mississippi, Missouri, Texas and Washington as discussed above.
- In January 2013, our Kansas subsidiary, Sunflower State Health Plan, began operating under a statewide contract to serve members in the state's KanCare program, which includes TANF, ABD (dual and non-dual), foster care, LTC and CHIP beneficiaries.
- In January 2013, our Florida subsidiary, Sunshine State Health Plan, was notified by the Florida Agency for Health Care Administration it has been recommended for a contract award in 10 of 11 regions of the Medicaid Managed Care Long Term Care program. Upon execution of a contract and regulatory approval, enrollment will be implemented by region, beginning in August 2013 and continuing through March 2014.
- In January 2013, we signed a definitive agreement to acquire AcariaHealth, a comprehensive specialty pharmacy company, for $152.0 million. The transaction consideration is anticipated to be financed through a combination of Centene common stock, cash on hand and existing credit facilities. The acquisition is expected to close in the first quarter of 2013, subject to regulatory approval and other customary conditions.
- In November 2012, our Illinois subsidiary, IlliniCare Health Plan, was selected to serve dual-eligible members in Cook, DuPage, Lake, Kane, Kankakee and Will counties (Greater Chicago region) as part of the Illinois Medicare-Medicaid Alignment Initiative. Enrollment is expected to begin in late 2013.
- In August 2012, we were notified by the Ohio Department of Job and Family Services (ODJFS) that Buckeye Community Health Plan (Buckeye), our Ohio subsidiary, was selected to serve Medicaid members in a dual- eligible demonstration program in three of Ohio's pre-determined seven regions: Northeast (Cleveland), Northwest (Toledo) and West Central (Dayton). This three-year program, which is part of the state of Ohio's Integrated Care Delivery System (ICDS) expansion, will serve those who have both Medicare and Medicaid eligibility. Enrollment is expected to begin in the second half of 2013.
- In June 2012, we were notified by the ODJFS that Buckeye was selected to be awarded a new and expanded contract to serve Medicaid members in Ohio. Under the new state contract, Buckeye will operate statewide through Ohio's three newly aligned regions (West, Central/Southeast, and Northeast). Enrollment is expected to begin in July 2013.
- In May 2012, we announced that the Governor and Executive Council of New Hampshire had given approval for the Department of Health and Human Services to contract with our subsidiary, Granite State Health Plan, to serve Medicaid beneficiaries in New Hampshire. Operations are currently expected to commence in the second half of 2013.

In October 2012, we announced that our subsidiary, Kentucky Spirit Health Plan (Kentucky Spirit), notified the Cabinet for Health and Family Services that it is exercising a contractual right that it believes allows Kentucky Spirit to terminate its Medicaid managed care contract with the Commonwealth of Kentucky effective July 5, 2013. Kentucky Spirit has also filed a formal dispute with the Cabinet for damages incurred under the contract. That dispute is currently on appeal to the Finance and Administration Cabinet. In addition, we have filed a lawsuit in Franklin Circuit Court against the Commonwealth of Kentucky seeking declaratory relief as a result of the Commonwealth's failure to completely and accurately disclose material information. On January 23, 2013, the Franklin Circuit Court denied the Commonwealth's Motion to Dismiss and retained jurisdiction of the lawsuit, but stayed the proceedings pending a formal, written determination by the Finance and Administration Cabinet.

MEMBERSHIP

From December 31, 2010 to December 31, 2012, we increased our at-risk managed care membership by 1,026,800, or 67.0%. The following table sets forth our membership by state for our managed care organizations:

	December 31,		
	2012	2011	2010
Arizona	23,500	23,700	22,400
Florida	214,000	198,300	194,900
Georgia	313,700	298,200	305,800
Illinois	18,000	16,300	—
Indiana	204,000	206,900	215,800
Kentucky	135,800	180,700	—
Louisiana	165,600	—	—
Massachusetts	21,500	35,700	36,200
Mississippi	77,200	31,600	—
Missouri	59,600	—	—
Ohio	157,800	159,900	160,100
South Carolina	90,100	82,900	90,300
Texas	949,900	503,800	433,100
Washington	57,200	—	—
Wisconsin	72,400	78,000	74,900
Total at-risk membership	2,560,300	1,816,000	1,533,500
Non-risk membership	—	4,900	4,200
Total	2,560,300	1,820,900	1,537,700

The following table sets forth our membership by line of business:

	December 31,		
	2012	2011	2010
Medicaid	1,977,200	1,336,800	1,177,100
CHIP & Foster Care	237,700	213,900	210,500
ABD & Medicare	307,800	218,000	104,600
Hybrid Programs	29,100	40,500	36,200
LTC	8,500	6,800	5,100
Total at-risk membership	2,560,300	1,816,000	1,533,500
Non-risk membership	—	4,900	4,200
Total	2,560,300	1,820,900	1,537,700

The following table identifies the Company's dual eligible membership by line of business. The membership tables above include these members.

	December 31,		
	2012	2011	2010
ABD	72,800	45,400	22,200
LTC	7,700	6,200	4,600
Medicare	5,100	3,200	2,700
Total	85,600	54,800	29,500

The following table provides supplemental information of other membership categories:

	December 31,		
	2012	2011	2010
Cenpatico Behavioral Health:			
Arizona	157,900	168,900	174,600
Kansas[1]	49,800	46,200	39,200

(1) Effective January 1, 2013, Cenpatico Behavioral Health's contract in Kansas was discontinued and members began receiving benefits under the statewide KanCare program.

From December 31, 2011 to December 31, 2012 our membership increased as a result of:

- operations commenced in Louisiana, Missouri and Washington
- contract awards and geographic expansion in Texas

From December 31, 2010 to December 31, 2011 our membership increased as a result of:

- operations commenced in Illinois, Kentucky and Mississippi
- contract awards and geographic expansion in Texas
- expanded contract awards in Arizona

RESULTS OF OPERATIONS

The following discussion and analysis is based on our consolidated statements of operations, which reflect our results of operations for the years ended December 31, 2012, 2011 and 2010, prepared in accordance with generally accepted accounting principles in the United States.

Summarized comparative financial data for the years ended December 31, 2012, 2011 and 2010 is as follows ($ in millions):

	2012	2011	2010	% Change 2011-2012	% Change 2010-2011
Premium	$8,126.2	$5,077.2	$4,192.2	60.1%	21.1%
Service	112.7	103.8	91.6	8.7%	13.2%
Premium and service revenues	8,238.9	5,181.0	4,283.8	59.0%	20.9%
Premium tax	428.7	159.6	164.5	168.6%	(3.0)%
Total revenues	8,667.6	5,340.6	4,448.3	62.3%	20.1%
Medical costs	7,446.0	4,324.8	3,584.5	72.2%	20.7%
Cost of services	87.7	78.1	63.9	12.3%	22.2%
General and administrative expenses	704.6	587.0	477.7	20.0%	22.9%
Premium tax expense	428.4	160.4	165.1	167.1%	(2.9)%
Impairment loss	28.0	—	—	—%	—%
Earnings (loss) from operations	(27.1)	190.3	157.1	(114.2)%	21.2%
Investment and other income, net	15.5	(15.4)	(2.8)	(200.4)%	454.0%
Earnings (loss) from continuing operations, before income tax expense	(11.6)	174.9	154.3	(106.6)%	13.4%
Income tax expense (benefit)	(0.3)	66.5	59.9	(100.5)%	11.1%
Earnings (loss) from continuing operations, net of income tax	(11.3)	108.4	94.4	(110.4)%	14.8%
Discontinued operations, net of income tax expense of $0, $0, and $4.4 respectively	—	—	3.9	—%	(100.0)%
Net earnings (loss)	(11.3)	108.4	98.3	(110.4)%	10.3%
Noncontrolling interest	(13.2)	(2.8)	3.5	360.7%	(183.1)%
Net earnings attributable to Centene Corporation	$ 1.9	$ 111.2	$ 94.8	(98.3)%	17.3%
Amounts attributable to Centene Corporation common shareholders:					
Earnings from continuing operations, net of income tax expense	$ 1.9	$ 111.2	$ 90.9	(98.3)%	22.3%
Discontinued operations, net of income tax expense	—	—	3.9	—	(100.0)%
Net earnings	$ 1.9	$ 111.2	$ 94.8	(98.3)%	17.3%
Diluted earnings per common share attributable to Centene Corporation:					
Continuing operations	$ 0.03	$ 2.12	$ 1.80	(98.6)%	17.8%
Discontinued operations	—	—	0.08	—%	(100.0)%
Total diluted earnings per common share	$ 0.03	$ 2.12	$ 1.88	(98.6)%	12.8%

Revenues and Revenue Recognition

Our health plans generate revenues primarily from premiums we receive from the states in which we operate. We generally receive a fixed premium per member per month pursuant to our state contracts. We generally receive premium payments and recognize premium revenue during the month in which we are obligated to provide services to our members. In some instances, our base premiums are subject to an adjustment, or risk score, based on the acuity of our membership. Generally, the risk score is determined by the state analyzing submissions of processed claims data to determine the acuity of our membership relative to the entire state's membership. Some contracts allow for additional premiums associated with certain supplemental services provided such as maternity deliveries. For performance-based contracts, we do not recognize revenue subject to refund until data is sufficient to measure performance.

Revenues are recorded based on membership and eligibility data provided by the states, which is adjusted on a monthly basis by the states for retroactive additions or deletions to membership data. These eligibility adjustments are estimated monthly and subsequently adjusted in the period known. We continuously review and update those estimates as new information becomes available. It is possible that new information could require us to make additional adjustments, which could be significant, to these estimates.

Our specialty services generate revenues under contracts with state programs, healthcare organizations, and other commercial organizations, as well as from our own subsidiaries. Revenues are recognized when the related services are provided or as ratably earned over the covered period of services.

Premium and service revenues collected in advance are recorded as unearned revenue. Premium and service revenues due to us are recorded as premium and related receivables and are recorded net of an allowance based on historical trends and our management's judgment on the collectibility of these accounts. As we generally receive payments during the month in which services are provided, the allowance is typically not significant in comparison to total revenues and does not have a material impact on the presentation of our financial condition or results of operations.

Some states enact premium taxes, similar assessments and provider and hospital pass-through payments, collectively, premium taxes, and these taxes are recorded as a component of revenues as well as operating expenses. We exclude premium taxes from our key ratios as we believe the premium tax is a pass-through of costs and not indicative of our operating performance.

The Centers for Medicare and Medicaid Services (CMS) deploys a risk adjustment model that retroactively apportions Medicare premiums paid according to health severity and certain demographic factors. The model pays more for members whose medical history indicates they have certain medical conditions. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient, physician treatment settings as well as prescription drug events. The Company estimates the amount of risk adjustment based upon the diagnosis and pharmacy data submitted and expected to be submitted to CMS and records revenues on a risk adjusted basis.

Operating Expenses

Medical Costs

Medical costs include payments to physicians, hospitals, and other providers for healthcare and specialty services claims. Medical costs also include estimates of medical expenses incurred but not yet reported, or IBNR, and estimates of the cost to process unpaid claims. We use our judgment to determine the assumptions to be used in the calculation of the required IBNR estimate. The assumptions we consider include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims.

Our development of the IBNR estimate is a continuous process which we monitor and refine on a monthly basis as claims receipts and payment information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expense in the period in which the changes are identified.

Additionally, we contract with independent actuaries to review our estimates on a quarterly basis. The independent actuaries provide us with a review letter that includes the results of their analysis of our medical claims liability. We do not solely rely on their report to adjust our claims liability. We utilize their calculation of our claims liability only as additional information, together with management's judgment, to determine the assumptions to be used in the calculation of our liability for medical costs.

While we believe our IBNR estimate is appropriate, it is possible future events could require us to make significant adjustments for revisions to these estimates. Accordingly, we cannot assure you that medical costs will not materially differ from our estimates.

Results of operations depend on our ability to manage expenses associated with health benefits and to accurately predict costs incurred. The health benefits ratio, or HBR, represents medical costs as a percentage of premium revenues (excluding premium taxes) and reflects the direct relationship between the premium received and the medical services provided.

Cost of Services

Cost of services expense includes the pharmaceutical costs associated with our pharmacy benefit manager's external revenues and certain direct costs to support the functions responsible for generation of our service revenues. These expenses consist of the salaries and wages of the professionals who provide the services and associated expenses.

General and Administrative Expenses

General and administrative expenses, or G&A, primarily reflect wages and benefits, including stock compensation expense, and other administrative costs associated with our health plans, specialty companies and centralized functions that support all of our business units. Our major centralized functions are finance, information systems and claims processing. G&A expenses also include business expansion costs, such as wages and benefits for administrative personnel, contracting costs, and information technology buildouts, incurred prior to the commencement of a new contract or health plan.

The G&A expense ratio represents G&A expenses as a percentage of premium and service revenues, and reflects the relationship between revenues earned and the costs necessary to earn those revenues.

Other Income (Expense)

Other income (expense) consists principally of investment income from cash and investments, earnings in equity method investments, and interest expense on debt.

Discontinued Operations

In November 2008, we announced our intention to sell certain assets of UHP, our New Jersey health plan. Accordingly, the results of operations for UHP are reported as discontinued operations for all periods presented. We completed the sale in the first quarter of 2010.

Year Ended December 31, 2012 Compared to Year Ended December 31, 2011

Premium and Service Revenues

Premium and service revenues increased 59.0% in the year ended December 31, 2012 over the corresponding period in 2011 as a result of the additional revenue from our Illinois, Kentucky, Louisiana, Mississippi, Missouri and Washington contracts, Texas and Arizona expansions, pharmacy carve-ins in Texas and Ohio, and organic membership growth. During the year ended December 31, 2012, we received premium rate adjustments which yielded a net 2.5% composite increase across all of our markets.

The State of Georgia maintains a reconciliation process associated with membership eligibility and has continued to reconcile membership from previous periods as far back as 2006. The amount of any reduction to revenue related to this review is subject to consideration of rate adequacy calculations, as part of actuarially sound standards, for the appropriate periods. We have estimated the revenue impact related to reconciliation adjustments to the retroactive eligibility reductions due to the state and have adjusted our accrual in our consolidated financial statements. There can be no assurance that future adjustment of amounts related to membership reconciliations will not have a material adverse effect on the Company.

Premium Tax Revenue

Premium tax revenue increased 168.6% in the year ended December 31, 2012 over the corresponding period in 2011 as a result of one of our states paying us approximately $180 million during the year to immediately pass through to specified providers.

Operating Expenses

Medical Costs

The table below depicts the HBR for our membership by member category for the year ended December 31:

	2012	2011
Medicaid and CHIP	91.2%	82.4%
ABD and Medicare	92.1	89.8
Specialty Services	92.5	89.1
Total	91.6	85.2

The consolidated HBR for the year ended December 31, 2012, of 91.6% was an increase of 640 basis points over the comparable period in 2011. The increase compared to last year primarily reflects (1) the continued high level of medical costs in Kentucky including a $41.5 million premium deficiency reserve for for the contract period January 1, 2013 through July 5, 2013, (2) a high level of medical costs in the March 1, 2012 expansion areas in Texas, (3) a high level of medical costs in our individual health business, especially for policies issued to members who converted in the first quarter of 2012 and (4) a high level of flu costs during the fourth quarter of 2012. Excluding our Kentucky operations, the HBR for the year ended December 31, 2012, was 89.6% compared to 84.7% for the year ended December 31, 2011.

General & Administrative Expenses

General and administrative expenses, or G&A, increased by $117.6 million in the year ended December 31, 2012, compared to the corresponding period in 2011. This was primarily due to expenses for additional staff and facilities to support our membership growth, partially offset by a reduction in performance based compensation expense in 2012.

The consolidated G&A expense ratio for the years ended December 31, 2012 and 2011 was 8.6% and 11.3% respectively. The year over year decrease in the G&A expense ratio reflects the leveraging of expenses over higher revenues in 2012 and a reduction in performance based compensation expense in 2012 which lowered the G&A expense ratio by approximately 60 basis points.

Impairment Loss

During 2011, the Company completed its annual goodwill and intangible asset impairment testing and concluded that the fair value of all reporting units with material amounts of goodwill was substantially in excess of the carrying value as of our impairment testing date. Specifically, the Company tested its Celtic reporting unit under a quantitative model which included anticipated financial performance for new business to be converted in 2012. Under the quantitative model, the testing revealed that the carrying value exceeded fair value of the Celtic reporting unit by approximately 190%.

During the second quarter of 2012, our subsidiary, Celtic Insurance Company, experienced a high level of medical costs for individual health policies, especially for recently issued policies related to members converted from another insurer during the first quarter of 2012. Additionally, in June 2012, the U.S. Supreme Court upheld the constitutionality of the Patient Protection and Affordable Care Act. The Affordable Care Act, among other things, limits the profitability of the individual health insurance business because of minimum medical loss ratios, guaranteed issue policies, and increased competition in the exchange market. As a result of these factors, our expectations for future growth and profitability were lower than previous estimates and we conducted an impairment analysis of the identifiable intangible assets and goodwill of the Celtic reporting unit. The impairment analysis resulted in goodwill and intangible asset impairments of $28.0 million, recorded as an impairment loss in the consolidated statement of operations. The impaired identifiable intangible assets of $2.3 million and goodwill of $25.7 million were reported under the Specialty Services segment; $26.6 million of the impairment loss is not deductible for income tax purposes.

Other Income (Expense)

The following table summarizes the components of other income (expense) for the year ended December 31, ($ in millions):

	2012	2011
Investment income	$ 16.6	$ 13.1
Gain on sale of investments	1.5	0.3
Gain on sale of investment in convertible note	17.9	—
Debt extinguishment costs	—	(8.5)
Interest expense	(20.5)	(20.3)
Other income (expense), net	$ 15.5	$(15.4)

Investment income. The increase in investment income in 2012 primarily reflects higher investment balances in 2012.

Gain on sale of investments. During the year ended December 31, 2012, we recognized $1.5 million in net gains primarily as a result of the liquidation of $75.5 million of investments held by the Georgia health plan in order to meet short-term liquidity needs due to delays in premium receipts from the state.

Gain on sale of investment in convertible note. Between July 2008 and October 2011, we made an investment of $30.0 million in secured notes receivable to a third party as part of an investment in certain Medicaid and Medicare related businesses. The notes included a feature to convert the note balance into an equity ownership in the underlying businesses. In September 2012, we executed an agreement with the borrower whereby the borrower agreed to pay us total consideration of $50.0 million for retirement of the outstanding notes and equity ownership conversion feature. As a result, during the third quarter of 2012, we recorded a pre-tax gain of $17.9 million in other income representing the fair value of the total consideration in excess of the carrying value of the loans on the balance sheet.

Interest expense. Interest expense increased during the year ended December 31, 2012 by $0.2 million reflecting the issuance of an additional $175 million in Senior Notes in November 2012, partially offset by the refinancing of our $250 million Senior Notes and execution of the associated interest rate swap agreement in May 2011.

Income Tax Expense

In the year ended December 31, 2012, we recorded a tax benefit of $0.3 million compared to tax expense of $66.5 million in the corresponding period in 2011. The tax benefit for the year ended December 31, 2012 primarily resulted from decreased earnings in 2012 and a tax benefit resulting from the clarification by a state taxing authority regarding a state income tax calculation. Accordingly, we reversed the reserve associated with the uncertain tax position and recognized a net tax benefit of $5.8 million. These tax benefits were partially offset by Celtic's non-deductible goodwill impairment recorded in the second quarter of 2012.

Noncontrolling Interest

In the year ended December 31, 2012, we recorded a $13.2 million add back of expense attributable to noncontrolling interest in our Louisiana and Missouri health plans and Casenet. During the fourth quarter of 2012, we acquired the remaining ownership interest in Casenet and our Louisiana health plan, bringing our ownership to 100%. In the year ended December 31, 2011, we recorded a $2.9 million reduction in earnings attributable to the noncontrolling interest in Casenet.

Segment Results

The following table summarizes our operating results by segment for the year ended December 31, (in millions):

	2012	2011	% Change 2011-2012
Premium and Service Revenues			
Medicaid Managed Care	$ 7,483.3	$4,515.5	65.7%
Specialty Services	2,550.9	1,484.3	71.9%
Eliminations	(1,795.3)	(818.8)	119.3%
Consolidated Total	$ 8,238.9	$5,181.0	59.0%
Earnings (Loss) from Operations			
Medicaid Managed Care	$ (83.2)	$ 153.0	(154.4)%
Specialty Services	56.1	37.3	50.2%
Consolidated Total	$ (27.1)	$ 190.3	(114.2)%

Medicaid Managed Care

Premium and service revenues increased 65.7% in the year ended December 31, 2012, due to the addition of our Illinois, Kentucky, Louisiana, Mississippi, Missouri and Washington contracts, Texas expansion, pharmacy carve-ins in Texas and Ohio, and organic membership growth. Earnings from operations decreased $236.2 million in the year ended December 31, 2012, primarily due to higher medical costs in our Texas health plan specifically in the expansion areas, a premium deficiency reserve of $41.5 million recorded for our Kentucky health plan contract, an operating loss in our Kentucky health plan and increased flu costs during the fourth quarter of 2012.

Specialty Services

Premium and service revenues increased 71.9% in the year ended December 31, 2012, due to (1) the carve-in of pharmacy services in Texas and Ohio, (2) Specialty Company revenue related to the growth in our Medicaid segment and the associated specialty services provided to this increased membership and (3) the Arizona expansion. Earnings from operations increased $18.8 million in the year ended December 31, 2012, reflecting growth in our pharmacy business and the associated specialty services provided to our increased Medicaid membership, partially offset by the impairment loss of $28.0 million recorded in the second quarter of 2012 and a high level of medical costs in Celtic Insurance Company, especially for members converted in the first quarter of 2012.

Year Ended December 31, 2011 Compared to Year Ended December 31, 2010

Revenues

Premium and service revenues increased 20.9% in 2011 over 2010 as a result of membership growth discussed under the heading "Membership". The premium rates specified in our state contracts are generally updated on an annual basis through contract amendments. In 2011, we received premium rate adjustments which yielded a net 0.9% composite decrease across all of our markets.

Operating Expenses

Medical Costs

The table below depicts the HBR for our membership by member category for the year ended December 31,:

	2011	2010
Medicaid and CHIP	82.4%	85.0%
ABD and Medicare	89.8	87.1
Specialty Services	89.1	86.2
Total	85.2	85.5

The consolidated HBR of 85.2% for 2011 represented a 0.3% decrease from the 2010 consolidated HBR of 85.5%. The decrease is primarily due to lower levels of utilization and contract enhancements.

General and Administrative Expenses

The consolidated G&A expense ratio for the years ended December 31, 2011 and 2010 was 11.3% and 11.2%, respectively. The increase in the ratio in 2011 primarily reflects increased business expansion costs to support new business in Illinois, Kentucky, Louisiana and Texas, partially offset by the leveraging of our expenses over higher revenues.

Investment and Other Income, Net

The following table summarizes the components of other income (expense) for the year ended December 31, ($ in millions):

	2011	2010
Investment income	$ 13.1	$ 14.9
Gain on sale of investments	0.3	2.5
Impairment of investment	—	(5.5)
Gain on Reserve Primary Fund distributions	—	3.3
Debt extinguishment costs	(8.5)	—
Interest expense	(20.3)	(18.0)
Other income (expense), net	$(15.4)	$ (2.8)

Investment income. The decrease in investment income in 2011 reflects the continued low market interest rates, partially offset by an increase in investment balances.

Net gain on sale of investments. As a result of tightening our investment criteria for municipal securities, we sold municipal securities resulting in net gains of $2.5 million during 2010.

Impairment of investment. During 2010, we determined we had an other-than-temporary impairment of our cost method investment in Casenet, LLC, and recorded an impairment charge of $5.5 million.

Gain on Reserve Primary Fund distributions. In 2010, we received distributions from the Reserve Primary Fund of $5.7 million resulting in a gain of $3.3 million recorded for the distributions received in excess of our adjusted basis.

Debt extinguishment costs. In May 2011, the Company redeemed its $175.0 million 7.25% Senior Notes due April 1, 2014 at 103.625% and wrote off unamortized debt issuance costs. Debt extinguishment costs totaled $8.5 million, or $0.10 per diluted share.

Interest expense. Interest expense for 2011 increased by $2.3 million from 2010 primarily due to borrowings on the mortgage loan associated with the real estate development including our corporate headquarters. The real estate development was placed in service in the third quarter of 2010 and, accordingly, we

ceased capitalizing interest on the project. The increase in interest expense was partially offset by reduced interest expense reflecting the refinancing of our Senior Notes and lower interest rate as a result of the execution of the associated interest rate swap agreements in 2011.

Income Tax Expense

Excluding the amounts attributable to noncontrolling interest, our effective tax rate in 2011 was 37.4% compared to 39.7% in 2010. The decrease in the effective tax rate was driven by a higher rate in 2010 resulting from legislation enacted in May 2010 in the state of Georgia which replaced the state income tax with a premium tax for Medicaid managed care organizations effective July 1, 2010. Accordingly, a deferred tax asset of $1.7 million related to Georgia state net operating loss carry forwards was written off during 2010. Additionally, the higher effective tax rate in 2010 was also related to a decrease in tax exempt interest and an increase in state income taxes.

Segment Results

The following table summarizes our operating results by segment for the year ended December 31, (in millions):

	2011	2010	% Change 2010-2011
Premium and Service Revenues			
Medicaid Managed Care	$4,515.5	$3,740.5	20.7%
Specialty Services	1,484.3	1,112.1	33.5%
Eliminations	(818.8)	(568.8)	44.0%
Consolidated Total	$5,181.0	$4,283.8	20.9%
Earnings from Operations			
Medicaid Managed Care	$ 153.0	$ 117.1	30.6%
Specialty Services	37.3	40.0	(6.6)%
Consolidated Total	$ 190.3	$ 157.1	21.1%

Medicaid Managed Care

Premium and service revenues increased 20.7% in 2011 due to the addition of the Mississippi, Illinois and Kentucky contracts, the Texas market expansion, and overall membership growth. Earnings from operations increased 30.6% in 2011 reflecting overall growth in our membership, reduced HBR and leveraging of our general and administrative expenses.

Specialty Services

Premium and service revenues increased 33.5% in 2011 primarily due to the growth in our Medicaid segment and the associated specialty services provided to this increased membership. Earnings from operations decreased 6.6% in 2011 reflecting the addition of the care management software business which operates at a loss and lower earnings in our individual health insurance business.

LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows for the years ended December 31, 2012, 2011 and 2010, used in the discussion of liquidity and capital resources ($ in millions).

	Year Ended December 31,		
	2012	2011	2010
Net cash provided by operating activities	$ 278.7	$ 261.7	$ 168.9
Net cash used in investing activities	(187.9)	(129.1)	(210.6)
Net cash provided by financing activities	179.5	6.9	72.1
Net increase in cash and cash equivalents	$ 270.3	$ 139.5	$ 30.4

Cash Flows Provided by Operating Activities

Normal operations are funded primarily through operating cash flows and borrowings under our revolving credit facility. Operating activities provided cash of $278.7 million in 2012, compared to $261.7 million in 2011 and $168.9 million in 2010.

Cash flows from operations in each year were impacted by the timing of payments we receive from our states. States may prepay the following month premium payment, which we record as unearned revenue, or they may delay our premium payment, which we record as a receivable. We typically receive capitation payments monthly, however the states in which we operate may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period. The table below details the impact to cash flows from operations from the timing of payments from our states ($ in millions).

	Year Ended December 31,		
	2012	2011	2010
Premium and related receivables	$(116.6)	$ (11.3)	$(23.4)
Unearned revenue	24.7	(109.1)	25.7
Net (decrease) increase in operating cash flow	$ (91.9)	$(120.4)	$ 2.3

The cash provided by operations in 2012 was primarily related to an increase in medical claims liabilities related to the start up of our Louisiana, Missouri and Washington plans and the expansion of our Texas health plan as well as pre-payment of premiums in one of our states at December 31, 2012, partially offset by increases in premium and related receivables resulting from our health plan growth in 2012.

Net cash provided by operating activities in 2011 was negatively impacted by the timing of payments from our states by $120.4 million. As of December 31, 2011, we had received all December 2011 capitation payments from our states and had not received any prepayments of January 2012 capitation. This was offset by an increase in medical claims liabilities related to the start up of our Mississippi, Illinois and Kentucky health plans, as well as expansion of our Texas health plan in 2011.

Net cash provided by operating activities benefited in 2010 as a result of prepayments from several of our states. Cash flows from operations in 2010 also reflected an increase in premium and related receivables and medical claims liability primarily due to increased business in Florida, Massachusetts and South Carolina.

Cash Flows Used in Investing Activities

Investing activities used cash of $187.9 million in 2012, $129.1 million in 2011 and $210.6 million in 2010. Cash flows from investing activities in 2012 and 2011 primarily consisted of additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long-term investments, and capital expenditures.

Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets within our guidelines. Net cash provided by and used in investing activities will fluctuate from year to year due to the timing of investment purchases, sales and maturities. As of December 31, 2012, our investment portfolio consisted primarily of fixed-income securities with an average duration of 2.6 years. These securities generally are actively traded in secondary markets and the reported fair market value is determined based on recent trading activity, recent trading activity in similar securities and other observable inputs. Our investment guidelines comply with the regulatory restrictions enacted in each state. We had unregulated cash and investments of $37.3 million at December 31, 2012, compared to $38.3 million at December 31, 2011.

We spent $82.1 million, $73.7 million and $118.6 million in 2012, 2011 and 2010 respectively, on capital expenditures for system enhancements, a new datacenter and market expansions including $20.9 million in 2012 for land in close proximity to our corporate headquarters to support future growth and $55.3 million in 2010 for a real estate development that included the Company's corporate headquarters. We anticipate spending approximately $75 million on capital expenditures in 2013 primarily associated with system enhancements and market expansions.

Cash Flows Provided by Financing Activities

Our financing activities provided cash of $179.5 million, $6.9 million and $72.1 million in 2012, 2011 and 2010 respectively. Financing activities in 2012, 2011 and 2010 are discussed below.

2012. In November 2012, pursuant to a shelf registration statement, we issued an additional $175 million of non-callable 5.75% Senior Notes due June 1, 2017 ($175 million Add-on Notes) at a premium to yield 4.29%. The indenture governing the $175 million Add-on Notes contains non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio. Interest is paid semi-annually in June and December. We used the net proceeds from the offering to make capital contributions to our regulated subsidiaries.

2011. In January 2011, we replaced our $300 million revolving credit agreement with a new $350 million revolving credit facility, or the revolver. The revolver is unsecured and has a five-year maturity with non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt to EBITDA ratios and minimum net worth. Borrowings under the revolver will bear interest based upon LIBOR rates, the Federal funds rate, or the prime rate. There is a commitment fee on the unused portion of the agreement that ranges from 0.25% to 0.50% depending on the total debt to EBITDA ratio.

In May 2011, we exercised our option to redeem the $175 million 7.25% Senior Notes due April 1, 2014 ($175 million Notes). We redeemed the $175 million Notes at 103.625% and wrote off unamortized debt issuance costs, resulting in a pre-tax expense of $8.5 million.

In May 2011, pursuant to a shelf registration statement, we issued $250 million of non-callable 5.75% Senior Notes due June 1, 2017 ($250 million Notes) at a discount to yield 6%. The indenture governing the $250 million Notes contains non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio. Interest is paid semi-annually in June and December. We used a portion of the net proceeds from the offering to repay the $175 million Notes and call premium and to repay approximately $50 million outstanding on our revolving credit facility. The additional proceeds were used for general corporate purposes. In connection with the issuance, we entered into $250 million notional amount of interest rate swap agreements (Swap Agreements) that are scheduled to expire June 1, 2017. Under the Swap Agreements, we receive a fixed rate of 5.75% and pay a variable rate of LIBOR plus 3.5% adjusted quarterly, which allows us to adjust the $250 million Notes to a floating rate. We do not hold or issue any derivative instrument for trading or speculative purposes.

2010. During the first quarter of 2010, we completed the sale of 5.75 million shares of common stock for $19.25 per share. Net proceeds from the sale of the shares were approximately $104.5 million. A portion of the net proceeds was used to repay the outstanding indebtedness under our $300 million revolving credit loan facility ($84.0 million as of December 31, 2009). The remaining net proceeds were used to fund our acquisition in South Carolina as well as capital expenditures.

Liquidity Metrics

As of December 31, 2012, we had no borrowings outstanding under our $350 million revolving credit facility, leaving availability of $350.0 million, and we were in compliance with all covenants. We had outstanding letters of credit of $17.3 million as of December 31, 2012, which are not part of our revolving credit facility. The letters of credit bore interest at 1.07% as of December 31, 2012.

Under the terms of our revolving credit facility debt covenants at December 31, 2012, we were required to maintain a maximum total debt to EBITDA ratio of 2.75. As of December 31, 2012, our borrowing availability under our revolving credit facility would have been limited as a result of this ratio. In February 2013, we amended our $350 million revolving credit facility to add an additional pricing tier, increase the maximum total debt to EBITDA ratio during the first three quarters of 2013 to provide for increased borrowing availability and change the maximum total debt to EBITDA ratio to 3.0 as of December 31, 2013 and thereafter.

At December 31, 2012, we had working capital, defined as current assets less current liabilities, of $176.5 million, as compared to $102.4 million at December 31, 2011. We manage our short-term and long-term investments with the goal of ensuring that a sufficient portion is held in investments that are highly liquid and can be sold to fund short-term requirements as needed.

At December 31, 2012, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 36.1%, compared to 27.3% at December 31, 2011. Excluding the $75.4 million non-recourse mortgage note, our debt to capital ratio is 32.7%, compared to 22.6% at December 31, 2011. We utilize the debt to capital ratio as a measure, among others, of our leverage and financial flexibility.

We have a stock repurchase program authorizing us to repurchase up to four million shares of common stock from time to time on the open market or through privately negotiated transactions. No duration has been placed on the repurchase program. We reserve the right to discontinue the repurchase program at any time. We did not make any repurchases under this plan during 2012 or 2011.

During the year ended December 31, 2012, 2011 and 2010, we received dividends of $29.0 million, $69.1 million, $67.9 million, respectively, from our regulated subsidiaries.

2013 Expectations

In January 2013, we signed a definitive agreement to acquire AcariaHealth, one of the nation's largest, independent, comprehensive specialty pharmacy companies for $152.0 million. The transaction consideration is anticipated to be financed through a combination of approximately 60% Centene common stock with the remainder from cash on hand and existing credit facilities. The acquisition is expected to close in the first quarter of 2013, subject to regulatory approval and other customary conditions.

We expect to make capital contributions to our insurance subsidiaries of approximately $450 million during 2013 associated with our growth. These capital contributions are expected to be funded by unregulated cash flow generation in 2013 and borrowings on our revolving credit facility.

Based on our operating plan, we expect that our available cash, cash equivalents and investments, cash from our operations and cash available under our credit facility, along with the issuance of shares of Centene common stock in connection with the acquisition of AcariaHealth discussed above will be sufficient to finance our general operations, planned acquisition of AcariaHealth and capital expenditures for at least 12 months from the date of this filing.

CONTRACTUAL OBLIGATIONS

The following table summarizes future contractual obligations. These obligations contain estimates and are subject to revision under a number of circumstances. Our debt consists of borrowings from our senior notes, credit facility, mortgages and capital leases. The purchase obligations consist primarily of software purchase and maintenance contracts. The contractual obligations and estimated period of payment over the next five years and beyond are as follows (in thousands):

	Payments Due by Period				
	Total	Less Than 1 Year	1-3 Years	3-5 Years	More Than 5 Years
Medical claims liability	$ 926,302	$ 926,302	$ —	$ —	$ —
Debt and interest	665,669	31,893	70,750	475,109	87,917
Operating lease obligations	102,941	22,053	38,398	28,595	13,895
Purchase obligations	46,716	20,184	25,536	832	164
Other long-term liabilities [1]	—	—	—	—	—
Total	$1,741,628	$1,000,432	$134,684	$504,536	$101,976

[1] Our Consolidated Balance Sheet as of December 31, 2012 includes $55,344 of other long-term liabilities. This consists primarily of long-term deferred income taxes, liabilities under our deferred compensation plan, and reserves for uncertain tax positions. These liabilities have been excluded from the table above as the timing and/or amount of any cash payment is uncertain. As of December 31, 2012 , reserves for uncertain tax positions totaled $7,870. See the "Income Taxes" footnote for additional information regarding our deferred tax positions and accruals for uncertain tax positions. Other long-term liabilities also includes $7,487 separate account liabilities from third party reinsurance that will not be settled in cash.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

Our operations are conducted through our subsidiaries. As managed care organizations, these subsidiaries are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us. Generally, the amount of dividend distributions that may be paid by a regulated subsidiary without prior approval by state regulatory authorities is limited based on the entity's level of statutory net income and statutory capital and surplus.

Our subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of December 31, 2012, our subsidiaries had aggregate statutory capital and surplus of $990.3 million, compared with the required minimum aggregate statutory capital and surplus requirements of $617.0 million. Excluding our Kentucky health plan, we estimate our Risk Based Capital, or RBC, percentage to be in excess of 350% of the Authorized Control Level.

The National Association of Insurance Commissioners has adopted rules which set minimum risk-based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. As of December 31, 2012, each of our health plans was in compliance with the risk-based capital requirements enacted in those states.

RECENT ACCOUNTING PRONOUNCEMENTS

For this information, refer to Note 2, *Summary of Significant Accounting Policies*, in the Notes to the Consolidated Financials Statements, included herein.

CRITICAL ACCOUNTING POLICIES AND ESTIMATES

Our discussion and analysis of our results of operations and liquidity and capital resources are based on our consolidated financial statements which have been prepared in accordance with GAAP. Our significant accounting policies are more fully described in Note 2, *Summary of Significant Accounting Policies,* to our consolidated financial statements included elsewhere herein. Our accounting policies regarding medical claims

liability and intangible assets are particularly important to the portrayal of our financial position and results of operations and require the application of significant judgment by our management. As a result, they are subject to an inherent degree of uncertainty. We have reviewed these critical accounting policies and related disclosures with the Audit Committee of our Board of Directors.

Medical claims liability

Our medical claims liability includes claims reported but not yet paid, or inventory, estimates for claims incurred but not reported, or IBNR, and estimates for the costs necessary to process unpaid claims at the end of each period. We estimate our medical claims liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors.

Actuarial Standards of Practice generally require that the medical claims liability estimates be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate. In many situations, the claims amounts ultimately settled will be different than the estimate that satisfies the Actuarial Standards of Practice. We include in our IBNR an estimate for medical claims liability under moderately adverse conditions which represents the risk of adverse deviation of the estimates in our actuarial method of reserving.

We use our judgment to determine the assumptions to be used in the calculation of the required estimates. The assumptions we consider when estimating IBNR include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to fee schedules, and the incidence of high dollar or catastrophic claims.

We apply various estimation methods depending on the claim type and the period for which claims are being estimated. For more recent periods, incurred non-inpatient claims are estimated based on historical per member per month claims experience adjusted for known factors. Incurred hospital inpatient claims are estimated based on known inpatient utilization data and prior claims experience adjusted for known factors. For older periods, we utilize an estimated completion factor based on our historical experience to develop IBNR estimates. The completion factor is an actuarial estimate of the percentage of claims incurred during a given period that have been received or adjudicated as of the reporting period to the estimate of the total ultimate incurred costs. When we commence operations in a new state or region, we have limited information with which to estimate our medical claims liability. See "Risk Factors — Failure to accurately predict our medical expenses could negatively affect our financial position, results of operations or cash flows." These approaches are consistently applied to each period presented.

Additionally, we contract with independent actuaries to review our estimates on a quarterly basis. The independent actuaries provide us with a review letter that includes the results of their analysis of our medical claims liability. We do not solely rely on their report to adjust our claims liability. We utilize their calculation of our claims liability only as additional information, together with management's judgment, to determine the assumptions to be used in the calculation of our liability for claims.

Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as additional claims receipts and payment information becomes available. As more complete claim information becomes available, we adjust the amount of the estimates, and include the changes in estimates in medical costs in the period in which the changes are identified. In every reporting period, our operating results include the effects of more completely developed medical claims liability estimates associated with previously reported periods. We consistently apply our reserving methodology from period to period. As additional information becomes known to us, we adjust our actuarial models accordingly to establish medical claims liability estimates.

The paid and received completion factors, claims per member per month and per diem cost trend factors are the most significant factors affecting the IBNR estimate. The following table illustrates the sensitivity of these factors and the estimated potential impact on our operating results caused by changes in these factors based on December 31, 2012 data:

Completion Factors[1]:		Cost Trend Factors[2]:	
(Decrease) Increase in Factors	Increase (Decrease) in Medical	(Decrease) Increase in Factors	Increase (Decrease) in Medical
	(in thousands)		(in thousands)
(2.0)%	$ 107,600	(2.0)%	$(31,700)
(1.5)	80,300	(1.5)	(23,900)
(1.0)	53,300	(1.0)	(15,900)
(0.5)	26,500	(0.5)	(8,100)
0.5	(26,300)	0.5	8,100
1.0	(52,200)	1.0	16,000
1.5	(77,900)	1.5	24,200
2.0	(103,300)	2.0	32,200

(1) Reflects estimated potential changes in medical claims liability caused by changes in completion factors.
(2) Reflects estimated potential changes in medical claims liability caused by changes in cost trend factors for the most recent periods.

While we believe our estimates are appropriate, it is possible future events could require us to make significant adjustments for revisions to these estimates. For example, a 1% increase or decrease in our estimated medical claims liability would have affected net earnings by $5.8 million for the year ended December 31, 2012. The estimates are based on our historical experience, terms of existing contracts, our observance of trends in the industry, information provided by our providers and information available from other outside sources.

The change in medical claims liability is summarized as follows (in thousands):

	Year Ended December 31,		
	2012	2011	2010
Balance, January 1,	$ 607,985	$ 456,765	$ 470,932
Incurred related to:			
Current year	7,499,437	4,390,123	3,652,521
Prior years[1]	(53,400)	(65,377)	(68,069)
Total incurred	7,446,037	4,324,746	3,584,452
Paid related to:			
Current year	6,535,537	3,788,808	3,203,585
Prior years	550,708	384,718	395,034
Total paid	7,086,245	4,173,526	3,598,619
Less: Premium deficiency reserve	41,475	—	—
Balance, December 31,	$ 926,302	$ 607,985	$ 456,765
Claims inventory, December 31	641,000	495,500	434,900
Days in claims payable[2]	41.1	45.3	44.7

1 Excluding the impact of the medical costs related to the retroactive assignment of members in our Kentucky health plan, the amount of "Incurred related to: Prior years" shown for 2012 in the table above would have been $(61.7) million.
2 Days in claims payable is a calculation of medical claims liability at the end of the period divided by average expense per calendar day for the fourth quarter of each year, excluding the Kentucky premium deficiency reserve liability.

Medical claims are usually paid within a few months of the member receiving service from the physician or other healthcare provider. As a result, the liability generally is described as having a "short-tail," which causes less than 5% of our medical claims liability as of the end of any given year to be outstanding the following year. We believe that substantially all the development of the estimate of medical claims liability as of December 31, 2012 will be known by the end of 2013.

Changes in estimates of incurred claims for prior years are primarily attributable to reserving under moderately adverse conditions. In addition, claims processing initiatives yielded increased claim payment recoveries and coordination of benefits related to prior year dates of service. Changes in medical utilization and cost trends and the effect of medical management initiatives may also contribute to changes in medical claim liability estimates. While we have evidence that medical management initiatives are effective on a case by case basis, medical management initiatives primarily focus on events and behaviors prior to the incurrence of the medical event and generation of a claim. Accordingly, any change in behavior, leveling of care, or coordination of treatment occurs prior to claim generation and as a result, the costs prior to the medical management initiative are not known by us. Additionally, certain medical management initiatives are focused on member and provider education with the intent of influencing behavior to appropriately align the medical services provided with the member's acuity. In these cases, determining whether the medical management initiative changed the behavior cannot be determined. Because of the complexity of our business, the number of states in which we operate, and the volume of claims that we process, we are unable to practically quantify the impact of these initiatives on our changes in estimates of IBNR.

The following are examples of medical management initiatives that may have contributed to the favorable development through lower medical utilization and cost trends:

- Appropriate leveling of care for neonatal intensive care unit hospital admissions, other inpatient hospital admissions, and observation admissions, in accordance with Interqual criteria.
- Tightening of our pre-authorization list and more stringent review of durable medical equipment and injectibles.
- Emergency department, or ED, program designed to collaboratively work with hospitals to steer non-emergency care away from the costly ED setting (through patient education, on-site alternative urgent care settings, etc.)
- Increase emphasis on case management and clinical rounding where case managers are nurses or social workers who are employed by the health plan to assist selected patients with the coordination of healthcare services in order to meet a patient's specific healthcare needs.
- Incorporation of disease management which is a comprehensive, multidisciplinary, collaborative approach to chronic illnesses such as asthma.
- Prenatal and infant health programs utilized in our *Start Smart For Your Baby* outreach service.

Goodwill and Intangible Assets

We have made several acquisitions that have resulted in our recording of intangible assets. These intangible assets primarily consist of customer relationships, purchased contract rights, provider contracts, trade names and goodwill. At December 31, 2012, we had $256.3 million of goodwill and $20.3 million of other intangible assets.

Intangible assets are amortized using the straight-line method over the following periods:

Intangible Asset	Amortization Period
Purchased contract rights	5 – 15 years
Provider contracts	7 – 10 years
Customer relationships	5 – 15 years
Trade names	7 – 20 years

Our management evaluates whether events or circumstances have occurred that may affect the estimated useful life or the recoverability of the remaining balance of goodwill and other identifiable intangible assets. If the events or circumstances indicate that the remaining balance of the intangible asset or goodwill may be

impaired, the potential impairment will be measured based upon the difference between the carrying amount of the intangible asset or goodwill and the fair value of such asset. Our management must make assumptions and estimates, such as the discount factor, future utility and other internal and external factors, in determining the estimated fair values. While we believe these assumptions and estimates are appropriate, other assumptions and estimates could be applied and might produce significantly different results.

Goodwill is reviewed annually during the fourth quarter for impairment. In addition, an impairment analysis of intangible assets would be performed based on other factors. These factors include significant changes in membership, state funding, medical contracts and provider networks and contracts. The fair value of all reporting units with material amounts of goodwill was substantially in excess of the carrying value as of our annual impairment testing date.

ITEM 7A. ***Quantitative and Qualitative Disclosures About Market Risk.***

INVESTMENTS AND DEBT

As of December 31, 2012, we had short-term investments of $139.1 million and long-term investments of $649.5 million, including restricted deposits of $34.8 million. The short-term investments generally consist of highly liquid securities with maturities between three and 12 months. The long-term investments consist of municipal, corporate and U.S. Treasury securities, government sponsored obligations, life insurance contracts, asset backed securities and equity securities and have maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states' requirements, these investments are classified as long-term regardless of the contractual maturity date. Our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2012, the fair value of our fixed income investments would decrease by approximately $17.8 million. Declines in interest rates over time will reduce our investment income.

We entered into interest rate swap agreements with creditworthy financial institutions to manage the impact of market interest rates on interest expense. Our swap agreements convert a portion of our interest expense from fixed to variable rates to better match the impact of changes in market rates on our variable rate cash equivalent investments. As a result, the fair value of our $250 million Senior Note debt varies with market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2012, the fair value of our debt would decrease by approximately $11.3 million. An increase in interest rates decreases the fair value of the debt and conversely, a decrease in interest rates increases the value.

For a discussion of the interest rate risk that our investments are subject to, see "Risk Factors–Risks Related to Our Business–Our investment portfolio may suffer losses from reductions in market interest rates and changes in market conditions which could materially and adversely affect our results of operations or liquidity."

INFLATION

The inflation rate for medical care costs has been higher than the inflation rate for all items. We use various strategies to mitigate the negative effects of healthcare cost inflation. Specifically, our health plans try to control medical and hospital costs through our state savings initiatives and contracts with independent providers of healthcare services. Through these contracted care providers, our health plans emphasize preventive healthcare and appropriate use of specialty and hospital services. Additionally, our contracts with states require actuarially sound premiums that include health care cost trend.

While we currently believe our strategies to mitigate healthcare cost inflation will continue to be successful, competitive pressures, new healthcare and pharmaceutical product introductions, demands from healthcare providers and customers, applicable regulations or other factors may affect our ability to control the impact of healthcare cost increases.

Item 8. ***Financial Statements and Supplementary Data***

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
Centene Corporation:

We have audited the accompanying consolidated balance sheets of Centene Corporation and subsidiaries as of December 31, 2012 and 2011, and the related consolidated statements of operations, comprehensive earnings, stockholders' equity, and cash flows for each of the years in the period ended December 31, 2012. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements 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 includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes 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, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Centene Corporation and subsidiaries as of December 31, 2012 and 2011, and the results of their operations and their cash flows for each of the years in the period ended December 31, 2012, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Centene Corporation's internal control over financial reporting as of December 31, 2012, based on criteria established in *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), and our report dated February 18, 2013 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

KPMG LLP

St. Louis, Missouri
February 18, 2013

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS
(In thousands, except share data)

	December 31, 2012	December 31, 2011
ASSETS		
Current assets:		
Cash and cash equivalents	$ 843,952	$ 573,698
Premium and related receivables	263,452	157,450
Short-term investments	139,118	130,499
Other current assets	127,080	78,363
Total current assets	1,373,602	940,010
Long-term investments	614,723	506,140
Restricted deposits	34,793	26,818
Property, software and equipment, net	377,726	349,622
Goodwill	256,288	281,981
Intangible assets, net	20,268	27,430
Other long-term assets	64,282	58,335
Total assets	$2,741,682	$2,190,336
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$ 926,302	$ 607,985
Premium deficiency reserve	41,475	—
Accounts payable and accrued expenses	191,343	216,504
Unearned revenue	34,597	9,890
Current portion of long-term debt	3,373	3,234
Total current liabilities	1,197,090	837,613
Long-term debt	535,481	348,344
Other long-term liabilities	55,344	67,960
Total liabilities	1,787,915	1,253,917
Commitments and contingencies		
Stockholders' equity:		
Common stock, $.001 par value; authorized 100,000,000 shares; 55,339,160 issued and 52,329,248 outstanding at December 31, 2012, and 53,586,726 issued and 50,864,618 outstanding at December 31, 2011	55	54
Additional paid-in capital	450,856	421,981
Accumulated other comprehensive income:		
Unrealized gain on investments, net of tax	5,189	5,761
Retained earnings	566,820	564,961
Treasury stock, at cost (3,009,912 and 2,722,108 shares, respectively)	(69,864)	(57,123)
Total Centene stockholders' equity	953,056	935,634
Noncontrolling interest	711	785
Total stockholders' equity	953,767	936,419
Total liabilities and stockholders' equity	$2,741,682	$2,190,336

The accompanying notes to the consolidated financial statements are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS
(In thousands, except share data)

	Year Ended December 31,		
	2012	2011	2010
Revenues:			
Premium	$ 8,126,205	$ 5,077,242	$ 4,192,172
Service	112,742	103,765	91,661
Premium and service revenues	8,238,947	5,181,007	4,283,833
Premium tax	428,665	159,575	164,490
Total revenues	8,667,612	5,340,582	4,448,323
Expenses:			
Medical costs	7,446,037	4,324,746	3,584,452
Cost of services	87,705	78,114	63,919
General and administrative expenses	704,604	587,004	477,765
Premium tax expense	428,354	160,394	165,118
Impairment loss	28,033	—	—
Total operating expenses	8,694,733	5,150,258	4,291,254
Earnings (loss) from operations	(27,121)	190,324	157,069
Other income (expense):			
Investment and other income	35,957	13,369	15,205
Debt extinguishment costs	—	(8,488)	—
Interest expense	(20,460)	(20,320)	(17,992)
Earnings (loss) from continuing operations, before income tax expense	(11,624)	174,885	154,282
Income tax expense (benefit)	(329)	66,522	59,900
Earnings (loss) from continuing operations, net of income tax expense	(11,295)	108,363	94,382
Discontinued operations, net of income tax expense of $0, $0, and $4,388, respectively	—	—	3,889
Net earnings (loss)	(11,295)	108,363	98,271
Noncontrolling interest	(13,154)	(2,855)	3,435
Net earnings attributable to Centene Corporation	$ 1,859	$ 111,218	$ 94,836
Amounts attributable to Centene Corporation common shareholders:			
Earnings from continuing operations, net of income tax expense	$ 1,859	$ 111,218	$ 90,947
Discontinued operations, net of income tax expense	—	—	3,889
Net earnings	$ 1,859	$ 111,218	$ 94,836
Net earnings per common share attributable to Centene Corporation:			
Basic:			
Continuing operations	$ 0.04	$ 2.22	$ 1.87
Discontinued operations	—	—	0.08
Basic earnings per common share	$ 0.04	$ 2.22	$ 1.95
Diluted:			
Continuing operations	$ 0.03	$ 2.12	$ 1.80
Discontinued operations	—	—	0.08
Diluted earnings per common share	$ 0.03	$ 2.12	$ 1.88
Weighted average number of common shares outstanding:			
Basic	51,509,366	50,198,954	48,754,947
Diluted	53,714,375	52,474,238	50,447,888

The accompanying notes to the consolidated financial statements are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENT OF COMPREHENSIVE EARNINGS
(In thousands)

	Year Ended December 31,		
	2012	2011	2010
Net earnings (loss)	$(11,295)	$108,363	$98,271
Reclassification adjustment, net of tax	(1,789)	(549)	(1,660)
Change in unrealized gains on investments, net of tax	1,217	(114)	736
Other comprehensive earnings (loss)	(572)	(663)	(924)
Comprehensive earnings (loss)	(11,867)	107,700	97,347
Comprehensive earnings (loss) attributable to the noncontrolling interest	(13,154)	(2,855)	3,435
Comprehensive earnings attributable to Centene Corporation	$ 1,287	$110,555	$93,912

The accompanying notes to the consolidated financial statements are an integral part of this statement.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENT OF STOCKHOLDERS' EQUITY

(In thousands, except share data)

	Centene Stockholders' Equity								
	Common Stock					Treasury Stock			
	$.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Income	Retained Earnings	$.001 Par Value Shares	Amt	Non controlling Interest	Total
Balance, December 31, 2009	45,593,383	$46	$281,806	$7,348	$358,907	2,414,010	$(47,262)	$ 18,582	$619,427
Consolidation of noncontrolling interest	—	—	—	—	—	—	—	3,104	3,104
Comprehensive Earnings:									
Net earnings	—	—	—	—	94,836	—	—	3,435	98,271
Change in unrealized investment gains, net of $(511) tax	—	—	—	(924)	—	—	—	—	(924)
Total comprehensive earnings									97,347
Common stock issued for stock offering	5,750,000	6	104,528	—	—	—	—	—	104,534
Common stock issued for employee benefit plans	828,654	—	4,254	—	—	—	—	—	4,254
Issuance of stock warrants	—	—	296	—	—	—	—	—	296
Common stock repurchases	—	—	—	—	—	141,203	(3,224)	—	(3,224)
Stock compensation expense	—	—	13,874	—	—	—	—	—	13,874
Excess tax benefit from stock compensation	—	—	868	—	—	—	—	—	868
Redemption / purchase of noncontrolling interest	—	—	(21,420)	—	—	—	—	(14,056)	(35,476)
Distributions to noncontrolling interest	—	—	—	—	—	—	—	(7,949)	(7,949)
Balance, December 31, 2010	52,172,037	$52	$384,206	$6,424	$453,743	2,555,213	$(50,486)	$ 3,116	$797,055
Comprehensive Earnings:									
Net earnings	—	—	—	—	111,218	—	—	(2,855)	108,363
Change in unrealized investment gain, net of $(334) tax	—	—	—	(663)	—	—	—	—	(663)
Total comprehensive earnings									107,700
Common stock issued for employee benefit plans	1,414,689	2	15,435	—	—	—	—	—	15,437
Exercise of stock warrants	—	—	—	—	—	(50,000)	1,172	—	1,172
Common stock repurchases	—	—	—	—	—	216,895	(7,809)	—	(7,809)
Stock compensation expense	—	—	18,171	—	—	—	—	—	18,171
Excess tax benefits from stock compensation	—	—	4,169	—	—	—	—	—	4,169
Contributions from Noncontrolling interest	—	—	—	—	—	—	—	813	813
Deconsolidation of Noncontrolling interest	—	—	—	—	—	—	—	(289)	(289)
Balance, December 31, 2011	53,586,726	$54	$421,981	$5,761	$564,961	2,722,108	$(57,123)	$ 785	$936,419
Comprehensive Earnings:									
Net earnings (loss)	—	—	—	—	1,859	—	—	(13,154)	(11,295)
Change in unrealized investment gain, net of $(296) tax	—	—	—	(572)	—	—	—	—	(572)
Total comprehensive earnings (loss)									(11,867)
Common stock issued for employee benefit plans	1,752,434	1	16,725	—	—	—	—	—	16,726
Common stock repurchases	—	—	—	—	—	287,804	(12,741)	—	(12,741)
Stock compensation expense	—	—	25,332	—	—	—	—	—	25,332
Excess tax benefits from stock compensation	—	—	10,999	—	—	—	—	—	10,999
Purchase of noncontrolling interest	—	—	(24,181)	—	—	—	—	11,988	(12,193)
Contribution from noncontrolling interest	—	—	—	—	—	—	—	1,092	1,092
Balance, December 31, 2012	55,339,160	$55	$450,856	$5,189	$566,820	3,009,912	$(69,864)	$ 711	$953,767

The accompanying notes to the consolidated financial statements are an integral part of this statement.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)

	Year Ended December 31,		
	2012	2011	2010
Cash flows from operating activities:			
Net earnings (loss)	$ (11,295)	$ 108,363	$ 98,271
Adjustments to reconcile net earnings to net cash provided by operating activities			
Depreciation and amortization	65,866	58,327	52,000
Stock compensation expense	25,332	18,171	13,874
Impairment loss	28,033	—	5,531
Gain on sale of investment in convertible note	(17,880)	—	—
Gain on sale of investments, net	(1,484)	(287)	(6,337)
Gain on sale of UHP	—	—	(8,201)
Debt extinguishment costs	—	8,488	—
Deferred income taxes	(14,438)	2,031	10,317
Changes in assets and liabilities			
Premium and related receivables	(116,558)	(11,306)	(23,359)
Other current assets	(36,818)	(11,812)	(3,240)
Other assets	2,825	(2)	(2,028)
Medical claims liabilities	359,792	149,756	(30,421)
Unearned revenue	24,707	(109,082)	25,700
Accounts payable and accrued expenses	(21,474)	38,889	37,398
Other operating activities	(7,917)	10,160	(573)
Net cash provided by operating activities	278,691	261,696	168,932
Cash flows from investing activities:			
Capital expenditures	(82,144)	(73,708)	(118,556)
Purchases of investments	(695,687)	(318,397)	(615,506)
Sales and maturities of investments	589,921	267,404	570,423
Proceeds from asset sales	—	—	13,420
Investments in acquisitions, net of cash acquired	—	(4,375)	(60,388)
Net cash used in investing activities	(187,910)	(129,076)	(210,607)
Cash flows from financing activities:			
Proceeds from exercise of stock options	15,912	15,815	3,419
Proceeds from borrowings	400,500	419,183	218,538
Proceeds from stock offering	—	—	104,534
Payment of long-term debt	(218,234)	(416,283)	(195,728)
Excess tax benefits from stock compensation	10,996	4,435	963
Common stock repurchases	(12,741)	(7,809)	(3,224)
Contribution from (to) noncontrolling interest	1,092	813	(7,387)
Purchase of noncontrolling interest	(14,429)	—	(48,257)
Debt issue costs	(3,623)	(9,242)	(769)
Net cash provided by financing activities	179,473	6,912	72,089
Net increase in cash and cash equivalents	270,254	139,532	30,414
Cash and cash equivalents, beginning of period	573,698	434,166	403,752
Cash and cash equivalents, end of period	$ 843,952	$ 573,698	$ 434,166
Supplemental disclosures of cash flow information:			
Interest paid	$ 21,605	$ 27,383	$ 17,296
Income taxes paid	$ 42,877	$ 50,444	$ 53,938

The accompanying notes to the consolidated financial statements are an integral part of these statements.

1. Organization and Operations

Centene Corporation, or the Company, is a diversified, multi-line healthcare enterprise operating in two segments: Medicaid Managed Care and Specialty Services. The Medicaid Managed Care segment provides Medicaid and Medicaid-related health plan coverage to individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program, or CHIP, Long-term Care (LTC), Foster Care, Medicare Special Needs Plans and the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program, or collectively ABD. The Specialty Services segment offers products for behavioral health, care management software, health insurance exchanges, individual health insurance, life and health management, LTC programs, managed vision, telehealth services, and pharmacy benefits management to state programs, healthcare organizations, employer groups and other commercial organizations, as well as to our own subsidiaries. The health plans in Arizona, operated by our LTC company, and Massachusetts, operated by our individual health insurance provider, are included in the Specialty Services segment.

2. Summary of Significant Accounting Policies

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of Centene Corporation and all majority owned subsidiaries and subsidiaries over which the Company exercises the power and control to direct activities significantly impacting financial performance. All material intercompany balances and transactions have been eliminated. The assets, liabilities and results of operations of University Health Plans, Inc. are classified as discontinued operations for all periods presented.

Certain amounts in the consolidated financial statements have been reclassified to conform to the 2012 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles in the United States, or GAAP, requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Future events and their effects cannot be predicted with certainty; accordingly, the accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of the consolidated financial statements will change as new events occur, as more experience is acquired, as additional information is obtained and as the operating environment changes. The Company evaluates and updates its assumptions and estimates on an ongoing basis and may employ outside experts to assist in our evaluation, as considered necessary. Actual results could differ from those estimates.

Cash and Cash Equivalents

Investments with original maturities of three months or less are considered to be cash equivalents. Cash equivalents consist of commercial paper, money market funds, repurchase agreements and bank certificates of deposit and savings accounts.

The Company maintains amounts on deposit with various financial institutions, which may exceed federally insured limits. However, management periodically evaluates the credit-worthiness of those institutions, and the Company has not experienced any losses on such deposits.

Investments

Short-term investments include securities with maturities greater than three months to one year. Long-term investments include securities with maturities greater than one year.

Short-term and long-term investments are generally classified as available for sale and are carried at fair value. Certain equity investments are recorded using the cost or equity method. Unrealized gains and losses on investments available for sale are excluded from earnings and reported in accumulated other comprehensive income, a separate component of stockholders' equity, net of income tax effects. Premiums and discounts are amortized or accreted over the life of the related security using the effective interest method. The Company monitors the difference between the cost and fair value of investments. Investments that experience a decline in value that is judged to be other than temporary are written down to fair value and a realized loss is recorded in investment and other income. To calculate realized gains and losses on the sale of investments, the Company uses the specific amortized cost of each investment sold. Realized gains and losses are recorded in investment and other income.

The Company uses the equity method to account for certain of its investment in entities that it does not control and for which it does not have the ability to exercise significant influence over operating and financial policies. These investments are recorded at the lower of their cost or fair value.

Restricted Deposits

Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. These investments are classified as long-term, regardless of the contractual maturity date, due to the nature of the states' requirements. The Company is required to annually adjust the amount of the deposit pledged to certain states.

Fair Value Measurements

In the normal course of business, the Company invests in various financial assets and incurs various financial liabilities. Fair values are disclosed for all financial instruments, whether or not such values are recognized in the Consolidated Balance Sheets. Management obtains quoted market prices and other observable inputs for these disclosures. The carrying amounts reported in the Consolidated Balance Sheets for cash and cash equivalents, premium and related receivables, unearned revenue, accounts payable and accrued expenses, and certain other current liabilities are carried at cost, which approximates fair value because of their short-term nature.

The following methods and assumptions were used to estimate the fair value of each financial instrument:

- Available for sale investments and restricted deposits: The carrying amount is stated at fair value, based on quoted market prices, where available. For securities not actively traded, fair values were estimated using values obtained from independent pricing services or quoted market prices of comparable instruments.
- Senior unsecured notes: Estimated based on third-party quoted market prices for the same or similar issues.
- Variable rate debt: The carrying amount of our floating rate debt approximates fair value since the interest rates adjust based on market rate adjustments.
- Interest rate swap: Estimated based on third-party market prices based on the forward 3-month LIBOR curve.

Property, Software and Equipment

Property, software and equipment are stated at cost less accumulated depreciation. Capitalized software includes 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. Depreciation is calculated principally by the straight-line method over estimated useful lives. Leasehold improvements are depreciated using the straight-line method over the shorter of the expected useful life or the remaining term of the lease. Property, software and equipment are depreciated over the following periods:

Fixed Asset	Depreciation Period
Buildings and land improvements	5 – 40 years
Computer hardware and software	2 – 7 years
Furniture and equipment	3 – 10 years
Leasehold improvements	1 – 20 years

The carrying amounts of all long-lived assets are evaluated to determine if adjustment to the depreciation and amortization period or to the unamortized balance is warranted. Such evaluation is based principally on the expected utilization of the long-lived assets.

The Company retains fully depreciated assets in property and accumulated depreciation accounts until it removes them from service. In the case of sale, retirement, or disposal, the asset cost and related accumulated depreciation balance is removed from the respective account, and the resulting net amount, less any proceeds, is included as a component of earnings from operations in the consolidated statements of operations.

Goodwill and Intangible Assets

Intangible assets represent assets acquired in purchase transactions and consist primarily of customer relationships, purchased contract rights, provider contracts, trade names and goodwill. Intangible assets are amortized using the straight-line method over the following periods:

Intangible Asset	Amortization Period
Purchased contract rights	5 – 15 years
Provider contracts	7 – 10 years
Customer relationships	5 – 15 years
Trade names	7 – 20 years

The Company tests for impairment of intangible assets as well as long-lived assets whenever events or changes in circumstances indicate that the carrying value of an asset or asset group (hereinafter referred to as "asset group") may not be recoverable by comparing the sum of the estimated undiscounted future cash flows expected to result from use of the asset group and its eventual disposition to the carrying value. Such factors include, but are not limited to, significant changes in membership, state funding, state contracts and provider networks and contracts. If the sum of the estimated undiscounted future cash flows is less than the carrying value, an impairment determination is required. The amount of impairment is calculated by subtracting the fair value of the asset group from the carrying value of the asset group. An impairment charge, if any, is recognized within earnings from operations.

The Company tests goodwill for impairment using a fair value approach. The Company is required to test for impairment at least annually, absent a triggering event including a significant decline in operating performance that would require an impairment assessment. Absent any impairment indicators, the Company performs its goodwill impairment testing during the fourth quarter of each year. The Company recognizes an impairment charge for any amount by which the carrying amount of goodwill exceeds its implied fair value.

The Company first assesses qualitative factors to determine whether it is necessary to perform the two-step quantitative goodwill impairment test. The Company does not calculate the fair value of a reporting unit unless it determines, based on a qualitative assessment, that it is more likely than not that its fair value is less than its carrying amount.

If the two-step quantitative test is deemed necessary, the Company uses discounted cash flows to establish the fair value as of the testing date. The discounted cash flow approach includes many assumptions related to future growth rates, discount factors, future tax rates, etc. Changes in economic and operating conditions impacting these assumptions could result in goodwill impairment in future periods. When available and as appropriate, the Company uses comparative market multiples to corroborate discounted cash flow results.

Medical Claims Liability

Medical claims liability includes claims reported but not yet paid, or inventory, estimates for claims incurred but not reported, or IBNR, and estimates for the costs necessary to process unpaid claims at the end of each period. The Company estimates its medical claims liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors.

Actuarial Standards of Practice generally require that the medical claims liability estimates be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate. In many situations, the claims amounts ultimately settled will be different than the estimate that satisfies the Actuarial Standards of Practice. The Company includes in its IBNR an estimate for medical claims liability under moderately adverse conditions which represents the risk of adverse deviation of the estimates in its actuarial method of reserving.

The Company uses its judgment to determine the assumptions to be used in the calculation of the required estimates. The assumptions it considers when estimating IBNR include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to fee schedules, and the incidence of high dollar or catastrophic claims.

The Company's development of the medical claims liability estimate is a continuous process which it monitors and refines on a monthly basis as additional claims receipts and payment information becomes available. As more complete claim information becomes available, the Company adjusts the amount of the estimates, and includes the changes in estimates in medical costs in the period in which the changes are identified. In every reporting period, the operating results include the effects of more completely developed medical claims liability estimates associated with previously reported periods. The Company consistently applies its reserving methodology from period to period. As additional information becomes known, it adjusts the actuarial model accordingly to establish medical claims liability estimates.

The Company periodically reviews actual and anticipated experience compared to the assumptions used to establish medical costs. The Company establishes premium deficiency reserves if actual and anticipated experience indicates that existing policy liabilities together with the present value of future gross premiums will not be sufficient to cover the present value of future benefits, settlement and maintenance costs.

Revenue Recognition

The Company's health plans generate revenues primarily from premiums received from the states in which it operates health plans. The Company receives a fixed premium per member per month pursuant to its state contracts. The Company generally receives premium payments during the month it provides services and recognizes premium revenue during the period in which it is obligated to provide services to its members. In some instances, the Company's base premiums are subject to an adjustment, or risk score, based on the acuity of its membership. Generally, the risk score is determined by the State analyzing submissions of processed claims data to determine the acuity of the Company's membership relative to the entire state's Medicaid membership. Some states enact premium taxes, similar assessments and provider pass-through payments, collectively premium taxes, and these taxes are recorded as a separate component of both revenues and operating expenses. Some contracts allow for additional premiums related to certain supplemental services provided such as maternity deliveries.

Revenues are recorded based on membership and eligibility data provided by the states, which is adjusted on a monthly basis by the states for retroactive additions or deletions to membership data. These eligibility adjustments are estimated monthly and subsequent adjustments are made in the period known. We continuously review and update those estimates as new information becomes available. It is possible that new information could require us to make additional adjustments, which could be significant, to these estimates.

The Company's specialty companies generate revenues under contracts with state programs, individuals, healthcare organizations and other commercial organizations, as well as from the Company's own subsidiaries. Revenues are recognized when the related services are provided or as ratably earned over the covered period of service.

Premium and Related Receivables and Unearned Revenue

Premium and service revenues collected in advance are recorded as unearned revenue. For performance-based contracts the Company does not recognize revenue subject to refund until data is sufficient to measure performance. Premiums and service revenues due to the Company are recorded as premium and related receivables and are recorded net of an allowance based on historical trends and management's judgment on the collectibility of these accounts. As the Company generally receives payments during the month in which services are provided, the allowance is typically not significant in comparison to total revenues and does not have a material impact on the presentation of the financial condition or results of operations. Activity in the allowance for uncollectible accounts for the years ended December 31, is summarized below:

	2012	2011	2010
Allowances, beginning of year	639	17	1,338
Amounts charged to expense	1,350	865	(48)
Write-offs of uncollectible receivables	(1,208)	(243)	(1,273)
Allowances, end of year	781	639	17

Significant Customers

Centene receives the majority of its revenues under contracts or subcontracts with state Medicaid managed care programs. The current contracts expire on various dates between June 30, 2013 and December 31, 2016. States whose aggregate annual contract value exceeded 10% of annual revenues and the respective percentage of the Company's total revenues for the years ended December 31, are as follows:

2012		2011		2010	
Texas	36%	Georgia	13%	Georgia	17%
		Ohio	10%	Ohio	13%
		Texas	26%	Texas	30%

Reinsurance

Centene's subsidiaries report reinsurance premiums as medical costs, while related reinsurance recoveries are reported as deductions from medical costs. The Company limits its risk of certain catastrophic losses by maintaining high deductible reinsurance coverage.

Other Income (Expense)

Other income (expense) consists principally of investment income, interest expense and equity method earnings from investments. Investment income is derived from the Company's cash, cash equivalents, restricted deposits and investments. Interest expense relates to borrowings under the senior notes, interest rate swap, credit facilities, interest on capital leases and credit facility fees.

Income Taxes

Deferred tax assets and liabilities are recorded for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax law or tax rates is recognized in income in the period that includes the enactment date.

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. In determining if a deductible temporary difference or net operating loss can be realized, the Company considers future reversals of existing taxable temporary differences, future taxable income, taxable income in prior carryback periods and tax planning strategies.

Contingencies

The Company accrues for loss contingencies associated with outstanding litigation, claims and assessments for which it has determined it is probable that a loss contingency exists and the amount of loss can be reasonably estimated. The Company expenses professional fees associated with litigation claims and assessments as incurred.

Stock Based Compensation

The fair value of the Company's employee share options and similar instruments are estimated using the Black-Scholes option-pricing model. That cost is recognized over the period during which an employee is required to provide service in exchange for the award. Excess tax benefits related to stock compensation are presented as a cash inflow from financing activities.

Recent Accounting Pronouncements

In 2011, the Financial Accounting Standards Board issued accounting guidance for the health insurance industry's annual fees mandated by the Patient Protection and Affordable Care Act. The fees will be imposed beginning in 2014 based on the Company's share of the industry's net premiums written during the preceding calendar year. In addition, these fees will not be tax deductible. Under the guidance, the liability for the fee will be estimated and recorded in full each year beginning in 2014 when health insurance is first provided. A corresponding deferred cost will be recorded and amortized to operating expense over the calendar year. The Company is currently evaluating the impact of these fees on the consolidated financial position, results of operations and cash flows.

3. Noncontrolling Interest and Acquisitions

During the year ended December 31, 2012, the Company maintained less than a 100% ownership interest in Casenet, LLC, Home State Health Plan, and Louisiana Healthcare Connections. During the year ended December 31, 2011, the Company maintained less than a 100% ownership interest in Casenet, LLC. As of December 31, 2012, the Company's subsidiary, Home State Health Plan, is the only subsidiary where the Company maintains less than 100% ownership. The Company maintained a 95% ownership interest in Home State Health Plan at December 31, 2012. Net income attributable to Centene Corporation and transfers from (to) noncontrolling interest entities are as follows:

	Year Ended December 31,		
	2012	2011	2010
Net earnings attributable to Centene Corporation	$ 1,859	$111,218	$ 94,836
Transfers from (to) the noncontrolling interest:			
Decrease in equity for purchase of, distribution to and redemption of noncontrolling interest	(12,193)	(289)	(43,425)
Increase in equity for distributions from and consolidation of noncontrolling interest	1,092	813	3,104
Net transfers from (to) noncontrolling interest	(11,101)	524	(40,321)
Changes from net earnings attributable to Centene Corporation and net transfers from (to) the noncontrolling interest	$ (9,242)	$111,742	$ 54,515

Ownership changes and acquisitions are described in more detail below. Pro forma disclosures related to the acquisitions have been excluded as immaterial.

Access Health Solutions, LLC. In December 2010, the Company exercised its right to obtain the remaining assets and ownership interest in Access Health Solutions, LLC, or Access, for zero dollars. Subsequent to the acquisition of the remaining interest, Access continues to be consolidated in the Company's Medicaid Managed Care segment results as a wholly owned subsidiary of the Company. During 2011, the Company made a conversion payment to the former owners of Access resulting in additional goodwill of $1,773. All of the goodwill is deductible for income tax purposes.

Carolina Crescent Health Plan. In June 2010, the Company acquired certain assets of Carolina Crescent Health Plan, a South Carolina Medicaid managed care organization for $17,993 in total consideration. The Company's allocation of fair value resulted in goodwill of $16,543 and other identifiable intangible assets of $1,450. The acquisition is recorded in the Medicaid Managed Care segment. All of the goodwill is deductible for income tax purposes.

Casenet, LLC. In December 2010, the Company acquired an additional ownership interest in Casenet, LLC (Casenet) for total consideration of $6,619, bringing its ownership interest to 68%. Casenet is a provider of care management solutions that automate the clinical, administrative, and technical components of care management programs. The Company performed an initial allocation of total consideration to assets acquired and liabilities assumed based on its initial estimates of fair value using methodologies and assumptions that it believed were reasonable. The initial allocation resulted in goodwill of $1,752 and other identifiable intangible assets of $4,500 that were recorded in the Specialty Services segment. During 2011, the Company finalized the allocation of the fair value that resulted in goodwill of $8,975, other identifiable intangible assets of $3,561 and an increase in unearned revenue of $6,284. All of the goodwill is deductible for income tax purposes. During 2011, the Company increased its ownership interest in Casenet to 81%. In December 2012, the Company acquired the remaining ownership interest in Casenet for $4,429. The excess purchase price over the noncontrolling interest was recorded to additional paid in capital, net of the related deferred tax asset.

Centene Center LLC. In December 2010, the Company acquired the remaining ownership interest in Centene Center LLC for $48,250. The excess purchase price over the noncontrolling interest was recorded to additional paid in capital, net of the related deferred tax asset of $12,779. Centene Center LLC is a real estate development entity created for the construction of a real estate development that includes the Company's corporate headquarters. The Company previously reported its investment in Centene Center as a consolidated VIE. The operating results of Centene Center LLC are included in general and administrative expense of the Company's Medicaid Managed Care segment.

Citrus Health Care, Inc. In December 2010, the Company acquired certain assets in non reform counties of Citrus Health Care, Inc., a Florida Medicaid and LTC health plan for $28,689. The Company performed a preliminary allocation of fair value that resulted in goodwill of $22,951 and other identifiable intangible assets of $5,738 that were recorded in the Medicaid Managed Care segment. During 2011, the Company finalized the allocation of the fair value that resulted in goodwill of $19,069 and other identifiable intangible assets of $9,620. All of the goodwill is deductible for income tax purposes.

Louisiana Healthcare Connections. In February 2012, the Company began operations under a new contract in Lousiana through a joint venture subsidiary, Louisiana Healthcare Connections. The Company initially owned a 51% interest in the subsidiary and in October 2012, acquired the remaining noncontrolling interest for $10,000. The purchase price in excess of the noncontrolling interest was recorded to additional paid in capital. The operating results of Louisiana are included in the Company's Medicaid Managed Care segment.

NovaSys Health, LLC. In July 2010, the Company acquired certain assets and liabilities of NovaSys Health, LLC, a third party administrator in Arkansas and paid $4,330 in cash. The Company's allocation of fair value resulted in goodwill of $1,444 and other identifiable intangible assets of $3,050 that were recorded in the Specialty Services segment. The goodwill was subsequently written off in 2012 and was deductible for income tax purposes.

4. Short-term and Long-term Investments and Restricted Deposits

Short-term and long-term investments and restricted deposits by investment type consist of the following:

	December 31, 2012				December 31, 2011			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$117,434	$ 594	$(221)	$117,807	$ 29,014	$ 638	$ (13)	$ 29,639
Corporate securities	315,807	5,101	(198)	320,710	186,018	3,762	(751)	189,029
Restricted certificates of deposit	5,890	—	—	5,890	5,890	—	—	5,890
Restricted cash equivalents	14,460	—	—	14,460	13,775	—	—	13,775
Municipal securities:								
General obligation	88,690	1,173	(26)	89,837	126,806	2,828	(26)	129,608
Pre-refunded	5,337	85	—	5,422	33,247	465	—	33,712
Revenue	84,726	1,331	(30)	86,027	118,507	2,387	(34)	120,860
Variable rate demand notes	37,685	—	—	37,685	64,658	—	—	64,658
Asset backed securities	83,295	1,197	(17)	84,475	51,779	430	(17)	52,192
Cost and equity method investments	11,298	—	—	11,298	9,395	—	—	9,395
Life insurance contracts	15,023	—	—	15,023	14,699	—	—	14,699
Total	$779,645	$9,481	$(492)	$788,634	$653,788	$10,510	$(841)	$663,457

The Company's investments are classified as available-for-sale with the exception of life insurance contracts and certain cost and equity method investments. The Company's investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets with the focus on investment grade securities. The Company limits the size of investment in any single issuer other than U.S. treasury securities and obligations of U.S. government corporations and agencies. As of December 31, 2012, 40% of the Company's investments in securities recorded at fair value that carry a rating by S&P or Moody's were rated AAA/Aaa, 61% were rated AA-/Aa3 or higher and 95% were rated A-/A3 or higher. At December 31, 2012, the Company held certificates of deposit, life insurance contracts and cost and equity method investments which did not carry a credit rating.

The fair value of available-for-sale investments with gross unrealized losses by investment type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

	December 31, 2012				December 31, 2011			
	Less Than 12 Months		12 Months or More		Less Than 12 Months		12 Months or More	
	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$(219)	$ 56,033	$ (2)	$202	$ (13)	$ 2,184	$—	$—
Corporate securities	(198)	44,758	—	—	(751)	23,040	—	—
Municipal securities:								
General obligation	(26)	8,464	—	—	(26)	3,710	—	—
Revenue	(30)	3,325	—	—	(34)	12,597	—	—
Asset backed securities	(17)	9,321	—	—	(17)	20,417	—	—
Total	$(490)	$121,901	$ (2)	$202	$(841)	$61,948	$—	$—

As of December 31, 2012, the gross unrealized losses were generated from 34 positions out of a total of 371 positions. The decline in fair value of fixed income securities is a result of movement in interest rates subsequent to the purchase of the security.

For each security in an unrealized loss position, the Company assesses whether it intends to sell the security or if it is more likely than not the Company will be required to sell the security before recovery of the amortized cost basis for reasons such as liquidity, contractual or regulatory purposes. If the security meets this criterion, the decline in fair value is other-than-temporary and is recorded in earnings. The Company does not intend to sell these securities prior to maturity and it is not likely that the Company will be required to sell these securities prior to maturity; therefore, there is no indication of other than temporary impairment for these securities.

The contractual maturities of short-term and long-term investments and restricted deposits are as follows:

	December 31, 2012				December 31, 2011			
	Investments		Restricted Deposits		Investments		Restricted Deposits	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value
One year or less	$138,011	$139,118	$34,403	$34,435	$129,232	$130,499	$19,666	$19,666
One year through five years	474,068	481,381	358	358	406,140	413,953	7,085	7,152
Five years through ten years	94,006	93,878	—	—	34,945	34,961	—	—
Greater than ten years	38,799	39,464	—	—	56,720	57,226	—	—
Total	$744,884	$753,841	$34,761	$34,793	$627,037	$636,639	$26,751	$26,818

Actual maturities may differ from contractual maturities due to call or prepayment options. Asset backed securities are included in the one year through five years category, while equity securities and life insurance contracts are included in the five years through ten years category. The Company has an option to redeem at amortized cost substantially all of the securities included in the Greater than ten years category listed above.

Realized gains and losses are determined on the basis of specific identification or a first-in, first-out methodology, if specific identification is not practicable. The Company's gross recorded realized gains and losses were as follows:

	Year Ended December 31,		
	2012	2011	2010
Gains	$1,509	$314	$ 6,036
Losses	(25)	(27)	(270)
Impairment of investment	—	—	(5,531)
Net realized gains	$1,484	$287	$ 235

During 2012, the company recognized $1,484 in net gains from sales primarily as a result of the liquidation of $75,468 of investments held by the Georgia health plan in order to meet short-term liquidity needs due to the delays in premium receipts from the state.

The Company continuously monitors investments for other-than-temporary impairment. Certain investments have experienced a decline in fair value due to changes in credit quality, market interest rates and/or general economic conditions. The Company recognizes an impairment loss for cost and equity method investments when evidence demonstrates that it is other-than-temporarily impaired. Evidence of a loss in value that is other than temporary may include the absence of an ability to recover the carrying amount of the investment or the inability of the investee to sustain a level of earnings that would justify the carrying amount of the investment. During 2010, the Company determined it had an other-than-temporary impairment of its investment in Casenet, LLC. As a result, the Company recorded an impairment charge of $5,531, including $3,531 of convertible promissory notes. The impairment charge is included in investment and other income.

Investment amortization of $11,151, $10,335, and $10,750 was recorded in the years ended December 31, 2012, 2011 and 2010, respectively.

5. Fair Value Measurements

Assets and liabilities recorded at fair value in the consolidated balance sheets are categorized based upon the extent to which the fair value estimates are based upon observable or unobservable inputs. Level inputs are as follows:

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

The following table summarizes fair value measurements by level at December 31, 2012, for assets and liabilities measured at fair value on a recurring basis:

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$843,952	$ —	$—	$ 843,952
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 57,114	$ 46,250	$—	$ 103,364
Corporate securities	—	320,710	—	320,710
Municipal securities:				
General obligation	—	89,837	—	89,837
Pre-refunded	—	5,422	—	5,422
Revenue	—	86,027	—	86,027
Variable rate demand notes	—	37,685	—	37,685
Asset backed securities	—	84,475	—	84,475
Total investments	$ 57,114	$670,406	$—	$ 727,520
Restricted deposits available for sale:				
Cash and cash equivalents	$ 14,460	$ —	$—	$ 14,460
Certificates of deposit	5,890	—	—	5,890
U.S. Treasury securities and obligations of U.S. government corporations and agencies	14,443	—	—	14,443
Total restricted deposits	$ 34,793	$ —	$—	$ 34,793
Other long-term assets:				
Interest rate swap contract	$ —	$ 16,304	$—	$ 16,304
Total assets at fair value	$935,859	$686,710	$—	$1,622,569

The following table summarizes fair value measurements by level at December 31, 2011, for assets and liabilities measured at fair value on a recurring basis:

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$573,698	$ —	$—	$ 573,698
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 17,091	$ 5,395	$—	$ 22,486
Corporate securities	—	189,029	—	189,029
Municipal securities:				
General obligation	—	129,608	—	129,608
Pre-refunded	—	33,712	—	33,712
Revenue	—	120,860	—	120,860
Variable rate demand notes	—	64,658	—	64,658
Asset backed securities	—	52,192	—	52,192
Total investments	$ 17,091	$595,454	$—	$ 612,545
Restricted deposits available for sale:				
Cash and cash equivalents	$ 13,775	$ —	$—	$ 13,775
Certificates of deposit	5,890	—	—	5,890
U.S. Treasury securities and obligations of U.S. government corporations and agencies	7,153	—	—	7,153
Total restricted deposits	$ 26,818	$ —	$—	$ 26,818
Other long-term assets:				
Interest rate swap contract	$ —	$ 11,431	$—	$ 11,431
Total assets at fair value	$617,607	$606,885	$—	$1,224,492

The Company periodically transfers U.S. Treasury securities and obligations of U.S. government corporations and agencies between Level I and Level II fair value measurements dependent upon the level of trading activity for the specific securities at the measurement date. The Company's policy regarding the timing of transfers between Level I and Level II is to measure and record the transfers at the end of the reporting period. At December 31, 2012, there were $1,388 of transfers from Level I to Level II and $304 of transfers from Level II to Level I. The Company utilizes matrix pricing services to estimate fair value for securities which are not actively traded on the measurement date. The Company designates these securities as Level II fair value measurements. The aggregate carrying amount of the Company's life insurance contracts and other non-majority owned investments, which approximates fair value, was $26,321 and $24,094 as of December 31, 2012 and December 31, 2011, respectively.

6. Notes Receivable

Between July 2008 and October 2011, the Company made an investment of $30,000 in secured notes receivable to a third party as part of an investment in certain Medicaid and Medicare related businesses. The notes included a feature to convert the note balance into an equity ownership in the underlying businesses.

In September 2012, the Company executed an agreement with the borrower whereby the borrower agreed to pay the Company total consideration of $50,000 for retirement of the outstanding notes and equity ownership

conversion feature. Under the terms of the agreement, the borrower paid the Company $30,000 in December 2012, and agreed to pay the Company $10,000 by September 30, 2013 and $10,000 by September 30, 2014. All outstanding balances are secured by liens on certain underlying businesses as well as guaranteed personally by the principal owner of the businesses. The $10,000 notes to be paid on or before September 30, 2013 and September 30, 2014 are non-interest bearing and, as a result, total consideration was discounted by $2,120 to reflect imputation of interest. As a result, during the third quarter of 2012, the Company recorded a pre-tax gain of $17,880 in other income representing the fair value of the total consideration in excess of the carrying value of the loans on the Company's balance sheet.

7. Property, Software and Equipment

Property, software and equipment consist of the following as of December 31:

	2012	2011
Computer software	$ 164,797	$ 158,672
Building	193,187	186,194
Land	70,276	47,614
Computer hardware	57,851	51,805
Furniture and office equipment	44,327	37,865
Leasehold improvements	50,671	44,766
	581,109	526,916
Less accumulated depreciation	(203,383)	(177,294)
Property, software and equipment, net	$ 377,726	$ 349,622

As of December 31, 2012 and 2011, the Company had assets acquired under capital leases included above of $6,133 and $6,316, net of accumulated amortization of $1,595 and $1,285, respectively. Amortization on assets under capital leases charged to expense is included in depreciation expense. Depreciation expense for the years ended December 31, 2012, 2011 and 2010 was $50,112, $42,249 and $37,131, respectively.

8. Goodwill and Intangible Assets

During 2011, the Company completed its annual goodwill and intangible asset impairment testing and concluded that the fair value of all reporting units with material amounts of goodwill was substantially in excess of the carrying value as of our impairment testing date. Specifically, the Company tested its Celtic reporting unit under a quantitative model which included anticipated financial performance for new business to be converted in 2012. Under the quantitative model, the testing revealed that the fair value exceeded the carrying value of the Celtic reporting unit by approximately 190%.

During the second quarter of 2012, the Company's subsidiary, Celtic Insurance Company, experienced a high level of medical costs for individual health policies, especially for recently issued policies related to members converted from another insurer during the first quarter of 2012. Additionally, in June 2012, the U.S. Supreme Court upheld the constitutionality of the Patient Protection and Affordable Care Act. The Affordable Care Act, among other things, limits the profitability of the individual health insurance business because of minimum medical loss ratios, guaranteed issue policies, and increased competition in the exchange market. As a result of these factors, the Company's expectations for future growth and profitability were lower than previous estimates. The Company conducted an impairment analysis of the identifiable intangible assets and goodwill of the Celtic reporting unit. For the purpose of testing goodwill, the fair value of the Celtic reporting unit was determined using discounted expected cash flows. For the purpose of testing the customer relationship intangible, the fair value was determined using the discounted expected cash flows. The impairment analysis resulted in goodwill and intangible asset impairments of $28,033, recorded as an impairment loss in the consolidated

statement of operations. The impaired identifiable intangible assets of $2,340 and goodwill of $25,693 were reported under the Specialty Services segment; $26,589 of the impairment loss is not deductible for income tax purposes.

The following table summarizes the changes in goodwill by operating segment:

	Medicaid Managed Care	Specialty Services	Total
Balance as of December 31, 2010	$154,696	$123,355	$278,051
Acquisitions	1,773	—	1,773
Other adjustments	(5,067)	7,224	2,157
Balance as of December 31, 2011	151,402	130,579	281,981
Impairment	—	(25,693)	(25,693)
Balance as of December 31, 2012	$151,402	$104,886	$256,288

Goodwill acquisitions and other adjustments were related to the acquisitions and finalization of fair value allocations discussed in Note 3, *Noncontrolling Interest and Acquisitions*.

Intangible assets at December 31, consist of the following:

			Weighted Average Life in Years	
	2012	2011	2012	2011
Purchased contract rights	$ 21,988	$ 21,988	7.5	7.5
Provider contracts	2,737	2,737	9.8	9.8
Customer relationships	13,396	16,056	8.0	7.9
Trade names	6,495	6,495	16.3	16.3
Intangible assets	44,616	47,276	9.1	9.0
Less accumulated amortization:				
Purchased contract rights	(11,010)	(8,554)		
Provider contracts	(1,241)	(931)		
Customer relationships	(10,214)	(8,753)		
Trade names	(1,883)	(1,608)		
Total accumulated amortization	(24,348)	(19,846)		
Intangible assets, net	$ 20,268	$ 27,430		

Amortization expense was $4,822, $5,561 and $4,119 for the years ended December 31, 2012, 2011 and 2010 respectively. Estimated total amortization expense related to intangible assets for each of the five succeeding fiscal years is as follows:

Year	Expense
2013	$4,000
2014	3,500
2015	3,100
2016	3,000
2017	2,300

9. Medical Claims Liability

The change in medical claims liability is summarized as follows:

	Year Ended December 31,		
	2012	2011	2010
Balance, January 1,	$ 607,985	$ 456,765	$ 470,932
Incurred related to:			
Current year	7,499,437	4,390,123	3,652,521
Prior years	(53,400)	(65,377)	(68,069)
Total incurred	7,446,037	4,324,746	3,584,452
Paid related to:			
Current year	6,535,537	3,788,808	3,203,585
Prior years	550,708	384,718	395,034
Total paid	7,086,245	4,173,526	3,598,619
Less: Premium deficiency reserve	41,475	—	—
Balance, December 31,	$ 926,302	$ 607,985	$ 456,765

Changes in estimates of incurred claims for prior years are primarily attributable to reserving under moderately adverse conditions. In addition, claims processing initiatives yielded increased claim payment recoveries and coordination of benefits related to prior year dates of service. Changes in medical utilization and cost trends and the effect of medical management initiatives may also contribute to changes in medical claim liability estimates. While the Company has evidence that medical management initiatives are effective on a case by case basis, medical management initiatives primarily focus on events and behaviors prior to the incurrence of the medical event and generation of a claim. Accordingly, any change in behavior, leveling of care, or coordination of treatment occurs prior to claim generation and as a result, the costs prior to the medical management initiative are not known by the Company. Additionally, certain medical management initiatives are focused on member and provider education with the intent of influencing behavior to appropriately align the medical services provided with the member's acuity. In these cases, determining whether the medical management initiative changed the behavior cannot be determined. Because of the complexity of its business, the number of states in which it operates, and the volume of claims that it processes, the Company is unable to practically quantify the impact of these initiatives on its changes in estimates of IBNR. Excluding the impact of the medical costs related to the retroactive assignment of members in our Kentucky health plan, the amount of "Incurred related to: Prior years" shown for 2012 in the table above would have been $(61,733).

The Company had reinsurance recoverables related to medical claims liability of $9,668 and $5,313 at December 31, 2012 and 2011, respectively, included in premium and related receivables.

The Company periodically reviews actual and anticipated experience compared to the assumptions used to establish medical costs. The Company establishes premium deficiency reserves if actual and anticipated experience indicates that existing policy liabilities together with the present value of future gross premiums will not be sufficient to cover the present value of future benefits, settlement and maintenance costs.

In October 2012, the Company notified the Kentucky Cabinet for Health and Family Services that it is exercising a contractual right that it believes allows Kentucky Spirit to terminate its Medicaid managed care contract with the Commonwealth of Kentucky effective July 5, 2013. As a result, the Company recorded a premium deficiency reserve included in Medical costs expense of $41,475 for its Kentucky contract in the year ended December 31, 2012. The premium deficiency reserve encompasses the contract period from January 1, 2013 through July 5, 2013.

10. Debt

Debt consists of the following at December 31,:

	2012	2011
Senior notes, at par	$425,000	$250,000
Unamortized premium (discount) on senior notes, net	7,823	(2,814)
Interest rate swap fair value	16,304	11,431
Senior notes, net	449,127	258,617
Revolving credit agreement	—	—
Mortgage notes payable	84,081	86,948
Capital leases and other	5,646	6,013
Total debt	538,854	351,578
Less current portion	(3,373)	(3,234)
Long-term debt	$535,481	$348,344

Senior Notes

In May 2011, the Company issued non-callable $250,000 5.75% Senior Notes due June 1, 2017 (the $250,000 Notes) at a discount to yield 6%. In connection with the May 2011 issuance, the Company entered into an interest rate swap for a notional amount of $250,000. Gains and losses due to changes in the fair value of the interest rate swap completely offset changes in the fair value of the hedged portion of the underlying debt and are recorded as an adjustment to the $250,000 Notes. At December 31, 2012, the fair value of the interest rate swap increased the fair value of the notes by $16,304 and the variable interest rate of the swap was 3.81%.

In November 2012, the Company issued an additional $175,000 non-callable 5.75% Senior Notes due June 1, 2017 ($175,000 Add-on Notes) at a premium to yield 4.29%. The indenture governing the $250,000 Notes and the $175,000 Add-on Notes contains non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio. Interest is paid semi-annually in June and December. At December 31, 2012, the total net unamortized debt premium on the $250,000 Notes and $175,000 Add-on Notes was $7,823.

Revolving Credit Agreement

The Company has a $350,000 revolving credit facility due in January 2016. The revolver is unsecured and has non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt to EBITDA ratios and minimum net worth. Borrowings under the revolver bear interest based upon LIBOR rates, the Federal funds rate, or the prime rate. As of December 31, 2012, the Company had no borrowings outstanding under the agreement, leaving availability of $350,000.

In February 2013, the Company amended the $350,000 revolving credit facility to add an additional pricing tier, increase the maximum total debt to EBITDA ratio during the first three quarters of 2013 to provide for increased borrowing availability and change the maximum total debt to EBITDA ratio to 3.0 as of December 31, 2013 and thereafter.

The Company has outstanding letters of credit of $17,280 as of December 31, 2012, which are not part of the revolver. The letters of credit bore interest at 1.07% as of December 31, 2012.

Mortgage Notes Payable

The Company has a non-recourse mortgage note of $75,381 at December 31, 2012 collateralized by its corporate headquarters building. The mortgage note is due January 1, 2021, bears a 5.14% interest rate and has a financial covenant requiring a minimum debt service coverage ratio. The collateralized property had a net book value of $164,861 at December 31, 2012.

The Company also has a mortgage note of $8,700 at December 31, 2012 collateralized by another building and parking garage. The collateralized properties had a net book value of $26,077 at December 31, 2012. The mortgage is due August 31, 2014 and bears interest at the LIBOR rate plus 3% or the bank's certificate of deposit rate plus 2%. The mortgage includes a financial covenant requiring a minimum fixed charge coverage ratio. The weighted average interest rate of the mortgage note was 3.09% at December 31, 2012.

Aggregate maturities for the Company's debt are as follows:

2013	$ 3,373
2014	11,320
2015	3,173
2016	3,337
2017	428,511
Thereafter	65,013
Total	$514,727

The fair value of outstanding debt was approximately $543,611 and $351,578 at December 31, 2012 and 2011, respectively.

11. Interest Rate Swap

In May 2011, the Company entered into $250,000 notional amount of interest rate swap agreements (Swap Agreements) that are scheduled to expire June 1, 2017. Under the Swap Agreements, the Company receives a fixed rate of 5.75% and pays a variable rate of the three month LIBOR plus 3.5% adjusted quarterly, which allows the Company to adjust $250,000 of its senior notes to a floating rate. The Company does not hold or issue any derivative instrument for trading or speculative purposes. At December 31, 2012, the variable rate was 3.81%.

The interest rate swaps are formally designated and qualify as fair value hedges. The interest rate swaps are recorded at fair value in the Consolidated Balance Sheet in other assets or other liabilities. Gains and losses due to changes in fair value of the interest rate swaps completely offset changes in the fair value of the hedged portion of the underlying debt. Therefore, no gain or loss has been recognized due to hedge ineffectiveness. Offsetting changes in fair value of both the interest rate swaps and the hedged portion of the underlying debt both were recognized in interest expense in the Consolidated Statement of Operations.

The fair value of the Swap Agreements as of December 31, 2012 was an asset of approximately $16,304, and is included in other long term assets in the Consolidated Balance Sheet. The fair value of the Swap Agreements excludes accrued interest and takes into consideration current interest rates and current likelihood of the swap counterparties' compliance with its contractual obligations.

12. Stockholders' Equity

The Company has 10,000,000 authorized shares of preferred stock at $.001 par value. At December 31, 2012, there were no preferred shares outstanding.

The Company's Board of Directors has authorized a stock repurchase program for up to 4,000,000 shares of the Company's common stock from time to time on the open market or through privately negotiated transactions. No duration has been placed on the repurchase program. The Company has 1,667,724 available shares remaining under the program for repurchases as of December 31, 2012. The Company reserves the right to discontinue the repurchase program at any time. During the year ended December 31, 2012, the Company did not repurchase any shares through this publicly announced program.

As a component of the employee stock compensation plan, employees can use shares of stock which have vested to satisfy minimum statutory tax withholding obligations. As part of this plan, the Company repurchased 287,804 shares at an aggregate cost of $12,741 in 2012 and 216,895 shares at an aggregate cost of $7,809 in 2011. These shares are included in the Company's treasury stock.

13. Statutory Capital Requirements and Dividend Restrictions

Various state laws require Centene's regulated subsidiaries to maintain minimum capital levels specified by each state and restrict the amount of dividends that may be paid without prior regulatory approval. At December 31, 2012 and 2011, Centene's subsidiaries, had aggregate statutory capital and surplus of $990,300 and $619,900, respectively, compared with the required minimum aggregate statutory capital and surplus of $617,000 and $342,000, respectively.

14. Income Taxes

The consolidated income tax expense consists of the following for the years ended December 31:

	2012	2011	2010
Current provision:			
Federal	$ 15,852	$59,641	$46,259
State and local	(5,604)	5,186	6,868
Total current provision	10,248	64,827	53,127
Deferred provision	(10,577)	1,695	6,773
Total provision for income taxes	$ (329)	$66,522	$59,900

The reconciliation of the tax provision at the U.S. Federal Statutory Rate to the provision for income taxes is as follows:

	2012	2011	2010
Earnings from continuing operations, before income tax expense	$(11,624)	$174,885	$154,282
Less flow through noncontrolling interest	(2,540)	(2,855)	3,435
Earnings from continuing operations, less noncontrolling interest, before income tax expense	(9,084)	177,740	150,847
Tax provision at the U.S. federal statutory rate	(3,179)	62,209	52,797
State income taxes, net of federal income tax benefit	(3,812)	3,411	6,231
Nondeductible goodwill impairment	8,487	—	—
Other, net	(1,825)	902	872
Income tax expense	$ (329)	$ 66,522	$ 59,900

The tax effects of temporary differences which give rise to deferred tax assets and liabilities are presented below for the years ended December 31:

	2012	2011
Deferred tax assets:		
Medical claims liability and other accruals	$52,838	$46,222
State net operating loss carry forward	9,055	8,761
Stock compensation	12,615	13,234
Other	20,573	8,723
Deferred tax assets	95,081	76,940
Valuation allowance	(8,325)	(8,521)
Net deferred tax assets	$86,756	$68,419
Deferred tax liabilities:		
Intangible assets	$12,441	$10,756
Prepaid assets	4,767	4,508
Depreciation and amortization	31,742	31,398
Other	5,855	6,777
Deferred tax liabilities	$54,805	$53,439
Net deferred tax assets	$31,951	$14,980

The Company's deferred tax assets include federal and state net operating losses, or NOLs, of which $3,012 were acquired in business combinations. Accordingly, the total and annual deduction for those NOLs is limited by tax law. The Company's federal NOLs expire between the years 2013 and 2032 and the state NOLs expire between the years 2013 and 2033. Valuation allowances are recorded for those NOLs the Company believes are more likely than not to expire unused. During 2012 and 2011, the Company recorded valuation allowance additions in the tax provision of $2,093 and $1,671, respectively. In 2012 and 2011, the Company recorded valuation allowance reductions of $2,289 and $528, respectively.

The Company maintains a reserve for uncertain tax positions that may be challenged by a tax authority. A roll-forward of the reserve is as follows:

	2012	2011
Gross unrecognized tax benefits, beginning of period	$13,552	$ 3,036
Gross increases:		
Current year tax positions	4,107	10,863
Prior year tax positions	451	—
Gross decreases:		
Prior year tax positions	(9,925)	(347)
Settlements	(53)	—
Statute of limitation lapses	(262)	—
Gross unrecognized tax benefits, end of period	$ 7,870	$13,552

Included in the balance of unrecognized tax benefits at December 31, 2012 are potential benefits of $4,095 that, if recognized, would affect the effective tax rate on income from continuing operations. Also included in the reserve balance are liabilities of $3,775 that, if recognized, would be recorded as an adjustment to deferred taxes. The December 31, 2011 reserve balance of $13,552 would have decreased tax expense, if recognized.

The Company recognizes interest accrued related to unrecognized tax benefits in the provision for income taxes. During the year ended December 31, 2012, the Company recognized a tax benefit of $170 generated from the net reduction in interest accrued. During the year ended December 31, 2011, the Company recognized $451 of interest expense. Interest accrued, net of federal benefit, was $933, $1,157 and $707 as of December 31, 2012, 2011 and 2010, respectively. No penalties have been accrued.

The Internal Revenue Service is currently performing an examination of the Company's 2010 and 2011 tax returns. The Company files in numerous state jurisdictions with varying statutes of limitation. The unrecognized state tax benefits are related to returns from 2006 to 2012.

15. Stock Incentive Plans

The Company's stock incentive plans allow for the granting of restricted stock or restricted stock unit awards and options to purchase common stock. Both incentive stock options and nonqualified stock options can be awarded under the plans. No option will be exercisable for longer than ten years after the date of grant. The plans have 2,284,953 shares available for future awards. Compensation expense for stock options and restricted stock unit awards is recognized on a straight-line basis over the vesting period, generally three to five years for stock options and 1 to 10 years for restricted stock or restricted stock unit awards. Certain restricted stock unit awards contain performance-based as well as service-based provisions. Certain awards provide for accelerated vesting if there is a change in control as defined in the plans. The total compensation cost that has been charged against income for the stock incentive plans was $25,332, $18,171 and $13,874 for the years ended December 31, 2012, 2011 and 2010, respectively. The total income tax benefit recognized in the income statement for stock-based compensation arrangements was $8,952, $5,804 and $4,713 for the years ended December 31, 2012, 2011 and 2010, respectively.

Option activity for the year ended December 31, 2012 is summarized below:

	Shares	Weighted Average Exercise Price	Aggregate Intrinsic Value	Weighted Average Remaining Contractual Term
Outstanding as of December 31, 2011	2,196,562	$20.75		
Exercised	(864,466)	18.09		
Forfeited	(32,700)	25.56		
Outstanding as of December 31, 2012	1,299,396	22.39	24,184	3.4
Exercisable as of December 31, 2012	1,229,929	$22.51	22,745	3.3

The fair value of each option grant is estimated on the date of the grant using the Black-Scholes option-pricing model with the following weighted-average assumptions:

	Year Ended December 31,		
	2012[1]	2011	2010
Expected life (in years)	—	5.2	5.8
Risk-free interest rate	—	0.9%	2.7%
Expected volatility	—	49.9%	48.2%
Expected dividend yield	—	—	—

[1] No options were awarded in the year ended December 31, 2012.

For the years ended December 31, 2012, 2011 and 2010, the Company used a projected expected life for each award granted based on historical experience of employees' exercise behavior. The expected volatility is primarily based on historical volatility levels along with the implied volatility of exchange traded options to purchase Centene common stock. The risk-free interest rates are based on the implied yield currently available on U.S. Treasury instruments with a remaining term equal to the expected life.

Other information pertaining to option activity is as follows:

	Year Ended December 31,		
	2012[1]	2011	2010
Weighted-average fair value of options granted	—	$ 13.94	$11.60
Total intrinsic value of stock options exercised	$24,120	$11,744	$1,999

[1] No options were awarded in the year ended December 31, 2012.

A summary of the Company's non-vested restricted stock and restricted stock unit shares as of December 31, 2012, and changes during the year ended December 31, 2012, is presented below:

	Shares	Weighted Average Grant Date Fair Value
Non-vested balance as of December 31, 2011	2,118,603	$28.55
Granted	1,035,721	44.69
Vested	(953,033)	26.20
Forfeited	(142,383)	35.84
Non-vested balance as of December 31, 2012	2,058,908	$37.25

The total fair value of restricted stock and restricted stock units vested during the years ended December 31, 2012, 2011 and 2010, was $38,576, $22,280 and $13,012, respectively.

As of December 31, 2012, there was $67,834 of total unrecognized compensation cost related to non-vested share-based compensation arrangements granted under the plans; that cost is expected to be recognized over a weighted-average period of 1.7 years. The actual tax benefit realized for the tax deductions from stock option exercises totaled $1,078, $955 and $883 for the years ended December 31, 2012, 2011 and 2010, respectively.

The Company maintains an employee stock purchase plan and has issued 47,613 shares, 34,966 shares, and 37,048 shares in 2012, 2011 and 2010, respectively.

16. Retirement Plan

Centene has a defined contribution plan which covers substantially all employees who are at least twenty-one years of age. Under the plan, eligible employees may contribute a percentage of their base salary, subject to certain limitations. Centene may elect to match a portion of the employee's contribution. Company expense related to matching contributions to the plan was $6,959, $5,146 and $4,044 during the years ended December 31, 2012, 2011 and 2010, respectively.

17. Commitments

Centene and its subsidiaries lease office facilities and various equipment under non-cancelable operating leases which may contain escalation provisions. The rental expense related to these leases is recorded on a straight-line basis over the lease term, including rent holidays. Tenant improvement allowances are recorded as a liability and amortized against rent expense over the term of the lease. Rent expense was $27,935, $22,734 and $21,393 for the years ended December 31, 2012, 2011 and 2010, respectively. Annual non-cancelable minimum lease payments over the next five years and thereafter are as follows:

2013	$ 22,053
2014	20,423
2015	17,975
2016	16,655
2017	11,940
Thereafter	13,895
	$102,941

18. Contingencies

The Company is routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters is uncertain, the Company does not expect the results of any of these matters discussed above individually, or in the aggregate, to have a material effect on its financial position or results of operations.

19. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings per common share for the years ended December 31:

	2012	2011	2010
Earnings attributable to Centene Corporation:			
Earnings from continuing operations, net of tax	$ 1,859	$ 111,218	$ 90,947
Discontinued operations, net of tax	—	—	3,889
Net earnings	$ 1,859	$ 111,218	$ 94,836
Shares used in computing per share amounts:			
Weighted average number of common shares outstanding	51,509,366	50,198,954	48,754,947
Common stock equivalents (as determined by applying the treasury stock method)	2,205,009	2,275,284	1,692,941
Weighted average number of common shares and potential dilutive common shares outstanding	53,714,375	52,474,238	50,447,888
Net earnings per common share attributable to Centene Corporation:			
Basic:			
Continuing operations	$ 0.04	$ 2.22	$ 1.87
Discontinued operations	—	—	0.08
Basic earnings per common share	$ 0.04	$ 2.22	$ 1.95
Diluted:			
Continuing operations	$ 0.03	$ 2.12	$ 1.80
Discontinued operations	—	—	0.08
Diluted earnings per common share	$ 0.03	$ 2.12	$ 1.88

The calculation of diluted earnings per common share for 2012, 2011 and 2010 excludes the impact of 142,425 shares, 106,219 shares and 2,010,183 shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

20. Segment Information

Centene operates in two segments: Medicaid Managed Care and Specialty Services. The Medicaid Managed Care segment consists of Centene's health plans including all of the functions needed to operate them. The Specialty Services segment consists of Centene's specialty companies offering products for behavioral health, care management software, health insurance exchanges, individual health insurance, life and health management, LTC, managed vision, telehealth services, and pharmacy benefits management. The health plans in Arizona, operated by our LTC company, and Massachusetts, operated by our individual health insurance provider, are also included in the Specialty Services segment.

Factors used in determining the reportable business segments include the nature of operating activities, existence of separate senior management teams, and the type of information presented to the Company's chief operating decision maker to evaluate all results of operations.

Segment information as of and for the year ended December 31, 2012, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$7,394,173	$ 844,774	$ —	$8,238,947
Premium and service revenues from internal customers	89,143	1,706,161	(1,795,304)	—
Total premium and service revenues	7,483,316	2,550,935	(1,795,304)	8,238,947
Earnings from operations	(83,189)	56,068	—	(27,121)
Total assets	2,365,651	376,031	—	2,741,682

Segment information as of and for the year ended December 31, 2011, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$4,450,336	$ 730,671	$ —	$5,181,007
Premium and service revenues from internal customers	65,215	753,596	(818,811)	—
Total premium and service revenues	4,515,551	1,484,267	(818,811)	5,181,007
Earnings from operations	152,995	37,329	—	190,324
Total assets	1,754,108	436,228	—	2,190,336

Segment information as of and for the year ended December 31, 2010, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$3,679,807	$ 604,026	$ —	$4,283,833
Premium and service revenues from internal customers	60,676	508,157	(568,833)	—
Total premium and service revenues	3,740,483	1,112,183	(568,833)	4,283,833
Earnings from operations	117,106	39,963	—	157,069
Total assets	1,552,886	390,996	—	1,943,882

21. Quarterly Selected Financial Information

(In thousands, except share data and membership data)
(Unaudited)

	For the Quarter Ended			
	March 31, 2012	June 30, 2012	September 30, 2012	December 31, 2012
Total revenues	$1,712,148	$2,110,746	$2,448,121	$2,396,597
Net earnings attributable to Centene Corporation common shareholders	$ 23,978	$ (34,999)	$ 3,819	$ 9,061
Net earnings (loss) per share attributable to Centene Corporation:				
Basic earnings (loss) per common share	$ 0.47	$ (0.68)	$ 0.07	$ 0.17
Diluted earnings (loss) per common share	$ 0.45	$ (0.68)	$ 0.07	$ 0.17
Period end at-risk membership	2,149,500	2,397,500	2,503,000	2,560,300

	For the Quarter Ended			
	March 31, 2011	June 30, 2011	September 30, 2011	December 31, 2011
Total revenues	$1,216,357	$1,315,014	$1,302,035	$1,507,176
Net earnings attributable to Centene Corporation common shareholders	$ 23,745	$ 28,374	$ 28,987	$ 30,112
Net earnings per share attributable to Centene Corporation:				
Basic earnings per common share	$ 0.48	$ 0.57	$ 0.58	$ 0.60
Diluted earnings per common share	$ 0.46	$ 0.54	$ 0.55	$ 0.57
Period end at-risk membership	1,542,500	1,580,500	1,615,700	1,816,000

22. Condensed Financial Information of Registrant

Centene Corporation (Parent Company Only)
Condensed Balance Sheets
(In thousands, except share data)

	December 31, 2012	December 31, 2011
ASSETS		
Current assets:		
Cash and cash equivalents	$ 22,279	$ 28,527
Short-term investments, at fair value (amortized cost $6,500 and $0, respectively)	6,500	—
Other current assets	42,230	36,354
Total current assets	71,009	64,881
Long-term investments, at fair value (amortized cost $1,356 and $4,164, respectively)	1,356	4,164
Investment in subsidiaries	1,298,648	1,105,491
Other long-term assets	42,523	32,105
Total assets	$1,413,536	$1,206,641
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities	$ 4,333	$ 3,100
Long-term debt	449,127	258,617
Other long-term liabilities	6,309	8,505
Total liabilities	459,769	270,222
Stockholders' equity:		
Common stock, $.001 par value; authorized 100,000,000 shares; 55,339,160 issued and 52,329,248 outstanding at December 31, 2012, and 53,586,726 issued and 50,864,618 outstanding at December 31, 2011	55	54
Additional paid-in capital	450,856	421,981
Accumulated other comprehensive income:		
Unrealized gain on investments, net of tax	5,189	5,761
Retained earnings	566,820	564,961
Treasury stock, at cost (3,009,912 and 2,722,108 shares, respectively)	(69,864)	(57,123)
Total Centene stockholders' equity	953,056	935,634
Noncontrolling interest	711	785
Total stockholders' equity	953,767	936,419
Total liabilities and stockholders' equity	$1,413,536	$1,206,641

See notes to condensed financial information of registrant.

Centene Corporation (Parent Company Only)
Condensed Statements of Operations
(In thousands, except share data)

	Year Ended December 31,		
	2012	2011	2010
Expenses:			
General and administrative expenses	$ 4,090	$ 4,488	$ 3,502
Other income (expense):			
Investment and other income	19,921	(8,790)	(4,700)
Interest expense	(15,757)	(15,494)	(14,844)
Earnings (loss) before income taxes	74	(28,772)	(23,046)
Income tax benefit	(9,668)	(12,825)	(8,576)
Net earnings (loss) before equity in subsidiaries	9,742	(15,947)	(14,470)
Equity in earnings from subsidiaries	(7,883)	127,165	109,306
Net earnings	$ 1,859	$ 111,218	$ 94,836
Net earnings per share from continuing operations:			
Basic earnings per common share	$ 0.04	$ 2.22	$ 1.87
Diluted earnings per common share	$ 0.03	$ 2.12	$ 1.80
Weighted average number of shares outstanding:			
Basic	51,509,366	50,198,954	48,754,947
Diluted	53,714,375	52,474,238	50,447,888

See notes to condensed financial information of registrant.

Centene Corporation (Parent Company Only)
Condensed Statements of Cash Flows
(In thousands)

	Year Ended December 31,		
	2012	2011	2010
Cash flows from operating activities:			
Cash provided by operating activities	$ 327,940	$ 72,754	$ 23,504
Cash flows from investing activities:			
Net dividends from and capital contributions to subsidiaries	(539,575)	(50,581)	(17,172)
Purchase of investments	(7,320)	(21,915)	(86,549)
Sales and maturities of investments	30,000	11,111	90,121
Acquisitions, net of cash acquired	—	(1,773)	(48,656)
Proceeds from asset sales	—	—	13,420
Net cash used in investing activities	(516,895)	(63,158)	(48,836)
Cash flows from financing activities:			
Proceeds from borrowings	400,500	419,183	91,000
Payment of long-term debt and notes payable	(215,000)	(413,644)	(115,000)
Proceeds from exercise of stock options	15,912	15,815	3,419
Common stock offering	—	—	104,534
Common stock repurchases	(12,741)	(7,809)	(3,224)
Debt issue costs	(3,623)	(9,242)	—
Distribution to noncontrolling interest	—	—	(8,158)
Contributions from noncontrolling interest	1,092	813	771
Purchase of noncontrolling interest	(14,429)	—	(48,257)
Excess tax benefits from stock compensation	10,996	4,435	963
Net cash provided by financing activities	182,707	9,551	26,048
Net increase (decrease) in cash and cash equivalents	(6,248)	19,147	716
Cash and cash equivalents, beginning of period	28,527	9,380	8,664
Cash and cash equivalents, end of period	$ 22,279	$ 28,527	$ 9,380

See notes to condensed financial information of registrant.

Notes to Condensed Financial Information of Registrant

Note A – Basis of Presentation and Significant Accounting Policies

The parent company only financial statements should be read in conjunction with Centene Corporation's audited consolidated financial statements and the notes to consolidated financial statements included in this Form 10-K.

The parent company's investment in subsidiaries is stated at cost plus equity in undistributed earnings of the subsidiaries. The parent company's share of net income of its unconsolidated subsidiaries is included in income using the equity method of accounting. Certain unrestricted subsidiaries receive monthly management fees from our restricted subsidiaries. The management and service fees received by our unrestricted subsidiaries are associated with all of the functions required to manage the restricted subsidiaries including but not limited to salaries and wages for all personnel, rent, utilities, medical management, provider contracting, compliance, member services, claims processing, information technology, cash management, finance and accounting, and other services. The management fees are based on a percentage of the restricted subsidiaries revenue.

Due to our centralized cash management function, all cash flows generated by our unrestricted subsidiaries, including management fees, are transferred to the parent company, primarily to repay borrowings on the parent company's revolving credit facility. The parent company may also utilize the cash flow to make acquisitions, fund capital contributions to subsidiaries and fund its operations. During the years ended December 31, 2012, 2011 and 2010, cash flows received by the parent from unrestricted subsidiaries was $318,198, $88,701, and $37,974 and was included in cash flows from operating activities.

Certain amounts presented in the parent company only financial statements are eliminated in the consolidated financial statements of Centene Corporation.

Note B – Dividends

During 2012, 2011 and 2010, the Registrant received dividends from its subsidiaries totaling $29,000, $69,100 and $67,900, respectively.

23. Subsequent Events

In January 2013, the Company signed a definitive agreement to acquire AcariaHealth, a comprehensive specialty pharmacy company, for $152,000. The transaction consideration is anticipated to be financed through a combination of approximately 60% Centene common stock with the remainder from cash on hand and existing credit facilities. The acquisition is expected to close in the first quarter of 2013, subject to regulatory approval and other customary conditions.

Item 9. ***Changes in and Disagreements With Accountants on Accounting and Financial Disclosure***

None.

Item 9A. ***Controls and Procedures.***

Evaluation of Disclosure Controls and Procedures — Our management, with the participation of our Chief Executive Officer and Chief Financial Officer, evaluated the effectiveness of our disclosure controls and procedures as of December 31, 2012. The term "disclosure controls and procedures," as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act, means controls and other procedures of a company that are designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is accumulated and communicated to the company's management, including its principal executive and principal financial officers, as appropriate to allow timely decisions regarding required disclosure. Management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving their objectives and management necessarily applies its judgment in evaluating the cost-benefit relationship of possible controls and procedures. Based on the evaluation of our disclosure controls and procedures as of December 31, 2012, our Chief Executive Officer and Chief Financial Officer concluded that, as of such date, our disclosure controls and procedures were effective at the reasonable assurance level.

Management's Report on Internal Control Over Financial Reporting — Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Exchange Act Rules 13a-15(f) and 15d-15(f). Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation 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. Based on our evaluation under the framework in *Internal Control — Integrated Framework*, our management concluded that our internal control over financial reporting was effective at the reasonable assurance level as of December 31, 2012. Our management's assessment of the effectiveness of our internal control over financial reporting as of December 31, 2012 has been audited by KPMG LLP, an independent registered public accounting firm, as stated in their report which is included herein.

Changes in Internal Control Over Financial Reporting — No change in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) occurred during the year ended December 31, 2012 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
Centene Corporation:

We have audited Centene Corporation's internal control over financial reporting as of December 31, 2012, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). Centene Corporation'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, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included 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 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 its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that 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, Centene Corporation maintained, in all material respects, effective internal control over financial reporting as of December 31, 2012, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Centene Corporation and subsidiaries as of December 31, 2012 and 2011, and the related consolidated statements of operations, comprehensive earnings, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2012, and our report dated February 18, 2013 expressed an unqualified opinion on those consolidated financial statements.

KPMG LLP

St. Louis, Missouri
February 18, 2013

Item 9B. ***Other Information***

None.

PART III

Item 10. ***Directors, Executive Officers and Corporate Governance***

(a) Directors of the Registrant

Information concerning our directors will appear in our Proxy Statement for our 2013 annual meeting of stockholders under "Proposal One: Election of Directors". This portion of the Proxy Statement is incorporated herein by reference.

(b) Executive Officers of the Registrant

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant."

Information concerning our executive officers' compliance with Section 16(a) of the Exchange Act will appear in our Proxy Statement for our 2013 annual meeting of stockholders under "Section 16(a) Beneficial Ownership Reporting Compliance." Information concerning our audit committee financial expert and identification of our audit committee will appear in our Proxy Statement for our 2013 annual meeting of stockholders under "Board of Directors Committees." Information concerning our code of ethics will appear in our Proxy Statement for our 2013 annual meeting of stockholders under "Corporate Governance and Risk Management." These portions of our Proxy Statement are incorporated herein by reference.

(c) Corporate Governance

Information concerning certain corporate governance matters will appear in our Proxy Statement for our 2013 annual meeting of stockholders under "Corporate Governance and Risk Management." These portions of our Proxy Statement are incorporated herein by reference.

Item 11. ***Executive Compensation***

Information concerning executive compensation will appear in our Proxy Statement for our 2013 Annual Meeting of Stockholders under "Information About Executive Compensation." Information concerning Compensation Committee interlocks and insider participation will appear in the Proxy Statement for our 2013 Annual Meeting of Stockholders under "Compensation Committee Interlocks and Insider Participation." These portions of the Proxy Statement are incorporated herein by reference.

Item 12. ***Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters***

Information concerning the security ownership of certain beneficial owners and management and our equity compensation plans will appear in our Proxy Statement for our 2013 annual meeting of stockholders under "Information About Stock Ownership" and "Equity Compensation Plan Information." These portions of the Proxy Statement are incorporated herein by reference.

Item 13. ***Certain Relationships and Related Transactions, and Director Independence***

Information concerning director independence, certain relationships and related transactions will appear in our Proxy Statement for our 2013 annual meeting of stockholders under "Corporate Governance and Risk Management" and "Related Party Transactions." These portions of our Proxy Statement are incorporated herein by reference.

Item 14. ***Principal Accountant Fees and Services***

Information concerning principal accountant fees and services will appear in our Proxy Statement for our 2013 annual meeting of stockholders under "Proposal Two: Ratification of Appointment of Independent Registered Public Accounting Firm." This portion of our Proxy Statement is incorporated herein by reference.

PART IV

Item 15. ***Exhibits and Financial Statement Schedules***

(a) **Financial Statements and Schedules**

The following documents are filed under Item 8 of this report:

1. Financial Statements:

   Report of Independent Registered Public Accounting Firm
   Consolidated Balance Sheets as of December 31, 2012 and 2011
   Consolidated Statements of Operations for the Years ended December 31, 2012, 2011 and 2010
   Consolidated Statements of Stockholders' Equity for the Years ended December 31, 2012, 2011 and 2010
   Consolidated Statements of Cash Flows for the Years ended December 31, 2012, 2011 and 2010
   Notes to Consolidated Financial Statements

2. Financial Statement Schedules:

   None.

3. The exhibits listed in the accompanying Exhibit Index are filed or incorporated by reference as part of this filing.

EXHIBIT INDEX

EXHIBIT NUMBER	DESCRIPTION	FILED WITH THIS FORM 10-K	INCORPORATED BY REFERENCE [1]		
			FORM	FILING DATE WITH SEC	EXHIBIT NUMBER
3.1	Certificate of Incorporation of Centene Corporation		S-1	October 9, 2001	3.2
3.1a	Certificate of Amendment to Certificate of Incorporation of Centene Corporation, dated November 8, 2001		S-1/A	November 13, 2001	3.2a
3.1b	Certificate of Amendment to Certificate of Incorporation of Centene Corporation as filed with the Secretary of State of the State of Delaware		10-Q	July 26, 2004	3.1b
3.2	By-laws of Centene Corporation		S-1	October 9, 2001	3.4
4.1	Indenture, dated May 27, 2011, among the Company and The Bank of New York Mellon Trust Company, N.A., relating to the Company's 5.75% Senior Notes due 2017 (including Form of Global Note as Exhibit A thereto)		8-K	May 27, 2011	4.1
10.1**	Contract between the Texas Health and Human Services Commission and Superior HealthPlan, Inc.		10-Q	October 25, 2011	10.2
10.1a**	Amendment A (Version 2.1) to Contract between the Texas Health and Human Services Commission and Superior HealthPlan, Inc.		10-Q	April 24, 2012	10.1
10.1b**	Amendment B (Version 2.2) to Contract between the Texas Health and Human Services Commission and Superior HealthPlan, Inc.		10-Q	July 24, 2012	10.1
10.1c**	Amendment C (Version 2.3) to Contract between the Texas Health and Human Services Commission and Superior HealthPlan, Inc.		10-Q	October 23, 2012	10.1
10.2*	1996 Stock Plan of Centene Corporation, shares which are registered on Form S-8 – File Number 333-83190		S-1	October 9, 2001	10.9
10.3*	1998 Stock Plan of Centene Corporation, shares which are registered on Form S-8 – File number 333-83190		S-1	October 9, 2001	10.10
10.4*	1999 Stock Plan of Centene Corporation, shares which are registered on Form S-8 – File Number 333-83190		S-1	October 9, 2001	10.11
10.5*	2000 Stock Plan of Centene Corporation, shares which are registered on Form S-8 – File Number 333-83190		S-1	October 9, 2001	10.12

EXHIBIT NUMBER	DESCRIPTION	FILED WITH THIS FORM 10-K	INCORPORATED BY REFERENCE [1]		
			FORM	FILING DATE WITH SEC	EXHIBIT NUMBER
10.6*	2002 Employee Stock Purchase Plan of Centene Corporation, shares which are registered on Form S-8 – File Number 333-90976		10-Q	April 29, 2002	10.5
10.6a*	First Amendment to the 2002 Employee Stock Purchase Plan		10-K	February 24, 2005	10.9a
10.6b*	Second Amendment to the 2002 Employee Stock Purchase Plan		10-K	February 24, 2006	10.10b
10.70*	Centene Corporation Amended and Restated 2003 Stock Incentive Plan, shares which are registered on Form S-8 – File Number 333-108467		8-K	April 30, 2010	10.1
10.8*	2012 Stock Plan of Centene Corporation, shares which are registered on Form S-8 – File Number 333-180976		DEF 14A	March 9, 2012	4
10.9*	Centene Corporation Non-Employee Directors Deferred Stock Compensation Plan		10-Q	October 25, 2004	10.1
10.9a*	First Amendment to the Non-Employee Directors Deferred Stock Compensation Plan		10-K	February 24, 2006	10.12a
10.10*	Centene Corporation Employee Deferred Compensation Plan		10-K	February 22, 1010	10.10
10.11*	Centene Corporation 2007 Long-Term Incentive Plan		8-K	April 26, 2007	10.2
10.12*	Centene Corporation Short-Term Executive Compensation Plan		10-K	February 22, 2011	10.12
10.13*	Executive Employment Agreement between Centene Corporation and Michael F. Neidorff, dated November 8, 2004		8-K	November 9, 2004	10.1
10.13a*	Amendment No. 1 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	October 28, 2008	10.2
10.13b*	Amendment No. 2 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	April 28, 2009	10.2
10.13c*	Amendment No. 3 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	October 23, 2012	10.2
10.14*	Form of Executive Severance and Change in Control Agreement		10-Q	October 28, 2008	10.3

EXHIBIT NUMBER	DESCRIPTION	FILED WITH THIS FORM 10-K	INCORPORATED BY REFERENCE [1]		
			FORM	FILING DATE WITH SEC	EXHIBIT NUMBER
10.14a*	Amendment No. 1 to Form of Executive Severance and Change in Control Agreement		10-Q	October 23, 2012	10.3
10.15*	Form of Restricted Stock Unit Agreement		10-Q	October 28, 2008	10.4
10.16*	Form of Non-statutory Stock Option Agreement (Non-Employees)		8-K	July 28, 2005	10.3
10.17*	Form of Non-statutory Stock Option Agreement (Employees)		10-Q	October 28, 2008	10.5
10.18*	Form of Non-statutory Stock Option Agreement (Directors)		10-K	February 23, 2009	10.18
10.19*	Form of Incentive Stock Option Agreement		10-Q	October 28, 2008	10.6
10.20*	Form of Stock Appreciation Right Agreement		8-K	July 28, 2005	10.6
10.21*	Form of Restricted Stock Agreement		10-Q	October 25, 2005	10.8
10.22*	Form of Performance Based Restricted Stock Unit Agreement #1		10-Q	October 28, 2008	10.7
10.23*	Form of Performance Based Restricted Stock Unit Agreement #2		10-K	February 23, 2009	10.23
10.24*	Form of Long Term Incentive Plan Agreement		8-K	February 7, 2008	10.1
10.25	Credit Agreement dated as of January 31, 2011 among Centene Corporation, the various financial institutions party hereto and Barclays Bank PLC		10-K	February 22, 2011	10.26
10.25a	Amendment No. 1 to Credit Agreement dated as of November 2, 2012 among Centene Corporation, the various financial institutions party hereto and Barclays Bank PLC		8-K	November 7, 2012	10.1
10.25b	Amendment No. 2 to Credit Agreement dated as of February 12, 2013 among Centene Corporation, the various financial institutions party hereto and Barclays Bank PLC		8-K	February 15, 2013	10.1
12.1	Computation of ratio of earnings to fixed charges	X			
21	List of subsidiaries	X			
23	Consent of Independent Registered Public Accounting Firm incorporated by reference in each prospectus constituting part of the Registration Statements on Form S-3 (File Numbers 333-174164) and on Form S-8 (File Numbers 333-108467, 333-90976, 333-83190 and 333-180976)	X			

EXHIBIT NUMBER	DESCRIPTION	FILED WITH THIS FORM 10-K	INCORPORATED BY REFERENCE [1]		
			FORM	FILING DATE WITH SEC	EXHIBIT NUMBER
31.1	Certification Pursuant to Rule 13a-14(a) and 15d-14 (a) of the Exchange Act, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 (Chief Executive Officer)	X			
31.2	Certification Pursuant to Rule 13a-14(a) and 15d-14 (a) of the Exchange Act, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 (Chief Financial Officer)	X			
32.1	Certification Pursuant to 18 U.S.C. Section 1350 (Chief Executive Officer)	X			
32.2	Certification Pursuant to 18 U.S.C. Section 1350 (Chief Financial Officer)	X			
101.1	XBRL Taxonomy Instance Document.	X			
101.2	XBRL Taxonomy Extension Schema Document.	X			
101.3	XBRL Taxonomy Extension Calculation Linkbase Document.	X			
101.4	XBRL Taxonomy Extension Definition Linkbase Document.	X			
101.5	XBRL Taxonomy Extension Label Linkbase Document.	X			
101.6	XBRL Taxonomy Extension Presentation Linkbase Document.	X			

[1] SEC File No. 001-31826 (for filings prior to October 14, 2003, the Registrant's SEC File No. was 000-33395).

* Indicates a management contract or compensatory plan or arrangement.

** The Company has requested confidential treatment of the redacted portions of this exhibit pursuant to Rule 24b-2 under the Securities Exchange Act of 1934, as amended, and has separately filed a complete copy of this exhibit with the Securities and Exchange Commission.

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, as of February 19, 2013.

CENTENE CORPORATION

By: /s/ MICHAEL F. NEIDORFF
Michael F. Neidorff
Chairman and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities as indicated, as of February 19, 2013.

Signature	Title
/s/ MICHAEL F. NEIDORFF **Michael F. Neidorff**	Chairman and Chief Executive Officer (principal executive officer)
/s/ WILLIAM N. SCHEFFEL **William N. Scheffel**	Executive Vice President and Chief Financial Officer (principal financial officer)
/s/ JEFFREY A. SCHWANEKE **Jeffrey A. Schwaneke**	Senior Vice President, Corporate Controller and Chief Accounting Officer (principal accounting officer)
/s/ ORLANDO AYALA **Orlando Ayala**	Director
/s/ ROBERT K. DITMORE **Robert K. Ditmore**	Director
/s/ FRED H. EPPINGER **Fred H. Eppinger**	Director
/s/ RICHARD A. GEPHARDT **Richard A. Gephardt**	Director
/s/ PAMELA A. JOSEPH **Pamela A. Joseph**	Director
/s/ JOHN R. ROBERTS **John R. Roberts**	Director
/s/ DAVID L. STEWARD **David L. Steward**	Director
/s/ TOMMY G. THOMPSON **Tommy G. Thompson**	Director

EXHIBIT 31.1

CERTIFICATION

I, Michael F. Neidorff, certify that:

1. I have reviewed this Annual Report on Form 10-K of Centene Corporation;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
    a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
    b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, 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;
    c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
    d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
    a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
    b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: February 19, 2013

/s/ MICHAEL F. NEIDORFF

Chairman, President and Chief Executive Officer
(principal executive officer)

EXHIBIT 31.2

CERTIFICATION

I, William N. Scheffel, certify that:

1. I have reviewed this Annual Report on Form 10-K of Centene Corporation;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
   a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
   b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, 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;
   c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
   d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
   a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: February 19, 2013

/s/ WILLIAM N. SCHEFFEL

Executive Vice President and Chief Financial Officer
(principal financial officer)

EXHIBIT 32.1

**CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the annual report on Form 10-K of Centene Corporation (the Company) for the period ended December 31, 2012, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, Michael F. Neidorff, Chairman, President and Chief Executive Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: February 19, 2013

/s/ MICHAEL F. NEIDORFF

Chairman, President and Chief Executive Officer
(principal executive officer)

EXHIBIT 32.2

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the annual report on Form 10-K of Centene Corporation (the Company) for the period ended December 31, 2012, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, William N. Scheffel, Executive Vice President and Chief Financial Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: February 19, 2013

/s/ WILLIAM N. SCHEFFEL

Executive Vice President and Chief Financial Officer
(principal financial officer)

nebraska total care™

C. CHANGE OF OWNERSHIP

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.

A change in ownership of Nebraska Total Care (NTC) is not anticipated during the 12 months following the proposal due date. A change in ownership of NTC's parent, Centene Corporation, is not anticipated during the 12 months following the proposal due date.

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D. OFFICE LOCATION

D. OFFICE LOCATION

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.

Nebraska Total Care, Inc. office location:
1299 Farnam Street
Suite 300
Omaha, NE 68102

nebraska total care™

E. RELATIONSHIPS WITH THE STATE

E. RELATIONSHIPS WITH THE STATE

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.

Neither Nebraska Total Care, nor any named party in its proposal response, has contracted with the State currently or over the previous five years.

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F. BIDDER'S EMPLOYEE RELATIONS TO STATE

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.

Nebraska Total Care has not employed any individuals that were previous employees of the State within the last twelve months.

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.

As of December 31, 2015, Nebraska Total Care has not employed or subcontracted with any individual that has state of Nebraska employment experience within the last twelve months.

nebraska total care™

G. CONTRACT PERFORMANCE

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.

Nebraska Total Care and its subcontractors have performed successfully in accord with contract requirements in all engagements defined in the RFP and have not had a contract terminated for default, except in the following circumstances during the previous five years.

The following Proposed Subcontractors have had zero terminations for reason of default:

- Cenpatico Behavioral Health
- Centene Management Company
- National Imaging Associates
- Nurtur Health, Inc.
- Opticare Managed Vision
- US Medical Management
- US Script
- LifeShare

Our affiliated subcontractor NurseWise has had the following terminations for default within the past five years. Please see table on the following page for a detailed description.

Client	Termination Date	Client Contact	Client Address	Client Phone	Reason for Termination/ Non-renewal
Boston University	5/2/2011	Dr. David McBride	881 Commonwealth Ave, Boston, MA 02215	617-353-3575	Contract fully terminated with cause. Client dissatisfied with the engagement of on-call providers for Behavioral Health Calls by call center staff. Improper paging of University Behavioral Health on-call provider by Nurse Advice Line Staff. Resolution - Nurse Response developed several processes to ensure the proper utilization of on-call providers. The Quality Department, along with Call Center Operations Management team developed a plan to move the Behavioral Health Calls to a defined pod of representatives to handle the specialized Behavioral Health calls. As well, Nurse Response increased auditing to monitor process.
California Polytechnic – Pomona	6/30/2015	Becky Pepping, Procurement Buyer California State Polytechnic University, Pomona	3801 West Temple Ave., Pomona, CA 91768	909-869-6842	Canceled due to concerns regarding overall responsiveness and late or missing monthly reports.

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.

Nebraska Total Care is a newly formed entity for the sole purpose of responding to the statewide Medicaid Integrated Managed Care RFP. Nebraska Total Care has not incurred any contract terminations due to default in the past five years.

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.

Nebraska Total Care and its subcontractors declare that we have not incurred any contract terminations due to convenience, or non-allocation of funds. As noted above, NurseWise contracts with Boston University and California Polytechnic – Pomona, were terminated due to performance issues within the past five years.

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H. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

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.

Similarities Between NTC's Experience and This Request for Proposal

Nebraska Total Care (NTC) is a wholly-owned subsidiary of Centene Corporation (Centene). NTC is a Nebraska-based company established for the sole purpose of providing Medicaid managed care services through the Heritage Health program. Centene and its affiliated health plans are recognized leaders in government sponsored managed care programs. NTC will utilize and expand upon Centene's national expertise and best practices for our health plan in Nebraska. With the wealth of experience and the support of our corporate team as well as that of our affiliated health plans and specialty companies, we have tailored our approach to service delivery to maximize effectiveness, efficiency and accountability. We look forward to bringing this experience to the Heritage Health program to implement innovative programs that will meet the unique needs of our members, providers and community stakeholders.

Our experience includes serving members in all aid categories. We currently provide services to similar populations as those covered by the Heritage Health program, including integrated behavioral health and pharmacy in California, Florida, Illinois, Indiana, Kansas, Louisiana, Mississippi, New Hampshire, Ohio, Oregon, South Carolina, Washington, Wisconsin and Texas. Please see the figure below for more details

on our experience in serving all aid categories. ***Figure 1: Categories of Aid Covered by Centene***

	AZ	AR	CA	FL	GA	IL	IN	KS	LA	MA	MI	MN	MS	MO	NH	OH	OR	SC	TN	TX	VT	WA	WI
Categories of Aid																							
TANF			•	•	•	•	•	•	•				•	•	•	•	•	•		•		•	•
Medicaid Expansion		•	•			•	•			•					•	•	•					•	
CHIP			•	•	•		•	•	•				•	•	•	•	•	•		•		•	•
ABD (non-duals)			•	•		•	•	•	•				•		•	•	•	•		•		•	•
ABD (Medicaid only dual-eligibles)			•	•				•							•	•	•			•			•
Dual Demonstrations (including LTSS)						•					•					•		•		•			
Intellectually/Developmentally Disabled						•		•							•					•			
Long-Term Services and Supports	•			•		•		•							•	•				•			
Foster Care			•	•			•	•	•				•	•	•					•		•	
Medicare Special Needs Plan	•			•	•						•					•	•			•			•
Health Insurance Marketplaces		•		•	•	•	•			•			•			•	•			•		•	•
Correctional Healthcare										•		•	•						•		•		
Specialty Services																							
Pharmacy Benefits	•	•	•	•	•	•	•	•	•	•	•		•		•	•		•		•		•	
Behavioral & Specialty Therapies	•	•	•	•	•	•	•	•	•	•	•		•	•	•	•		•		•		•	•
Life & Health Management	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•		•	•	•		•	•
Primary Care Solutions for Complex Populations				•			•	•						•		•				•			•
Managed Vision	•	•	•	•	•	•	•	•	•	•	•		•	•	•	•		•		•		•	•
Dental Benefits	•	•		•	•	•		•		•	•		•	•		•				•			•
Telehealth (Nurse Triage and Education Line)	•	•	•	•	•	•	•	•	•	•	•		•	•	•	•		•		•		•	•

NH: *Waiver HCBS services and nursing facility services are anticipated to go-live January 1, 2016 and July 1, 2016, respectively.*
Dental Benefits: *Centene is in process of transitioning dental services from external vendors to our new dental benefit management subsidiary.*

In addition to the experience of our affiliate health plans, NTC will draw on the experience and services of our affiliate specialty companies. The ability to rely on affiliated specialty companies to perform our subcontracted activities leads to a seamless service delivery system for our members. A full list of our specialty health solutions and the markets where they are contracted with our affiliate health plans is presented in the figure below.

Figure 2: Health Services Corporate Experience

Specialty Health Solutions	AZ	AR	CA	FL	GA	IL	IN	KS	LA	MA	MI	MN	MS	MO	NH	OH	OR	SC	TN	TX	VT	WA	WI
Pharmacy Benefits	•	•	•	•	•	•		•	•	•	•		•		•	•		•		•		•	
Behavioral & Specialty Therapies	•	•	•	•	•	•	•	•	•	•	•		•	•	•	•		•		•		•	•
Life & Health Management	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•		•	•	•		•	•
Primary Care Solutions for Complex Populations				•			•	•						•		•				•			•
Managed Vision	•	•	•	•	•	•	•	•	•	•	•		•	•	•	•		•		•		•	•
Dental Benefits[1]	•	•		•	•	•		•		•	•		•	•		•				•			•
Telehealth (Nurse Triage and Education Line)	•	•	•	•	•	•	•	•	•	•	•		•	•	•	•		•		•		•	•

[1] *Centene is in process of transitioning dental services from external vendors to our new dental benefit management subsidiary.*

A National Partner with Broad Medicaid Expertise

Centene is a veteran leader in providing managed care services to and improving health outcomes for Medicaid and other public sector populations (such as children and adults with complex/special needs and child/youth in Child Welfare or receiving adoption assistance). With over 30 years of experience, Centene currently serves more than 4.8 million individuals enrolled in government funded programs in rural/urban and underserved markets. We also have built and retained contracted partnerships with more than 248,000 physicians and 2,300 hospitals (many of them academic institutions) nationwide.

We are solely focused on Medicaid and other government sponsored health programs, allowing us to bring a full compendium of best practices to Nebraska. Centene provides Medicaid and Medicaid-related health plan coverage to individuals through government-subsidized programs, including Temporary Assistance for Needy Families (TANF), the Children's Health Insurance Program (CHIP), Supplemental Security Income (SSI)/Aged, Blind and Disabled (collectively ABD), Foster Care/Adoption Assistance, Long Term Services and Supports (LTSS), subsidized commercial health insurance for uninsured (Exchange) and Medicare enrollees (the latter through Special Needs Plans).

Centene Specialty Services include pharmacy benefits management, behavioral health, dental benefits administration, vision care, life and health management, a 24/7 nurse advice line, medication treatment compliance and in-home health services. Through our internal Specialty Services, NTC brings a comprehensive solution designed for integrated health care solutions that address the often complex needs of Medicaid Members.

Longstanding Experience Serving Different Populations. Centene affiliates successfully manage all populations and services nationwide, and we bring deep organizational expertise serving individuals with complex needs as well as supporting the providers who serve them. We especially bring Nebraska significant knowledge and expertise based on serving children, adults and their families enrolled in the following programs:

- **TANF**: 3.5 million
- **ABD** and **Dual Eligibles**: 445,000
- **CHIP & Foster Care**: 245,200
- **LTSS**: 74,000

In addition, we bring experience and best practices from Kansas, New Hampshire and Texas from our plans that are working with the Intellectually and Developmentally Disabled populations, providers and support services. Our Arizona affiliate is working with Native American Tribes with a focus on behavioral health, substance abuse and social determinant related care. Their Tribal Liaison, Sheina Yellowhair, has partnered with the Arizona tribal communities to adapt the state's Meet Me Where I Am (MMWIA) best practice for tribal communities. This is a key differentiator amongst the competitors in the market. In all aspects of these and the more traditional populations we have been working to build strong support and community based services to strengthen the coordination and levels of care to our members.

Child Welfare. Centene plans are the **sole source health plan** for children/youth in foster care and/or adoption assistance in three states (Texas, Florida, Mississippi and most recently a soon-to-be fourth in Washington state), and provide managed care services to children/youth in a total of 10 states. Our Texas affiliate has managed the first fully integrated, sole source managed care program for children in foster care in the country since 2008, and created the national gold standard for Foster Care provider networks, including a trauma-informed specialty network. Our award-winning Health Passport community health record ensures that all key stakeholders have access to the most critical information about each child when placements change.

We also have developed national expertise in trauma training. We were the first MCO in the nation to hire 1 of only 50 Trauma Focused-Cognitive Behavioral Therapy model experts in the country as a full-time dedicated Director of Trauma and Evidence-Based Intervention. NTC's behavioral health affiliate has been offering Foster Care training to Nebraska providers and caregivers over the past couple of years. Through Centene, NTC will bring unparalleled expertise with the child welfare population and look forward to sharing the many best practices we have developed and/or experienced over the years.

NTC affiliates encompass a broad diversity of experience across the country, from California to New Hampshire, with unique and diverse programs served by state contract. Because of this broad experience in multiple states, serving multiple populations, we can customize national best practices and bring fresh ideas and innovation to the Heritage Health Program. Centene and NTC affiliates have extensive experience in implementing new and expanded Medicaid programs and invest in dedicated and experienced project management leadership to oversee start-up activities.

Similarities in Size, Scope, Complexity Highlights

For our three previous projects similar to this Request for Proposal in size, scope, and complexity, we have selected our health plans in **New Hampshire, Kansas, and Florida**, to highlight our experience and preparation for serving as an MCO for Heritage Health. In each of these states, the contracts have evolved over time to include additional higher acuity populations and services. Changes of this magnitude require a health plan partner that is flexible and can leverage lessons learned from affiliate health plans in other states; better anticipating needs and proactively addressing those needs before they become issues.

New Hampshire

Our New Hampshire affiliate, New Hampshire (NH) Healthy Families is one of two managed care organizations in the state of New Hampshire. The New Hampshire program, with the same population to Heritage Health in size, complexity, and urban/rural landscape, has phased populations into the managed care program. Residents in New Hampshire experience the same lack of services and access while having concern over higher acuity populations being moved into managed care.

NH Healthy Families earmarked $500,000 for the PCA to fund the "Capacity Access Initiative", which supports recruitment of physicians into rural areas.

NH Healthy Families went live in 2014 with the goal of additional populations being phased in over time. Currently the health plan manages approximately 72,000 TANF, CHIP, ABD (dual and non-dual) members. Similar to Nebraska, the last phase of integration will be adding acute and LTSS for all nursing home eligible and waiver recipients as well as I/DD (acute only) for those that have not already opted in to managed care. To prepare for these populations to integrate, NH Healthy Families has partnered with the state to ensure a smooth transition. For example, NH Healthy Families is participating in care coordination case reviews with the state, as well as participating in high-touch meetings with area and individual case management agencies to ensure collaboration and to review current complex cases.

NH Healthy Families has contracts with all Acute Care Hospitals as well as the FQHCs and RHCs and direct contracts with providers in bordering states, such as Vermont and New York. Like all affiliate health plans, NH Healthy Families contracts with any willing provider and provides support and funding to increase access for members. For example, NH Healthy Families earmarked $500,000 for the Primary Care Association to fund the "Capacity Access Initiative", which supports recruitment of physicians into rural areas. We anticipate similar opportunities in Nebraska as we partner with providers.

Kansas

In Kansas, our affiliate Sunflower Health has successfully faced and addressed many of the same challenges that Nebraska faces, including a shortage of providers and a large portion of the state being rural/frontier. Kansas and Nebraska have similar member demographics and state size. Like Nebraska, the state of Kansas began with lower acuity populations in managed care with the goal of moving higher acuity populations into managed care. The state of Kansas' Medicaid Program, KanCare, brought separate

*Sunflower Health is the **largest Medicaid plan** in the state of Kansas, including 47% of the IDD waiver population.*

contracts for physical and behavioral health managed care into one integrated contract, just like what is occurring with the Heritage Health Program. Sunflower Health has managed to bring many innovations and best practices to Kansas, which has led to being the largest managed care plan in the state of Kansas with 47% of the managed care population of people on the I/DD waiver and 64% of persons in Intermediate Care Facilities.

Sunflower Health began operations in 2013 while achieving network adequacy statewide. Sunflower Health is a leader in the state of Kansas in working with providers to expand services in rural areas and expand their capabilities to provide tailored services to communities. NTC will also look at non-traditional provider sources, partner with key organizations, and consistently forge relationships and collaborate with all provider types.

Florida

*Today, Sunshine Health is the second largest Medicaid plan and the **largest LTSS plan** in the State of Florida.*

Our affiliate Sunshine Health has been a managed care contractor in the state of Florida since 2009. During this time, Sunshine Health has partnered with the state to implement new delivery systems and integrate additional populations, similar to the Heritage Health program. In 2010, Sunshine Health acquired a health plan providing services in the Nursing Home Diversion Waiver program. The state redesigned the entire LTSS program with an RFP issued in 2012. Sunshine Health won 10 out of 11 regions to manage long term services and supports in the State of Florida. Similarly, in 2013 the state redesigned their Medicaid program, and Sunshine health now provides the full range of Medicaid services (including integrated medical and behavioral health services) to TANF, ABD, Dual-Eligible and Foster Care populations. Sunshine Health started as a health plan that served approximately 100,000 members and has grown to serving over 485,000 members today.

All of our affiliate plans have brought quality health care, improved outcomes and innovative solutions to their State partners, members and providers. We look forward to successful outcomes with Nebraska as we partner with MLTC to bring a fresh and innovative approach to the Heritage Health program. Please see the following for a summary matrix listing for Nebraska Total Care's similar affiliate experience.

Similar Corporate Experience	a) Time Period of Project	b) Scheduled & Actual Completion Dates	c) Contractor Responsibilities	d) Customer Name, Contact Person, Phone, Fax number & Email Address	e) Prime or Subcontractor	a. Original Scheduled Completion Date /Budget b. Actual (or planned) Completion Date /Budget
NEW HAMPSHIRE TANF, ABD, CHIP, Foster Care	12/2012-12/2018	Scheduled: 7/2012 to 6/2015 Actual: 12/2013 to 12/2018	Medical, BH, Substance Use, pharmacy, vision, NEMT, LTSS & Waiver Services	New Hampshire Department of Health and Human Services Kathleen Dunn Phone: 603-271-9384 Fax: n/a Email: kdunn@dhhs.state.nh.us	Prime Contractor	a. Scheduled 7/2012 to 6/2015 - $530M b. Actual 12/2013 to 12/2018 - Est $ 770M
KANSAS TANF, CHIP, ABD, LTSS, Foster Care	1/2013-12/2018	Scheduled: 1/2013 - 12/2015 Actual: 1/2013 - 12/2018	Medical, BH, Substance Use, pharmacy, emergency transportation dental, vision	Kansas Dept. of Health and Environment Susan Mosier, MD Phone: 785-296-0461 Fax: 785-296-7240 Email: smosier@kdheks.gov	Prime Contractor	a. Scheduled 1/2013 to 12/2015 $2.9B b. Actual 1/2013 to 12/2018 Est: $5.1B
FLORIDA TANF, SSI, Foster Care, LTSS	Original Contract 9/2012-8/2014; Current Contract; 1/2014 -12/2018; Services began for TANF/SSI members on 5/1/2014 and LTC services on 8/1/2013.	Scheduled: 1/2014 – 12/2018 Actual: 1/2014 – 12/2018	Medical, BH with Substance Abuse, pharmacy, dental, vision	Agency for Health Care Administration Jennifer E. Courtney, FCCM Phone: 850-412-4067 Fax: n/a Email: Jennifer.Courtney@ahca.myflorida.com	Prime Contractor	a. Scheduled 12/31/2018 Est. $15B b. Actual 12/31/2018 Est. $15B
FLORIDA Healthy Kids	Original contract 10/2012 - 9/2015 Current contract 10/2015 – 9/2017	Scheduled: 10/2012 - 9/2015 Actual: 10/2012 - 9/30/2017	Medical, BH Substance Use, pharmacy, vision	Florida Healthy Kids Corporation, Frank Fonseca Phone: 850-701-6102 Fax: n/a Email: fonsecaf@healthykids.org	Prime Contractor	a. Scheduled 9/30/2017 Est. $130M b. Actual 9/30/2017 Est. $130M

NTC's Ability, Capacity, and Skill to Implement

Across the nation and across all lines of business, since 2010 Centene \ has achieved an impeccable record of successful implementations that represent more than **2,850,000 new members** across 15 states. This includes new health plans, reprocurements/service area expansions, and product expansions. Our high-touch, local approach to implementation and state-centered operating models are at the core of our business philosophy and ensure we will become an efficient and transparent partner with the Division of Medicaid and Long Term Care (MLTC). During the last five years alone, Centene has successfully implemented new managed care plans in highly penetrated managed care markets similar to what we will experience in Nebraska, in states as diverse as Washington, Mississippi and Missouri. We have also seamlessly implemented new health plans (network and operations) in multiple markets and we have never delayed an implementation date. Centene also has completed a number of significant program expansions including adding Aging, Blind and Disabled populations and services such as Behavioral Health and Long Term Services and Supports that required extensive network development and staff recruitment. Based on these experiences in implementing our flexible healthcare delivery model, we will tailor our approach to meet/exceed all MLTC requirements and expectations.

We have never delayed an implementation date.

Centene's efforts in Nebraska are already well underway. Over the past several years our Business Development team has been on the ground in Nebraska creating strong partnerships across the state that will serve as a strong foundation for our implementation and our ongoing program operations. Immediately following the contract award, as we begin our actual implementation activities we will involve our Provider Engagement (PE) team to continue identifying opportunities to engage providers and community stakeholders to improve our knowledge of and programs in Nebraska. Also post contract award, the PE team will schedule provider trainings and town hall meetings to create a strong handoff, building on the trusted relationships we have established to create tremendous momentum within our implementation process.

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I. SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

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.

Proposed Approach

Nebraska Total Care (NTC) has designed a program and management approach that will be fully resourced and focused on understanding the unique populations to be served by Heritage Health, including needs, challenges, and health disparities; knowing the providers who serve these members; recognizing the resources available across the state; and leveraging the infrastructure and lessons learned of Centene and our affiliate plans serving over 4.8 million members across 23 states. Nebraska Total Care, Incorporated, a Centene subsidiary, is a Nebraska Corporation, fully incorporated under Nebraska statute, with a corporate office and registered agent within the state. As such, NTC will be governed and operated by a Board of Directors from within the state of Nebraska whose membership will include a majority of Nebraska providers and representatives from Advocacy and Health Association organizations.

Our personnel/management approach for this project includes the following critical program elements:

- Local Presence, Accountability and Decision Making with Central Support
- Suitable, Sufficient and Trained Staff and Staff Support
- Well-Tested, Multi-Dimensional Implementation Plan

The staffing level projected for NTC, based on projected membership of 76,000, is approximately 179 employees located in Nebraska and 14 corporate-based staff.

National Best Practices, Applied Locally. From health plan name, to approach, to operation. NTC is a locally-based, Nebraska corporation, to be headquartered in Lincoln with satellite offices located in Omaha, Scottsbluff and the Tri-Cities area.

NTC's Senior Management is empowered by our corporate owner, Centene Corporation (Centene), for local decision making that make sense for Nebraska. Functions such as Quality, Pharmacy, Medical Management (Care Management/Special Needs Unit, Maternal Health/EPSDT, Member Outreach, Utilization Management); Network Development and Contracting (Value-Based Purchasing/Provider Performance, Provider Engagement, Contracting), Compliance (Compliance, Grievance and Appeals, Government Relations); and Operations (Member and Provider Services - including Member and Provider Call Centers, Marketing and Community Outreach, and our BH Liaisons) will all be located in Nebraska. All executive and senior management staff will be located in Nebraska in our Lincoln office.

We will integrate staff across the state of Nebraska, promoting ***high-touch service delivered locally*** by staff who live in, and understand each unique community we serve. From care and utilization management and concurrent review staff, to clinical trainers and provider services specialists, NTC's local staff will understand our members, providers and the community as a whole, and our Call Center will be staffed by representatives who share the dialects and local knowledge of our members, not by people who reside in other states.

This ***boots on the ground*** approach has already begun, with Centene staff in-market today, meeting with providers across the continuum of care, advocates, associations, community-based organizations, Regional Behavioral Health Authorities, Public Health Departments, and other stakeholders. Our goal is to understand the needs of communities across Nebraska as well as challenges and health disparities. We have developed relationships with providers, learned of resources available across the state and learned about opportunities to implemented innovative solutions to add the most value to the state of Nebraska and to Heritage Health.

As we hire staff, recruit board members and identify committee members, our local knowledge will be invaluable in identifying the best candidates to meet the needs of our members, Heritage Health and the state. Our Board of Directors include:

Table i.1 Board of Directors

Steve White	President and CEO, NTC
Ryan Sadler	Chief Operating Officer, NTC
Jeremy Corbett	Chief Medical Officer, NTC
Heath Body	President and CEO, Nebraska Health Care Organization
Patrick O'Connell	VP, Behavioral Health, Compliance and Government Relations, Boy's Town
Beth Baxter	Administrator, Region 3 Behavioral Health
Kenny McMorris	President and CEO, Charles Drew Health Center
Harold Krueger	President and CEO, Chadron Regional Health Center
Crystal Appleton	Health Systems Administrator, Omaha Tribe
Bryan Health	Physician Designee to be named by Bryan Health Board
UNMC	Physician Designee to be named by UNMC Board
CHI Health	Physician Designee to be named by Cliff Robertson
UniNet	Physician Designee to be named by Ann Oasan

We have already identified a number of individuals to serve our local committees. Proposed committee representatives identified as of today are included in ***Table i.2*** below.

Table i.2 Local Committee Representatives

Laura Richards	Administrator, Region 1 Behavioral Health
Kathy Seacrest	Administrator, Region 2 Behavioral Health
Beth Baxter	Administrator, Region 3 Behavioral Health
Ingrid Gansebom	Administrator, Region 4 Behavioral Health
C.J. Johnson	Administrator, Region 5 Behavioral Health
Patti Jurjevich	Administrator, Region 6 Behavioral Health
Topher Hansen	CEO, CenterPointe
Donna Polk	CEO, Nebraska Urban Indian Coalition
Michael Burcham	CEO, Thayer County Health Services
Dr. Adi Pour	Director, Douglas County Health Department
Judith Halstead	Director, Lancaster County Health Department
Dr. Joseph Evans	Director, Psychology, Monroe Meyer Institute (UNMC)
Joni Cover	EVP, Nebraska Pharmacy Association
Susan Bockrath, MPH	Executive Dir., Nebraska Assoc. of Local Health Directors
Carol Wang	Executive Director, Metro Omaha Medical Society
Annette Dubas	Executive Director, NABHO
Cathy Webber	Health Information Dir., Franklin County Memorial Hospital
Crystal Appleton	Omaha Tribe
Jan Henderson	Ponca Tribe

Galen Bernadt	Program Coordinator, Lincoln ED Connections
Pat Lopez	Public Health Advocate
Vietta Swalley	Santee Sioux Tribe
Tina Vest, NP	Vest Psychiatric Services
Pat Connell	VP, Behavioral Health
Ricky Trobaugh	Winnebago Tribe
Martha Kakenkamp	Program Manager, Aging Partners
Ann Suiter	Billing and Customer Service Rep Supervisor, Good Neighbor Community Health Center
Nicole Carlson	Office Manager, Park Street Medical Clinic
Victoria Vinton	Director, Nebraska Action Coalition-Future of Nursing
Mike Schafer	CEO, League of Human Dignity
Joe Lohrman	CEO, Annie Jeffrey Memorial County Health Center
Joni Thomas	Executive Director, Independence Rising
Janelle Kircher, CNO	VP, Ancillary Services, Community Hospital (McCook, NE)
Sandy Roes	Director, Western Community Health Resources
Sandy Lutz	Senior Care Operations Supervisor, Aging Partners

Corporate Support. Our local presence and understanding is backed by a multi-national company with more than 30 years of experience successfully implementing state solutions to provide the better, more efficient and more appropriate care to vulnerable populations. Best practices drawn from this experience will be localized for Nebraska. To support Nebraska Total Care with sophisticated and integrated capabilities, Centene's corporate offices in St. Louis, Missouri will provide certain centralized functions such as our Management Information System (MIS) and award-winning proprietary and comprehensive family of integrated decision support and health care informatics solutions, claims and encounter processing, and some finance functions. NTC will benefit from economies of scale, best practices, proven processes, industry knowledge from across the country, and innovative IT functionality to equip our core Nebraska operations with the means to offer our members the right care at the right time.

NTC will have direct access to national staff who have successfully planned, implemented and currently operate our affiliates managing similar services in 23 markets, including a carefully selected implementation team committed to this program implementation. Working with the local NTC leadership and staff, implementation experts will provide intensive support onsite in Nebraska to provide best practice strategies, assist with staffing and hiring decisions, and provide management and staff training and other guidance throughout and after implementation .

Suitable, Sufficient and Trained Staff and Staff Support. In developing and maintaining the appropriate staffing for Nebraska, NTC will adhere to the requirements found in Section IV.D.1 of the RFP. NTC's staffing plan has been established based on Centene best practices, as developed from experience with similar contracts in other states. As described, our operating model revolves around a high-touch approach with members and providers through local health plan operations. During the launch of a new health plan, our corporate office has the responsibility to assist in administering the functions of the new health plan, on an interim basis, and to provide on-site support until the plan can run independently. For example, to make our approach a reality, Ryan Sadler will serve as our Chief Operations Officer, bringing operational lessons learned from his experience in Louisiana as the Vice President of Operations.

During the pre-launch period, Centene has staff in the field meeting with providers and stakeholders as described above to help shape our recruitment plans and strategies and inform each hire to ensure the best fit for the position.

Estimated Staff. Because staffing plans are tailored to enrollment levels and service areas, and for the sake of consistency and clarity, our staffing plan is based on an estimated projection of NTC enrollment of approximately 76,000 Members. The staffing level projected for NTC based on the 76,000 membership projection is approximately **179 employees located in Nebraska** and an additional 14 dedicated to support the health plan that are corporate-based in St. Louis. NTC will ensure the appropriate staff at all times and maintain compliance with contract requirements. NTC will closely monitor performance and staffing levels, particularly during the first year. We will track enrollment trends to facilitate early forecasting of enrollment increases and recruit additional staff in a timely manner. If needed, we also have the option to leverage staff from other Centene health plans or the corporate office, who can step in on an interim basis to supplement staffing and provide hands-on staff training.

We will notify the State at least 30 calendar days in advance of any plans to change, hire or reassign designated Key Personnel. If a key employee is voluntary or involuntarily terminated, we will report this information to the State no later than five business days prior to the last date the employee is employed to the extent possible. We will fill key positions, with approval of the State, within 60 calendar days of departure unless a different timeframe is approved by the State. We will ensure a complete knowledge transfer occurs from the employee leaving the position to the new employee.

Sufficient and Experienced Staff at Start Up. To ensure adequate and experienced staffing upon start up, as in any new market, we will fill leadership and key staff roles with interim staff from corporate and affiliate plans, who will be located full time in Nebraska, until permanent, local staff are hired and fully trained. This approach has been successfully used in other states and is especially beneficial during the implementation phase. NTC will take advantage of the skills and experience of corporate and affiliate staff in comparable markets who have successfully planned, implemented and/or currently operate integrated managed care plans serving similar populations. This carefully selected leadership team will provide intensive support onsite in Nebraska to provide best practice strategies, assist with staffing and hiring decisions, and provide management and staff training and other guidance as identified through every stage of the implementation process. As the health plan gains operating momentum, the intensity of the affiliate support will decline but will continue to be available to the NTC team at all times.

Comprehensive Staff Training. NTC will provide a structure and process whereby clinical and non-clinical staff are trained from onboarding through the employee experience. Training activities are based on a commitment to continuous quality improvement activities and ensuring full contract compliance and appropriate care and services. The main objectives of our training programs are to develop a system of training that:

- Supports a diversity of knowledge and skill sets
- Is patient-centered and relevant to unique and distinct member and community needs
- Is clinically-sound and incorporates evidence-based practices
- Is contract and program specific, ensuring a comprehensive understanding of and compliance with contract requirements
- Is measured, monitored, and continuously improved

All staff within NTC will participate in the New Employee Orientation process, either in-person, or for field-based staff, via a remote log in conference line. All clinical staff participates in New Employee Orientation in addition to mandatory clinical training. Clinical staff training includes three weeks of onboarding inclusive of classroom training, online training, Policy and Procedure review, individual shadowing, and supervisor shadowing. Additional annual mandatory training is held throughout the year on a monthly or quarterly basis to ensure that all staff have an opportunity to attend. Training includes topics such as cultural competency, social determinants of health, privacy and security, fraud, waste and

abuse, evidence-based practices, and an annual review of Policy and Procedures including but not limited to member rights, privacy practices, performance standards, clinical practice guidelines, and level of care guidelines. We also offer lunch-and-learns – one hour training webinars focused on clinical topics and evidence base practices for the clinical team – and access to on demand, online education and training.

To ensure that all staff has the necessary training, education, experience, orientation, and credentialing, as applicable, to perform assigned job duties, the NTC training team will provides organized oversight of all required trainings to track outcomes, assess competency during training, and evaluate the trainers. Oversight will include:

- Attendance tracking
- Pre/Post Tests, and % change
- Training evaluations
- Follow up satisfaction survey

Staff Support. To strengthen communication and ensure consistent service delivery and best business practice sharing, the local plan management overseeing each health plan functional area is aligned with key personnel at Centene's corporate office and has access to peer staff in each affiliate health plan, before we begin providing managed care services. This face-to-face training support allows for lessons learned to be realized early on so our employees are ready from day one. During NTC's initial implementation phases, this corporate support will be intensive and will involve substantial time spent onsite at the health plan. NTC's leadership team managing the Heritage Health program will consist of highly-qualified leaders, not only experienced in providing managed care to TANF, CHIP, Foster Care, ABD, LTC and I/DD populations, but also experienced in successfully integrating PH, BH, and pharmacy. We understand the challenges and know how to help states achieve their goals and objectives while meeting member and provider needs.

Staff Quality Oversight. To support our integrated model and the services described, NTC's staffing structure will provide for sufficient leadership and oversight for all employees. For example, Directors provide guidance and ultimate accountability for contract compliance and positive outcomes, while Managers and Supervisors provide more day-to-day staff supervision to monitor performance and the consistent application and implementation of policies and procedures. Executives, Directors, and Managers/Supervisors regularly monitor Key Performance Indicators through a system-wide dashboard, and all staff has an annual performance appraisal which looks at job specific metrics and performance. Clinical staff may require additional auditing. For example, NTC must make UM decisions in a fair, impartial and consistent manner. Assessment of the consistency of application of Medical Necessity Criteria occur using three primary methodologies:

- Ongoing Supervisor quality management audits including call monitoring and chart audits
- Review of problem/complex cases during weekly UM "rounds", overseen by a Medical Director and supervisory staff
- Annual Inter-rater Reliability Testing

Problems or concerns regarding contract performance, member care and access to services will be identified and reported through our Quality Assurance and Performance Improvement (QAPI) Program. Once identified, impacted departments will act to resolve quickly, reporting outcomes to or getting support from the QAPI Committee and/or Senior Executive to intervene, track and/or trend as appropriate.

Cultural Competency. Individuals who live in the community of the people we serve are ideally suited to understand the community-based values, traditions and customs of our members and how to best support them in their local environment. As we build out our team of staff in Nebraska, we will seek out individuals who represent the cultural variations of our population and have the special skills and training

required to deliver services that are culturally appropriate and sensitive to member needs, including those with limited English proficiency, hearing impairments, speech or language disorders, physical disabilities, developmental disabilities, differential abilities or diverse cultural and ethnic backgrounds. For example, Mary Troupe, our Manager of Community Engagement, is dedicated to ensuring our advocacy committees are part of ongoing operations, with particular focus on persons with disabilities. We will work with local organizations, such as League of Human Dignity and local NAMI chapters and Universities, to recruit staff who are active in their communities, and who speak the prevalent languages. Our recruiting software allows us to incorporate specific language requirements for job postings, and we monitor language needs of our staff and within our membership to help us hire to any gaps. Adhering to the National Standards on Culturally and Linguistically Appropriate Services (CLAS standards), we will continuously work to minimize physical, mental, and cultural barriers to care and to preserve the dignity of our members. We will work with organizations such as Lutheran Family Services to address the multiple cultures represented by the refugee programs that they coordinate and assist. It has been the NTC approach over the past year to meet and build relationships with the four recognized Native American Tribes headquartered in Nebraska and we will employ, a member of NTC's core staff, a Tribal Liaison currently working in or with the tribal health system and population. Sheina Yellowhair, Supervisor of Tribal Program Development for NTC's affiliate plan in Arizona is working with NTC as we continue to build, implement and execute our relationships, hiring practices and execution of programs in partnership with the tribes.

Well-Tested, Multi-Dimensional Implementation Plan

Immediately upon notice of Contract Award, NTC will deploy a dedicated, veteran *Transition Leadership Team (TLT)* who will work onsite in Nebraska and in collaboration with Centene's corporate *Business Implementation and Integration Team (BIIT) – collectively the Team*. The Team will be comprised of veteran executive, management and technical staff who understand how to and have implemented Medicaid programs. They have significant collective experience in health plan operations, network development, project management and new health plan implementations.

Our project management approach consists of the following key elements:

- A Work Plan constructed with a consistent project lifecycle methodology with defined stages and activities, beginning with defining requirements, objectives or deliverables, to acceptance of deliverables, and finally to closing of project and transition to operations
- The deployment of dedicated, highly specialized professionals with defined levels of authority to implement new Contract requirements
- A customized communication plan and consistent communication among all implementation participants
- A set of industry standard and proprietary tools to define accountability, track progress and identify and mitigate risks to implementing the new program
- A proactive review of implementation progress against baseline objectives or deliverables
- An escalation process to monitor and capture changes to baseline, and to conduct issue/risk identification/assessment, alternative analysis and resolution

The BIIT will manage the Work Plan, resources and schedules to help ensure timelines are met; identify and manage risks; and manage cross-functional teams to achieve project goals. The TLT will, at a minimum, direct program and process design; develop policies and procedures; oversee network provider contracting, credentialing and new Provider training; oversee the recruitment and training of all permanent health plan staff; oversee all systems testing; work closely with newly hired health plan staff to prepare for and participate in readiness review; and work collaboratively with health plan staff to ensure the effective transition of health plan operations to health plan staff post Go Live. The TLT will continue to be available to health plan staff as advisors for no less than six months post Go Live.

Accountability for Success. NTC Plan President and CEO Steve White will have ultimate responsibility for the successful implementation of the new contract. Mr. White has over 25 years of diversified healthcare insurance experience, extensive experience leading successful HMO and PPO organizations, including eight years running Medicare and Medicaid plans. Mr. White has held multiple President and Regional President Positions with large national insurance companies and has a strong background in negotiating provider contracts, developing provider networks, running medical management operations, directing quality programs to obtain NCQA accreditation and leading sales teams to achieve growth.

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.

Please see the following table for the specific professionals who will work on the State's project if Nebraska Total Care is awarded the contract.

Key Staff						
Key Staff *Section of the Contract*	**State of Nebraska Position Title**	**Nebraska Total Care Job Responsibilities**	**Nebraska Total Care Title**	**Name(s)**	**# Years of Experience**	**Proposed Location of Staff**
D.2.a	1. Chief Executive Officer (CEO)*	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.	Chief Executive Officer (CEO)*	Steve White	25 years of experience	NEBRASKA
D.2.b	2. Medical Director/Chief Medical Officer*	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.	Chief Medical Officer*	Jeremy Corbett	8 years of experience	NEBRASKA
D.2.c	3. Behavioral Health Clinical Director	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	Behavioral Health Clinical Director	Michael Neboisa Bojkovic	More than 25 years of experience	

		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.				
D.2.d	4. Behavioral Health Manager*	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.	Director of Behavioral Health Integration	Jeremy Riddle	More than 10 years of experience	NEBRASKA
D.2.e	5. 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 Operating Officer (COO)*	Ryan Sadler	More than 8 years of experience	NEBRASKA
D.2.f	6. 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.	Vice President, Finance*	Brian Butts	More than 25 years of experience	NEBRASKA
D.2.g	7. Program Integrity Officer*	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	VP, Compliance*	Bob Miromonti	More than 20 years of experience	NEBRASKA

		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.				
D.2.h	8. 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.	Manager, Grievance and Appeals*	Emsija Dolic-Muratagic	More than 5 years of experience	NEBRASKA
D.2.i	9. 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.	Emergency Response & Business Continuity Specialist	Glen Woita	More than 20 years of experience	MISSOURI
D.2.j	10. Contract Compliance Coordinator*	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.	Manager of Compliance and Reporting*	Marcia Albridge	More than 20 years of experience	NEBRASKA
D.2.k	11. Quality Management (QM) Coordinator*	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.	Director, Quality Improvement*	Mary Kay Jones	More than 20 years of experience	NEBRASKA
D.2.l	12. Performance and Quality Improvement	Primary responsibilities include: 1. Focusing organizational efforts on the	Performance and Quality	Laura Fraser	More than 10 years of	NEBRASKA

	Coordinator*	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.	Improvement Coordinator*		experience	
D.2.m	13. Maternal Child Health (MCH)/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coordinator*	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.	Supervisor, Maternal Health/EPSDT/Child Care Management*	Cathie Krueger	More than 20 years of experience	NEBRASKA
	14. Medical Management Coordinator	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	Vice President, Medical Management	Mary Digman	More than 30 years of experience	MISSOURI

		ensuring that decisions are made in a consistent manner, based on clinical criteria, and that all decisions meet timeliness standards.				
D.2.n	15. 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.	Director, Provider Engagement*	Carolyn Gollub	More than 20 years of experience	NEBRASKA
D.2.o	16. 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.	Director, Member and Provider Services*	Dennis Henson	18 years of experience	NEBRASKA
D.2.p	17. 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.	Sr. Vice President, Claims Operations	Ed Gallegos	More than 20 years of experience	MISSOURI

		4. Ensuring minimization of claims recoupments. 5. Meeting MLTC encounter reporting requirements.				
D.2.q	18. Provider Claims Educator	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.	Provider Claims Educator	Shari Rothwell	More than 20 years of experience	NEBRASKA
D.2.r	19. Case Management Administrator*	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.	Director, Care Management*	Jenny Clark	More than 20 years of experience	NEBRASKA

D.2.s	20. Information Management and Systems Director	The position is responsible for: 1. Establishing and maintaining connectivity with MLTC information systems. 2. Providing necessary and timely data and reports to MLTC.	Vice President, Information Technology	Keith Hibbard	More than 25 years of experience	MISSOURI
D.2.t	21. 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.	Senior Director, Encounters	Jessica Silver	More than 14 years of experience	MISSOURI
D.2.u	22. 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 member services staff.	Tribal Network Liaison*	Sheina Yellowhair	More than 8 years of experience	NEBRASKA
D.2.v	23. Pharmacist/Pharmacy Director*	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.	Director, Pharmacy*	Gaurang Gandhi	More than 12 years of experience	NEBRASKA

		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.				

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.

The Resumes of all Key Staff presented by Nebraska Total Care have been provided in the Redacted Envelope. All Resumes include experience, academic background, degrees, professional certifications, understanding of the process, and three references as required by the State.

nebraska total care™

J. SUB-CONTRACTORS

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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);

Below are Nebraska Total Care (NTC) sub-contractors' name, address, and telephone information; services to be provided by each sub-contractor, the percentage of performance hours intended for each sub-contract, and total percentage of sub-contractors performance hours. Also, NTC will submit all subcontracts to MLTC for review at least 90 calendar days before implementation. Further, NTC will comply with all requirements in Section O, 42 CFR 438.6(1), 438.230(a) and 438.230(b)(1), (2), and (3) including:

- Responsible for oversight of all sub-contractors' performance accountable for any function and responsibility that is delegated to a sub-contractor, including, but not limited to:
- Evaluation of sub-contractor's ability to perform delegated activities
- Certify that sub-contractors are financially stable
- Provide a written contract between NTC and its subcontractors specifying the activities and reporting responsibilities delegated to each sub-contractor including revoking delegation or imposing other sanctions if a sub-contractor's performance is inadequate
- Monitor each sub-contractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards.
- Identify any deficiencies or areas for improvement, and take corrective action

Additionally, NTC will guard against executing a sub-contract with any entity that has been excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 of the Social Security Act (42 U.S.C. §1320a-7), or is otherwise barred from participation in the Medicaid or Medicare programs. The MCO must not enter into any relationship with a sub-contractor debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

Subcontractors	Name, address, and telephone number
Centene Management Company	Centene Management Company 7700 Forsyth Boulevard St. Louis, Missouri 63105 (314) 725-4706
US Script, Inc.	US Script, Inc. 2425 West Shaw Avenue Fresno, CA 93711 (559) 244-3700
OptiCare Managed Vision, Inc.	OptiCare Managed Vision, Inc. 112 Zebulon Ct. Rocky Mount, NC 27804
National Imaging Associates, Inc.	National Imaging Associates, Inc. 6950 Columbia Gateway Drive Columbia, Maryland 21046 (410) 953-1000
NurseWise, LP	NurseWise, L.P. 7700 Forsyth Boulevard St. Louis, Missouri 63105 (314) 725-4477

Nurtur Health, Inc,	Nurtur Health, Inc. 20 Batterson Park Road, 2nd Floor Farmington, Connecticut 06032 (800) 293-0056
U.S. Medical Management, LLC (USMM)	U.S. Medical Management, LLC 500 Kirts Boulevard Troy, Michigan 48084 (248) 824-6000
Cenpatico Behavioral Health, LLC	Cenpatico Behavioral Health, LLC 12515-8 Research Boulevard, Suite 400 Austin, Texas 78759 (512) 406-7200
LifeShare Management Group, LLC	LifeShare Management Group, LLC 60 Rogers Street, Suite 2 Manchester, New Hampshire 03103 (603) 625-8825

vii. specific tasks for each Subcontractor(s);

Subcontractors	Specific tasks to be performed for Nebraska Total Care
Centene Management Company	Centene Management Company will support NTC by providing information system support, and claims processing and administration; SIU/fraud and abuse; provider data management; human resources support; and finance systems.
US Script, Inc.	US Script will provide pharmacy benefit management (PBM) services to clients through Preferred Drug List (PDL) administration, clinical authorizations, pharmacy network contracting and management, rebate administration, reporting, claims adjudication, account management, pharmacy provider call center and services, pharmacy and therapeutics support, pharmacy auditing, and selected drug utilization review and quality improvement functions, subject to client oversight.
OptiCare Managed Vision, Inc.	OptiCare will perform all medically necessary eye care, vision examinations, prescriptive lenses, frames, and treatments services for Heritage Health including: • Network contracting and credentialing claims processing and payment; • Customer service and provider relations • Full utilization and quality management • Encounter submissions and reporting • HEDIS outreach
National Imaging Associates, Inc.	National Imaging Associate will provide prior authorization and utilization management services, clinical protocols, and efficient provider tools for MR, CT, CCTA and PET nuclear cardiology, stress echocardiography, and echocardiography; provider quality assessment and privileging (Post Go-live) to Plan Free Standing Facilities (FSF) and in-office providers performing advanced imaging services; provider training and Education; and customized, proprietary claim edits.

NurseWise, LP	NurseWise will provide health education to NTC members, including: • Accurately identifies patients' needs to ensure they are directed to the appropriate level of care for their situation • Offer around-the-clock access to a highly skilled triage clinical team • Use nationally recognized algorithms to provide the best course of action • Support patients through a Clinical Care Center team comprised of more than 60% bilingual English-Spanish staff, with support of other languages through real-time access to live call translation services in more than 220 languages • Provide simple and useful advice about medications, procedures, screenings, health conditions or any other health-related topics • Listen and comforts patients in a culturally and linguistically sensitive manner • Provide a seamless extension to their clients to eliminate confusion as to who is providing the service • Offer further information through access to a full health information library, in both an audio and online format in multiple languages • Empower patients to make confident and appropriate decisions about their care and treatment
Nurtur Health, Inc.	Nurtur will implement health plan disease management programs to aid NTC members in gaining more control over their own health by learning how to change behaviors through: • Providing patient-centered care across the care continuum. Nurtur actively partners with Centene's other programs as well as external programs to deliver a seamless member care experience. • Driving increased member engagement through telephonic outreach, web portal and mobile resources. Nurtur will encourage members to leverage the power of its *MyNurturLife* Web portal and mobile app in order to drive clinically appropriate engagement in health benefits. • Offering members access to the latest innovative health technologies. Nurtur's accredited DM programs are further powered by many optional new technologies. For example, through its optional Telecare Monitoring Program (TCM), Nurtur engages with certain high-risk members with multiple or complex co-morbid chronic conditions through TCM.
U.S. Medical Management, LLC (USMM)	USMM / Visiting Physicians Association (VPA) will provide NTC's high acuity members with in-home health services such as in-home primary care through nurse and physician visits. Services provided will include health risk assessments, vaccinations and immunizations, medical and disease management, one-on-one comprehensive patient health and disease management education, and radiology, ultrasound, and laboratory testing services.
Cenpatico Behavioral Health, LLC	Cenpatico Behavioral Health, LLC will provide behavioral health care benefits, provider services and training, customer services, and clinical services through a regional administration model, including integrating and analyzing data from diverse data sources in order to provide centralized and efficient management of behavioral health services. Cenpatico will also collaborate with medical healthcare providers to ensure integration of

	care for members through the Service Management/Service Coordination model.
LifeShare Management Group, LLC	LifeShare Management Group, LLC will provide IDD specific acute care services such as behavioral health care benefits, provider services and training, customer services, and clinical services through a regional administration model, including integrating and analyzing data from diverse data sources in order to provide centralized and efficient management of services. LifeShare will also collaborate with medical healthcare providers and IDD providers to ensure integration of care for members through the Service Management/Service Coordination model. In addition to IDD-specific services, LifeShare will provide a super utilizer solution which coordinates with health plan case management to address unnecessary overutilization of health care services by members that fall into the top 5% with impactable costs, through an integrated, community-based approach.

viii. percentage of performance hours intended for each Subcontract; and

Subcontractors	Percentage of performance hours intended for each subcontractor
Centene Management Company	Percentage of performance hours intended for Centene Management Company is 6.5%.
US Script	Percentage of performance hours intended for US Script 2.0%.
OpticCare	Percentage of performance hours intended for OptiCare is 1.0 %.
National Imaging Associates	Percentage of performance hours intended for National Imaging Associates is 0.70%.
NurseWise	Percentage of performance hours intended for NurseWise is 1.0 %.
Nurtur	Percentage of performance hours intended for Nurtur is 4%.
USMM	Percentage of performance hours intended for USMM is .80%.
Cenpatico	Percentage of performance hours intended for Cenpatico is 19%.
LifeShare	Percentage of performance hours intended for LifeShare is .80%.

ix. total percentage of Subcontractor(s) performance hours.

The total percentage of Centene Management Company, US Script, OptiCare, National Imaging Associates, NurseWise, Nurtur, USMM, Cenpatico, and LifeShare performance hours is 35.80%.

3. TECHNICAL APPROACH

A. UNDERSTANDING OF THE PROJECT REQUIREMENTS

Nebraska Total Care, Inc. (NTC), a subsidiary of Centene Corporation (Centene), is pleased to respond to the Request for Proposals for Heritage Health (RFP 5151 Z1) issued by the Nebraska Department of Health and Human Services (DHHS). NTC is a Nebraska company and looks forward to being a strong corporate citizen. The entire health plan staff will reside in Nebraska, the majority of them being Nebraskans hired by NTC to staff the plan. NTC's Board of Directors is an operating Board and will be populated by NTC's CEO, COO and the remainder being external members from the provider community representing the populations, providers and services that are to be delivered by NTC in response to Heritage Health.

Centene and NTC staff have worked on the ground in Nebraska for 2 years, traveling the State and meeting with providers, advocates and associations. As a result of this work NTC is uniquely aligned and prepared to provide solutions to Nebraska's Medicaid populations and meet the requirements of Heritage Health. We have attended, participated in and sponsored trade conferences, video conferences and webinars throughout the state in order to learn and fully understand Nebraska. Through our time spent in the state, we have come to understand the unique nuances Nebraskans, providers and all stakeholders face in healthcare delivery. The urban, rural and frontier nature of the state, various industries and lifestyles as well as cultural diversity must all be considered to identify existing strengths, weaknesses and gaps. We have worked with Native American populations, refugee relocation programs and those in the livestock and farming industries to ensure we are building a health plan focused not only on achieving urban-rural parity, but overcoming cross-cultural disparities.

We have built relationships and partnerships with providers and stakeholders to assure that as we structure and build NTC and our provider network, we are responsive to the needs of Nebraskans and are providing solutions that will guarantee a fully-integrated, person-centered delivery model for all populations and needs. To incentivize providers and their organizations to work in a collaborative and consistent way, we have engaged partners such as ENHANCE Health Network, Catholic Health Initiatives and the state's seven FQHCs in meaningful, quality-measured Value Based Purchasing agreements. NTC has already identified providers to participate in Community Health Collaboratives, participate in telehealth programs that include utilization of traveling specialists, and engage Primary Care Providers in integrated behavioral health programs that address co-existing conditions. Drawing upon experience and best practices from affiliates such as Arizona, NTC is working closely with Nebraska's Native American Tribes to recognize their desire to maintain sovereignty and health care independence while providing their members with full access to care and the benefits NTC will deliver as a part of Heritage Health. Additionally, we will work with local, independent pharmacies to maintain fair reimbursement while ensuring that our members have appropriate access to the medications they need.

We look forward to bringing the experiences and best practices of Centene Corporation, our parent company, to Nebraska. Founded as a single health plan in 1984, Centene provides Medicaid and Medicaid-related health plan coverage to individuals through government subsidized programs, including Temporary Assistance for Needy Families (TANF), the State Children's Health Insurance Program (SCHIP), Supplemental Security Income (SSI)/Aged, Blind and Disabled (ABD), Foster Care, Long

Term Services and Supports, subsidized and commercial health insurance for uninsured and Medicare (Special Needs Plans). Centene health plans currently serve 4.8 million members in managed care plans across 23 states.

The success of our health plan begins with a corporation-wide commitment to readiness. For more than 30 years, Centene has consistently surpassed state readiness review benchmarks by dedicating to new markets all the resources required to meet the needs of our members, providers and state partners. NTC, and our entire organization, are without distraction and have every tool at our disposal to implement innovative, integrated health care solutions in the state of Nebraska. From small scale deployments for specific populations, services or geographies, to comprehensive statewide, full-risk implementations, our implementation team and process provides the experience and flexibility to tailor a program intended to meet the expectations of DHHS.

NTC's experience and commitment to the communities we serve sets us apart from other Medicaid health plans and positions us to offer an approach that aligns with DHHS's priorities:

- **Local Approach:** Our fundamental principle is that health care is best delivered locally. Our employees are hired from and know the communities we serve. NTC is a Nebraska corporation and will begin operations licensed in the state with more than 179 local employees and in excess of 193 total employees, including corporate support. We understand that culturally competent, in-person interaction is a key ingredient to effectively engaging members, providers and the community to improve not only care delivery, but to positively affect social determinants of health. All benefits and services related to our members and the employees delivering them are to be located in Nebraska.

- **Integrated and Coordinated Healthcare Solutions:** NTC will draw on Centene's more than 30 years of experience providing similar services across 20 states including the provision of medical, behavioral health and pharmacy services. Supported by Centene's expertise, NTC has the necessary tools to effectively and efficiently provide covered services and other benefits to the Heritage Health population in compliance with the requirements set forth in the RFP.

  We will offer consolidated, integrated systems and approaches to facilitate member and provider use of services, holistic care delivery and continuity of care. For example, our interdepartmental structure is supported by TruCare, our member-centric health management platform for collaborative care coordination, case and disease management, and utilization management. TruCare supports medical, behavioral health and pharmacy program administration on one integrated platform. NTC will employ proven, multi-faceted processes and approaches to engage, incentivize and collaborate with providers in the continual delivery of high-quality, cost-effective care and with members to assist their access to needed services and supports.

  NTC's person-centered, whole-health approach to care coordination will be evidence-based, consistent and tailored for managing different conditions. Our approach will remove silos and integrate medical, behavioral health, pharmacy and other services to create a system of care around the member. Our integrated, individualized system will effectively address not only the clinical needs of the member, but also the functional, social and other non-clinical needs that affect health and quality of life.

- **Provider Partnerships that Lead to Improved Access and Quality of Care:** The partnerships and relationships discussed above will allow us to address existing barriers to care in order to ensure that our members have access to appropriate and high-quality healthcare. We realize that our providers are at the forefront of improving our members' health status and quality of life, and we will support our providers through robust data and reporting solutions that make information easy for providers to access. Through Centelligence™, we have the ability to report on all datasets in our platform, including, for example, HEDIS, EPSDT services and claims timeliness. We are also able to offer our providers solutions incorporating evidence-based, proprietary Care Gap/Health Risk "alerts" that identify and report significant health risks at population, member, and Provider levels. We also support our providers through innovative enhanced payment models that reward quality of care.

Nebraska Total Care's local approach, integrated model, innovative solutions and focus on partnerships designed to work cooperatively with DHHS's ambition to improve quality and accessibility across the continuum of care and throughout the state uniquely positions us partner with DHHS to serve Nebraska's Heritage Health population.

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3. TECHNICAL APPROACH

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A. UNDERSTANDING OF THE PROJECT REQUIREMENTS

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B. RESPONSE TO PROPOSAL STATEMENTS AND QUESTIONS IN ATTACHMENT 19 PROPOSAL STATEMENTS AND QUESTIONS

B. RESPONSE TO PROPOSAL STATEMENTS AND QUESTIONS IN ATTACHMENT 19 – PROPOSAL STATEMENTS AND QUESTIONS; AND

(2 page limit)

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.

Risk-Bearing Subcontractor Agreements

As described in our response to Question 56, Nebraska Total Care (NTC) will subcontract with OptiCare Vision Company Inc. for vision services. OptiCare will be capitated for all required visual care services covered per 471 NAC 24-002.01, with the exception of eye surgeries.

NTC understands that we will be ultimately responsible for all products, services and obligations agreed to and described in the Scope of Work (SOW) and required by 42 CFR 438.6(1), 438.230(a) and 438.230(b)(1), (2), and (3). Our process for monitoring and evaluating performance and compliance for OptiCare and our other subcontractors is detailed in our response to Question 58.

Value-Based Provider Contracts

In accordance with Section IV.Q.6.c of the RFP, NTC will:

- notify MLTC within 15 calendar days of finalization of the risk-sharing agreements detailed in our response to Question 97 as well as risk-sharing contracts with any other providers;
- submit encounter data within 90 calendar days of the date of service for any contracts containing capitation payments;
- ensure such provider contracts comply with the requirements set forth in Section IV.I Provider Network Requirements of the RFP and are in compliance with 42 CFR 434.6;
- and maintain all provider contracts in compliance with the provisions specified in the RFP as well as in 42 CFR 438.12 and 42 CFR 438.214.

(page limit N/A)
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.

Nebraska Total Care Inc. has provided a table listing that includes all of the regulatory actions and/or sanctions received by our parent company, affiliates and subsidiaries, including monetary and non-monetary sanctions imposed by any federal or state regulatory entity within the last five years on the following pages.

Corrective Action Plans, Regulatory Actions and Sanctions received by Centene Entities – This report lists the official notices received by all Centene entities from their governing contractors related to regulatory actions, corrective action requests and sanctions or liquidated damages.

Bankers Reserve Life Insurance Company of Wisconsin: A wholly-owned subsidiary of Centene Corporation providing reinsurance to Health Plans		
Date	**Summary of Issue**	**Action**
12/12/11	A $1,000 civil fine was issue by the Louisiana Department of Insurance (LDI) for not filing an Anti-Fraud Plan on or before April 1st, 2011 as required by LSA-R.S. 22:572.1.	$1,000

Centene Corporation		
Date	**Summary of Issue**	**Action**
02/27/15	Centene Corporation was issued a late filing fee of $552 by the State of Michigan, Department of State's Bureau of Elections, due to the late submission of the Financial Summary Report required under Michigan's Lobby Registration Act. The report was filed 23 days late ($24 per day late).	$552

AcariaHealth: A wholly-owned subsidiary of Centene Corporation through an acquisition that was completed in April 2013. AcariaHealth provides specialty pharmacy services to Health Plans, providers, patients and manufacturers. AcariaHealth is headquartered in Orlando Florida and operates physical pharmacy locations in California, Texas, New York and Virginia.		
Date	**Summary of Issue**	**Action**
12/20/11	Prosperity Specialty Pharmacy/Alabama – The Alabama State Board of Pharmacy entered into a Consent Oder with Prosperity Specialty Pharmacy that resulted from a complaint that it did not submit data or zero reports related to the dispensing of controlled substances as required by Alabama law.	Consent Order

02/12/14	AcariaHealth Pharmacy #16 Fairfax VA – As a result of an inspection by the Virginia Board of Pharmacy, a $500 fine and CAP requests were issued relating to 1 major and 4 minor deficiencies identified as follows: Major ($500 fine and CAP): Pharmacist not documenting final verification of non-sterile compounding. Minor 13: Inventories taken on time, but not in compliance. Minor 44: Alarm incapable of sending an alarm signal to the monitoring entity when breached if the communication line is not operational. Minor 19: Not properly documenting partial filling of prescriptions. Partial filled prescriptions are not properly documented. Minor 30: Required compounding records are not complete.	$500 fine and CAP requests
08/13/14	As a result of a site inspection by the Virginia Board of Pharmacy, AcariaHealth PC #16 was assessed $250 for pharmacy remodeling without submission of a remodel application or Board approval. The pharmacy constructed a modular clean room complex that was completed January 2014. An application for remodel along with the required fee was not submitted to the Board. The deficiency was determined to be non-compliant with regulation 18 VAC 110-20-140 of the Virginia Administrative Code.	$250

Medicare - Centene Corporate: Below is a list of sanctions or regulatory actions issued to Centene through its Medicare Service Contracts
Centene received its contract from CMS to provide comprehensive medical and pharmacy services to beneficiaries enrolled under the Medicare Advantage program as of January 1, 2008. Centene offers Medicare Advantage Prescription Drug plans in 5 states (as of February 2013): Texas (contract H5294), Arizona (contract H5590), Ohio (contract H0908), Georgia (contract H7173) Wisconsin (contract H8189) and Florida (contract H5190). All of these plans started offering services as of January 1, 2008, except Georgia which began January 1, 2011.

Date	Summary of Issue	Action
2/11/13	On February 22, 2013, CMS released findings resulting from an on-site program audit conducted in December 2012 that identified the need for 73 CAPs across multiple functional areas including; Part D formulary and Benefits Administration (14), Part D Coverage Determinations and Appeals (21), Part D Grievances (1), Part C Organization Determinations and Appeals (11), Part C Grievances (2), Part C Access to Care (2), Part C and Part D Compliance Program Effectiveness (7), Agent/Broker Oversight (4) and Enrollment/Disenrollment(12). Of these 73 CAPs, 11 were identified as Immediate Corrective Action Requests (ICARS) during the onsite audit in December 2012; 8 ICARs were related to Part D performance and 3 were related to Organizational Determination, Appeals and Grievances performance. Centene responded to each of the ICARs and completed the actions necessary to remediate the deficiencies by target completion date of January 10, 2013. Centene submitted its CAP response to the audit findings on May, 21, 2013	ICARs and CAPs

4/3/13	$100,000 civil monetary penalty issued by CMS resulting from findings in the onsite program audit conducted in December 2012 related to violations of Medicare Part D requirements. Centene failed to carry out the terms of its contract with CMS, and in a manner consistent with the effective and efficient implementation of the program.	$100,000 Civil Monetary Penalty
10/24/13	CMS issued a $25,710 Civil Monetary Penalty for Medicare Advantage - Prescription Drug Plan Contracts: Superior Health Plan, Inc. (H5294) and Managed Health Services Wisconsin (H8189). The action is based on the organization providing inaccurate benefit and coverage information to enrollees in the combined Contract Year 2013 Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) documents. Specifically, incorrectly stating that beneficiaries do not have a coverage gap and incorrectly stating the limit for the Initial Coverage Stage as $4,750, the correct limit is $2,970.	$25,710
04/17/14	CMS issued a compliance notice and CAP request related to low star-ratings to Superior Health Plan (H5294) to improve its Part D Summary Star Rating of 2 to a Star Rating to 3 or higher. CMS did not request a CAP be submitted for their review and approval. Instead, they will review Superior's Summary Rating performance in the coming year to determine whether the necessary corrective actions were followed to achieve the 3 Star Rating.	CAP only
04/17/14	CMS issued a compliance notice and CAP request related to low star-ratings to Bridgeway Health Plan (H5590) to improve its Part C Summary Star Rating of 2.5 to a Star Rating to 3 or higher. CMS did not request a CAP be submitted for their review and approval. Instead, they will review Bridgeway's Summary Rating performance in the coming year to determine whether the necessary corrective actions were followed to achieve the 3 Star Rating.	CAP only
05/23/14	The Centers for Medicare & Medicaid Services (CMS) issued Superior Health Plan (contract # H5294), Peach State Health Plan (contract # H7173) and MHS WI (contract # H8189) a Notice of Non-Compliance letter due to the issuance of inaccurate Annual Notice of Change/Evidence of Coverage (ANOC/EOC) documents to Medicare enrollees for the Contract Year 2014. The ANOC/EOC issued by these SNPs contained inaccurate benefit descriptions and/or cost sharing information.	Notice of Non-Compliance
05/30/14	The Centers for Medicare & Medicaid Services (CMS) issued Bridgeway Health Systems (contract # H5590) a warning letter due to the issuance of inaccurate Annual Notice of Change/Evidence of Coverage (ANOC/EOC) documents to Medicare enrollees for the Contract Year 2014. CMS's review of errata sheets identified inaccurate benefit descriptions and/or cost sharing information in the ANOC/EOC.	Warning Letter
08/07/14	The Centers for Medicare & Medicaid Services (CMS) issued Buckeye Community Health Plan (contract # H0908) and Sunshine State Health Plan (contract # H5190) a warning letter due to the issuance of inaccurate Annual Notice of Change/Evidence of Coverage (ANOC/EOC) documents to Medicare enrollees for the Contract Year 2014. CMS's review of errata sheets identified inaccurate benefit descriptions and/or cost sharing information in the ANOC/EOC.	Warning Letter

Arizona: Bridgeway Health Solutions of Arizona, LLC. (Bridgeway). Bridgeway began providing health care services to Medicaid Members in October 2006 under contract with the Arizona Health Care Cost Containment System (AHCCCS). Bridgeway began serving Dual Eligible membership as a Medicare Advantage Special Needs Plan in January 2008.		
Date	**Summary of Issue**	**Action**
03/03/11	**This Sanction amount was waived** - $415,525 sanction notice received ($231,730 for BWHS and $183,795 for ALTCS) for pended encounter volume aged over 120 days.	$415,525 - Waived
04/26/11	**CAP** request issued to address the low volume of adjudicated encounters and the high volume of pended encounters for the Acute and Long Term Care lines of business. The CAP response is due by May 31st.	CAP Only
05/10/11	**This Sanction amount was waived** - $373,665 sanction notice received ($197,320 for BWHS and $176,345 for ALTCS) for pended encounter volume aged over 120 days.	$373,665 - Waived
06/28/11	A Notice of Cure letter was received by Bridgeway that included two CAP requests for not meeting minimum performance standards in the rate of Eye Exams for diabetic members and Initiation of Home and Community Based Services. In both of these measurements, Bridgeway's rates were 0.1 percentage points below the performance standard.	CAP only
06/29/11	**This Sanction amount was waived** - $368,340 sanction notice received ($196,695 for BWHS and $171,645 for ALTCS) for pended encounter volume aged over 120 days.	$368,340 - Waived
07/26/11	CAP issued to BWHS Acute Care for not meeting the Minimum Performance Standards in the areas of Children's Access to PCPs and Well-Child Visits for ages three to six and adolescents.	CAP Only
10/13/11	**This Sanction amount was waived** - $249,930 sanction amount identified due to pended encounter volume aged over 120 days. (8,719 encounters totaling $143,625 for BWHS Acute and 6,332 encounters totaling $106,305 for ALTCS).	$249,930 -Waived
03/21/12	**This Sanction amount was waived** - $196,905 sanction amount identified due to pended encounter volume aged over 120 days. (7,741 encounters totaling $118,795 for BWHS Acute and 4,694 encounters totaling $78,110 for ALTCS).	$196,905 - Waived
08/23/12	**This Sanction amount was waived** – A potential $455,655 sanction amount identified due to pended encounter volume aged over 120 days. (18,741 encounters totaling $274,705 for BWHS Acute and 12,509 encounters totaling $180,950 for ALTCS)	$455,655 - Waived
01/18/13	$100, 000 sanction assessed by AHCCCS for not meeting the minimum performance in the recent measurement of diabetes screening rates that resulted in an outlier status in the market. There was a 14% variance from the statewide average of the measure. The deficient screenings were the Diabetes Lipid Profiles ($50K) and the Retinal Eye Exams ($50K). In addition, the HbA1C testing rate was non-compliant, but no sanctions were accessed. Instead, AHCCCS is requiring participation in quality improvement technical assistance meetings.	$100,000
10/10/13	A $150,000 sanction was assessed by AHCCCS due to Bridgeway not operating a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) in the expansion counties organized into two geographic service areas (GSAs): GSA 40 (Pinal and Gila counties) and GSA 46 (Graham, Greenlee and Cochise counties). The sanction was $75,000 for each GSA.	$150,000

01/08/14	On October 8th, 2013 AHCCCS issued a preliminary/potential sanction letter to Bridgeway totaling $80,050 due to the volume of pended encounters that aged over 120 days. Bridgeway responded with an appeal of the findings before the due date of November 6th, 2013. The final determination was issued by AHCCCS on January 8th, 2014 that assessed a final sanction assessment of $14,137.50.	$14,137.50
05/29/14	The Arizona Health Care Cost Containment System (AHCCCS) issued Bridgeway a CAP request to correct deficiencies in its ability to process the 820 capitation remittance files.	CAP only
06/20/14	On June 20rd, 2014 AHCCCS issued a final sanction notice to Bridgeway totaling $98,255 related the volume of pended encounters that aged over 120 days for the quarter ending December 2013. The total aged encounter volume was 1960 for Acute Care totaling $31,090 and 6578 for Long Term Care totaling $67,165.	$98,255
6/24/2014	A $300,000 sanction was assessed by AHCCCS due to Bridgeway not operating a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) in the expansion counties organized into two geographic service areas (GSAs): GSA 40 (Pinal and Gila counties) and GSA 46 (Graham, Greenlee and Cochise counties). The sanction was $150,000 for each GSA.	$300,000
09/05/14	On September 5th, 2014 AHCCCS issued a Final sanction letter to Bridgeway totaling $95,275 due to the volume of pended encounters that aged over 120 days (Acute Care 1614 encounters totaling $18,300 and LTC 5563 encounters totaling $76, 975) for the measurement period quarter ending March 2014.	$95,275
12/12/14	On December 12th, 2014 AHCCCS issued a final determination sanction letter to Bridgeway totaling $19,960 due to the volume of pended encounters that aged over 120 days for the quarter ending June 2014.	$19,960
02/25/15	On February 25th, 2015 AHCCCS issued a final determination sanction letter to Bridgeway totaling $24,035 due to the volume of pended encounters that aged over 120 days for the quarter ending September 2014.	$24,035
05/22/15	On May 22, 2015 AHCCCS issued a final determination sanction letter to Bridgeway totaling $45,770 due to the volume of pended encounters that aged over 120 days for the quarter ending December 2014.	$45,770
08/07/15	On August 07, 2015 AHCCCS issued a final determination sanction letter to Bridgeway totaling $16,115 due to the volume of pended encounters that aged over 120 days for the quarter ending March 2015.	$16,115

Bridgeway: The following sanctions or CAP requests were Issue by CMS related to the Medicare Advantage line of business.		
Date	**Summary of Issue**	**Action**
11/29/11	CAP issued by CMS to improve star ranking related to operational performance measures.	CAP only
1/7/15	CAP issued by CMS relating to Patient Safety Measures. The Plan's diabetes treatment rate is 79%, and does not meet the regulatory threshold of 87%. Corrective action plan is due January 15, 2015.	CAP Only

California: California Health & Wellness (CHW): CHW began serving Medicaid (Medi-Cal) recipients in November 2013 under its contract with the California Department of Health Care Services (DHCS).		
Date	**Summary of Issue**	**Action**
10/1/14	CHW was placed on a CAP by DHCS for not amending or replacing existing MOUs with county mental health plans (MHP's) as part of a new expanded mental health benefit effective January 1st 2014. CHW filed the CAP with DHCS on October 31st 2014. The Plan completed revisions of the MOU initiated the process of executing new MOUs and amending existing MOUs. Monthly updates are filed with DHCS to report progress of revised MOUs until completion.	CAP Only

Ohio: Buckeye Community Health Plan. Buckeye began serving Medicaid and CHIP Members in January 2004, under contract with the Ohio Department of Job and Family Services (ODJFS). Ohio uses a point system as well as monetary fines and CAPs.		
Date	**Summary of Issue**	**Action**
08/19/11	$8,000 sanction received resulting from the HSAG annual audit of Abortion, Sterilization and Hysterectomy payments to ensure the inclusion of the required forms. This audit tested 4Q2010 activities (one abortion, 53 hysterectomies, and 104 sterilizations). For the selected audit samples, forms were submitted for all procedures, however HSAG deemed four forms as incomplete/incorrect. Sanction assessed is $2,000 per claim for a total of $8,000.	$8,000
01/04/12	CAP request issued for not meeting the minimum performance standard for the SFY 2011 ABD emergency department diversion performance measure. For the reporting period of Jan through Dec 2010, BCHP's measurement results were 11.46 percent which is a 0.63 percent decrease in diversion from the previous measurement period and 0.12 percent variance from Baseline.	CAP only
03/07/12	A CAP was issued and 5 points assessed for not updating website provider directories as required and for not providing appropriate notification to ODJFS of provider panel terminations.	CAP and 5 pts only
04/20/12	$1,000 sanction issued for not meeting provider panel minimum requirements in Ottawa County. The exception request for the deficiency in the affected county was not filed timely with ODJFS.	$1,000
07/25/12	$3,000 sanction issued for not meeting the minimum provider panel requirements in three regions where BCHP operates ($1000 fine per finding): Southwest ABD (General Surgery), Northeast ABD (Vision) and Northwest CFC (PCP Capacity). The deficiencies in one county (Ottawa) were due to a denied exception request without an explanation from ODJFS. The other two were the result of a file submitted by BCHP the week before the 7/1 evaluation date. No error notices were issued by ODJFS, but two new records being submitted somehow deleted two providers that filled those two areas noted as deficient when ODJFS pulled the file on 7/1. Therefore, BCHP was not aware of any issue that would require submission of an exception request.	$3000
9/21/12	5 points assessed for not conducting a mailing of explanation of benefits (EOBs) to a statistically valid sample of enrollees to verify services rendered.	5points
10/23/12	$2,000 sanction issued for not meeting the minimum provider panel requirements in one region where BCHP operates for two different provider types ($1000 fine per finding): the Northwest CFC region for both Dentists and General Surgeons.	$2,000

08/05/13	A $15, 000 sanction was issued for not meeting minimum provider panel requirements by provider type in the following counties: Guernsey County (PCP/Capacity); Logan County (PCP/Capacity); Noble County (PCP/Capacity); Athens County (Vision), Belmont County (Vision); Gallia County (ENT and Vision); Jefferson County (OB/GYN); Knox County (Vision); Licking County (Orthopedics); Muskingum County (ENT, General Surgery and Vision), Washington County (Vision); Preble County (PCP/Capacity). A $1000 sanction was assessed for each provider type deficiency.	$15,000
10/04/13	A $2,000 sanction was issued for not meeting minimum provider panel requirements in the following areas ($1,000 for each deficiency): Logan County (PCP/Capacity) and Gallia County (Otolaryngology).	$2,000
06/12/14	The Ohio Department of Medicaid (ODM), Bureau of Managed Care (BMC) issued Buckeye and CAP request and a 5 point penalty assessment due to inaccurate provider directory information and not maintaining accurate provider panel information in the State's Managed Care Provider Network (MCPN) database.	CAP and 5 point penalty
10/01/14	On October 1st, 2014 a $7300 sanction and CAP was issued by ODM and BMC respectively for not meeting specified contractual due dates for information requests, including but not limited to: reports and constituent contacts for the Medicaid and MyCare Ohio programs. The BMC requires Buckeye to submit a Corrective Action Plan (CAP) outlining the changes/improvements that Buckeye will make to their processes in order to assure the timely response to all requests for information. The CAP was submitted October, 2014.	$7,300 and CAP
10/20/14	A CAP was issued by the Bureau of Managed Care (BMC) for not meeting the monthly call center abandonment rate for the month of August, 2014. Abandonment rate was reported at 7.9%; state requires a rate equal to or less than 5%. for either the member The Bureau of Managed Care (BMC) issued a notification of non-compliance due to the HP	CAP
10/30/14	The Bureau of Managed Care (BMC) assessed a 5 point penalty to Buckeye for submitting an untimely response to inquiries and information per the terms of an existing CAP.	$15,000
10/30/14	Buckeye received a sanction for not meeting the minimum performance standard for the High Risk Care Management (HRCM) staffing ratio. MCPs must meet the standard of one (1) FTE for every twenty-five (25) HRCM members or 0.040. Buckeye's result was 0.039. The penalty for this 1st instance not meeting minimum standards was a monetary sanction in amount of one quarter of one percent of the current month's premium which is refundable when Buckeye comes back into compliance.	$255,730 (Refundable if compliance is met)
11/3/14	The Ohio Department of Medicaid issued a CAP to Buckeye for not updating the provider directory dental listings for one Lucas County. Buckeye Health Plan must correct the information and ensure it is accurately reflected on in the MCPN no later than close of business, Thursday, November 17, 2014.	CAP only
11/7/14	Buckeye received an informal notice of noncompliance for the inadequate completion rate of health risk assessments for the MMP MyCare Ohio program. CMS is requesting a corrective action plan no later than November 18, 2014	CAP only
12/2/14	Buckeye received a Notice of Noncompliance October 1, 2014 for late submissions and provided Corrective Action Plans (CAPs) for Medicaid and MyCare Ohio on October 15, 2014, describing processes and procedures Buckeye implemented to ensure timely responses to inquiries and information requests. On November 14, 2014, the 3Q CY 2014 Cost Report was due. The cost report was received on 11/19/14. BMC assessed a 5 point penalty for not following an existing CAP. BMC has requested an update to the existing CAP. Buckeye was sanctioned $500.	$500, CAP and 5 point penalty
12/5/14	Buckeye received a notice of non-compliance from the Ohio Department of Medicaid for not meeting the provider panel requirements in ten counties. Deficiencies in the provider network result in an assessment of $1,000.00 non-refundable fine for each category and county. ODM is assessing a non-refundable sanction of $10,000.00.	$10,000

12/31/14	Buckeye received a monetary sanction for $1,820,966 from the Ohio Department of Medicaid (ODM) for not meeting minimum performance standards for 7 quality measures during 2013. On January 15th, 2015, the assessment was reduced to 6 measures not being met for revised sanction assessment of $1,560,828. Once Buckeye is determined to be in compliance with the standards to the satisfaction of ODM, the monetary sanction will be returned.	$1,560,828 (refundable once compliance is met)
01/21/15	A $4, 000 sanction was issued by the Ohio Department of Medicaid (ODM) for not meeting minimum provider panel requirements by provider type in the following counties: Fulton (Dentist); Gallia County (Vision); Washington County (Vision) and Lorain (Psychiatry). A $1000 sanction was assessed for each provider type deficiency.	$4,000
3/6/15	Buckeye received a letter of non-compliance and a corrective action plan (CAP) request for not implementing processes that result in correct and timely payment of claims in response to a complaint filed by provider. The CAP was submitted March 20, 2015and detailed the steps Buckeye is taking to ensure claims are paid correctly and timely for all providers impacted by the systemic error, including reprocessing claims as applicable.	CAP Only
3/19/15	Buckeye received a Notice of Non-Compliance from the Ohio Department of Medicaid due to incorrect reporting of the calendar year Q2 and Q3 cost reports. Buckeye must participate in a technical assistance conference call with Mercer and ODM staff, correct and resubmit the Quarter 4 CY2014 Cost Report as directed, and ensure the annual cost report, as well as, all future cost reports are submitted accurately.	Notice of Non-Compliance
4/29/15	Buckeye received a sanction assessment from the Ohio Department of Medicaid (ODM) for not meeting provider panel requirements in the following 5 counties at $1000 per defieciency: Lorain (Psychiatry), Mahoning (Psychiatry), Greene (General Surgeons), Seneca (PCP) and Van Wert (PCP). Union (ENT) deficiency was reversed on appeal and reduced original sanction by $1,000.	$5,000 – Reduced on Appeal from $6000
5/01/15	Buckeye received a $200 sanction assessment from the Ohio Department of Medicaid (ODM) for the 2 day late submission of the MyCare Ohio Coordination of Benefits Agreement (COBA) attachment ($100 per day date).	$200
06/05/15	The Ohio Department of Medicaid, Bureau of Managed Care (BMC) issued Buckeye a directed Corrective Action Plan request for not preparing and/or submitting summaries for three State Fair Hearings and for not attending those Hearings in March 2015.	CAP Only
07/07/15	The Ohio Department of Medicaid (ODM) issued Buckeye a $5,000 sanction, 15 point penalty and Corrective Action Plan (CAP) request for not coordinating care for 2 members care across appropriate providers, specialists and team members and for performing inadequate needs and health assessments.	$5,000, 15 points and CAP
07/07/15	The Ohio Department of Medicaid (ODM) issued Buckeye a $5,000 sanction, 5 point penalty assessment and CAP request related to impairing members' ability to obtain accurate information which caused delays in their ability to access servicess.	$5,000, 5 points and CAP
07/28/15	Buckeye received a sanction assessment from the Ohio Department of Medicaid (ODM) for not meeting provider panel requirements in the following 6 counties at $1,000 per defieciency: Logan (Vision), Morgan (Pharmacy), Lorain (Psychiatry), Morgan (Psychiatry), Fulton (Dentists) and Montgomery (Allergists). This sanction is current under appeal for reconsideration.	$6,000 – Under Appeal
08/14/15	The Ohio Department of Medicaid, Bureau of Managed Care issued Buckeye/MyCare a $20,000 sanction, corrective action plan request and a 50 point penalty related to audit results of Q1 2015 performance that indicate MyCare did not meet care management requirements for the following six standards: Risk Stratification, Comprehensive Assessment, Individualized Care Plan, Waiver Service Provision, Care Manager/Care Management Team, and Beneficiary Interaction. This sanction	$10,000, 25 points and CAP request

	was reduced on appeal in October 2015 to a $10,000 sanction and a 25 point assessment.	
08/21/15	The Ohio Department of Medicaid, Bureau of Managed Care issued Buckeye/MyCare a corrective action plan request for not meeting the data quality standard of 100% for dental encounters submitted and accepted in July 2015.	CAP only
10/27/15	The Ohio Department of Medicaid, Bureau of Managed Care issued Buckeye a sanction totaling $1,000 for not meeting provider panel minimum requirements in 1 counties: Lorain (Psychiatry). The sanction was assessed at a rate of $1,000 per county.	$1,000
10/27/15	The Ohio Department of Medicaid, Bureau of Managed Care issued Buckeye/MyCare a sanction totaling $2,000 for not meeting provider panel minimum requirements in 2 counties: Lorain (Psychiatry) and the Northeast Region (Out-of-Home Respite). The sanction was assessed at a rate of $1,000 per county.	$2,000
11/09/15	Buckeye Health Plan received a Notice of Non-Compliance/Remedial Action from the Ohio Department of Medicaid for failure to meet minimum performance standards for 8 quality measures in calendar year 2014. A refundable fine of $1,123,908 is assessed on 4 measures for which this is Buckeye's first instance of not meeting the minimum standard. Additionally, a non-refundable fine of $1,123,908 is assessed on 4 measures for which this is Buckeye's second consecutive instance of not meeting the minimum standard.	$2,247,816

Illinois: Celtic Insurance Company (Celtic). Acquired by Centene in 2008, Celtic offers insurance coverage for small employers through a statewide public private partnership and contract with the Texas Department of Insurance. Celtic also offers individual insurance coverage in every state except New York.

Date	Summary of Issue	Action
03/11	Celtic received a $550 sanction from the State of Colorado for not submitting the 2010 annual Average Hospital Reimbursement Rate Survey timely.	$550
10/11/11	Celtic was issued a CAP because it was determined that the new Third Party Administrator, Novasys, could not support certain HIPAA compliant transaction sets – the 270/271 (HealthCare Eligibility Inquiry and Response) and the 835 (HealthCare Electronic Remittance/Payment Advise. The non-compliant code sets were implemented and the CAP was removed on July 10th, 2012.	CAP only
11/21/11	Celtic Received a $1,000 administrative fine from the State of Nevada for not paying the annual appointment invoice timely.	$1,000
11/21/11	Celtic was issued a CAP from the Florida DOI to address non-compliance with Florida Statures that limits an insurer's ratio of accident/health annual written premium to current surplus as to policyholders to a maximum of 10:1 for gross written premiums and 4:1 for net written premium. The quarterly NAIC financial statement for the period ending September 30th, 2011 indicated a net written premium ratio of 4.14:1	CAP only
12/12/11	Celtic received a $500 sanction from the State of Louisiana for not submitting the Anti-Fraud Filing timely.	$500
2011	Celtic paid penalties in Texas in accordance with the Prompt Pay Penalty requirements (May $4425.87; June $22178.99; July $36498.37; August $43196.95;September $42940.44; Oct $44378.67; Nov $3087.10; Dec $17721.15)	$214,427.54
04/02/12	Celtic received a $550 sanction from the State of Colorado for not submitting a timely response (no additional information was provided).	$550
04/04/12	Celtic received a $550 sanction from the State of Colorado (no additional information provided)	$550
07/30/12	Celtic received a $550 sanction from the State of Colorado for not providing a complete response (no additional information provided).	$550

10/29/12	A $500 sanction issued by the State of Michigan, Office of Financial and Insurance Regulation for failure to give notice to a consumer of their grievance and appeals rights.	$500
11/08/12	A $4,500 sanction issued by the State of Washington Office of the Insurance Commissioner (OIC) for using unlicensed producers to sell, solicit and negotiate insurance policies. Identification of this issue was the result of a 2009 and 2010 market analysis of Celtic. Upon notification of this non-compliance, Celtic promptly complied with OIC's request to license its employees who were selling insurance to WA consumers.	$4,500
11/9/12	Received notice of hearing from the New Hampshire Insurance Department related to untimely filing of report submissions in August 2012. Celtic held an informal meeting in February 2013 with the New Hampshire Insurance Department (NHID), at that time a settlement agreement was reach requiring Celtic to execute a consent order and pay $30,000 penalty for the untimely report submissions.	$30,000
12/31/12	As of December 2012, Celtic paid penalties in Texas in accordance with the Prompt Pay Penalty requirements.(January $56,234.59; February $24,038.82; March $47,711.41; April $12,635.35; May $55,96.29; June $20,396.68; July $54,70.20; August $70,56.74; September $14,998.98; October $10,398.59; November $97,71.32; December $2,538.55).	$216,847.52
3/25/13	The Illinois Department of Insurance issued Celtic a Stipulation and Consent Order resulting from a Market Conduct Examination that covered the periods of December 2010 through November 2011 for claims and December 2009 through April 9th, 2011 for complaints. The Stipulation and Consent Order assessed a Civil Forfeiture/Penalty in the amount of $14,000 and requires proof of compliance, through process implementation, in the following areas identified as deficient: claims payment within 30 days, pay interest on delayed claims payment, deny claims coverage within 30 days, ensure claims payment accuracy and address issues that result in high volume of complaints.	$14,000 and Corrective Actions
12/31/13	As of December 2013, Celtic has paid penalties in Texas in accordance with the Prompt Pay Penalty requirements (January – $17,036.33; February - $4,336.07; March - $0.00, April - $16,119.08; May – $82.26; June – $30,007.84; July – $7,440.87; Aug – $6,422.13; September – $2,592.87; October – $29, 585.79; November - $12,603.68; December - $33,266.91).	$159,493.83
12/31/14	As of December 2014, Celtic has paid penalties in Texas in accordance with the Prompt Pay Penalty requirements (January – $12,318.33; February - $773.89; March - $0.00; April - $0.00; May - $4,580.80 ; June - $8,838.65; December - $671.53)	$27,183.20
06/02/14	The Connecticut Insurance Department issued Celtic a Stipulation and Consent Order resulting from a Market Conduct Examination that covered the period of calendar year 2012. The Stipulation and Consent Order assessed a CAP request and $1,500 fine resulting from findings that Celtic had utilized one producer acting as an agent without the required appointment.	$1,500 and CAP

Illinois: IlliniCare Health Plan (IHP). IlliniCare began serving Medicaid membership through its contract with the Illinois Department of Healthcare and Family Services (HFS) beginning in May 2011.

Date	Summary of Issue	Action
5/4/15	IlliniCare received a request for a Corrective Action Plan (CAP) from HFS to remediate the volume of preventable errors that occurred in encounter data submissions. IlliniCare submitted the CAP to HFS on May 15, 2015.	CAP Only
11/16/15	IlliniCare received a notice of noncompliance a request to cure from HFS related to on May 15, 2015.	

Louisiana: Louisiana HealthCare Connections (LHC). LHC began serving Medicaid membership through its contract with the Louisiana Department of Health and Hospitals (DHH) beginning February 1st, 2012.

Date	Summary of Issue	Action
12/12/11	LHC received a $1,000 sanction from the State of Louisiana Department of Insurance for not submitting the Anti-Fraud Filing timely.	$1,000

Indiana: Coordinated Care Corporation dba Managed Health Services. Coordinated Care Corp began serving Medicaid and CHIP Members in 1995 and uninsured adults in January 2011. The plan contracts with the Indiana Family and Social Services Administration (FSSA), Office of Medicaid Policy and Planning (OMPP).

Date	Summary of Issue	Action
05/15/12	MHS IN received sanctions totaling $74,214 and CAP requests related to non-compliant performance in multiple function areas. MHS IN is appealing the findings. This sanction amount was reduced on appeal to $67,148 on 6/14/12. The noncompliant performance includes: Incomplete Newborn Report - $14,460 Incomplete POWER Account Detail Report - $14,460 Incomplete HHW Top Costly Conditions Report - $14,460 Incomplete HIP Top Costly Conditions Report - $14,460 Incomplete HHW Claims Denials Report - $4,654 Incomplete HIP Claims Denials Report - $4,654 HIP Prior Auth Timeliness - $5,712 (rescinded on appeals 6/14), CAP only required HIP Member Call Timeliness - $1,354 (rescinded on appeals 6/14), CAP only required Behavioral Health Prior Auths - CAP only Medical Loss Ratio - CAP only	$67,148 and CAPs
10/31/12	Sanction letter issued by OMPP total $5,895 due to untimely and/or incomplete submission of performance reports (CAHPS report - $4,931, Medical Loss Ratio HHW Report - $482, and Medical Loss Ratio HIP Report - $482.	$5,895
11/14/14	Notice of Non-Compliance. MHSIN received a letter of non-compliance for not meeting the contractual requirements for new member health screenings for 1st, 2nd and 3rd quarters in 2014. The Plan must file a PIP with the Indiana Family Social Services Administration within 10 days of receipt of notification.	Notice of Non-Compliance letter
09/14/15	The OMPP issued MHS a sanction totaling $10,790 for not meeting the contract requirement to timely process 98% of clean institutional electronic claims (MHS met 97.88%) and clean institutional paper claims (MHS met 97.57%) in Q2, 2015. The sanction was assessed per the contract specified rate of $5,395 per non-complaint claim type in the measurement quarter.	$10,790
09/14/15	The OMPP issued MHS a sanction totaling $9,274 and a performance improvement plan request for not conducting health needs screenings with at least 70% of applicable members within the required timeframes in the Q2, 2015 measurement under the Hoosier Healthwise (MHS met 32%) and HIP (MHS met 33%) contracts. The sanction was assessed at $4,637 per the contract type.	$9,274
12/1/15	The OMPP issued MHS a sanction totaling $257,178 for not meeting the contract requirement: (1) by not timely and accurately submitting thirty-one (31) HIP Priority reports; (2) for not conducting health needs screenings with at least 70% of applicable members within the required timeframes; and (3) for not conducting health needs screenings with at least 70% of applicable members within the required timeframes.	$257,178

Wisconsin: Managed Health Services Insurance Corp. The health plan began operations in 1991; it contracts with the Wisconsin Department of Health Services to serve Medicaid and CHIP Members.		
Date	**Summary of Issue**	**Action**
10/13/14	A CAP request was issued by the Bureau of Fiscal Management within the Department of Health Service to all managed care plans to improve the quality of encounter data submissions to ensure accurate and complete data for rate setting purposes.	CAP only

Mississippi: Magnolia Health Plan. Magnolia began providing services to Medicaid Members in the State of Mississippi under the new statewide care coordination program called Mississippi Coordinated Access Network (MississippiCAN) on January 1, 2011.		
Date	**Summary of Issue**	**Action**
01/26/11	CAP request issued due to DME subcontractor issuing prior authorization letters to network providers indicating reimbursement rates less than Medicaid fee-for-service rates. They were using $.01 as a placeholder on their template letters. CAP was approved by DOM on 2/9/2011.	CAP only
1/27/15	Warning letter issued by DOM. Magnolia did not meet Abandoned Call Rate (ACR) of less than 5% as required by contract. DOM requested a detailed plan of action to be taken to remediate the issue 15 calendar days from receipt of letter.	Warning Letter Only
08/22/15	The Mississippi Department of Medicaid (DOM) assessed Magnolia a sanction totaling $5,600 for not timely notifying members of a breach occurrence within the regulatory timeframes.	$5,600

South Carolina: Absolute Total Care, formerly Total Carolina Care. Absolute Total Care began serving Medicaid members in December 2008 under contract with the South Carolina Department of Health and Human Services (SCDHHS).		
Date	**Summary of Issue**	**Action**
8/16/11	CAP issued by SCDHHS to address network adequacy deficiencies in 3 counties (Greenville, Laurens and Pickens).	CAP only
05/25/12	CAP only issued to remediate deficient performance in the areas of claims payment, provider contracting and prior authorizations.	CAP only

Arizona: Cenpatico Behavioral Health of Arizona (CBH AZ). CBH AZ began providing BH services as a regional behavioral health authority in July of 2005, under contract with the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS). ADHS/DBHS is a separate regulatory body from AHCCCS, cited above, which contracts with Bridgeway. The two agencies have separate and different policies and procedures. CBH AZ serves Medicaid and low-income uninsured Members.		
Date	**Summary of Issue**	**Action**
5/15/12	CAP issued resulting from SAPT and CMHS Block grant audit. Corrective Action Plan (CAP) and updates submitted to State. CBH AZ and other RBHAs continue to work with State to map funds to recipients via electronic recipient data submission, in the encounter file submission layouts and in the State's demographic submission file layouts.	CAP onlyUpdate 3.6.13 – CAP has been closed.

08/24/12	This sanction was waived- $23,775 sanction notice received related to the preliminary results of the pended encounter volume measurement for the period ending June 2012. The measurement identified 1427 pended encounters aged over 120 days.	$23,775 - Waived
12/03/12	Notice to ensure that all members in an Episode of Care undergo a complete assessment at least once annually and that clinical and demographic gathered during the assessment process and submitted to the State. Efforts to remediate included: (i) address with Providers for those who conduct the assessments untimely or not all and (ii) review assessments that were completed but the demographic that reports the date of the assessment was not received. CAP submitted but CBH AZ subject to other contractual remedies including sanctions.	CAP only
10/01/13	10/01/2013 - CBH AZ was sanctioned $33,812 by the ADHS/DBHS for not submitting the 85% minimum percentage of encounters for SFY 2011 and SFY 2012 in Regions 3 and 4.	$33,812

Rx Direct: A subsidiary of US Script providing full-service, mail order, and online pharmacy services

Each of the actions listed below relates back to a one-time administrative error that occurred in 2005 and resulted in failure to timely renew Rx Direct, Inc.'s ("RxDirect") licensure with the Arkansas Board of Pharmacy. Since that time, RxDirect has implemented internal process enhancements, which are directly supervised by the pharmacist-in-charge on a daily basis, to prevent such an administrative error from occurring in the future. In the unexpected event that RxDirect does encounter an issue in the future, RxDirect has implemented a process to timely notify, as required, the state Boards of Pharmacy and NABP of any such issues.

Date	Summary of Issue	Action
10/06	RxDirect made an administrative error and did not timely renew its Arkansas pharmacy license for 2006. Immediately after RxDirect became aware of this oversight, in June 2006, it contacted the Arkansas Board of Pharmacy to inform them of the situation, and RxDirect discontinued shipments to Arkansas until its new license was issued on June 21, 2006. RxDirect accepted full responsibility for this error, entered into a Consent Order with the Arkansas Board of Pharmacy on October 11, 2006, and paid a $1,000 penalty to the Board.	$1,000
04/08	RxDirect notified the Hawaii Board of Pharmacy about the Arkansas Board of Pharmacy Consent Order as part of the renewal of its Hawaii pharmacy license in 2007, which was the renewal period in Hawaii immediately following the effective date of the Consent Order. On February 15, 2008, RxDirect received notice from the Regulated Industries Complaint Office (the "Office") that the Office was reviewing the fact that RxDirect did not notify the Hawaii Board of Pharmacy about the Arkansas Consent Order within thirty days of the effective date of the Order. In April 2008, RxDirect entered into a Settlement Agreement Prior to Filing of Petition for Disciplinary Action and Board's Final Order in Hawaii and agreed to pay a $500 administrative fine to the State.	$500
01/09	RxDirect entered into an Agreed Board Order with the Texas State Board of Pharmacy on January 15, 2009 related to the Arkansas Consent Order. Pursuant to the Agreed Board Order, RxDirect's pharmacy license was reprimanded.	N/A
02/09	In late 2008, RxDirect entered into a Consent Agreement with the State of Delaware related to the Arkansas Consent Order and Hawaii Settlement Agreement. On February 18, 2009, the Delaware Board of Pharmacy signed an Order agreeing to this Consent Agreement. Per the terms of the Consent Agreement, the appropriate disciplinary sanction for RxDirect by Delaware is a letter of reprimand, which was received on March 9, 2009.	N/A

Florida: Sunshine State Health Plan. Sunshine State Health Plan began serving Medicaid members in December 2008, under contract with the Agency for HealthCare Administration.		
Date	**Summary of Issue**	**Action**
02/24/11	$1,200 sanction for late submission of the 80/20 behavioral health IBNR reconciliation report due on February 1st, 2011. The report was 6 days late and the plan was fined $200 per day. Sanction issued on 2/24/2011, received by SSHP on 3/2/2011.	$1,200
08/31/11	$1,600 sanction received for untimely submission of the Q2 2011 quarterly financial report. The report was submitted on time but was returned to SSHP because of missing information. The completed report was submitted 8 days after the due date. The sanction was calculated at $200 a day for being eight days late.	$1,600
02/27/12	A $400 sanction was issued to SSHP by AHCA for late filing of the 2012 Child Health Checkup (CHCUP) Corrective Action Plan (CAP). The CAP was due to AHCA on 02/15/2012, but was delivered two days later on 02/17/2012 resulting in a $200 per day sanction.	$400
08/22/12	A $200 sanction was issued to SSHP by AHCA for submitting one day late (Aug. 16th, 2012) the Q2, 2012 quarterly financial report for the period ending June 30th, 2012. The report is due within 45 calendar days of the end of the reporting period (Aug. 15th, 2012).	$200
11/20/12	**This Sanction was rescinded on appeal.** A $25,000 sanction issued to SSHP by AHCA for not submitting all pharmacy typical and atypical encounters with dates of service in September 2012 by October 15th, 2012. SSHP appealed this sanction on December 10th, 2012. Upon review, AHCA rescinded the sanction on February 25th, 2013 and refunded the $25,000 payment issued by Sunshine.	$0 ($25,000 – Rescinded On Appeal)
02/19/13	A $50,000 sanction was issued by AHCA for not achieving minimum standards for certain HEDIS performance measurement groups established for calendar year 2011. The deficient performance in the Reform counties were Preventative (group score 1.4 = $10,000), Prenatal/Postpartum (group score 0.7 = $7,500) and Chronic Care (group score 1.0 = $2,500). The deficient performance in the Non-Reform counties were Preventative (group score 0.4 = $10,000), Prenatal/Postpartum (group score 0.7 = $7,500), Chronic Care (group score 0.0 = $2,500) and the CBP individual measure (less than the 10th percentile - $10,000).	$50,000
04/10/13	A $1,000 sanction was issued by AHCA for not filing accurate encounter data for the 2011 IBNR Behavioral Health Annual 80/20 Expenditure Report. The Bureau of Managed Health Care received the complete and accurate report after the due date. An extension was given by the Bureau to March 21, 2013, but the report was not report was received until April 9th, 2013.	$1,000
04/19/13	$4,000 sanction issue for not timely filing a complete and accurate annual behavioral health 80/20 expenditure report for 2012.	$4000
02/07/14	The Agency for Health Care Administration (AHCA) issued Sunshine State Health Plan (Health Plan) a $25,000 sanction because it did not achieve the required Federal 80% Participation Ratio as reported in the Plan's unaudited CHCUP CMS 416 & FL 60% Screening Ratio report for federal fiscal year 2012-2013.	$25,000
04/07/14	The Agency for Health Care Administration (AHCA) issued Sunshine State Health Plan (Health Plan) a $2,000 sanction for not meeting the deadline to submit readiness review materials. The required material submission was due on January 16th under the implementation action plan. However, additional material was submitted on March 24th, 2014, outside the specified deadline.	$2,000
04/21/14	The Agency for Health Care Administration (AHCA) issued Sunshine State Health Plan (Health Plan) a sanction totaling $88,000 because it did not achieve minimum standards for the HEDIS performance measure groups (reform) and individual measures (non-reform) specified in the Medicaid Health Plan Contract for the period of calendar year 2012.	$88,000

05/12/14	The Agency for Health Care Administration (AHCA) issued Sunshine State Health Plan (Health Plan) a CAP request related to provisions of the provider contract templates used by its delegated home health/DME vendor, Univita. The provider contract templates contain language that prohibits or restricts the provider from entering into a commercial contract with another Managed Care Plan. The CAP requires the Health Plan to submit a revised provider contract template and to amend existing contracts that contain the non-complaint language to remove the provision.	CAP Only
7/29/14	**(Rescinded on appeal February 27th 2015)** On June 25, 2014, The Agency for Health Care Administration (AHCA) notified Sunshine State Health Plan, Inc. (SUN) via e-mail of the requirement to submit Quarter 4 Level of Care Performance Measure data in order for the Agency to fulfill federal reporting requirements. The requested data was due on July 23, 2014. It was not received by the Agency until July 24, 2014; therefore, it was not submitted timely to the Agency in accordance with Contract FP026.The Agency is assessing Sunshine State Health Plan, Inc., a total amount of $500 calculated at $500 per day for the period of July 23, 2014 through July 24, 2014 per the Agency's specifications.	$0 (rescinded on appeal)
8/11/14	On July 22, 2014, the Agency notified Sunshine State Health Plan, Inc., (SUN) via e-mail of the Unable To Locate enrollee reporting process per the Statewide Medicaid Managed Care (SMMC) Policy Transmittal 14-11. The requested data was due on August 5, 2014. It was not received by the Agency until August 6, 2014; therefore, it was not submitted timely to the Agency in accordance with Contract FP026. The Agency is assessing Sunshine State Health Plan, Inc., the sum total of $500 calculated at $500 per day for each calendar day beyond the due date until provided to the Agency per the Agency's specifications.	$500
9/11/14	Under Appeal - The Agency for Health Care Administration (AHCA) issued Sunshine State Health Plan a sanction totaling $3,000 due to not meeting access standards for specific medical services, lack of a contracted Birthing Center, in Region 1. Sunshine is currently appealing this sanction.	$3,000
9/23/14	Under Appeal - The Agency for Health Care Administration (AHCA) issued Sunshine State Health Plan a sanction totaling $2,500 as a result of a clinical record review of therapy services in August 2014. It was noted that on one occasion, Sunshine sought prior authorization for therapy services rendered to a member that transitioned into Sunshine State and was still in the Continuity of Care (COC) period with the State. Sunshine is currently appealing this sanction.	$2,500
10/3/14	The Agency for Health Care Administration (AHCA) issued Sunshine State Health Plan (Health Plan) a sanction totaling $500 for untimely submission of a critical incident report.	$500
10/3/14	The Agency for Health Care Administration (AHCA) issued Sunshine State Health Plan (Health Plan) a sanction totaling $1,500 for untimely submission of a critical incident report.	$1500
11/4/14	A $2,500 sanction was issued to Sunshine State Health Plan for providing promo items as give a ways to event participants during a marketing event.	$2,500
11/13/14	**(Rescinded on appeal February 27th 2015).** The Agency for Health Care Administration (AHCA) issued Sunshine State Health Plan (Health Plan) a sanction totaling $1000 for untimely submission of a critical incident report.	$0
12/2/14	The Agency for Health Care Administration (AHCA) issued Sunshine State Health Plan (Health Plan) a sanction totaling $51,500 for not developing a plan of care for long term care enrollees within timeframes specified per the contract.	$51,500

12/2/14	The Agency for Health Care Administration (AHCA) issued Sunshine State Health Plan (Health Plan) a sanction totaling $11,038 for not reporting missed covered services for a recipient enrolled in long term care plan for 3 months.	$11,038
12/2/14	The Agency for Health Care Administration (AHCA) issued Sunshine State Health Plan (Health Plan) a CAP request for: (1) untimely filing/reporting of missed covered services and (2) not developing plan of care for enrollees within timeframes specified per the contract. The CAP requires the Plan to address steps taken to improve processes as a result of findings to issues. CAP response is due within 20 days from receipt of letter from Agency.	CAP Only
12/17/14	The Agency for Health Care Administration (AHCA) issued Sunshine State Health Plan (Health Plan) a sanction totaling $250.00 for untimely submission of the Provider Network Verification (PNV) file. An error in the report format caused the submission to fail resulting in a one day delay.	$250
1/9/15	The Agency for Health Care Administration (AHCA) issued a CAP request to Sunshine State Health Plan related to the administration of therapy benefits. The therapy benefit delivery model utilized by Sunshine's therapy subcontractor does not ensure EPSDT and continuity of care requirements are met. The CAP is due for submission by March 15th, 2015. The CAP must include updated policies and procedure for administering the therapy benefits and auditing results of Sunshine's therapy subcontractor.	CAP Only
1/27/15	The Agency for Health Care Administration (AHCA) issued a Sunshine State a Notice of Sanction/Liquidated Damages assessment totaling $250 for submitting a Provider Network file that did not meet AHCA specifications.	$250
3/18/15	The Agency for Health Care Administration (AHCA) issued Sunshine State a sanction totaling $1,000 for untimely submission of 2 critical incident reports.	$1,000
5/5/15	The Agency for Health Care Administration (AHCA) issued Sunshine State a sanction totaling $2,500 because its transportation vendor did not transport a member in accordance with the provisions of the contract.	$2,500
5/6/15	Under Appeal - The Agency for Health Care Administration (AHCA) issued Sunshine State a sanction totaling $500 for untimely submission of a critical incident report. Sunshine is currently appealing this sanction.	$500
06/05/15	The Agency for Health Care Administration (AHCA) issued Sunshine State a sanction totaling $50,000 for not meeting HEDIS performance measures specified in the contract.	$50,000
08/28/15	The Agency for Health Care Administration (AHCA) issued Sunshine State Health Plan (Health Plan) a $25,000 sanction because it did not achieve the required Federal 80% Participation Ratio as reported in the Plan's unaudited CHCUP CMS 416 & FL 60% Screening Ratio report for federal fiscal year 2013 - 2014.	$25,000
08/28/15	Under Appeal - The Agency for Health Care Administration (AHCA) issued Sunshine State a sanction totaling $75,000 resulting from the Agency's determination that the health plan did not submit pharmacy encounter data supporting 95% of pharmacy expense. AHCA's analysis of Sunshine State's financials reports indicate that 91% of pharmacy expenses were reflected in pharmacy encounter submission. The sanction was applied at a rate of $25K per month for the 3 months of the reporting quarter. Sunshine is currently appealing this sanction.	$75,000
11/04/15	Under Appeal - The Agency for Health Care Administration (AHCA) issued Sunshine State a sanction totaling $10,000 due to the untimely filing of documentation related to a Medicaid State Fair Hearing. Sunshine is currently appealing this sanction.	$10,000
11/04/15	Under Appeal - The Agency for Health Care Administration (AHCA) issued Sunshine State a sanction totaling $10,000 due to the untimely filing of documentation related to a Medicaid State Fair Hearing. Sunshine is currently appealing this sanction.	$10,000

11/09/15	The Agency for Health Care Administration (AHCA) issued Sunshine State a sanction totaling $1,000 and a CAP request due to inaccuracies in Sunshine's online provider directory of Adult Psychiatry providers in Miami-Dade county.	$1,000 and CAP
12/4/15	Under Appeal - The Agency for Health Care Administration (AHCA) issued Sunshine State a sanction totaling $49,500 and a CAP request due to failure to transport enrollees to pre-scheduled appointments. Sunshine is currently appealing this sanction.	$49,500 and CAP

Texas: Superior HealthPlan Network (Superior Network). Superior Network began serving CHIP RSA Members in September 2004 and began serving Medicaid Foster Care Members in April 2008. Actions listed below indicate either CHIP RSA or Medicaid, for Medicaid Foster Care. Medicaid Foster Care actions include those relating to certain services provided by Superior Network's Material Subcontractor, Integrated Mental Health Services. Superior HealthPlan Network manages the follow contract service areas:
STAR and STAR+PLUS (Hidalgo Service Area)
STAR Medicaid RSA (includes Central, Northeast and West Rural Service Areas)
CHIP RSA and CHIP Perinate RSA
STAR Health

Date	Summary of Issue	Action
2/03/11	SHPN received a sanctions totaling $5,000 resulting from the Q4 SFY 2010 operational performance measurement in the following areas: Statewide behavioral health appealed claims underperformance (only 20 percent of appealed claims processed timely, the requirement is 98 percent within 30 days).	$5,000
05/09/11	$10,000 sanction received for not adjudicating 98 percent of clean dental claims within 30 days of receipt in the STARHealth statewide product during Q1 of SFY 2011. The dental subcontractor, DentaQuest, only achieved a 93.69 percent adjudication rate (1,392 claims untimely out of 21,635). This sanction was repaid to the health plan by DentaQuest.	$10,000
09/01/11	SHPN received a sanctions totaling $2,500 resulting from the Q2 SFY 2011 operational performance measurement in the following areas: Statewide behavioral health clean claims underperformance. The requirement is 98 percent of clean claims adjudicated within 30 days, the measured performance for this period was 93.81 percent.	$2,500
12/07/11	$10,000 sanction issued for not utilizing the appropriate language and guidelines when issuing medical necessity determinations and member denial notices. A denial notice issued on 8/11/11 did not include the correct Medicaid Manual reference, appropriate Federal citation, or fair hearing language.	$10,000
01/12/12	CAP issued as a result of the SFY 2010 THSteps Medical Checkup Reports related to Existing Member checkup participation rates below 35 percent. SHPN's performance was at 27 percent during the measurement period.	CAP Only
03/26/12	$1,925 sanction received for not submitting a timely and accurate PMUR report in the 4th quarter of SFY 2011.	$1,925
12/27/12	$56,950 in total sanctions received for various operational deficiencies in the SFY Q3 2012 performance measurement – Late or Inaccurate Third Party Liability Report ($200), Late or Inaccurate Financial Statistical Report ($1500), Single Claims On-Line Portal Implementation timeliness ($26,000), For not resolving 98 percent of Member/Provider complaints within 30 calendar days – only achieved 82.35 percent in measurement period ($24,250), and for not adjudicating 98 percent of Dental clean claims within 30days – only achieved 90.26 percent in measurement period ($5,000). Note - Final appeal determination received from HHSC on May 13th, 2013. This sanction was initially assessed on December 27th, 2012 totaling $73, 250. Superior appealed the findings resulting in HHSC issuing a final determination with reduced sanction assessments of $56,950 on May 13th, 2013. The sanctions related to Third Party Liability and Financial Statistical reporting were reduced on appeal.	$56,950

06/02/14	SHPN received sanctions totaling $1,200 resulting from deficiencies identified the Q1 2013 quarterly performance measurement in the following areas: Third Party Liability/Third Party Recovery report submitted timely/accurate/complete (STAR, STAR+PLUS, CHIP) - $1,100 (Reduced on appeal from $1,200) Added $1100 for STAR Health previously not assessed	$2,200 (Adjusted from $1,200 following appeal)
06/02/14	(Under Appeal) SHPN received sanctions totaling $7,325 resulting from deficiencies identified the Q2 2013 quarterly performance measurement in the following areas: Provider Hotline hold time is two minutes or less (STAR+PLUS, STAR, STAR Health, CHIP RSA) - $200 (Reduced on appeal from $400) Member Hotline 80% of calls answered within 30 seconds. (STAR) - $900 Member Complaints 98% resolved within 30 days (STAR) - $25 Appealed Claims Processing 98% adjudicated within 30 days (STAR+PLUS, STAR) - $0 (Waived on appeal from $6,000)	$1,125 (Reduced on appeal from $7,325
06/02/14	(Under Appeal) SHPN received sanctions totaling $70,750 resulting from deficiencies identified the Q3 2013 quarterly performance measurement in the following areas: Vision Claims Summary Reports submitted timely/accurate/complete (STAR, STAR+PLUS, STAR Health) - $3,500 (Reduced on appeal from $46,000) PCP as THSteps report submitted timely/accurate/complete (CHIP, STAR, STAR+PLUS) - $0 (Reduced on appeal from $7,250) STAR Health Liaison report submitted timely/accurate/complete (STAR Health) - $0 (Reduced on appeal from $7,250) Hotline report submitted timely/accurate/complete (STAR Health) - $0 (Reduced on appeal from $7,250) Timely response to HHSC Member/Provider Complaint (STAR) - $250 (Reduced on appeal from $3,000)	$3, 750 (Reduced on appeal from $70,750)
06/02/14	(Under Appeal) SHP received sanctions totaling $119,500 and a CAP resulting from deficiencies identified the Q4 2013 quarterly performance measurement in the following areas: Third Party Liability/Third Party Recovery report submitted timely/accurate/complete (STAR Health) - $0 (Reduced on appeal from $500) Timely perform an Administrative Service, Fair Hearing Non- Attendance (STAR+PLUS) - $10,500 and CAP (Reduced on appeal from $105,000) Timely response to HHSC Member/Provider Complaint (STAR, STAR+PLUS) - $3,400 (Reduced on appeal from $14,000)	$13,900 and CAP (Reduced on appeal from $119,500)
10/29/14	Liquidated damages assessed by Health and Human Services Commission (HHSC) against the Health plan for not attending scheduled Fair Hearing for members in: STAR+PLUS Hidalgo service area - $1,000 STAR MRSA N2 service area - $500 STAR MRSA N2 service area - $1,000 Liquidated damages assessed for submitting Claims Summary report on incorrect template: (Vision Claims) STAR HEALTH - $50 (Vision Claims) STAR HEALTH - $200 (Acute Claims) STAR - $50 (Acute Claims) STAR HEALTH - $200	$8,650

	(Acute Claims) STAR HEALTH - $50 (Behavior Health Claims) STAR HEALTH- $50 (Behavior Health Claims) STAR HEALTH- $200 (Behavior Health Claims) STAR- $50 (Pharmacy Claims) STAR HEALTH - $50 (Pharmacy Claims) STAR HEALTH - $200 (Pharmacy Claims) STAR - $50 Claims processed and adjudicated w/in 30 days at 95.80%; State requirement 98% - STAR+PLUS - $5,000	

Texas: Superior HealthPlan, Inc. (Superior). Superior began serving Medicaid Members in 1999 and CHIP Members in 2002 under contract with the Texas Health and Human Services Commission (HHSC). Superior began serving Dual Eligible membership as a Medicare Advantage Special Needs Plan in January 2008. Superior Health Plan manages the follow contract service areas:
STAR, CHIP and CHIP Perinate (includes Bexar, El Paso, Lubbock, Nueces and Travis Service Areas);
STAR+PLUS (includes Bexar, Lubbock and Nueces)
STAR+PLUS (Dallas Service Area)
STAR+PLUS MRSA (includes Central and West Medicaid Rural Service Areas);

Date	Summary of Issue	Action
05/09/11	$500 sanction issued in the Q1 SFY 2011 performance measurement due to the Quarterly Encounter Reconciliation Report for STAR+PLUS in Bexar and Nueces service areas ($250 for each service area) reporting a variance of greater than 2 percent. The acceptable reconciliation rate is 98 percent, however, Bexar had a 97 percent reconciliation rate and Nueces had a 93 percent reconciliation rate during Q1 SFY 2011.	$500
11/29/11	CAP issued by CMS to improve the Medicare star ranking related to operational performance measurements.	CAP only
12/07/11	$2,500 sanction issued as a result of the Q3 SFY 2011 operation performance measurement in the following area – for not adjudicating 98 percent of Acute Clean Claims within 30 days of receipt in the Dallas 9(H) service area of the STAR+PLUS product. SHP's performance during this measurement was 97.05 percent.	$2,500
01/12/12	CAP issued as a result of the SFY 2010 THSteps Medical Checkup Reports related to Existing and New Member checkup participation rates below 35 percent. The STAR product Existing Member Participation rate was below 35percent in the following service areas; Bexar 25 percent, 26 percent, Lubbock 20 percent, Nueces 27 percent, Travis 22 percent, Total MCO Participation 24 percent. The STAR+PLUS product New and Existing Member participation rate was below 35percent in the following service areas; Bexar (25 percent New, 22 percent Existing) and Nueces (16 percent New and 25 percent Existing).	CAP Only
03/26/12	$2,500 sanction received for exceeding 20 percent total dollars billed to an MCO for "other outpatient services" by out-of-network providers. During the 4th Quarter of SFY 2011, SHP had a 34 percent volume of charges fill by out of network providers.	$2,500
12/27/12	Sanctions totaling $385,600 for operational deficiencies in the SFY Q3 2012 performance measurement in the following operational areas: Late and inaccurate TPL Reporting inaccuracies ($2800), late and inaccurate Financial Statistical reporting ($17,500), inaccurate Frew Quarterly Monitoring report ($1300), Medicaid Single Claims On-line Portal implementation timeliness ($364,000).	$385,600

	Note - Final appeal determination received from HHSC on May 13th, 2013. This sanction was initially assessed on December 27th, 2012 totaling $723,300. Superior appealed the findings resulting in HHSC issuing a final determination with reduced sanction assessments of $385,600 on May 13th, 2013. The sanctions related to Third Party Liability, Financial Statistical and FREW reporting were reduced on appeal.	
05/29/13	SHP was issued sanctions $120,150 and a CAP request for the deficiencies listed below as identified in the Q4 SFY 2012 quarterly performance measurement: $117,000 – All Products, Claims/Encounters portion of MIS was set up to correctly process 5010 data elements 248 days late for 13 plan codes and 188 days late for 6 plan codes. (Reduced on appeal from $217,600 on December 6th, 2013). $75 – STAR Bexar, For not resolving 98 percent of Provider Complaints within 30 calendar days of receipt (96.3 percent) $50 – STAR Nueces, For not resolving 98 percent of Member Appeals within 30 calendars from the date the appeal is filed with MCO (94.74 percent) $250 – CHIP Nueces, Quarterly Encounter Reconciliation Report, which reconciles YTD claims paid in the FST report to paid dollars in the Encounter data, variance exceeded 2 percent (i.e. – less than a 98 percent match rate) (96 percent%). $500 – STAR Nueces, For not processing 98 percent of Acute Appealed Claims within 30 days (96.15 percent) $350 – All Products, two occasions MCO did not submit response to Provider Complaints timely. One was five days late and the second was nine days late $175 - All Products, two occasions MCO did not submit response to Provider Complaints timely. One was 6 days late and the second was one day late $500 – STAR MRSA Central, For not to adjudicating 98 percent of Behavioral Health Clean Claims within 30 days (95.96 percent). $500 – STAR MRSA Northeast, For not adjudicating 98 percent of Behavioral Health Clean Claims within 30 days (95.43 percent). $500 – STAR MRSA West, For not adjudicating 98 percent of Clean Claims within 30 days (95.42 percent). $250 – CHIP RSA, Quarterly Encounter Reconciliation Report, which reconciles YTD claims paid in the FST report to paid dollars in the Encounter data, variance exceeded two percent (i.e. – less than a 98 percent match rate) (93 percent - Medical and 103 percent - Pharmacy).	$120,150 and CAPs
06/02/14	(Under Appeal) SHP received sanctions totaling $19,950 resulting from deficiencies identified the Q1 2013 quarterly performance measurement in the following areas: Third Party Liability/Third Party Recovery report submitted timely/accurate/complete (STAR, STAR+PLUS, CHIP) - $11,000 (Reduced on appeal from $13,350. Member Appeals 98% resolved within 30 days. (STAR, STAR+PLUS) – $100 Encounter Reconciliation Report exceeds 2% variance (CHIP, STAR) - $1250 Claims Processing 98% adjudicated within 30 day (STAR) - $0 (Waived on appeal from $5000) Timely response to HHSC Member/Provider Complaint (STAR+PLUS) - $0 (Removed as error on appeal from $250)	$12,350 (Reduced on appeal from $19,950)
06/02/14	(Under Appeal) SHP received sanctions totaling $4,425 resulting from deficiencies identified the Q2 2013 quarterly performance measurement in the following areas: Provider Hotline hold time is two minutes or less. (STAR, STAR+PLUS) - $900 (Reduce on appeal from $1,500) Provider Hotline call abandonment rate 7% or less (STAR, STAR+PLUS) - $1,600 (Reduced on appeal from $2,400)	$2,900 (Reduced on appeal from $4425)

	Provider Complaints 98% resolved within 30 days (STAR, STAR+PLUS) - $25 Appealed Claims Processing 98% adjudicated within 30 days (STAR) - $0 (Waived on appeal from $500) Geo Mapping on time, accurate and complete (STAR+PLUS) $375 not originally assessed	
06/02/14	(Under Appeal) SHP received sanctions totaling $163,275 resulting from deficiencies identified the Q3 2013 quarterly performance measurement in the following areas: Vision Claims Summary Reports submitted timely/accurate/complete (CHIP, STAR, STAR+PLUS) – $7,000 (Reduced on appeal from $105,000) Acute Claims Summary Reports submitted timely/accurate/complete (CHIP, STAR, STAR+PLUS) – $500 (Reduced on appeal from $7,000) Provider Complaint Report submitted timely/accurate/complete (STAR) – $250 (Reduced on appeal from $5,750) GEOMapping Report submitted timely/accurate/complete (STAR+PLUS) - $750 (Reduced on appeal from $41,000) Timely response to HHSC Member/Provider Complaint (STAR, STAR+PLUS) - $250 (Reduced on appeal from 4,500) Member/Provider Complaints 98% resolved within 30 days. (STAR+PLUS) - $25	$8,775 (Reduced on appeal from $163,275)
06/02/14	(Under Appeal) SHP received sanctions totaling $52,000 and a CAP request resulting from deficiencies identified the Q4 2013 quarterly performance measurement in the following areas: Timely response to HHSC Member/Provider Complaint (STAR, STAR+PLUS) - $4,200 (Reduced on appeal from 25,000) Vision Claims Summary Reports submitted timely/accurate/complete (CHIP, STAR, STAR+PLUS) – $200 (Reduced on appeal from $2,000) Timely perform an Administrative Service, Fair Hearing Non- Attendance (STAR +PLUS) - $2,500 and CAP (Reduced on appeal from $25,000)	$6,900 and CAP (Reduced on appeal from 52,000)
10/29/14	Fine assessed for delivering CHIP ID cards to incorrect addresses – (CHIP) - $3000 Liquidated damages assessed by Health and Human Services Commission (HHSC) against the Health plan for not attending scheduled Fair Hearing for members in: Bexar 47 service area STAR +PLUS - $1,000 Dallas 9H service area STAR - $1,000 Liquidated damages assessed due to late submission of TPL/TPR report – STAR - $300 Liquidated damages assessed for submitting Claims Summary report on incorrect template: (Vision Claims) STAR +PLUS - $50 (Vision Claims) CHIP- $50 (Vision Claims) STAR - $50 (Acute Claims) STAR - $50 (Acute Claims) STAR +PLUS - $50 (Acute Claims) CHIP - $50 (Behavior Health Claims) STAR+PLUS $50 (Behavior Health Claims) CHIP- $50 (Behavior Health Claims) STAR- $50 (Pharmacy Claims) STAR+PLUS - $50	$12,850

	(Pharmacy Claims) CHIP - $50 (Pharmacy Claims) STAR - $50 (LTC Claims) STAR+PLUS - $50 Claims processed and adjudicated w/in 30 days at 96.00%; State requirement 98% - STAR - $500 Liquidated damages assessed by Health and Human Services Commission (HHSC) against the Health plan for not attending scheduled Fair Hearing for 2 members in Dallas service area (STAR+PLUS) - $4,000 Liquidated damages assessed for submitting Claims Summary report on incorrect template: (Vision Claims) STAR +PLUS - $200 (Vision Claims) CHIP- $200 (Vision Claims) STAR - $200 (Acute Claims) STAR - $200 (Acute Claims) STAR +PLUS - $200 (Acute Claims) CHIP - $200 (Behavior Health Claims) STAR+PLUS $200 (Behavior Health Claims) CHIP- $200 (Behavior Health Claims) STAR- $200 (Pharmacy Claims) STAR+PLUS - $200 (Pharmacy Claims) CHIP - $200 (Pharmacy Claims) STAR - $200	
11/19/14	HHSC placed Superior on a CAP to address deficiencies in the STAR+PLUS Home and Community Based Services Waive Upgrade program related to Utilization Review process. The deficient areas cited are timeliness of upgrades, appropriateness of upgrade process from request to start of care, responsiveness to members and care assessments. HHSC approved Superior's CAP submission on May 11, 2015.	CAP Only
01/23/15	SHP received sanctions totaling $41,200 and a CAP request resulting from operational deficiencies identified the Q 1– Q3 of State Fiscal Year (SFY) 2014 quarterly performance measurement in the following areas: Non-attendance at State Fair Hearing (2 product/service areas) - $4,000 and CAP Appealed Claims Timely Processing (14 product/service areas) - $30,000 Frew Quarterly Report Inaccuracies (2 Quarters) - $700 Claims Summary Report Errors (Pharmacy, Behavioral Health, Vision, Acute and Long Term Care) – $6,500 and CAP	$41,200
02/23/15	SHP received sanctions totaling $17,200 and a CAP request resulting from operational deficiencies identified the Q4 of State Fiscal Year (SFY) 2014 quarterly performance measurement in the following areas: $12,200 and CAP request- All claims summary reports submission errors $5,000 - Appealed claims process less than 98% (95.5% CHIP Bexar)	17,200 and CAP request
3/9/15	Superior Health Plan (Superior) received a notice of non-compliance from TX Health and Human Services Commission for not complying with STAR and STAR+PLUS Program requirements for Frew timely checkups for the state fiscal year (SFY) 2012 reporting period. The CAP is due within 10 days from date of notice.	CAP Only
06/05/15	SHP received sanctions totaling $5,250 and a CAP request resulting from operational deficiencies identified the Q1 of State Fiscal Year (SFY) 2015 quarterly performance measurement in the following areas: encounter data reconciliation variance	$5,250 and CAP request

	greater than 2% ($1,250) and Pharmacy Claims Summary Report submission errors ($4,000 and CAP request).	
11/05/15	SHP received a CAP request from HHSC to address deficiencies identified in customer service call audits for Community First Choice members.	CAP Only

North Carolina: OptiCare Managed Vision (OMV). OptiCare Managed Vision, a wholly-owned subsidiary of Centene Corporation, contracts with managed care organizations, qualified groups and third party payers to administer routine vision and medical surgical eye health benefits.

Date	Summary of Issue	Action
03/1/13	Failure to have TPA license in Florida from 2008 to 2011 for their customer Fidelity Security Life Insurance. The consent order, agreed to by Centene, is for $10,000. Order set as of March 1, 2013 from FL Office of Insurance Regulation.	$10,000

Delaware: NurseWise, LP a wholly-owned subsidiary of Centene Corporation, contracts with managed care organizations, qualified groups and third party payers to administer a Nurse Hotline.

Date	Summary of Issue	Action
02/2012	City of San Francisco fined NurseWise $1,000 when telephone line was unavailable for member calls in San Francisco Health Plan due to a telecom company system failure.	$1,000

Kentucky: Kentucky Spirit Health Plan. Kentucky Spirit began serving Medicaid, Dual Eligible and ABD beneficiaries in November 2011 through its contract with the Kentucky Cabinet for Finance and Administration. In October 2012, Kentucky Spirit notified the Kentucky Cabinet for Health and Family Services ("Cabinet") that Kentucky Spirit would exercise a contractual right that it believes allows the company to terminate its Medicaid managed care contract with the Commonwealth of Kentucky effective July 5, 2013.

Date	Summary of Issue	Action
03/13/13	A CAP was issued by DMS for not providing monthly reports of verified member Third Party Liability (TPL) resources. The CAP response was submitted on March 25th, 2013 and provided a timeline to correct the systems issues causing the delay in delivery of the Third Party Liability report. The CAP was closed in June 2013 with successful submission of the TPL report.	CAP only

Missouri: Home State Health Plan. Home State began serving Medicaid beneficiaries in July 2012 through its contract with the Missouri Department of Social Services, MO HealthNet Division (MHD).

Date	Summary of Issue	Action

01/17/14	Home State was issued a CAP by MHD for discrepancies it identified in Home State's online provider directory. Home State submitted the response and required CAP on January 29th, 2014.	CAP only

Washington: Coordinated Care of Washington. Coordinated Care began serving Medicaid beneficiaries in July 2012 through its contract with the Washington Health Care Authority (HCA).		
Date	**Summary of Issue**	**Action**
01/14/15	Coordinated Care was assessed a $25,000 sanction by the Washington Office of the Insurance Commissioner for using unapproved provider agreements in the vision network.	$25,000
07/28/15	The HCA assessed Coordinated Care a CAP request for not submitting encounter data or data related to the completion of Health Action Plans (HAPs) for enrollees of the Home Health program as required in the Apple Health contract. Coordinated Care submitted the CAP response on August 3rd, 2015 and had already implemented the remediation activities specified in the response.	CAP

Massachusetts: Massachusetts Partnership for Correctional Healthcare (MPCH). MPCH began providing health care services to the Massachusetts prison population in July 2013 through its contract with the Massachusetts Department of Corrections Health Services Division (MA DOC).		
Date	**Summary of Issue**	**Action**
04/10/15	The Massachusetts Department of Corrections issued MPCH a $15,000 sanction based on performance audit findings of continued noncompliance in 3 categories ($5,000 assessment each) at the MCI Cedar Junction facility. The deficient categories are the Problem List, Behavioral Management Unit (BMU) and Department Disciplinary Unit (DDU). MPCH is appealing this sanction assessment.	$15,000
04/10/15	The Massachusetts Department of Corrections issued MPCH a $15,000 sanction based on performance audit findings of continued noncompliance in 3 categories ($5000 assessment each) at the MCI Shirley (Medium) facility. The deficient categories are Intake/Transfer, Progress Notes and Treatment Planning. MPCH is appealing this sanction assessment.	$15,000
04/10/15	The Massachusetts Department of Corrections issued MPCH a $15,000 sanction based on performance audit findings of continued noncompliance in 1 category at the MCI Shirley (Minimum) facility. The deficient category is Intake/Transfer. MPCH is appealing this sanction assessment.	$5,000
04/10/15	The Massachusetts Department of Corrections issued MPCH a $15,000 sanction based on performance audit findings of continued noncompliance in 3 categories ($5,000 assessment each) at the NCCI-Gardner facility. The deficient categories are Intake/Transfer, Progress Notes and Treatment Planning. MPCH is appealing this sanction assessment.	$15,000
05/18/15	The Massachusetts Department of Corrections (MA DOC) issued MPCH a financial penalty of $28,000 related to processes that are non-compliant with regulations that govern the documentation and use of seclusion and restraints at one facility. This penalty was assessed at a rate of $1,000 per day for the period of April 1 through April 28, 2015.	$28,000
07/20/15	The Massachusetts Department of Corrections (MA DOC) issued MPCH a financial penalty of $34,000 related to processes that are non-compliant with regulations that govern the documentation and use of seclusion and restraints at one facility. This penalty was assessed at a rate of $1,000 per day for the period of May 23 through June 25, 2015.	$34,000

08/27/15	The Massachusetts Department of Corrections (MA DOC) issued MPCH a financial penalty of $39,000 related to processes that are non-compliant with regulations that govern the documentation and use of seclusion and restraints at one facility. This penalty was assessed at a rate of $1,000 per day for the period of June 26 to August 3, 2015.	$39,000
10/13/15	The Massachusetts Department of Corrections (MA DOC) issued MPCH a financial penalty of $29,000 related to processes that are non-compliant with regulations that govern the documentation and use of seclusion and restraints at one facility. This penalty was assessed at a rate of $1,000 per day for the period of August 4, 2015 to September 1, 2015.	$29,000
10/13/15	The Massachusetts Department of Corrections (MA DOC) issued MPCH a financial penalty of $5,000 as a result of a follow-up audit that determined the Massachusetts Alcohol and Substance Abuse Center (MASAC) failed to meet the compliance threshold in one (1) performance area, Progress Notes, that was cited as non-compliant in a previous audit conducted in June 2015.	$5,000
10/19/15	The Massachusetts Department of Corrections (MA DOC) issued MPCH a financial penalty of $29,000 related to processes that are non-compliant with regulations that govern the documentation and use of seclusion and restraints at one facility. This penalty was assessed at a rate of $500 per day for the period of September 2, 2015 to September 30, 2015.	$14,500

Centurion: Centurion began providing health care services to prison populations in July 2013.		
Date	**Summary of Issue**	**Action**
06/16/15	The Tennessee Department of Corrections (TDOC) issued Centurion a financial penalty of $42,800 related to non-compliant performance in two categories during the audit period of March 2015. The non-compliant performance areas were Emergency On Call staffing and Specialty Care Consultations. Centurion is currently appealing this penalty assessment.	$42,800
08/04/15	The Tennessee Department of Corrections (TDOC) issued Centurion a financial penalty of $85,638 related to non-compliant performance in two categories during the audit period of April 2015. The non-compliant performance areas were; (1) Emergency on-call: $5,000; (2) Annual TB Screening: $3,138; (3) Controlled Substance reconciliation log: $2,000; (4) Medication Administration Record: $26,500; (5) Specialty Care/Consultations: $34,000; (6) Utilization Management: $15,000.	$85,638
08/04/15	The Tennessee Department of Corrections (TDOC) issued Centurion a financial penalty of $24,000 related to non-compliant performance in two categories during the audit period of May 2015. The non-compliant performance areas were; 1) Emergency on-call: $3,000; (2) Specialty Care/Consultations: $3,000; (3) Utilization Management: $18,000.	$24,000

(page limit N/A)
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.

To the best of our knowledge and belief, Nebraska Total Care (NTC), its parent company, Centene Corporation, including affiliates and subsidiaries, are not and have not been the subject of past criminal or civil investigations by a state or federal agency within the past five years. In the ordinary course of business, Centene and its affiliates and subsidiaries are subject to reviews and audits by state and federal regulatory agencies that may result in regulatory actions and/or sanctions. All such regulatory actions or sanctions within the last five years are described in our response to Section 4.2.

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III.G. Insurance Requirements

III.G. Insurance Requirements

(2 page limit)

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.

Nebraska Total Care (NTC) intends to obtain reinsurance coverage as a form of risk management, in order to protect NTC, as well as its enrollees and MLTC. NTC will execute a contract with Bankers Reserve Life Insurance Company of Wisconsin (Bankers Reserve), an affiliated entity, for stop loss coverage with an attachment point appropriate for the size and risk of NTC. Bankers Reserve and NTC are wholly-owned subsidiaries of Centene Corporation. We will submit the contract to the MLTC and the Nebraska Department of Insurance for prior approval and will meet all applicable requirements set forth in Nebraska Administrative code, NE 210.57 and NE 210.65. Bankers Reserve is a Wisconsin-domiciled and licensed insurer authorized by the State of Nebraska Department of Insurance to transact the business of reinsurance in the State of Nebraska.

NTC's proposed premium cost for this policy under the Heritage Health contract will be set in coordination with Bankers Reserve actuaries, using claims data provided by MLTC from the rating book related to experience data, including claims histories, transplant information, and inpatient hospital costs. Bankers Reserve actuaries will estimate premium costs based on this information. Simultaneously, two external actuarial resources, Aon Hewitt and PartnerRe, will independently develop premium rates. NTC and Bankers Reserve will evaluate premium costs proposed by PartnerRe and Aon Hewitt to determine a fair market per member per month premium cost rate for the reinsurance arrangement.

If historical claims or projected utilization data is unavailable from MLTC, Bankers Reserve will leverage Aon Hewitt and PartnerRe's Nebraska-specific experience with hospitals and inpatient services or an analysis of their experience with similar state Medicaid managed care contract premium arrangements. This experience and/or analysis will aid them in determining a fair market per member per month premium cost rate for the reinsurance arrangement. PartnerRe has a minimum of three sources of actuarial data for each state, which permits them to price reinsurance coverage regardless of the deductible. This information along with the use of historical claims data, utilization, reimbursement and referral patterns for tertiary care all support the development of a reinsurance premium. Through these mechanisms, NTC and our reinsurance partners will determine a fair market premium cost rate for the Heritage Health contract reinsurance agreement.

nebraska total care™

IV.B Eligibility and Enrollment

IV.B Eligibility and Enrollment

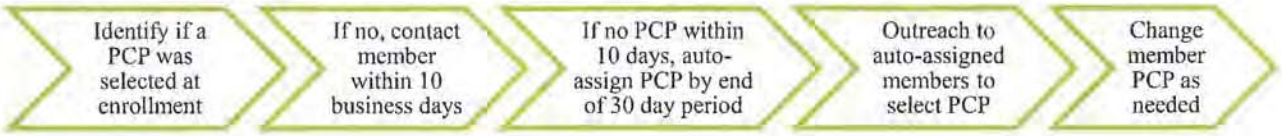
5. Provide a comprehensive discussion of the MCO's approach to maximizing the number of members who have a relationship with a PCP, including: (2 page limit)

Approach for Maximizing Member-PCP Relationships

Through Centene's experience with our 20 affiliated Medicaid health plans, we well understand the importance of a strong relationship between a member and a primary care provider (PCP) to serve as the member's medical home and oversee their care. Nebraska Total Care (NTC) will draw upon experiences and best practices from other Centene affiliated plans to develop and refine its approach to assigning members to PCPs. Through utilizing a combination of proactive member outreach, new member materials and tools, and proven practices through our member-facing departments, NTC will ensure that all members have a PCP within 30 calendar days.

Ensuring PCP Selection within One Month of Enrollment

Process for Assigning a PCP. NTC will follow the process outlined below to assign each new member to a PCP within 30 calendar days of enrollment. NTC will conduct a proactive approach to PCP assignment to maximize the number of members who have selected a PCP rather than remaining with an auto-assigned PCP. Our experience shows that when a member selects his or her own PCP, they have a stronger relationship.



We view auto-assignment of a PCP as a last resort and will work proactively with members to encourage them to each select their own PCP. In the event of auto-assignment, we will first attempt to auto-assign the member to a PCP with whom the member has had a historical provider relationship as long as the provider has good quality scores. At the beginning of the program, since the member will be new to NTC, we will examine available claims history to look for an appropriate assignment. NTC requests that MLTC provide two years of claims history to facilitate new member PCP assignment. Next, if no previous PCP relationship exists, we will attempt to assign the new member to a currently enrolled family member's PCP if the physician is age and gender appropriate, such as pediatricians for children and internists for adults. At the beginning of the program, this strategy will only be appropriate if the member already has family members enrolled in NTC. If no other family members are enrolled with NTC, we will auto-assign the member to a PCP based on age, gender, geographic proximity closest to the member's home (Geo-Mapping), and cultural/linguistic considerations such as language preferences. NTC will develop written policies and procedures for PCP assignment.

- ***The strategy the MCO will use initially, and on an ongoing basis, to ensure PCP selection within 30 calendar days.***

Strategies for Encouraging PCP Selection

Initial Calls to Members to Assist with PCP Selection. Initially, many new members to NTC will also be new to managed care. NTC will utilize its calls to members related to PCP assignment to not only explain the value of the PCP relationship and to help members select their own PCP, but we will also take this opportunity to educate members about managed care. We will discuss the concept of a medical home and the value this provides to members and how members can best work with their PCPs to coordinate their care. Through these calls, our member services staff will assist members with navigating the Provider Finder and will help them make a PCP selection. They will also refer the member to online resources if needed.

Proactive Outreach Calls to Members with an Auto-Assigned PCP. NTC understands that it is important that every member choose his or her own PCP in order to help strengthen the member-PCP relationship and the PCP's function as a medical home. To this end, NTC will conduct a proactive outreach campaign to all members who were auto-assigned a PCP. The campaign will be conducted within 30 days of auto assignment by trained staff and will review the current PCP assignment to ensure the selection matches the member's needs or assists members with selecting a new PCP. Calls will also highlight the function of a medical home and encourage members to set up a first appointment within 90 days of enrollment.

Member Incentives for Selecting and Visiting a PCP. To encourage member-PCP relationships, NTC will offer members an incentive through our CentAccount™ program. A member will be eligible to receive a $15 incentive for creating a log-in on the Member Portal and selecting a PCP within 30 calendar days of enrollment. They will also receive a $15 incentive after completing a visit to the PCP.

New Member Welcome Calls. NTC will initiate telephonic orientation for new members within 15 business days of receiving the enrollment file from the state. These calls will welcome the member to the plan and provide high level information on their benefits as well as how to contact a CSR directly. Approximately 30% of new and returning Centene members currently contact the call center following initial outreach, at which time the CSRs ensure that members confirm their choice of PCP and complete or update the Health Risk Screening. CSRs also remind members to make an initial (or annual) appointment with their PCP and provide assistance as needed in doing so. In addition, CSRs will utilize these calls to educate members about managed care and the value of a medical home.

- ***Examples of successful strategies and lessons learned in encouraging PCP relationships.***

Successful Strategies and Lessons Learned in Encouraging Member-PCP Relationships

Manual PCP Assignment for Members with Special Needs. Based on our experience gained through our 20 affiliate health plans, NTC understands that it is critical to ensure members with special needs have an appropriate medical home who will coordinate their care. NTC will work one-on-one with members with special needs to ensure they are assigned to a provider who can meet their needs and who has the greatest potential to build a strong relationship with the member. Members with special needs, including the ABD population and dual-eligible members, may benefit from a relationship with a specialist as their PCP, such as a psychiatrist for a member with behavioral health needs, or an obstetrician for a pregnant member. Disabled members will need to be assigned to PCPs whose officers are equipped to serve them and who have experience providing services to disabled individuals. NTC will work proactively with providers to assist them in their ability to provide services to this population. We will also ensure that dual eligible members can retain a Medicare PCP and will work to contract with out-of-network PCPs who provide care to our dual-eligible members.

Member Selection of the PCP. In our experience, members who select their own PCP are more likely to invest in that relationship and access preventive and primary care appropriately. On average, more than 30% of our new members select a PCP at the time of enrollment. To encourage member engagement in their own care, we encourage members to proactively select their own PCP as soon as they join NTC. When a member doesn't self-select initially, we will offer them myriad opportunities and both personal and electronic methods to voluntarily change their PCP after auto-assignment. All of our member-facing staff such as Customer Services Representatives (CSRs), Case Managers, MemberConnections Representatives (MCRs), Outreach Coordinators, Care Coordinators, and others will use every member contact to make sure the member knows who their PCP is, the importance of a PCP, how to contact their PCP, and confirm that the member's PCP meets their needs for location, culture, language, age, health status (such as pregnancy or other special or unique needs), or other preference. Any of these NTC staff will be able to help a member change his or her PCP as needed.

(1 page limit)

6. Describe the MCO's anticipated process to utilize the eligibility and enrollment files from MLTC or its designee to manage membership.

Experience in Daily and Monthly 834 Membership File Utilization and Processing

Our HIPAA compliant enterprise Management Information System (MIS) supports government sponsored health plans in 23 states today. We successfully process daily eligibility updates and weekly and monthly membership file reconciliations in virtually all of these states.

Detailed Process Description. ***Receiving Daily and Monthly 834 Files.*** Through the file communication component of our MIS we can support all file exchanges with MLTC's Medicaid Management Information System (MMIS). Our Data Communications subsystem will handle our automated file exchanges (transmission and receipt) with the Department. Once we receive an 834 file, our job scheduling software manages membership data load processes for overall process integrity. Inbound 834 files are automatically processed through our EDIFECS system for HIPAA 5010 compliance validation and translation. EDIFECS, in conjunction with our business process middleware, also edits for duplicate member records, date criteria validity, field data integrity, and valid date spans. Any membership records that trigger edits default into an Exception Report where they are systematically corrected prior to subsequent processing.

Reporting Discrepancies to MLTC. In accordance with MLTC requirements, our eligibility specialists will provide written notification to MLTC of any data inconsistencies identified via our reconciliation process within 10 calendar days of receipt of the 834 data file. Under no circumstances will we email entire membership files. ***Loading Our Production Membership System.*** Membership update records are then loaded into our Member Data Management (MDM) system through "Add, Delete, and Modify transactions" with accurate begin and end dates. Eligibility and enrollment files are used to populate our CRM which services as the source of member data accessed across all systems, including member services, claims, and care management. Through our integrated systems, this information is provided to our subcontractors and shared with providers. We establish member effective date as the first date of the month in which the member is determined Medicaid eligible, in accordance with section IV.B.2.h.

Include the process for resolving discrepancies between these files and internal membership records.

Resolving Discrepancies between Eligibility Files and Internal Membership Records. NTC will utilize processes in place across all of the Centene Managed Medicaid health plans related to reconciliation of membership data, configured specifically for MLTC, the enrollment broker, and Heritage Health. NTC will conduct weekly reconciliations of the enrollment/disenrollment file and daily enrollment/disenrollment activity against our records, and we will notify the enrollment broker of any discrepancies found within the data on the file within 10 calendar days via written notification. We will also use MLTC's 820 file each month to reconcile premium payments with enrollment information we have received from MLTC via the 834 process, and we will then address any discrepancies via an Exception Report with MLTC (or as otherwise directed by MLTC). Our MIS supports very similar reconciliation processes in many of the 20 states where our affiliates administer Managed Medicaid programs. NTC will also work with the enrollment broker and MLTC to reconcile enrollment and disenrollment issues at the end of each month, using an agreed upon written procedure.

Member Data Management System. As an integrated component of our MIS, our Member Data Management system (MDM) supports all informational aspects of our member's relationship with NTC, such as member identifiers, address and contact information, confirmed or potential family linkages, special needs, member preferences (e.g., communication options such as e-mail, phone, and/or mail), along with a history of any change to each attribute. Unified Member View. In 2014, we introduced our Unified Member View (UMV) capability into MDM, which gives us the automated ability to link an inbound member record with historic "eligibility spans" we may have on that member, (e.g. prior history as a member). UMV also features enhanced capabilities for validating member address and contact information, through integrated address standardization from *SmartyStreets* (a leading real time US Postal Service approved address validation service); and Identity Verification & Authentication data services from *LexisNexis*®, enhancing the accuracy and quality of member data we house and analyze.

(2 page limit)
7. Describe the interventions the MCO will use prior to seeking to disenroll a member who requests disenrollment outside the annual open enrollment period. Strategies to Avert Disenrollment

Interventions to Avoid Disenrollment:

NTC will take a multi-dimensional approach to addressing situations in which members exhibit abusive, fraudulent, or non-compliant behavior; or other behaviors typically cited as reasons for plan-initiated disenrollment requests. We will take reasonable measures to avoid a member's disenrollment, and have found that most of these types of behavior can be addressed by providing education, assistance, and/or counseling to the member. Our strategies are based on our philosophy of 'meet the member where they are,' both literally and figuratively. We will take into account the member's level of understanding, health literacy, and any health or behavioral health issues that may affect their ability or willingness to engage effectively with providers or NTC staff. We will also provide assistance in multiple ways, including in-person contact in the member's home or community to support the member and resolve identified issues.

Drilling Down to Root Causes

Barriers such as literacy, language, and other social issues often lie at the core of challenging situations, and represent areas the member may not otherwise have the opportunity or initiative to address. In some cases, face-to-face contact by a local MemberConnections Representative (MCR) is more likely to uncover the real genesis of an issue. Our MCRs are trained to detect and address such issues in a manner that is culturally competent and sensitive to the member's emotional response.

Care Management and Treatment

Some members have underlying physical or behavioral health issues that can result in challenging behaviors. To prevent such behaviors from occurring in the first place, our Care Managers thoroughly assess and address member needs, goals and preferences, and work with members to develop collaborative Care Plans that support access and adherence. For members with behavioral health needs, this includes, but is not limited to detecting and appropriately referring members with behavioral health issues to appropriate behavioral health treatment. Additionally, Care Managers work hard to build a trusting, interactive relationship with each member. The Care Manager offers the member ongoing opportunities to communicate one-on-one, as well as to share preferences and experiences that may represent causative factors for inappropriate behaviors. Underlying issues may easily be addressed, or even corrected, with a Care Manager's intervention.

Assistance with Access Issues

At times, issues may result when a member needs assistance with appropriately accessing services or communicating with providers. If a member is missing appointments because of transportation issues, or is having difficulty understanding when to go to their PCP, our Member Services staff will be available to provide assistance (such as arranging for transportation, helping the member make an appointment, or explaining the member's need to a provider).

Intensive Member Education and Outreach

Written materials and phone calls are not always the most effective ways to educate and help members understand how to appropriately access benefits and services. NTC's MemberConnections™ Program will go the extra mile to accommodate our members and meet them where they are. When issues arise that could potentially develop into a disenrollment situation, we will follow a rigorous outreach strategy using our MCRs and our community outreach staff we hire from within the communities they serve. Our MCRs know the language, the neighborhoods, and the organizations and providers that can help us locate and communicate with reluctant or challenging members. MCRs may work with a trusted community organization such as a church or community center to arrange to meet the member. MCRs spend time talking to the member about their options and educating them about the importance of taking control of their health care.

Resolving Member Concerns

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. We will 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 providing treatment, education, coordination of services, or case management. As with all member interactions, we document the intervention and any outcomes and follow-up required in our system of record. We engage with the member's PCP to collaborate on potential solutions.

Requesting Disenrollment

NTC will 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 either this particular member or other MCO members; the member attempts to exercise his/her rights under the MCO's grievance system; or the member attempts to exercise her/her right to change, for cause, the PCP that he/she has chosen or been assigned. NTC will request to disenroll members for the following administrative reasons: NTC has sufficient documentation to establish fraud, forgery or evidence of unauthorized use/abuse of services by the member; or 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. Additional reasons for disenrollment include changes in eligibility status. While we have never requested a disenrollment, should all interventions fail to result in a positive outcome, NTC will notify the member in writing that we are requesting disenrollment, the reason for the request, and the anticipated date of disenrollment. A disenrollment will not be effective any earlier than 45 days from the date of the event that prompted the request.

Provide examples of scenarios in which the MCO has effectively intervened to avert disenrollment of a member or members.

Examples of Successful Interventions to Prevent Member Disenrollment

Our approach to averting disenrollment can be illustrated through the following examples:

- A member called our Louisiana affiliate plan several times to complain about negative experiences with the transportation vendor. She was argumentative, confrontational, and used threatening language with plan staff, belittling and demeaning the CSR trying to resolve her issues. The Customer Service Supervisor agreed to assist the member, using techniques we teach in our CSR training about how to effectively communicate with members who are angry and disrespectful. On the member's behalf, the Customer Service Supervisor outreached to the transportation vendor to investigate and address the member's concerns. She provided re-training on issues related to the member's complaint, and also discussed the member's behavior and provided suggestions for how to appropriately handle similar behavior in the future. The member subsequently called the Customer Services Supervisor to say that she was happy with the service and how her problems were resolved.

- At Peach State Health Plan, our affiliate in Georgia, a member requested disenrollment because she was unable to locate a pain management specialist within her area. Upon receiving the request for disenrollment, the member's information was immediately forwarded to the plan's Member Advocate (MA) to personally assist the member with locating a provider. Our MA contacted the member and not only provided her with the option of two specialists in her area, but also assisted the member with setting up the appointment and coordinating transportation. In addition, our MA walked the member through using the Find a Provider tool to locate providers in the future and offered her direct contact information for further assistance.

(1 page limit)

8. Describe the MCO's process to identify unborn individuals anticipated to begin coverage at the time of birth.

Process to Identify Newborns before Birth

Utilizing the MLTC Unborn File. Nebraska Total Care (NTC) will utilize the supplemental Unborn File that is sent by the state through the 834 enrollment and eligibility file process described in the RFP and Attachment 31 to identify unborn individuals anticipated to begin coverage at the time of birth. NTC will utilize the Unborn File to create a temporary enrollment record for all unborn individuals.

Identifying Pregnant Members. NTC will implement our award-winning Start Smart For Your Baby™ perinatal management program. Start Smart staff utilize multiple information sources to identify pregnant mothers, including: 1) Pregnancy indicator on the enrollment file; 2) Information from the current provider; 3) Existing claims data; 4) Lab data for pregnancy tests and coding of office visits from OB/GYN providers; 5) Notification of Pregnancy (NOP) forms; and 6) In-house comprehensive screening. The Notification of Pregnancy (NOP) assessment process is an essential part of Start Smart. The NOP process is a well-organized approach to identify pregnant members at risk for pregnancy complications early in pregnancy and establish relationships among the member, provider, and health plan staff. We receive NOP forms from 70% of women before they deliver. These assessments also provide an expected delivery date, which helps us anticipate the beginning of coverage for each newborn.

Innovative Strategies for Identifying Newborns. In addition to the strategies we use to ensure early submission of NOP forms, our approach to meeting newborn enrollment requirements will incorporate innovative strategies, such as those highlighted below, to ensure newborns are enrolled in a NTC plan and have a PCP prior to birth or immediately thereafter: (1) through our CentAccount® Member Rewards Program, our pregnant members can earn rewards for completing and submitting the NOP form. These dollar rewards are put onto a personalized pre-paid reward card that can be used for a number of items such as diapers, formula, baby food, and clothing; (2) through our MemberConnections® (MC) outreach program MC representatives make home visits to each high risk member who cannot be reached by phone and assist her in selecting a PCP for the baby. (3) through our provider financial incentives programs, we will provide an NOP submission incentive for our contracted providers.

Describe the operational process to obtain identifying information when the unborn status changes to newborn.

Operational Process to Obtain Identifying Information for a Newborn

NTC will have utilized the Unborn File to create a temporary enrollment record for all unborn individuals. NTC will reconcile those temporary records to the state 834 file (using Medicaid ID, Date of Birth and Mother's / Sibling's Medicaid ID) to match the unborn record to the newborn 834 record and update the baby's status. This matching process will be utilized to obtain identifying information about the newborn individual.

Process to Identify Newborns after Birth

In accordance with state requirements, we will enroll an eligible newborn in NTC per enrollment files provided by the state through the normal eligibility file process. We also will have written policies and procedures by which newborns of assigned mothers enrolled at the time of the child's birth are covered by our health plan according to state requirements. NTC will utilize numerous approaches to assure that hospital providers report births within 24 hours of birth and that PCP selections made during the hospital stay are also reported, in accordance with state requirements.

Provider Contracts. Our hospital contracts will require hospital providers to report births within 24 hours of birth and to include PCP selection if this selection is made during the hospital stay.

Provider Training and Education. Our Provider Relations Specialists (PRS) will provide education about birth reporting and registration requirements and procedures during hospital provider orientation and ongoing trainings. PRSs will provide in-office and group training for PCPs, specialists, hospitals, and ancillary providers. A pilot program with the Lancaster County Health Department will utilize their existing visiting nurse program wherein newborns and their mothers are visited in the home and monitored. Each case is registered for care, education and other needs that exist due to social determinants. It is our intent to expand this program throughout the NTC network and Nebraska.

(1 page limit)
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.

Approach to Working with Other MCOs when Members Change Plans

Centene has worked with other MCOs in numerous states through its 20 affiliate managed Medicaid plans to ensure seamless transitions of care and the transfer of all relevant information when members change MCOs or move from the fee-for-service (FFS) system. We use a proactive, collaborative approach to transitions to prevent disruptions in needed care, particularly for members with special needs and those who require ongoing services. Nebraska Total Care (NTC) will build upon best practices and procedures from its affiliate plans to ensure smooth transitions for Heritage Health members.

Approach to Working with Outgoing MCO When Member Transitions into NTC. NTC understands the importance of reviewing and acting upon all available clinical information obtained from the relinquishing MCO in a timely manner to ensure a seamless transition for the member. We also understand the importance of timely transfer of relevant information to support our transitioning members as they move to a new MCO in order to ensure continuity of care.

Transitioning Members into NTC. We will identify new members transitioning to NTC using eligibility files and daily Transition of Care (TOC) reports, as well as through prior authorization requests from providers, hospital notifications, and contact from the member. We will identify existing services and providers, prescribed medications, and stratify members for outreach and transition support. We will authorize ongoing services and work to contract with out-of-network providers to provide continuity of care. A Transition Coordinator will work to obtain all necessary sources of information, including:

- **Two years of historical claims data** provided by MLTC or another MCO
- **Pharmacy data** provided by MLTC or another MCO to identify members with prescriptions that indicate a chronic or complex condition that may require ongoing services
- Information obtained from our **Health Risk Screening**
- Information obtained from **Notification of Pregnancy (NOP) forms**
- **Provider requests for authorizations and referrals**, and notification of special needs members
- Information from our **concurrent review nurses** onsite at network hospitals
- Contact from **members and their family/caregivers**
- **Outreach to the prior MCO, MLTC, or other payers** to obtain additional information
- **Services currently in place**: upcoming scheduled tests, procedures, specialty equipment needs, etc.

The Care Manager (CM) will engage with the member, their CM and other key contributors to understand continuum of care needs to be addressed.

Approach to Working with Receiving MCO when Member Transitions out of NTC. A Program Coordinator (PC) reviews the MLTC termination file daily to identify members who will be transitioning out of NTC and are currently receiving services. The PC immediately alerts the CM department via TruCare when a transitioning member is receiving Care or Disease Management services. Within two business days of becoming aware of a member leaving NTC for another MCO, the Care Manager attempts to identify the new MCO and communicate information on existing authorizations and special circumstances to the receiving MCO and provider(s). We send a Transition of Care (TOC) form via email to the receiving MCO with information about the member's care coordination needs, including open authorizations. When a member is engaged in CM services, we make our Care Manager available for case conferences to ensure continuity of care for our outgoing members.

Process for Transferring Information. In addition to providing a completed TOC form, we can export and securely transmit to other payers a transitioning member's open authorizations in HIPAA 278 format or other MLTC specified format, as well as historical service utilization data. We will assist our members (at their option) with the set/up of their own Microsoft Health Vault Personal Health Record (PHR) that can be downloaded by the member so that they have access to their historical care information. Information on setting up a PHR will be available on the Member Portal.

(page limit N/A)
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.

Approach to Compliance with State and Federal Laws and Regulations

Nebraska Total Care (NTC) will establish a Compliance and Ethics Program ("Program") to assist the organization in developing effective internal controls to ensure adherence to federal and state legislation and program requirements of federal, state law, and program regulations that are applicable to private health maintenance organizations and their contractors. The Program is also designed to prevent fraud, waste and abuse and erroneous payments throughout the organization while furthering NTC's fundamental mission to provide access to high-quality care to its members. The adoption and implementation of this Program demonstrates NTC's strong commitment to compliance with all applicable laws, regulations, and accreditation standards, including but not limited to: Part 439 of Chapter 42 of the CFR, the proposed changes in the Notice of Proposed Rule Making (NPRM) CMS-2390-P, and Nebraska Administrative Code (NAC) Titles 471, 472, 477, and 482. NTC meets all applicable requirements under all federal laws and regulations, including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and Americans with Disabilities Act; and Section 1903(m) and 1932 of the Social Security Act, as well as the implementing regulations set forth in 42 CFR 438, as may be amended.

Fundamentally, the Program is designed to ensure regulatory compliance, while creating a culture of compliance within NTC that promotes the prevention, detection and resolution of instances of conduct inconsistent with federal and state law, state and private payor healthcare program requirements, and internal (Centene Corporation's and NTC's) business and ethics policies. It will promote ethical behavior among NTC staff in their daily interactions with members, providers, regulators, co-workers, and vendors, and establish the foundation for compliant and ethical business practices that are part of the fabric of routine operations. Finally, the Program provides an additional focus on organizing and implementing a Fraud, Waste and Abuse Strategy to: 1) protect consumers in the delivery of healthcare services and 2) identify and reduce costs to NTC, providers, subscribers, enrollees and others caused by fraudulent activities.

Compliance Department Structure

NTC's Compliance Department is a combination of local and corporate staff collaborating to manage the oversight of NTC at the state and federal levels. NTC will designate its Vice President (VP) of Compliance as our Program Integrity Officer, who will report directly to the CEO. This position has the ultimate oversight, responsibility, and authority for the NTC compliance program. Hereinafter, this individual will be referred to as the Compliance Officer. The Compliance Officer will be located in Nebraska, be 100% dedicated to NTC, and will routinely communicate with Centene Corporate and their colleagues at affiliate health plans on common issues, best practices, and training initiatives.

NTC's Compliance Officer will also serve as the Contract Compliance Coordinator and will be the primary contact with MLTC on all Nebraska MCO contract compliance issues, including coordinating execution of the contract requirements, tracking and submitting contract deliverables, answering inquiries from MLTC, and coordinating random and periodic audits and ad hoc visits.

The Compliance Officer will also serve as chair of the NTC Compliance Committee. NTC's Compliance Committee will meet at least quarterly and will include leadership from every NTC department. This Committee will be tasked with reviewing compliance issues and determining when, or if, further actions should be taken.

The Compliance Officer will lead a bi-monthly Fraud Waste Abuse Workgroup with representatives from NTC Claims Research, Provider Relations, Provider Services, and Member Services, as well as Centene Corporation's Special Investigations Unit (SIU), to review and update all open FWA activities, share results of investigations, and discuss any outstanding issues. These meetings, as well as regular calls and ad hoc meetings, will allow the Compliance Officer and other NTC representatives to interface with the

SIU and exchange best practices and learn from other health plans. The SIU will provide this Workgroup with reports, analysis, and research on any potential issues and communicate with Nebraska's Medicaid Fraud and Patient Abuse Unit (MFPAU). The FWA Workgroup will provide reports to the Compliance Committee.
At the corporate level, Centene's Vice President of Ethics and Compliance has direct oversight of the SIU. The Director of the SIU is a member of the National Health Care Anti-Fraud Association's (NHCAA) Board of Governors, and the SIU staff regularly attends trainings and conferences hosted by the NHCAA. The SIU interacts with Centene's Chief Medical Officer, Medical Directors, Medical Management, Contracting, Compliance Coding and Claim Services Units as needed and shares all information and best practices with affiliate health plan staff, including Compliance representatives at NTC. This information, along with other input, provides us with cutting-edge information for inclusion in our program document and work plan. The SIU will have designated staff assigned to NTC, and those staff members will participate in state program integrity meetings as needed.

Regulatory Compliance Technology. Under the oversight of Centene and NTC's Compliance Officer, we will utilize the **Compliance 360** enterprise software system. Recognized internationally as the leading Governance, Risk Management and Compliance (GRC) software system across all industry segments (including healthcare), Compliance 360, a transparent system into which the state has visibility, allows NTC to effectively administer, document, and monitor our regulatory and contractual governance, as well as internal governance, all in an auditable and transparent fashion. All applicable regulations and contract terms, and Medicaid Managed Care regulations are loaded into Compliance 360. Compliance 360 provides for workflow-enabled policy and procedure formulation (with total history of documentation and sign-offs); distribution of documents to appropriate internal departments, subcontractors and external regulatory agencies; systematic tracking of compliance activities (also with auditable records of management approval and cited contract and regulatory mandates); ongoing, proactive assessment of compliance risks; and real-time contract monitoring. Through this monitoring and tracking, the compliance department is able to identify any potential risks to regulatory compliance, including the following:

1. Notices of any shortcomings in performance;
2. Shortfalls in reporting as to timeliness, completeness, sufficiency or accuracy;
3. Variance of contract terms;
4. Notice of potential sanctions;
5. Variance from laws or administrative rules;
6. Variance from internal policy;
7. Formal verbal or written warnings;
8. Performance improvement plans (PIPs);
9. Quality improvement plans (QIPs); and
10. Corrective action plans (CAPs).

Should a possible risk be identified in Compliance 360, or by NTC Staff, compliance staff work to identify a "control", A "Control" is a mitigation strategy, corrective action plan, work plan or other action which is currently taking place to help resolve the possible regulatory risk. The mitigation strategy, corrective action plan, work plan or other action undertaken and the responsible party and timeline for resolution are loaded into Compliance 360. If the risk has already occurred, the Control will also include the action being taken to prevent the risk from happening again. The possible risk, as well as the control, are constantly monitored by the compliance department, until the possibility of the risk is eliminated. Full risk reports are run and discussed at a minimum, monthly.
As regulations and contract terms may change, these edits are loaded into Compliance 360 and checked against NTC policies and procedures. Should these changes necessitate a change in NTC policies and

procedures, compliance staff, led by the Compliance Officer, will work to ensure they are updated immediately to ensure compliance.

Compliance Plan. NTC will develop and maintain a Compliance and Ethics Program (Program) that ensures adherence to all applicable laws, regulations, accreditation standards and contractual obligations defined in the contract with MLTC. This program will also be designed to prevent fraud, waste and abuse and erroneous payments throughout the organization while furthering NTC's fundamental mission to provide access to high-quality care to its members.
NTC will maintain a Program that conforms to the Compliance Program Guidance issued by the Office of the Inspector General of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Managed Care Manual – Chapter 21, and includes the seven elements (A-G) described in the Federal Sentencing Guidelines. In alignment with the Program, the Compliance Officer will develop an annual Compliance Work Plan (Plan) that will be reviewed and approved by the Compliance Committee. The Program and Plan will include the following:

A. Written Policies, Procedures, and Standards of Conduct. NTC will adopt the published Business Ethics and Conduct ("The Code") policy of its parent company, Centene Corporation, which includes a Code of Conduct. The Code is available on Centene's website and will be distributed to employees within 30 days of employment and annually thereafter. The Code represents the foundation of Centene Corporation's commitment to compliance. In addition to the Code, NTC has implemented or adopted various operational policies and procedures, as described below.

Policy and Procedure Development Process. NTC will maintain written policies and procedures (P&Ps) for each functional area in our organization and follow MLTC requirements regarding the development, review and approval of new policies; guidelines for annual review; and timeframes around completion of any MLTC requested policies or policy amendments. NTC will follow a similar process that our parent company, Centene, has successfully implemented across all of its affiliate plans. Having established procedures for the creation, maintenance and communication of policies provides us with the documented controls required by licensing and accrediting agencies and ensures we are upholding federal and state regulatory standards and MLTC contractual requirements.
Immediately upon award of a contract with MLTC, our functional area experts will review existing corporate policies and determine if a new customized policy is necessary to ensure that all MLTC contractual requirements are met. The finalized P&Ps are loaded into the Compliance 360 system, where the P&P is routed to the approvers based on the areas of responsibility within the policy. For example, our system requires that any P&Ps affecting medical or quality management services are reviewed and approved by the Medical Director.
NTC will review all policies and procedures annually to determine if updates or revisions are required. Any revisions will be submitted to MLTC for approval prior to implementation. A quarterly report monitors adherence to annual reviews of P&Ps, and any late reviews are communicated to management.

B. Designation of a Compliance Officer and Compliance Committee. NTC's Vice President of Compliance will serve as the Compliance Officer, the lead position charged with the administration and management of NTC's compliance efforts, including oversight for health plan contract compliance, delegated subcontractor compliance, HIPAA privacy and security, and all activities related to Fraud, Waste and Abuse and erroneous payments. The Compliance Officer also serves as chair of the Compliance Committee. The Compliance Officer will report directly to NTC's CEO, will have direct access to NTC's Board of Directors, and will provide regular updates to the Board of Directors. As chair, the Compliance Officer will convene the Compliance Committee at least quarterly and on an ad hoc basis when needed. All actions of the Compliance Committee will be reported to the NTC Board of Directors and made available to Centene's Chief Compliance Officer or designee as necessary. The Compliance

Officer is responsible for maintaining the Compliance Plan (Plan) and presenting the Plan to the Compliance Committee for annual review and approval.
The Compliance Committee will advise and assist the Compliance Officer in maintaining an effective Compliance Program. The Committee will consist of a cross-functional team of executives representing key business areas at NTC with the ability to execute and make decisions on behalf of their respective areas. They will evaluate the effectiveness of the Plan and recommend changes as necessary to meet new state or federal requirements.

C. Training and Education. NTC will communicate its standards and procedures to all employees (including executive management and temporary employees), subcontractors, members of its Board of Directors, and other significant agents by requiring participation in training programs or disseminating publications that explain specific requirements in a practical manner. Training programs and written publications include information on NTC's Compliance Program; identifying fraud, waste and abuse and mechanisms to report the same; Business Ethics and Conduct policy and other compliance-related policies and procedures; and standards. Training will take place upon hire, annually and on an ad hoc basis when circumstances warrant (e.g. in response to identified risks; as required by legislative edict or other material changes in law, policy, or to the Compliance Program). Attendance and participation in Compliance and Ethics training is mandatory. The Compliance Officer, in conjunction with NTC's Human Resources Department, tracks attendance and retains adequate records of its training of all employees, including attendance logs and distributed materials. Examples of the required training include the following:

Security Awareness and Training. As we do today for Centene and NTC's affiliate health plans, NTC will train staff on policies and procedures regarding their responsibilities in information security. HIPAA regulations and rules regarding PHI security are also part of mandatory training programs. All employees complete training shortly after their date of hire, upon job function changes, and when policies or procedures change. The Information Security Policy is distributed within 30 days of hire and annually thereafter at the same time the Business Ethics and Conduct Policy is distributed.

Staff Training. During New Employee Orientation, within 30 days of employment, and at least annually thereafter, employees receive training on the prevention, detection and reporting of fraud, waste and abuse. All employees, Board of Director members, and consultants, when hired or engaged, are required to review our Business Ethics and Code of Conduct Policy and provide written attestations that they have read the Code, understand it and will abide by it. In addition, the NTC Compliance Officer provides HIPAA training to all employees, performs ongoing HIPAA audits and investigates all reported incidents of potential HIPAA violations. All reported incidents of a HIPAA violation are promptly investigated in accordance with policy.

Provider Training. During provider orientation sessions, NTC's Provider Relations staff, in conjunction with Centene's Payment Integrity Unit and/or NTC's Compliance Officer, will educate providers about the Fraud, Waste and Abuse program, which includes obligations for reporting and instructions on how to report a concern directly to the Health Plan Compliance Department via the FWA Hotline (1-866-685-8664). In addition, NTC's provider manual will give providers an easy reference point for responsibilities and procedures for identifying and reporting fraud, waste and abuse, for Member grievances and appeals, and information on how to access additional training when needed.

Member Education. NTC will inform members about potential fraud waste and abuse issues in our Member Handbook. The handbook will include information for reporting via the FWA Hotline (1-866-685-8664). We will also educate Members during the New Member Orientation initial outreach call on how to report fraud, waste and abuse by calling Member Services or calling the FWA hotline.

Functional Area Training. NTC staff and subcontractors receive training on functional area policy and procedures concurrently. This practice allows the functional area to cover all the requirements of service delivery with the appropriate individuals to maintain a high level of continuity across all staff.

D. Auditing and Monitoring. NTC, through its parent company, Centene Corporation, audits and monitors provider claims for compliance with established billing practices, regulations, and payor requirements. Centene's SIU has a dedicated staff and data system to mine claims data to detect billing irregularities and other fraudulent or abusive billing practices. NTC's Compliance Officer will include an audit plan as part of the overall Annual Compliance Plan. These audits and reviews will inquire into NTC's compliance with specific contractual requirements, applicable federal and State laws, and include, but are not limited to:

Contract Assessments. It is the practice of Centene Corporate Compliance to upload the contract with the state into Compliance 360 prior to the go-live date. Ninety to 120 days prior to go-live, the first contract assessment will be performed. An assessment will be performed annually thereafter or within 30 days of an amendment to the contract. For each piece of the contract that NTC has an obligation, the item is researched and documented to demonstrate compliance. Based on the results of the assessment, items with gaps are further reviewed and researched until such time as the issue is resolved.

Vendor Oversight Program. NTC will adapt and adopt Centene's extensive Vendor Oversight Program (VOP) for the purpose of ensuring all subcontractors comply with federal and state laws, regulations and contract requirements. The VOP encompasses the following key elements: clear accountability, execution of contract terms and agreements, delegation audits, performance monitoring, administration of Corrective Action Plans, enforcement of contractual penalties, quarterly Joint Oversight Committee (JOC) meetings and coordination of day-to-day business operations. NTC's Vendor Oversight Manager, in collaboration with the respective NTC business counterparts, will monitor the day-to-day operations of the subcontractor through daily interactions with the subcontractors to promote transparency between NTC, the subcontractors, Members and providers. For example, our Pharmacy Director will have joint responsibility for day-to-day oversight and monitoring to assure that US Script pharmacy claims processing meets DHHS specifications. The JOC will include NTC's Senior Director of Quality Improvement, Compliance Officer, leadership from NTC and applicable Centene departments. The purpose of the JOC is to monitor all functions delegated to the subcontractor and to help facilitate meaningful health plan/subcontractor operational efficiencies. If an NTC subcontractor falls outside our monthly performance guidelines, NTC's Vendor Oversight Manager will contact the subcontractor to ensure that the subcontractor takes appropriate action. JOC meetings include a review of performance dashboards and Member/provider complaints to ensure performance deficiencies are addressed and remedied promptly. If performance is unsatisfactory, the subcontractor will be placed on a Quality Improvement Plan (QIP) or Corrective Action Plan (CAP) for further monitoring. We will also use the following tools and resources to monitor our subcontractors in satisfying program requirements:

Compliance Assessments. Centene's Corporate Compliance Performance Office will annually perform formal assessments of NTC's subcontractors, using an assessment tool which considers contractual, state, NCQA, and CMS requirements and will incorporate MLTC requirements. During an assessment, noncompliant findings result in a QIP or CAP. We will also assess the capability and responsibility of any potential subcontracted party through a Pre-Delegation Assessment before entering into any agreements. A more detailed description of NTC's Subcontractor Oversight is provided in Q57 of this RFP response. ***See Figure Q10.A.***

Figure Q10.A

Program Integrity Process with Special Investigation Unit. NTC, in partnership with Centene, will utilize a two-pillar approach to its Program Integrity Process, similar to that used by CMS, which takes advantage of both prospective and retrospective fraud detection methods. This two-pillar approach will allow NTC the flexibility to stop payment for potentially wasteful or abusive claims. By employing a robust prepayment editing system combined with clinician reviews, NTC will be able to stop payment on every potentially miscoded claim versus paying providers and then recouping or entering into a settlement retroactively. This includes claims that present upcoding, modifier misuse/abuse, unbundling, and age/gender issues.
A more detailed description of NTC Program Integrity efforts as part of the Compliance Program is provided in Q93 of this RFP response.

Ad hoc Functional Area Audits. NTC's Compliance Officer will perform ad hoc functional area audits of business processes as necessary. An example of these functional area audits would be when a contract requires notification to Members in the event of a provider termination. The Compliance Team may review the process from end-to-end to ensure the team is executing this process in accordance with contract requirements. The review could include the following steps: 1. Review policy to contracts to ensure compliance with contract requirements and presence of policy, 2. Interview staff to ensure they understand and follow policy, 3. Review recent provider termination(s) to ensure the process is followed, 4. Review letters sent to Members regarding the termination, 5. Notify regulator, as required, 6. Review geo access reports, etc. This process gives the Compliance Team the opportunity to review our processes to ensure the business is operating in accordance with policy and contract requirements.

Monitoring of Member and Provider Grievance and Appeals Activities. NTC receives all grievance and appeals from Members and providers and does not delegate this function to its subcontractors. Any grievance or appeal related to fraud, waste and abuse is immediately forwarded to the Compliance Officer for appropriate action. *Please see our answer to question 36 for a detailed description of the member grievance and appeals process.*

Risk Assessment and Reporting. The NTC Compliance Officer will produce a monthly risk report of all areas of operational non-compliance to be reviewed with the NTC and Centene executive management. Risks are also reviewed in detail during Compliance Committee meetings. When necessary, the Compliance Officer and other management staff take immediate steps to correct identified risks or violations and prevent them from reoccurring. In certain cases, ongoing monitoring or subsequent reviews will be implemented to ensure corrective actions have been executed successfully.

Exclusion Monitoring. In accordance with federal and state requirements, NTC will also ensure all employees, providers, contractors, subcontractors and temporary staff are screened monthly for any federal or state exclusions. In the event someone is identified, NTC will terminate the relationship and notify MLTC as required.

Compliance Dashboards. Compliance Dashboards will be used as a tool to monitor and manage NTC compliance. These summaries are distributed monthly to executive management at NTC and Centene Corporate and outline areas such as Internal Audit of Higher Risk Findings, policy compliance, vendor oversight compliance, and vendor updates on the Quality Improvement Plan (QIP) and Correction Action Plan (CAP). By utilizing these dashboards, we have the ability to monitor compliance consistently and maintain a global view of our compliance across each of our health plans.

Internal Audit of Compliance Department. On a quarterly basis, Centene Corporate Compliance performs an onsite compliance program review of all affiliated health plans, including:

- Reviewing compliance work plan
- Identifying goals and objectives, key issues and challenges
- Monitoring policy and procedures
- Assessing status of contracts
- Reviewing HIPAA program (desk audits, disclosures, processes)
- Reviewing privacy program oversight
- Performing an annual risk assessment
- Reviewing regulatory correspondence
- Reviewing vendor oversight program
- Auditing reviews to evaluate changes to P&Ps
- Reviewing internal audit findings and process to mitigate and correct deficiencies
- Monitoring completion of FWA, HIPAA and compliance trainings required by corporate.

After the quarterly onsite review is conducted, a summary of the findings is collected. Recommended actions are discussed, and completion dates for tasks are agreed upon. In addition to this detailed audit of the health plan functions, the Corporate Internal Audit department performs an annual audit of the health plan compliance program and reports the results to the Centene Board of Directors.
For new plans, the Corporate Internal Audit department performs a 90–120 day, post go-live audit to review processes and procedures to ensure the health plan meets all contract requirements.

E. Effective Lines of Communication. NTC requires its employees to report to management or the Compliance Officer all suspected and confirmed incidents of fraud, waste, abuse, illegal acts, inappropriate disclosures, and/or other incidents that contravene applicable law, regulations, or Centene's Business Ethics and Conduct policy. In addition, independent reporting paths are available for employees to report such acts. This includes an Ethics and Compliance Helpline (1-800-345-1642), as well as a separate Fraud, Waste and Abuse (FWA) Hotline (1-866-685-8664). The telephone lines are available to all employees 24 hours a day, 7 days a week, 365 days a year so that employees may report incidents and concerns anonymously. The FWA Hotline is also available for individuals outside the organization to report potential FWA. The FWA Hotline number is published externally in the Provider Manual and Member Handbook. Written procedures are available to all employees who need guidance on certain requirements or who wish to report actual or suspected violations of law or applicable company policies and procedures. NTC has adopted Centene's "Speaking Up" policy that requires all employees to report concerns, policy violations, misconduct and issues of non-compliance. In addition, confidentiality and non-retaliation policies have been developed and are widely publicized to all employees to encourage open communication and reporting. Centene's Compliance Officer maintains a file documenting each suspected violation, including the nature of any investigation and its results. Such information is reported to Centene's governing body and the CEO.

F. Disciplinary Guidelines. NTC's parent company, Centene Corporation, in conjunction with Centene's Human Resources Department, maintains a written policy statement setting forth the degrees of disciplinary actions that will be imposed upon corporate officers, managers, employees, and independent contractors for failing to comply with the company's standards, policies and applicable statutes and regulations. This policy statement applies to all employees and independent contractors of Centene's subsidiaries, including NTC. Intentional or reckless noncompliance will subject transgressors to significant sanctions. The commitment to compliance applies to all personnel levels within the company. The consequences of noncompliance will be consistently applied and enforced in order for the disciplinary policy to have the required deterrent effect. Disciplinary standards are communicated to employees at hire and again during annual and ad hoc Compliance and Ethics training sessions.

G. Response to Identified Offenses and Application of Corrective Action Initiatives. The NTC Compliance Officer, with assistance from Centene's Chief Compliance Officer or legal counsel, when

necessary, will promptly investigate all allegations of reasonable or suspected noncompliance or other illegal or improper activities by its employees, subcontractors, or providers to determine whether a material violation of applicable law or the requirements of the Compliance Program has occurred. If the investigation demonstrates that a material violation has occurred, NTC's Compliance Officer will take immediate steps to correct the problem and develop appropriate corrective action to prevent further occurrences. As appropriate, such steps may include (but are not limited to) immediate referral to criminal and/or civil law enforcement authorities; notification to the state, i.e. NMPI and MFPAU as appropriate if related to FWA; imposition of corrective action plans; termination from NTC's provider network; employee disciplinary action or reports to applicable state or federal authorities, as appropriate. All investigations and remediation efforts will be conducted in conjunction with or under the supervision of NTC's parent company, Centene Corporation. In the event of an internal conflict, Centene's Chief Compliance Officer will refer identified issues to an outside third party for investigation.

Review of CMS Proposed Rule CMS-2390-P. As required in Addendum 3 of this RFP, NTC will submit a plan that details processes with timeframes for NTC to implement changes to be in compliance with the new federal requirements. The plan will be submitted either 90 days prior to the contract start date or 60 days after the proposed rule is finalized (whichever is earlier). As directed in the RFP, NTC's plan will take into consideration the requirements CMS is placing on states that require MCO cooperation and compliance.

Centene's Compliance Department has completed the first phase of assessing the proposed rule for Medicaid Managed Care regulations, found at 42 CFR 438, and 457, Subpart L. The proposed rule has been loaded into Compliance 360, our compliance management software. Each area of the proposed regulation that holds the MCO accountable is being assessed against our present policies and procedures. The assessment will compare the requirements in the proposed rule with our current policies and procedures at both the corporate level and the health plan subsidiary level to determine where gaps exist in relation to proposed rule requirements. Upon completion of the assessment phase, the team will begin working with our affiliate health plans and any other stakeholders to update our policies and procedures to be compliant.

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IV.C Business Requirements

IV.C Business Requirements

(1 page limit, excluding copy of COA)

11. Describe how the bidder meets the Federal definition of a MCO. Include a copy of the COA from the Department of Insurance.

Nebraska Total Care (NTC) meets the Federal definition of a MCO under subsection 438.2(2), of 42 CFR and (ii) as an entity that meets the solvency standards of subsection 438.116, as shown below. NTC will also meet the solvency requirements as required by the Nebraska Department of Insurance.

NTC attests that it will apply for a Certificate of Authority to transact the business of health insurance in Nebraska as a health maintenance organization prior to executing the Heritage Health contract with the State of Nebraska and will obtain licensure by the contract start date.

12. Describe the MCO's proposed approach for collaboration with other entities and programs, as required in Section IV.C.6. (3 page limit)

Approach for Collaboration. Nebraska Total Care (NTC) recognizes that our responsibilities to our members as well as to MLTC includes establishment of effective relationships and service coordination among multiple entities. NTC has been working across the state to identify and build relationships with providers and with key State agencies. NTC's processes and procedures will include coordination with, but not limited to, the entities and programs below when serving members and identifying and responding to members' behavioral and physical health needs:

- Division of Behavioral Health funded programs
- 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
- Division of Developmental Disabilities programs that involve rehabilitative and habilitative services for persons with developmental disabilities
- The Nebraska Department of Education Early Development Network
- Community agencies including but not limited to the Area Agencies on Aging and League of Human Dignity Waiver Offices
- The Office of Probation
- Other programs and initiatives within MLTC related to primary care and behavioral health integration/coordination and pharmacy management

NTC collaborate with these entities and programs and its network providers regarding planning initiatives and system transformation. NTC is cognizant of current barriers to collaboration and coordination that exist between Physical Health and Behavioral Health Managed Care, other state agencies and programs as well as the many community organizations supporting Heritage Health populations. We will implement solutions and processes, establish partnerships, facilitate the exchange of information and work collaboratively with other programs designed to enhance cross-sector coordination that is tailored to local needs. NTC's organizational structure will be aligned to support internal and external coordination and collaboration. As detailed in our response to Question 19, our wholly-owned and integrated subsidiary structure, location of NTC's leadership as well as all member and provider facing staff in Nebraska and integrated care management structure will allow NTC to be locally responsive to coordination and collaboration efforts. Our leadership team will not only be experienced in providing managed care to TANF, CHIP, Foster Care, ABD, LTC and I/DD populations, but also experienced in successfully integrating PH, BH, and pharmacy. NTC will 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.

Designated Points of Contact. To ensure full and ongoing commitment to these efforts NTC will establish an Interagency Liaison position as the dedicated point of contact to manage Collaboration Reporting and facilitate resolution of collaboration issues. The Interagency Liaison will report to the Director of External Affairs and will provide an annual report of the collaboration activity across all entities and programs that will be included as part of our advisory committees' review process. This accountable structure will promote high-touch service delivered locally by staff who live in, and understand each unique community we serve.

To overcome barriers to the effective exchange of information, NTC's Management Information System (MIS) and award-winning proprietary and comprehensive family of integrated decision support and health care informatics solutions will not only equip our staff with the care coordination technology necessary to provide comprehensive and appropriate care our members as outlined in our response to Question 65, but support HIPPA compliant external information sharing and system-wide integration.

Through on-the-ground outreach efforts, we have already identified ***programs and partnerships that will fit within our broader integration strategy:***

- Our participation with the Nebraska Health Information Initiative (NeHII) described fully ***in our response to Question 53*** will allow us to drive EHR meaningful use through contribution of

clinical data, including medical, behavioral health, and pharmacy claims data, lab test results, assessments, and other information to NeHII.

- NTC will partner with local health departments to coordinate care, eliminate the duplication of services, and increase the speed at which clinical date can be shared in a HIPPA compliant fashion. For example, will work with the Lancaster County Public Health Department to exchange member health data, population health informatics and foster enhanced coordination of services offered by the department, such as adult dental health, prenatal care services and the STD screening and treatment collaboration described below.
- In order to increase the accuracy of our targeted STD interventions, NTC will work with DHHS's STD Program to supplement the key metrics we track through our TruCare platform. Additionally, through collaboration with confidential STD screening clinics, such as the Douglas and Lancaster County Health Departments, we will develop strategies to reach at-risk members to whom outreach efforts might otherwise be stymied due to the sensitive nature of STD screening. These efforts will initially be focused on regions with a worsening rate of STDs, such as Lancaster County which has experienced a 50% increase in the incidence of chlamydia from 2003 and 2013.
- We are focused on implementing programs and strategies that promote full integration of physical and behavioral health in collaboration with six behavioral health regions, NABHO, the Department of Behavioral Health and other providers and provider organizations across the state. We will focus on improving data-sharing, transitions of care into and out of Nebraska's three Regional Centers in Lincoln, Norfolk and Hastings and day-to-day service coordination.
- As outlined in our response to Question 66, we will support coordination of HCBS services and our relationships with the Nebraska Health Care Association, Area Agencies on Aging (AAAs), Centers for Independent Living (CILs) and other social service organizations with a dedicated LTSS Liaison. We have already begun work on a program with Aging Partners (AP) and League of Human Dignity (LHD) that will focus on discharge planning in an effort to reduce readmissions.
- We have engaged in outreach to each Federally Recognized tribe headquartered in Nebraska to understand their concerns and identify opportunities to improve coordination between Medicaid, Indian Health Service (IHS), tribal 638 and Urban Indian and other services such as diabetes treatment and prevention programs. Tribal coordination and collaboration will be facilitated by NTC's Tribal Network Liaison, Tribal Healthcare Advisory Committee and a position on NTC's Board of Directors representing Nebraska's tribes.
- We are implementing Community Health Collaboratives (CHCs) as partnerships between key providers in regions across Nebraska to provide opportunities for onsite Care Management staff to enhance communication and collaboration in order to increase capacity and remove barriers inhibiting access to available resources. The CHC model will also promote data-sharing to provide insight into improper ED utilization and other opportunities to provide better care in the appropriate setting. In Norfolk, we are forming a CHC with Midtown Health Center, Faith Regional Health Services, Region 4 Behavioral Health and tribal representatives from the region and we are in the process of forming CHCs in Lincoln, the Tri-Cities and Scottsbluff.

The early efforts outlined above are a part of our overarching philosophy of using cooperative relationships with the Division of Behavioral Health and Children and Family Services and Developmental Disabilities funded programs, the Nebraska Department of Education Early Development Network, community agencies such as AAAs and League of Human Dignity Waiver Offices, the Office of Probation outlined in Section IV.C.6 as minimum guidance. We will fully collaborative and comply as required with each of these agencies, as well as with other programs and initiatives within MLTC related to primary care and behavioral health integration, coordination and pharmacy management, put we will also strive to develop innovative partnerships, alliances and pilot programs to further align services and supports across the continuum of care for Heritage Health members beyond the basic requirements.

Experienced and Proven Collaboration. NTC knows the importance of collaborating with other MCOs and will apply best practices from its affiliate health plans in other states that continuously identify local and regional needs and the organizations and individuals that are actively addressing them. A primary strength of Centene affiliated health plans is a commitment to establishing partnerships and building relationships with local expertise – in the provider community, with social services agencies, and with the community at large. Our affiliated plans have a long history of working with safety net and community service providers, schools, churches and other social agencies to meet the needs of the all populations, including the physically and cognitively fragile. Examples of success in other markets include:

- **Collaboration Effort in Texas:** Our Texas affiliate, Superior Health Plan, worked closely with other Texas MCOs while executing the expansion of Managed Care for the IDD population in 2014. Persons with IDD were added to Medicaid managed care STAR+PLUS as mandatory enrollees for their acute care services only. Their LTSS waiver benefits remain with their state Care Managers in the applicable state agency (The Department of Aging & Disability Services or The Department of Assistive and Rehabilitative Services). The MCOs partnered with the state (HHSC), as well as provider associations, to ensure provider, member and members' families understood the changes and the enrollment process. Superior, in conjunction with the other MCOs, had regularly scheduled meetings and participated in multiple stakeholder education sessions, developed FAQs that were posted to all organizations web sites, and worked very closely with HHSC to ensure all significant traditional providers were offered an opportunity to contract. This collaboration worked well to help make a smooth transition into managed care for these members.
- **Collaboration Effort in New Hampshire:** The behavioral health department for NH requested that the MCOs participate in a LEAN project regarding how to streamline and modernize the access issues of emergency services for behavioral health treatment. Working with the Community Mental Health Centers, Emergency Rooms, Inpatient facilities, managed care entities, and others, New Hampshire Healthy Families (Centene) participated in the LEAN project for approximately three months, where the entire group focused on working to identify the gaps and barriers and potential solutions areas to implement across the state.
- **Collaboration Effort in Louisiana:** The Louisiana Department of Health and Hospitals (DHH) and the Office of Behavioral Health (OBH) carved behavioral health into the existing Bayou Health Managed Care, but decided not to simultaneously carve-in the CSoC program for children with significant behavioral health challenges despite covering medical benefits for the population under Bayou Health. During the transition, Centene (LHCC) participated in a state run workgroup, collaborated with SMO, DHH, OBH, and the other Bayou Health MCOs to develop integrated process flows, referral sheets, and appropriate collaboration techniques to coordinate care and support the transition process for CSoC Children.

Future Outreach Efforts. NTC has met with all the identified entities and many health care leaders in Nebraska. We are committed to developing meaningful working relationships with key collaborators and to building programs to support existing programs and any new programs that developed and implemented by State agencies. Our Interagency Liaison will have an active role in NTC's Advisory committees to bring forward issues as they arise. The collaboration issues that are identified and resolved throughout the year will be reported annually to MLTC to show the timeframes for resolution.

We look forward to working with MLTC to coordinate efforts with the state agencies and the contracted MCOs as our affiliate in Louisiana did recently. MLTCs focus on collaboration and coordination across the system of care aligns with NTC's philosophy that providing better care, in the right setting, at the right time requires comprehensive internal and external integration. As our success in other states has demonstrated, effective coordination is mutually beneficial to states and MCOs alike and results in reduced inefficiencies for providers and stakeholders and most importantly, better member health outcomes.

(1 page limit)
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.

Centene Corporation (Centene) and its affiliate health plans, have received recognition over the years for their commitment to providing clinical and service excellence to the Members for which they serve. For example, national recognition for our asthma management program (Environmental Protection Agency) and for health risk assessment and diabetes education for patients with serious mental illness, (Medicaid Health Plans of America Center for Best Practices). In addition, Nebraska Total Care (NTC) contracts with NCQA certified vendors to perform our Member Satisfaction CAHPS surveys, including CAHPS Adult surveys and CAHPS Child surveys with children with chronic conditions supplemental items. NTC will also use current NCQA Standards and Guidelines as well as applicable state regulations for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action. Our Medicaid health plans eligible for NCQA accreditation currently hold an accreditation status or expect accreditation by 2017 as well Centene's specialty companies hold national accreditation for their specific area of focus. ***See Figure Q13.A.***

NCQA Accredited Affiliates - Medicaid

- Absolute Total Care (SC)
- Granite State Health Plan (NH)
- Managed Health Services (IN)
- MHS Health Wisconsin
- Peach State Health Plan (GA)
- Superior Health Plan (TX)

- Buckeye Health Plan (OH)
- Celtic Insurance Company
- Coordinated Care (WA)
- Home State Health (MO)
- IlliniCare Health (IL)
- Louisiana Healthcare Connections (LA)
- Magnolia Health Plan (MS)
- Sunflower Health Plan (KS)
- Sunshine Health (FL)

Figure Q13.A

Attaining Accreditation in Nebraska

NTC will employ the same best practices as our affiliate Health Plans that maintain full NCQA Health Plan Accreditation; and all Policies & Procedures are state, federal and NCQA compliant at the time of go live. After go-live, the Centene Corporate Accreditation staff performs a complete gap analysis to assess NCQA readiness; then guides the Health Plan through the entire process. This includes Health Plan staff education and training on the NCQA standards and survey process, assessment of Health Plan processes to assure compliance with NCQA standards, identification of data reports required for analysis, mock file reviews to prepare for NCQA review, etc. NTC will submit the application for accreditation as soon after the contract's start date as allowed by NCQA and NTC will provide MLTC with a copy of all correspondence between NCQA regarding the application process, the accreditation requirements, and our progress toward accreditation. If NTC receives provisional accreditation, we will submit a corrective action plan to MLTC within 30 days. However, Centene has never been granted provisional status, and has always come out of the process fully NCQA accredited on all of our health plans initial attempts. NTC will be NCQA accredited within 18 months of the contract award.

(1 page limit)
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.

Nebraska Total Care does not restrict coverage for counseling or referral services based on moral or religious obligation.

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IV.C ATTACHMENTS

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IV.D Staffing Requirements

IV.D Staffing Requirements

(3 page limit, excluding organizational chart)

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.

Nebraska Total Care Organizational Structure

Number of Employees. Locally Driven Accountability and Decision Making with Central Support. Nebraska Total Care (NTC) anticipates hiring 193 experienced and highly-qualified individuals dedicated to the Heritage Health program. NTC is committed to local accountability – *all of our health plan staff will be located in Nebraska*, with additional support from our corporate functional experts and affiliate subcontractor staff. Member and Provider facing functions such as care management, care coordination, member outreach, network contracting, credentialing, utilization management (UM), disease management, compliance, quality improvement (QI), and fraud and abuse prevention staff as well as our member and provider call center will all be located in Nebraska. During implementation, a transition team located in Nebraska will provide assistance as local leadership is hired and trained. NTC's transition team leverages the skill and experience of corporate and affiliate plan staff from comparable markets who have successfully planned, implemented and are currently operating integrated managed care plans serving similar populations. This carefully selected leadership team will provide intensive onsite support, provide best practice strategies, assist with staffing and hiring decisions, provide management and staff training and other guidance through each stage of the implementation process. Post-implementation, NTC will continue to closely collaborate with corporate and affiliate staff to ensure that all requisite resources and capabilities are at NTC's disposal.

Lines of Business. NTC will begin operations in the state of Nebraska under the contract awarded for this RFP as a fully licensed Medicaid MCO. We have a strong history and proven success in other states that will support a new Medicaid health plan in Nebraska. Our parent organization, Centene, has **over 30 years** of experience in full-risk managed care and currently serves over **4.8 million members** in **23 states.** ***Table 15*** illustrates the populations covered and services provided in each state programs.

Table 15: Categories of Aid Covered and Specialty Services Provided by Centene

	AZ	AR	CA	FL	GA	IL	IN	KS	LA	MA	MI	MN	MS	MO	NH	OH	OR	SC	TN	TX	VT	WA	WI
Categories of Aid																							
TANF			•	•	•	•	•	•	•				•	•	•	•	•	•		•		•	•
Medicaid Expansion		•	•			•	•			•					•	•	•					•	
CHIP			•	•	•		•	•	•				•	•	•	•	•	•		•		•	•
ABD (non-duals)			•	•		•	•	•	•				•		•	•	•	•		•		•	•
ABD (Medicaid only dual-eligibles)			•	•				•							•	•	•			•			•
Dual Demonstrations (including LTSS)						•					•					•		•		•			
Intellectually/Developmentally Disabled						•		•							•					•			
Long-Term Services and Supports	•			•		•		•							•	•				•			
Foster Care			•	•			•	•	•				•	•	•					•		•	
Medicare Special Needs Plan	•			•	•						•					•	•			•			•
Health Insurance Marketplaces		•		•	•	•	•			•			•			•	•			•		•	•
Correctional Healthcare										•		•	•						•		•		
Specialty Services																							
Pharmacy Benefits	•	•	•	•	•	•	•	•	•	•	•		•		•	•		•		•		•	
Behavioral & Specialty Therapies	•	•	•	•	•	•	•	•	•	•	•		•	•	•	•		•		•		•	•
Life & Health Management	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•		•	•	•		•	•
Primary Care Solutions for Complex Populations				•			•	•						•		•				•			•
Managed Vision	•	•	•	•	•	•	•	•	•	•	•		•	•	•	•		•		•		•	•
Dental Benefits	•	•		•	•			•		•	•		•	•		•				•			•
Telehealth (Nurse Triage and Education Line)	•	•	•	•	•	•	•	•	•	•	•		•	•	•	•		•		•		•	•

NH: Waiver HCBS services and nursing facility services are anticipated to go-live January 1, 2016 and July 1, 2016, respectively.

Dental Benefits: *Centene is in process of transitioning dental services from external vendors to our new dental benefit management subsidiary.*

Office Locations. NTC will establish headquarters in Lincoln, with satellite offices in Omaha, the tri-cities area and Scottsbluff. The majority of services for the MLTC Heritage Health contract will be performed in the Lincoln headquarters office including:

- Administration
- Behavioral Health
- Pharmacy
- Provider Relations
- Network and Development
- Member Connections
- Medical Director
- Quality Improvement
- Finance
- Medical Management, Case Management and Utilization
- Network
- Medical Home
- Facilities
- Clinical Education

Additional offices will function as satellite offices supporting the following functions:

- Behavioral Health
- Provider Relations
- Member Connections
- Medical Home

Organizational Chart Description

Nebraska Total Care's Contractual Relationships Organizational Chart depicts the corporate ownership structure and lines of responsibility and authority of NTC. NTC will be a statewide Health Maintenance Organization (HMO) and is the RFP Respondent. Administrative services from Centene's corporate office are provided through a Management Agreement with Centene Management Company, LLC (CMC). NTC connects and shares information with the affiliate health plans through our Management Agreement with CMC.

Subsidiaries. The chart demonstrates Nebraska Total Care's relationship to Centene Corporation, CMC, and the Delegated Agreements with U.S. Medical Management, LLC (USMM), a provider of in-home health services for high acuity populations; NCQA accredited Cenpatico, which provides outpatient therapy and basic behavioral health management services; URAC accredited US Script, Inc., which manages pharmacy benefits; NurseWise, LP, to provide a URAC accredited 24/7 nurse advice line and health assessment services; Nurtur Health, Inc. to provide NCQA and URAC accredited disease management programs; NCQA accredited and SSAE certified OptiCare Managed Vision, Inc., which provides vision services; and National Imaging Associates, Inc. (NIA), which provides diagnostic imaging.

Parent Organization. Centene's Subsidiary Organizational Chart shows the wholly-owned Specialty Companies and the affiliate Health Plans within the organization. Centene Corporation, a Fortune 500 company, is a leading multi-line healthcare enterprise that provides programs and services to government sponsored healthcare programs, focusing on under-insured and uninsured individuals. The Corporation operates local health plans and offers a range of health insurance solutions. It also contracts with other healthcare and commercial organizations to provide specialty services including behavioral health, care management software, correctional systems healthcare, in-home health services, life and health management, managed vision, pharmacy benefits management, specialty pharmacy and telehealth services.

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.

Figure Q.15.A below depicts the corporate ownership structure and lines of responsibility and authority of NTC, and the relationships between the policymaking bodies and the health plan. NTC will hold a statewide Health Maintenance Organization (HMO) license issued by the Nebraska Department of

Insurance and is the RFP Respondent. NTC is a wholly-owned subsidiary of Centene Corporation. As illustrated below, Centene's Board of Directors (BOD) has oversight of NTC's BOD. NTC's BOD has oversight over NTC. NTC's Board is its governing body and has legal and fiduciary responsibility for NTC operations and operates in accordance with Nebraska Law and regulations.

Nebraska Total Care Contractual Relationship Chart Figure Q15.A

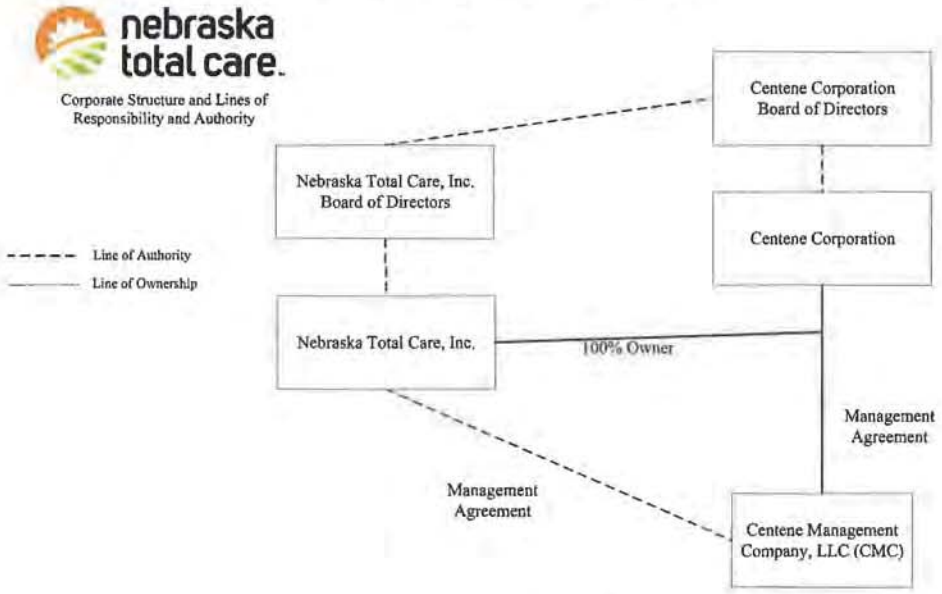

Figure Q15.B demonstrates NTC's parent organization, affiliates, and subsidiaries that will support this contract.

Centene Subsidiary Organizational Chart Figure Q15.B

(page limit N/A)
16. Provide an organizational chart for this contract, including but not limited to key staff and additional required staff. Label this "Nebraska Organizational Chart.

Nebraska Total Care has submitted its Organizational Charts for the contract located behind the ***IV.D Attachments tab,*** immediately following this section.

(page limit N/A)
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 Time Period

Proposed FTEs by Time Period shows the proposed number of FTEs for each of the key staff positions and the additional required staff positions beginning March 15, 2016 through June 30, 2017, which represents the anticipated contract start date through six months after operations. All the positions will be located in the State, except as allowed in the RFP and are marked accordingly and all staffing numbers shown are cumulative.

Table 17. Proposed FTEs by Time Period

MLTC Position Titles	Contract Award	9 Months Pre-start	6 Months Pre-start	3 Months Pre-start	Contract Start	3 Months Post-start	6 Months Post-start	Location
Chief Executive Officer (CEO)*	1							NE
Medial Director/Chief Medical Officer*	1							NE
Behavioral Health Clinical Director	1							TX
Behavioral Health Manager*		1						NE
Chief Operating Officer (COO)*	1							NE
Chief Financial Officer (CFO)*		1						NE
Program Integrity Officer *		1						NE
Grievance System Manager *		1						NE
Business Continuity Planning and Emergency Coordinator		1						MO
Contract Compliance Coordinator*		1						NE
Quality Management (QM) Coordinator	1							NE
Performance and Quality Improvement Coordinator*			1					NE
Maternal Child Health / Early and Periodic Screening, Diagnostic, and Treatment Coordinator*		1						NE
Medical Management Coordinator*		1						NE

MLTC Position Titles	Contract Award	9 Months Pre-start	6 Months Pre-start	3 Months Pre-start	Contract Start	3 Months Post-start	6 Months Post-start	Location
Provider Services Manager*	1							NE
Member Services Manager*	1							NE
Claims Administrator		1						MO
Provider Claims Educator		1						NE
Case Management Administrator*	1							NE
Information Management and Systems Director	1							MO
Encounter Data Quality Coordinator		1						MO
Tribal Network Liaison*		1						NE
Pharmacist/Pharmacy Director*		1						NE
Prior Authorization Staff*			5					NE
Concurrent Review Staff			5					NE
Clerical and Support Staff			11					NE
Provider Services Staff		6						NE
Member Services Staff		28	28	37				NE
Claims Processing Staff			1					MO, MT
Encounter Processing Staff			1					MO
Care Management Staff		58	58	102				NE
FWA Investigative Staff		2						NE
FTE Totals by Quarter	9	116	140	193	193	193	193	

(1 page limit per job description)
18. Provide job descriptions (including education and experience qualifications) of employees in key staff positions.

Nebraska Total Care, Inc. has submitted job descriptions for each of the key staff required. ***All Job Descriptions are located in the IV.D Attachments tab*** immediately following this section.

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. (4 page limit)

Nebraska Total Care's (NTC) parent company Centene's organizational structure by design was built with the primary goal of integrating services, and NTC's senior leadership understands, supports and promotes a culture of integrated services. Our pharmacy and behavioral health subcontractors are affiliated entities under the Centene suite of specialty companies. This integration enables us to bring focused expertise and present a unified seamless experience for our members and providers. With this underlying core structure in place, administration of these services is linked through people, processes and technology already in place today. NTC has designed its administrative structure to ensure that leadership, member and provider facing functions are 100% local. We will ensure integration through operational and delivery expectations and performance metrics that are data informed and transparent. Our administrative structure and practices fully support the integration of the delivery of physical health, behavioral health and pharmacy services.

Local Administrative Structure

Nebraska Total Care's administrative structure includes fully integrated staffing for local key leadership Medical Management, Care Management and Pharmacy Management. In addition, while NTC will be supported by our parent company, Centene, and the experience of its affiliate health plans providing services to Medicaid populations across the nation, all operational functions having ***direct member and provider interaction will be conducted in Nebraska.***

Integrated Delivery

NTC's administrative structure and practices will support integrated delivery of all covered services, including physical health, behavioral health and pharmacy, as well as incorporating social supports and determinants of health in a holistic way, through the strategic alignment and organization of all administrative functional areas. NTC's network development and behavioral health leadership have already met with many providers and leadership from the BH regions. We have talked with them regarding integrated service delivery. What we heard from these providers is a greater need for data sharing that supports providers in communicating across specialty, and ensuring that we develop broad models of integrated service delivery that meet providers where they are. NTC's synchronized organizational and operational structures will be optimally aligned to ensure that:

- **Practice Improvement Resource Center (PIRC)** that provides toolkits and resources to support providers in understanding integrated models of care.
- **Meaningful data** will be collected and integrated across NTC's internal functional units to promote our whole health approach to Care Management and accurately report performance results
- NTC's management structure supports a holistic, **fully integrated Care Management** model
- NTC's **multidisciplinary Care Coordination** function is executed by **on-the-ground staff**, working face-to-face with members and providers at every opportunity
- NTC staff and systems **push actionable data to all treating providers**, enabling integration at the service level
- **Providers are actively engaged in the integrated care delivery** process through initial and ongoing training and communication
- NTC's Member Services Line serves as the **member's single, central resource** for information related to their physical health, behavioral health, and pharmacy care.
- NTC will provide a **24/7 Psychiatric Access Line** to support primary care providers in appropriate BH prescribing, screening, identification and referral.

Provider Network

NTC understands that our providers play a key role in executing a fully integrated model at the practice level. Our administrative structure is designed to support this integration by through staffing, technical support and resources.

Staffing. NTC's **Provider Engagement Team** will work with network physical health and behavioral health providers to support integrated service delivery and coordination strategies that include, but are not limited to provider co-location (i.e PCPs in BH provider offices and vice versa), multi-disciplinary care team meetings (both face-to-face and virtual), and cross specialty communication. NTC also employs PCMH Content Experts to provide technical assistance and reporting support for Patient Centered Medical Homes (PCMH).

Technical Assistance. We will collaborate with our providers and local community-based services by offering technical assistance, training, information technology solutions and integration of our Care Team as needed. NTC is committed to engaging with and providing supports to our contracted providers, who are our partners in ensuring integrated care for our members. NTC will develop a comprehensive and ongoing provider outreach and training plan that addresses PH, BH and Pharmacy issues and meets all provider network requirements as set forth in the RFP. A key to successful administration and integration of PH, BH and Pharmacy services is through coordination of care. Through initial and ongoing training, we will educate providers on opportunities for greater integration of care, communication between treating providers, informed approaches to medication management (e.g. evidence-based prescribing patterns for psychotropic medications) and integrating and coordinating care across all types of providers. We will further provide education to providers, pharmacies and first responders regarding the support available from our Care Team model, 24/7 nurse-advice line and related NTC support services.

Resources for Integrating Services. Our contracts with providers require integration and coordination of care with all servicing providers, an approach supported by the medical home model. In addition to the technical support, we will educate providers about coordinating care during provider orientations, in our Provider Handbook, Provider Portal and our Practice Improvement Resource Center (PIRC). NTC will implement the use of a PH/BH Release of Information and Care Coordination form, which creates an efficient tool for providers to share information. We will educate providers and members about the importance of sharing information across treating providers. Our Care Team model will support providers in their efforts to integrate care by including and engaging them in the development of an **integrated plan of care** that includes PH, BH and Pharmacy services as applicable for each member. We have developed **BH Tool Kits for PCPs,** which include information on screening, commonly prescribed medications and resources. NTC will support providers in the coordination of care through access to our sophisticated information technology capabilities as described above. For example, our **Centelligence™ Health Record (CHR),** accessible through our secure Provider Portal, displays a user-friendly view of a member's claims utilization that includes PH, BH, and Pharmacy services. The member's care plan is also available to all of the providers on our Portal.

Internal Data Collection and Integration. NTC recognizes the critical success factor in an integrated delivery system is the appropriate and timely collection and sharing of relevant clinical and health data between and among the health plan, network providers, State partners, and other stakeholders. Our information technology system is highly integrated; using a service oriented architected base, our systems are engineered to integrate all functional application, database, and subsystem "layers" to support efficient, accurate, secure, and timely exchanges of pertinent health data among all major operational areas to promote *meaningful*, impactful outcomes.

The foundation of NTC's integrated data collection and reporting system will be the Centelligence™ platform. Centelligence™ provides the core, expansive business intelligence support for all interfacing systems, including our care management platform, web portals, and customer service platforms. The Centelligence™ enterprise platform integrates data from internal and external sources, producing actionable information and reports to major operational areas to manage the patient across their continuum of care. This includes everything from care gaps, which are displayed if a member is due for or missing a service recommended by evidence-based guidelines to key performance indicator (KPI) dashboards, provider clinical profiling analysis, population level health risk stratifications, and over 12,000 unique operational and compliance reports.

By employing role based access security, we further present information attuned to each user audience that is customized and adapted to the communication channel accessed (Web, Mobile, TruCare (Our Care Management Platform). However information is accessed, each major operational area will work off the same data, ensuring a "No Wrong Door Approach" to healthcare management, ensuring that NTC's integrated teams and our local delivery system demonstrate a holistic view of each member. Additional information related to NTC's integrated approach to Information Systems is provided in our response to question 101.

Functionally Integrated Operational Areas. NTC shares MLTC's position that a fully integrated operations system supports optimal member care. All member-facing NTC staff will be located in Nebraska; however, for those operational teams located out-of-state, we will foster a culture of collaboration, communication, commitment, and consistency to ensure functional integration through a shared data platform, telephonic and e-mail communications, video conferencing, and regular meetings and case rounds. This approach has been effective among NTC's affiliates, as it enables members and providers to benefit from locally delivered services while, at the same time, enabling MLTC to benefit from cost efficiencies and economies of scale by using a centralized approach for performing services that do not touch members or providers directly. Supporting NTC in our mission to provide exceptional service to each Nebraska member is a dedication shared by each of our employees. NTC will manage the functional linkage of each major operational area described in the RFP using the following methods:

- Ensuring representation from each major operational area throughout each phase of the implementation project planning process to promote seamless operational support beginning on Day One
- Coordinating policies and procedures for each major operational area to ensure consistent cross-functional coordination is embedded into processes across all major operational areas
- Delivering employee training curricula designed to:
  - Address cross-functional processes and promote collaboration and best practice sharing across all major operational areas
  - Ensure operations staff is provided comprehensive initial and ongoing education on Nebraska-specific policies and operations, and on all applicable Contract provisions
- Developing and enhancing technology solutions that allow for employees across all major operational areas to access and share information
- Dedicating members of NTC's leadership team as closely aligned partners with leaders from corresponding major operational areas to maintain ongoing communication and support operational excellence

Integrated Programing. NTC's PH and BH care coordination staff's office workstations will be adjoining to maximize communication and collaboration among all functional areas in support of care integration. Our Pharmacy Director and Pharmacy Coordinators will be based in our Lincoln office and participate in case consultation and provide support during clinical rounds. Our Pharmacy Coordinator oversees regulations around controlled substances and monitors to ensure pharmacy providers are checking databases; monitors for contraindications, side effects and over utilization (e.g. pain medication) and underutilization (e.g. asthma medication). For example, NTC will introduce integrated care with coordination and a multidisciplinary approach for providing support to the member, and real-time data to the member's treating providers to enable accurate, integrated service support. Examples of our programs that include PH, BH and pharmacy integration include:

- **Prenatal Substance Use Program.** NTC will implement a Prenatal Substance Use Program which was first implemented by our Ohio affiliate to address the use of opiates, alcohol, and other drugs during pregnancy. The Program received the **2014 Ohio Association of Health Plan's Pinnacle Award** for Best Practice Healthcare Programs. A team of nurse and BH clinician care managers, social workers, and non-clinical staff collaborate to address the needs of the whole person, recognizing that successful recovery requires significant supports beyond covered PH/BH services. Initial program implementation **reduced average neonatal inpatient length-of-stay to**

13 days among infants delivered to participants, compared to 15.9 days for infants born to non-participating Members. This program includes care management support for expecting mothers who have a history of SUD, works with OB and BH providers to identify the right care plan, which may include suboxone or other psychotropic medication, carefully monitored to support for a healthy birth outcome and reduced likelihood of NICU admission.

- **Medication Adherence.** NTC's Centelligence™ provides care management staff an efficient way to identify non-adherence to medication, flagged as a care gap. Having this information easily accessible to our care managers allows for quick follow-up whenever a gap is identified, while addressing other barriers to filling medications.
- **Psychotropic Medication Utilization Review.** Retrospective review process that analyzes pharmacy claims data to ensure psychotropic medications are prescribed within evidence based clinical parameters and provides care management and/or peer-to-peer consultation to enhance compliance.

Each of our integrated care programs is supported by integrated systems for a holistic view of members' care and outcomes reporting. Our Provider Services management team will maintain a staff that understands the full benefit including PH, BH and Pharmacy services, and all Provider facing staff will be educated to ensure they are generally knowledgeable across PH, BH and Pharmacy services for efficiency in answering provider questions on all categories. For provider questions that require additional research or insight, provider services staff will be trained on triage processes and will know how to engage the correct resources for optimal service to the provider. Similarly, NTC's Customer Services team will ensure that all Customer Services Representatives (CSR) are trained to have an overall knowledge of PH, BH and Pharmacy information, and will be knowledgeable of triage processes. This could include instant message to local NTC BH clinicians or Pharmacy Coordinators, or accessing detail on a claim through our integrated information technology systems.

Integrated Care Teams. NTC will ensure integration of services through a holistic care management program design, staff work flows, and system supports at the ground level. Our integrated Care Teams include medical nurses, BH clinicians, Pharmacy Coordinators and social workers. NTC's care management program is modeled after the evidence-based Integrated Case Management program promoted by the Case Management Society of America (CMSA). Our person-centered approach to care coordination will integrate all services the member receives to create a system of care around that individual. Creating this individualized system allows us to address more effectively the clinical as well as the functional, social and other non-clinical needs that have an impact on a person's health and quality of life. NTC's approach collapses silos often found in traditional care management by training Care Team professionals, regardless of health focus, in techniques that will allow them to provide interdisciplinary assistance. Care Team staff will be trained to include all aspects of a member's health, PH, BH, medication and social determinants of health into a member's care plan. For example, staff training will include but is not limited to person-centered planning, pharmacy benefits and initiatives, functional assessments, self-directed care option and quality of life goals. The Care Team staff will also receive training regarding preventive care guidelines, common physical and behavioral health co-morbidities, common psychotropic medications and contraindications, and basic self-management skills for chronic conditions. A comprehensive discussion of NTC's care management/coordination strategies can be found in our response to Technical Approach Question 58.

Call Center. NTC's member-centric model is designed to meet PH and BH needs, including access to pharmacy support, through "no wrong door" access via the member call center. NTC will provide one phone number to members for access to all services. CSRs are trained to identify specific needs such as BH needs or crisis and will warm transfer the caller to BH staff through our integrated Care Team and our 24/7 call centers for nurse advice and BH support that are equipped with training, expertise and resources to support the member.

20. Describe how the MCO will train staff on issues that affect its members, including: issues related to housing, education, food, physical& sexual abuse, violence, food security; behavioral health risk & protective factors; finding community resources & making referrals to these agencies & other programs; meeting the needs of the LTSS population, including individuals with developmental disabilities & mental health concerns. 6 page limit

Staff Training on Social Determinants of Health and LTSS

Nebraska Total Care (NTC) is committed to educating and training all health plan staff on issues that impact a member's health and addressing the needs of the LTSS population, including individuals with developmental disabilities and mental health concerns. NTC and our affiliate health plans have in-depth experience and a long history of meeting the health and social support needs of our members and connecting members to community resources and social services. Our approach to care is based on a population health framework designed to address the needs of our members, including social, behavioral and environmental factors that impact an individual's overall health and well-being. NTC's parent company, Centene Corporation, also has in-depth experience serving the LTSS population including individuals with intellectual and developmental disabilities. Drawing from this experience and expertise coupled with our local knowledge of the market, we will develop and implement a comprehensive training program to ensure staff are equipped to meet the holistic needs of our members.

Below we describe the following:

- A summary of our approach and methods for educating and training health plan staff
- Overview of core topics for our supplemental training on social determinants of health, linking members to community resources and meeting the needs of the LTSS population
- Available resources and tools to support staff training and education
- Processes to assess training effectiveness

Methods for Educating and Training Staff

NTC has a comprehensive program and process in place to ensure all health plan staff, including subcontractors, have training, education and appropriate experience to compete their job functions and responsibilities. Health plan staff participate in a combination of classroom, on-the-job, self-tutorial, preceptor, hands on demonstrations, interactive online modules, and incorporated quizzes to ensure comprehension of content. Departmental experts, such as from Compliance, Long Term Care, HCBS for IDD, Pharmacy, and Care Management, inform the coursework, stressing each department's role in the integrated, member-centric system of care that supports each member. Our training program, includes an initial new employee orientation training and regular ongoing training for all employees. MLTC will be welcome to attend any staff trainings and will be notified of training dates, times and locations no less than 14 days prior to their occurrence.

New Employee Orientation. New employee orientation will be provided locally. The training incorporates a combination of facilitator-led and Computer Based Training (CBT), and covers accessing services; overview of Division of Medicaid and Long Term Care (MLTC), its policies and contract; in-depth review of populations and covered services, including limitations; exclusions and co-payments, where applicable; the member-centric, integrated system of care approach; value-added benefits; advance directives, role and importance of the medical home; EPSDT schedules; NTC website, Member and Provider Portals, and mobile applications and State and Federal requirements specific to individual job functions and NTC operations. After completion of the Nebraska-based Medicaid training, each new employee participates in an extensive CBT program called "Centene 101," which covers a wide variety of topics including the role of key functional areas and operational policies and procedures. In addition, staff 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. As part of our new employee orientation, all staff are required to complete our Cultural Competency Training Program upon hire and annually thereafter. This program is based on the National Standards for Culturally Appropriate Services in Health Care (CLAS Standards). The training reviews daily challenges facing many members such as poverty, Limited English Proficiency (LEP), low

literacy, limited mobility, behavioral health conditions, and lack of shelter, food security, child care and social supports. Health plan staff that interface with members and the community are also **trained on disability sensitivity,** using People First Language.
Our initial training for new staff is comprised of a minimum of four weeks of local in-person instruction, with concurrent shadowing in specific areas of job responsibility. Because staff must demonstrate mastery of information, customer service skills, and understanding of the populations before working independently, some staff may require additional in-field mentoring to acquire the skill and confidence required for the specific responsibilities.
NTC will use Cornerstone, a corporate wide learning management system complete with online courses, to enhance our classroom training. The tutorials provide on-demand, anytime learning, at a pace set by each individual. The Cornerstone technology is flexible and intuitive and will allow NTC to develop our own course content, incorporate videos from external sources, create flexible scheduling including parameters around frequency, duration, and our own required completion dates. In addition, courses may include a real-time assessment with guided corrections as well as post-tests to evaluate staff understanding of course content.
The system provides a variety of management tools and individual employee files containing certificates of completion, all of which aid in maintaining current, individualized educational development plans for staff. Cornerstone will issue notifications of upcoming training to all staff, and provide management with electronic notices to confirm which staff required to participate have in fact participated in the training within the timeframe indicated, along with the results of any related content mastery testing.

Ongoing Training. On an ongoing basis our Trainers will develop and deploy continuing education modules addressing topics such as cultural competency, social determinants of health, new community resources, LTSS, disability awareness, new requirements, and a variety of other topics. At least quarterly, all-staff will participate in on-going trainings based on health plan-wide needs. Additionally, each department will provide ongoing training specific to each department and job function. For example, care management staff participate in post on-boarding training sessions at 30, 60 and 90 day intervals following completion of the initial training. Examples of applicable course content for these post-onboarding training sessions includes caregiving 101, long-term care population management, issues affecting the aged and disabled, Alzheimer's disease and related disorders and Mental Health First Aid. Quarterly, League of Human Dignity will offer an on-site, in person training program for NTC employees on the needs and rights of individuals with disabilities. We will offer the same training to our providers in hopes of increasing the capacity of our physical network to serve individuals with disabilities.

Community Partnerships. We have learned from experience that working with stakeholders as partners is critical to successfully impacting the members we serve. We will work with and seek to partner with officials from Public Health Departments and Disability Advocacy groups to assist with staff training efforts. We will collaborate with the University of Nebraska Medical Center's Munroe-Meyer Institute, the League of Humanity Dignity and the Nebraska Disability Rights Center to provide input on our training curriculum and to participate in our staff trainings on a formal and regular basis. Further, as NTC develops its capacity for effective referrals in the state, we will look for opportunities to deepen relationships, support community-based organizations, such as Community Action Partnership of Western Nebraska, Community Action Partnership of Mid Nebraska and Panhandle Partnership, among others that are effectively serving our members and provide leadership to identify and address service gaps in the community.

Supplemental Training on Social Determinants of Health, Linking Members to Community Resources and Meeting the Needs of the LTSS population

In addition to NTC's standard new employee and on-going training curriculum that includes Cultural Competency and Disability Sensitivity as well as other key topics, we will develop and implement a supplemental training program focused on:

- Understanding the social determinants of health and issues that affect our members;
- Identification of and referrals to available community resources, and
- Understanding and meeting the needs of the LTSS population

NTC recognizes the efforts of Nebraska Centers for Independent Living to protect the right for individuals with disabilities to live independently. NTC staff will refer members to LHD for services such as peer support and counseling, aimed at helping adults below age 65 transition to the least restrictive setting for care. NTC staff serving members in central Nebraska will be able to offer opportunities to utilize services from Independence Rising, such as their driving program, which work well to reduce the transportation barrier for consumers in the large, rural, 39 county service areas.

Social Determinants of Health and Linking Members to Community Resources. To ensure staff are prepared to handle and respond to issues related to housing, education, food, physical and sexual abuse, violence, food security and behavioral health risk and protective factors (referred to broadly as "social determinants"), we will deliver comprehensive training on the social determinants of health to staff. A primary objective of the training is to ensure staff have an understanding of social determinants and the profound way in which they influence health outcomes. Staff will understand the potential for better health outcomes when the member is connected to resources that address their social needs. They will have an understanding of the resources available to make referrals to resources in the community and have clear information on how members seek that support from Care Managers, Member Services Representatives and Member Connections Representatives.

The specific context in which members live and work is critical to effective interaction, referral and support of members enrolled in Heritage Health. Training curriculum will cover Nebraska-specific challenges such as the high rate of alcohol consumption, high incidence of infectious disease, high obesity rates, the state's ranking as 46th in health equity and high rates of poverty. The geography and socio-cultural diversity in the state will also be covered, highlighting unique rural and frontier conditions and access issues related to transportation, healthy food, and health care services, including state-defined practitioner shortage areas and the correct pronunciation of cities, towns, and surnames.

The state's most pressing health disparities will also be covered and awareness of the underlying social determinants will be set as priorities for staff. When studying poverty, trainers will instruct on real conditions in Nebraska such an inability to pay for services, deficient resources for healthcare, food, housing and utilities and the plight of impoverished communities devoid of almost all services and resources, and will support utilization of Division of Child and Family Services Alternative Response project, when appropriate and available. The instruction on sociocultural diversity and specific cultural influences will include racial and ethnic minority populations, Native American populations, and the uniquely high population of refugees, migrants and immigrants. Additionally, details on population aging, caregiver stress and shortages and variations between rural, frontier and urban communities will be covered. From our conversation with the UNMC Center for Reducing Health Disparities, we learned of communities such as Omaha ZIP Code 68111, where gun violence rates are higher than state and national averages and healthy food options and employment opportunities are low. Instruction on the environment will put some focus on specific trends in Nebraska including unsafe community factors (violence, risky behaviors, occupational hazards such as agricultural industry risks, etc.), a lack of services or infrastructure in some communities such as housing, transportation and local employment, and a lack of career or technical education centers. Education content will provide a focus on a lack of culturally and cognitively appropriate and accessible education for all cognitive abilities and for members with disabilities, early childhood health education, healthy eating and activities, reading/literacy and post-secondary training and college preparatory programs in many areas. Disease incidence and health prioritization will cover disease states in priority areas of heart disease, stroke, cancer, diabetes, obesity, high cholesterol and STDs.

To inform our work in this area, we have begun working with various public health officials and health policy leaders. We will maintain ongoing engagement and collaboration with these key stakeholders to

maintain strong knowledge of the most pressing problems and priorities in the state in order to accordingly adjust training content and social service linkages, as appropriate.
Due to the deeply sensitive nature of some material, training will pay special attention to equipping staff with the knowledge and proficiency they need to address all topics fully and directly without projecting any sense of shame or judgement on the members. Behavioral health risk and protective factors vary greatly across the life span and can have deeply personal cultural elements to them. Understanding the broad range of factors that both put a member at risk of behavioral health problems as well as insulate and protect them requires detailed training as they are more complex than other social factors.
The following is an overview of the Social Determinants of Health Training Curriculum. ***See Table Q20.A.***

Supplemental Social Determinants Training Curriculum Table Q20.A

Content Area	Key Topics
Diversity Competencies: CLAS Standards	Review and explore standards (*noted*) most relevant to addressing social determinants of health, member LTSS and I-DD needs ○ **Culturally Competent Care** ***(Care delivery compatible with cultural and linguistic practices; Staffing that reflects the service area; Ongoing training)*** ○ **Language Access Services** ***(Language assistance; Notification of rights; Availability of interpreters; member materials in appropriate languages)*** ○ **Organizational Supports** ***(CLAS strategic plan; Organizational self-assessment; Record of member needs; Demographic profile of community served; Community partnerships; Grievance resolution process; Publication of CLAS progress)***
Diversity Competencies: Poverty	Poverty: the most powerful condition underlying social determinants ○ Types of poverty (generational, working class, situational, immigrant) ○ Discussion of actual conditions and barriers, negating myths such around social mobility, government assistance, access to education, diversity of poverty populations ○ Theories to support poverty population (Strengths Perspective approach, Resiliency Theory, Asset Theory, Social Capital Theory, Faulty Attribution Theory) ○ Learning styles and communication amongst poverty population
Social Determinants in Action	Review of housing, education, nutrition, food security, transportation and employment. ○ In-depth exploration of each and its link to health ○ Review of real examples of health outcome consequences if needs go unmet ○ Two case studies on successful linkages to services ○ Risk and Protective Factors Exist in Multiple Contexts ○ Relationships; Communities; Society ○ Universal, Selective, and Indicated Prevention Interventions ○ Universal - target schools, whole communities, or workplaces ○ Selective – target biological, psychological, or social risk factors more prominent among high-risk groups than among the wider population ○ Indicated - target individuals who show signs of being at risk ○ Serving NTC members and targeting as individuals ○ Guidelines for member interactions and referrals (see also Into Action below) ○ Physical/sexual abuse and violence ○ Many forms and consequences of sexual and physical abuse ○ Identifying abuse ○ Vulnerable populations – children, aged and disabled, ○ Medical and emotional support ○ Documentation, information and referral
Nebraska	• Nebraska's health outcome disparities (RWJF county health rankings), in depth review • Demographics • Sociocultural diversity

	• Geography and culture, distribution of population/services • Nebraska prevalence of homelessness • Nebraska rates of food insecurity • Nebraska key transportation systems and gaps • Nebraska rates of unemployment • Nebraska rates of domestic violence disturbance reporting • Nebraska prevalence of prescription drug and illegal substances abuse
Nebraska Social Service Providers and Community Resources	• What services are available and how to link to them o Resources for finding services in communities o Community Resource Database -community based social service providers o Information on NTC community partnerships o Highlights of local agencies with capacity to serve members o Finding information to refer and for social service agency intake
NTC resources for addressing social determinants and making referrals	• NTC community resource database and screening tool • Roles and responsibilities of health plan staff to make referrals internally • Roles and responsibilities of member services and case management staff to support members in addressing social determinants • Guidelines and process for making and documenting referrals for members systems training
In Action	• Detecting and confirming social situations • Empathetic interpersonal approaches and strategies • Disarming defensiveness and pride • Guidelines for follow-up and addressing resistance of hard to engage members

Meeting the Needs of LTSS Population Supplemental Training Curriculum. NTC will also utilize our LTSS Training curriculum to ensure staff are prepared to meet the needs of the LTSS population, including individuals with intellectual and developmental disabilities and mental health concerns. Below are excerpts from our comprehensive training program that are applicable to meeting the needs of LTSS population. ***See Table Q20.B.***

Supplemental LTSS Training Curriculum Table Q20.B

Content Area	Key Topics
Heritage Health and MLTSS	• Heritage Health overview • Eligible populations • Covered benefits and services • Collaboration with local Service Coordinators
LTSS 101	• LTC eligibility and enrollment overview • LTC benefits overview, including HCBS waiver services and providers • Independence and self-direction • Activities of Daily Living • How to access LTSS for Heritage Health members • NTC's role in coordination of LTSS services and other carved-out benefits • Aging Support and Education • Disability Awareness and Sensitivity • Case studies
Profile and characteristics of LTSS population	• Age, gender, income, education levels • Profile and characteristics of LTSS population • Residential settings for LTSS population
IDD System Overview	• Guardianship rights • Political developments past, present and future • Parallels between the Service Delivery System and the Civil Rights Movement:

	Discussion of political changes and federal requirements in response to the treatment of people with IDD • The evolution of the managed care movement- discussion of the funding system and covered benefits and services both federally and locally.
Approach to Services for IDD population and individuals with disabilities	• Best practices- case studies • Social role of people with IDD in the community • People First Language • Learning the persons language: how to approach people who are categorized as non-verbal or behaviorally complex • Identifying the needs of people we support and finding ways to address those needs • Nutrition and well-being • Polypharmacy • Discharge planning and coordination
The 5 Pathways- Service Delivery	• Overview of 5 Pathways and visions for an integrated life o Behavioral, medical, employment, residential and member directed services o How to determine if an individual requires support in a particular area • Discussion of questions that can be asked to determine if a presenting issue is a behavioral, medical or related to another Pathway such as employment • Solutions to address the needs of the individual based on the individual's presenting symptoms • Overview of the working teams with members who may use a different approach and proper facilitation practices to implement the approach to services

Staff Resources and Tools- Community Resource Database. In addition to formal training, health plan staff will have access to resources such as training manuals, policies and procedures, process flows and job aids and a variety of other tools. The Community Resource Database is an example of a tool designed to help our care management and member services staff, identify, refer, and follow-up with members in need of social, behavioral health or LTSS. To ensure our staff are adept at using these community resources effectively, we will train and educate staff on the array of community services available, the organizations specializing in each type of service, and how to arrange services for the member. Our training curriculum ensures that health plan staff and our provider partners that interface with members are well positioned to provide assistance and facilitate access to community resources and services, including LTSS delivered under fee-for-service. As we add additional community resources to our database, we will conduct refresher training as appropriate and continue working with local stakeholders to expand our offering of training courses, led by external local stakeholders, well versed in the needs and rights of individuals in Nebraska with disabilities.

Processes to Assess Training Effectiveness. All trainings will have evaluation components to measure effect on knowledge, attitude, and behavior and create mechanism for evaluation feedback loop for quality improvement. In addition, staff will receive ongoing, quarterly training on a wide range of topics, including upcoming changes in program practices or inconsistent staff approaches to ensure increased consistency, while being dynamic enough to meet the unique individual needs of each members. NTC will use a wide range of training methods to meet the needs of staff, including in-person and virtual training practices. Supervisors will conduct quarterly audits, including review of assessments, referrals, service plans (e.g., meet unmet need as identified in the assessment and include emergency back-up services), and timeliness of any follow-up or warm hand-off. Supervisors also will ride along with care management staff quarterly, where appropriate, to review their assessment and service planning skills as well as their overall member interactions. NTC will look for successful linkages to community based supports to share with staff internally as mini-case studies to reinforce putting all of its training principles into action for its members in Nebraska.

(2 page limit)
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.

NTC acknowledges that certain services will be carved-out of the managed care contract and will be provided by other providers and organizations. NTC recognizes, however, that although we do not have a financial responsibility, we do have an obligation to ensure coordination for our members of these carved-out services with the services for which NTC is responsible. Consistent with our patient-centered, holistic approach to coordination of care, NTC will assist members with development of goals and determining preferences, and matching these with available service options including services carved out of the managed care contract and educate them on how to access the dental benefit via the Member Handbook and on our website. As with all NTC members, NTC's purpose is to provide high quality, fully integrated and member centered services that encourage improved outcomes for the member. NTC will coordinate with dental providers to ensure good oral health and integration of care for our members. We understand that untreated dental issues can have significant health consequences, particularly for those with chronic illness or who are pregnant.

Coordinating with the DBM. NTC will coordinate with the DBM to manage MLTC covered services with dental services by creating a Memorandum of Understanding (MOU) documenting procedures and coordination of mixed services protocols (e.g. dental anesthesia), and the reciprocal referral processes. Through the MOU, we will facilitate the integration of dental health and provide for the appropriate continuity of care.

Identifying Members for Referral. High priority members for referral to the DBM for co-management will be those members whom:

- Are pregnant with periodontal disease
- Have a chronic or complex condition
- Require or are receiving transplant services
- Are Members with behavioral health and Intellectual and Developmental Disabilities issues
- Have had ED visits for dental pain (likely to present to ED for medication, not treatment)
- Have nutritional deficiencies due to poor dental health

We will identify members for referral to the DBM through Care and Utilization Management staff review or analysis of a variety of information/data sources (***Table Q21***), including:

Sources Used to Identify Members for Referral to DBM Table Q21
Our **Health Risk Screening**, conducted with all new Members within 30 days of enrollment, indicating a need for dental care
Historical claims provided by MLTC at enrollment and ongoing : • EPSDT screenings for age eligible members with identified dental needs • Provider visits with claims related to dental needs • ED admissions data showing dental pain as a reason for the visit • Inpatient claims data showing aspiration or other dental-related needs for age eligible members
Notice of Pregnancy (NOP) for age eligible members with identified dental needs
Provider referrals, including referrals related to dental needs identified during EPSDT screenings, and referrals from dental providers indicating medical needs
Phone or in-person contact from members or family/caregivers requesting a referral for dental services

Reciprocal Referral Process. As part of our coordination with the DBM vendor on development of an MOU, NTC will establish a reciprocal referral process. This process will incorporate a secure email address for each party to use for sending member referrals, which contain protected health information (PHI). It also includes a form with critical elements provided by the referring party. These elements would include, but are not limited to, assessment results that indicate the need for the referred service(s), other health conditions, medications, treating provider information, and assigned Care Manager or other staff who serve as the point of contact for the member's case.
NTC staff will document all referrals to and from the DBM in our TruCare system to ensure and capture the member's care information. Care Management staff will also document follow-up contacts to ensure the member received the services for which we provided or received a referral.

Identifying a Dental Services Liaison.
The Manager of Vendor Relationships will serve as NTC's Dental Services Liaison and assist in developing and implementing the MOU. The Dental Liaison will conduct monthly meetings and document discussions, issues, attendees, action items, and member or provider issues with the DBM.

Outreach and Education
NTC will continually seek to improve member access to primary and preventive care. We will work with the DBM on developing joint education and outreach initiatives, such as the following, to improve member and provider awareness of the importance of accessing dental care:

- Coordinated outreach and education for shared members emphasizing the connection between good oral health and general health
- Co-development of educational materials provided to pregnant mothers
- Co-branding or dual participation in local health fairs
- Joint outreach to PCPs and members, as well as individual outreach by both NTC and the DBM to their respective networks regarding the value of the dental benefit
- Joint education initiatives to members on tobacco cessation with emphasis on how tobacco use in any form increases the risks for gum disease and cancer
- Coordinated effort on EPSDT outreach to help ensure that all EPSDT required screening elements are completed
- Training for NTC Customer Service and Care Management staff to include dental care reminders
- Coordinated reminders to PCPs twice a year to talk to members about the importance of following up with dental referrals as part of their screenings
- Joint protocols for NTC's Customer Service Department for warm transferring to the DBM call center for members who present with dental concerns.

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IV.D ATTACHMENTS

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Organizational Charts have been redacted and are included in the enveolope of redacted Information

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Attachment
Q.18 Job Descriptions

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JOB DESCRIPTION

State Position Title: **Chief Executive Officer**
Health Plan Position Title: Chief Executive Officer
Reports to: Nebraska Total Care Board of Directors

Position Purpose: Plans, directs and has authority for all aspects of the Managed Care Organization's (MCO) operations including achievement of the MLTC Program goals; has overall authority and responsibility for the short- and long-term profitability and growth of Nebraska Total Care.

Knowledge/Experience: Bachelor's degree in health care administration, public administration, business or related field; Master's degree preferred. Five to eight years' senior level HMO experience, preferably as a health plan operating officer and/or chief executive officer; experience managing an HMO offering government services products and working with government agencies. Demonstrated experience and success in strategic planning and development of managed care programs. Successful profit and loss experience in a managed care environment, including provider contracting. Thorough knowledge of Medicaid, Medicare and managed care regulations and best practices.

Competencies: *Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge/Compassionate and Culturally Astute*

Position Responsibilities:

- Oversees the development and execution of all strategic and operating plans, and provide oversight and direction to plan staff to ensure MLTC Program and MCO goals and objectives are achieved
- Oversees administration of day-to-day business activities; plans, directs, prioritizes, and oversees development all of the MCO's operating policies and processes; and ensures full and final compliance with established standards, regulations and Nebraska MLTC contractual requirements
- Represents the health plan at MLTC CEO meetings and discussions
- Directly interfaces with and represents the MCO with key stakeholder groups, community organizations, Members and Providers to ensure Member, Provider and key stakeholder needs are identified and met
- Develops and implements integration models that ensure coordination with system partners; represents the MCO in its relationships with competitors, government agencies, professional societies and similar groups, and major subcontractors to ensure implementation of effective coordination protocols
- Collaborates with the Chief Medical Director, Chief Operating Officer and senior clinical and operational leadership to identify or develop, implement and monitor key performance measures; analyze quality and medical cost drivers/trends, and Member/Provider satisfaction data; identify and reduce disparities in care; identify risks, trends and root causes of issues; and develops and evaluates sound mitigation strategies to ensure continuous improvement in quality of care and service
- Actively participates in internal Quality and Operating Committees, and represents the MCO on key external committees, such as the Administration Simplification Committee and Provider Advisory Committees and Forums
- Ensures the adequacy and soundness of the organization's financial structure and systems, and that working capital requirements are consistently met
- Collaborates with the VP, Network to establish a competitive cost structure and ensures solid Provider relationships are formed

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JOB DESCRIPTION

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

Position Purpose: Provides clinical oversight, expertise, and leadership across functions to ensure delivery of high quality, appropriate, and cost-effective health care to our Members. Oversees/advises the quality improvement, utilization management, care management, disease management, credentialing and other major clinical programs to ensure proper provision of Covered Services to MLTC Program enrollees in support of MLTC goals and established medical policies and procedures.

Knowledge/Experience: Medical Doctor or Doctor of Osteopathy; minimum three years' training in medical specialty and five years of actual clinical practice. Experience working with Medicaid populations is required, including treating or managing care for culturally diverse populations understanding and applying care, disease, and utilization management principles across multiple specialties and disciplines. Five or more years' previous experience as a Medicaid managed care Medical Director is preferred, as well as the ability to influence physician/provider behavior to promote quality and efficiency in health care. Knowledge of quality accreditation standards and a Master's degree in Business Administration, Public Health, Healthcare Administration or related field preferred.

Licenses/Certifications: Board certified in Family Practice, Internal Medicine, or other specialty recognized by the American Board of Medical Specialists; current unencumbered Nebraska medical license and Nebraska Drug Enforcement Agency Certificate

Competencies: *Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge/Compassionate and Culturally Astute*

Position Responsibilities:

- Has day-to-day responsibility for the MCOs Quality Assessment and Performance Improvement (QAPI) Program, including identifying trends and gaps in care; evaluating and improving MLTC services; and preparing and presenting/submitting all QAPI and other clinical program reports to the Board of Directors and MLTC
- Provides leadership and expertise in the development, implementation and consistent interpretation and application of service authorization and clinical review criteria/guidelines; as well as quality-related policies (such as credentialing, grievance/appeals, etc.)
- Performs medical review activities pertaining to prior authorization, precertification, concurrent review, appeals, and complex, controversial, or experimental medical services; issues all denials or reductions of services
- Oversees monitoring of provider performance against evidence-based practices, reviews all quality of care issues, and implements/monitors corrective action plans as necessary. Directs/oversees methods to detect/address potential under, over and inappropriate utilization of services
- Provides clinical leadership in development of innovative Provider partnership approaches, including
- Value Based Purchasing contracting arrangements, innovative payment solutions, and promotion and support of Patient Centered Medical Homes
- Chairs/co-chairs the Quality Assurance and Performance Improvement and Clinical Advisory Committees, as well as leading other Quality Committees such as the Utilization Management, Provider Advisory, and Credentialing Committees; represents the MCO at every Quality meeting with MLTC and other system partners, and as requested by MLTC, including the annual Quality Committee meeting

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JOB DESCRIPTION

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

Position Purpose: Oversight and responsibility for all behavioral health (BH) clinical programs/activities. Direct/oversee BH clinical initiatives and programs to ensure processes are consistent with NCQA Standards, as well as MLTC mandates and contract requirements. Provide BH expertise to the MCO's medical management team and take an active role in clinical and policy decisions to ensure the effective integration of BH and physical health services.

Knowledge/Experience: Currently practicing psychiatrist or clinical psychologist. Must have a minimum of 5 years' combined clinical experience in mental health and substance use disorder services and be knowledgeable about primary care/BH integration. Experience and expertise working with the Medicaid population is required. Previous Medicaid managed care experience preferred, including treating/managing culturally diverse populations.

Licenses/Certifications: Board certification in psychiatry or PhD in Clinical Psychology. Current Nebraska license without restrictions

Competencies: *Critical Thinking/Execution, Adaptability/Flexibility, Communication and Relationship Development, Technical and Professional Knowledge, Compassionate and Culturally Astute*

Position Responsibilities:

- Provides leadership and BH expertise in the development, implementation and interpretation of BH clinical policies, criteria and guidelines; as well as BH quality policies that promote recovery and positive health outcomes, and ensure compliance with parity regulations
- Performs medical review activities pertaining to prior authorization; precertification; concurrent and retrospective review; appeals; and complex, controversial, or experimental, unusual or new BH services in order to determine medical necessity and appropriate payment. Issues all adverse determinations related to BH services
- Plans and establishes goals and policies to improve quality and cost- effectiveness of BH care and services for Members. Serves as BH clinical advisor to all MCO clinical programs and staff, and provides BH expertise in the operation of QI and UM programs in accordance with MLTC, regulatory, State, accreditation, and corporate policy requirements
- Participates in and provides BH expertise to all Quality Committees; chairs the BH Advisory Committee and participates in the MLTC BH Health Integration Advisory Committee
- Provides input into development of care, utilization and disease management programs to ensure appropriate integration of BH and PH services and collaboration between PH and BH providers. Directs development of comprehensive care and disease management programs for youth and adults with BH concerns typically treated by PCPs, such as ADHD and depression
- Provides clinical consultations and guidance to contracted PCPs treating BH-related concerns not requiring referral to BH specialists. Develops and oversees targeted education and training for PCPs that commonly encounter BH issues
- Oversees, monitors, and assists with the management of psychopharmacology pharmacy benefit, including the establishment of prior authorization clinical appropriateness of use, and step therapy requirements for the use of stimulants/antipsychotics for all Members < 18
- Oversees monitoring of BH Provider performance against evidence-based practices, reviews all BH quality of care issues, and implements corrective action plans as necessary; directs and oversees methods to detect/address potential under, over and inappropriate utilization of BH

JOB DESCRIPTION

State Position Title: Behavioral Health Manager
Position Title: Director, Behavioral Health Integration
Reporting Relationship: Chief Executive Officer

Position Purpose: Leadership position overseeing the integration and delivery of behavioral health services across all MCO operations and functional areas. Ensures MCO initiatives and performance are holistic, person-centered and recovery-oriented. Position is responsible for collaboration and coordination across departments, and supporting collaboration with external stakeholders.

Knowledge/Experience: Master's or Doctoral degree in a behavioral health field. Five to seven years of related experience in behavioral health utilization management, case management or clinical supervision experience in a behavioral health setting.

Licenses/Certifications: A behavioral health professional, such as a psychologist (PhD), psychiatrist (MD), social worker (LCSW), psychiatric nurse (RN), marriage and family therapist (LMFT), or mental health counselor licensed (i.e., LPC) in the State of Nebraska. .

Competencies: Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge, Culturally Astute.

Position Responsibilities:

- Ensures the health plan's behavioral health operations, providers, and any subcontractors are in compliance with the terms the contract
- Coordinates behavioral health care in all areas of the health plan, including quality management, utilization management, network development and management, provider services, member outreach and education, member services, contract compliance, and reporting
- Participates in the Behavioral Health Advisory Committee and other Quality Committees to facilitate total behavioral health integration within the health plan
- Strategically plans for Nebraska-specific infrastructure needs, innovative interventions and resource allocation for behavioral health services and to enhance integration
- Participates in developing clinical initiatives that target priorities for mental health and substance use disorder prevention, early intervention and treatment that is in line with State agency goals and programmatic needs based on data analysis.
- Monitors care management, utilization management and disease management programs to ensure appropriate behavioral health metrics are in place to measure effectiveness and deliver positive outcomes
- Develops the behavioral health component of integrated program descriptions, develops specific behavioral health program descriptions and evaluates programs to meet established guidelines
- Ensures behavioral health and integrated clinical initiatives are consistent with URAC, NCQA and State mandates
- Interfaces across various business units and corporate departments to ensure effective processes and communication strategies are utilized
- Collaborates with external stakeholders including, but not limited to: schools, Providers, Federally Qualified Health Centers, Community Mental Health Centers, the Regional Behavioral Health Authorities, Division of Medicaid and Long-term Care, Department of Behavioral Health, Department of Children and Family Services and Office of Juvenile Services to ensure appropriateness of programming and initiatives

JOB DESCRIPTION

State Position Title: **Chief Operating Officer (COO)**
Position Title: Chief Operating Officer (COO)
Reporting Relationship: Chief Executive Officer

Position Purpose: Develops, implements and oversees business processes required to deliver high-quality service to Members, Providers, and State agencies. Ensures MLTC performance standards are achieved, and contractual/regulatory requirements are met.

Knowledge/Experience: Bachelor's degree in health care administration, public administration, business or related field; Master's degree preferred. A minimum of five years' senior level HMO experience, preferably as a health plan operating officer and/or chief executive officer; experience in claims/customer service operations as well as contract acquisition and operations management required. Experience working with Medicaid populations is required, as well as a thorough knowledge of Medicaid, Medicare and managed care regulations and best practices.

Licensure/Certifications. None required.

Competencies: *Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge, Culturally Competent*

Position Responsibilities:

- Serves as a key contact for MLTC operational issues
- Plans/directs, and oversees day-to-day operations of the health plan Network Development/Contracting, Member Services, Provider Services, Marketing and Community Outreach functions, ensuring performance measures and MLTC and Federal Requirements are met; oversees and collaborates with corporate staff (Sr. Director, Encounters,; Vice President, Information Technology, and Emergency Response and Business Continuity Specialist) to ensure all MLTC standards and requirements related to Information Technology, Claims Processing, Encounter Processing and Submission, and Emergency Response and Business Continuity are met
- Actively engages in, and provides support for, health plan implementation activities
- Works directly with corporate Claims staff to resolve Provider or Member issues/concerns related to claims payment
- Develops and implements strategic and tactical plans to ensure further health plan growth and development and ensure positive financial results; oversees development and execution of operating plans and achievement of goals for functional areas of accountability
- Monitors claims, encounter submission and call center metrics to ensure performance goals are achieved; establishes criteria for measuring and assessing the success/performance of each functional area
- In collaboration with the Vice President, Compliance, oversees and ensures required reports related to areas of accountability are prepared and timely submitted to MLTC and regulatory agencies. Actively participates in Program Integrity discussions with the Nebraska Medicaid Program Integrity Unit
- Actively participates on a number of Quality Committees including, but not limited to the QAPIC, Performance Improvement Team, and Provider and Member Advisory Committees. Oversees implementation of committee directives related to areas of accountability
- Represents health plan to key stakeholders as required and requested. Takes business action based on impact and responds to customer service issues that require management intervention ensuring expectations are met or exceeded

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JOB DESCRIPTION

State Position Title: **Chief Financial Officer**
Health Plan Position Title: Vice President, Finance
Reporting Relationship: Chief Executive Officer

Position Purpose: Provides leadership and oversight of all aspects of finance for the health plan, including budget, accounting systems, financial reporting and auditing activities.

Knowledge/Experience: Bachelor's degree in Finance, Accounting, Economics, Business Administration or equivalent; Master's degree preferred. Minimum of five years' experience in a senior level finance position in the healthcare or insurance industry required; Medicaid managed care experience preferred. Experience working with Medicaid populations required.

License/Certificates: CPA preferred.

Competencies: *Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge, Culturally Competent.*

Position Responsibilities:

- Oversees all health plan finance related activities, including developing and monitoring progress against the annual budget, and staff and resource planning
- Establishes financial strategic vision, objectives, policies and procedures in support of the overall strategic plan
- Ensures accuracy and timely submission of all financial reports to MLTC and other regulatory bodies.
- Oversees revenue reconciliation activities and reports discrepancies to MLTC
- Conducts financial analysis, identification of month end financial drivers, and forecasting
- Identifies medical cost trends and leads/directs medical cost improvement initiatives
- Reviews health plan monthly performance and financial results and provides performance improvement recommendations to senior/executive management
- Coordinates internal and external audit activities ensuring state requirements and accuracy tests are performed and met
- Oversees and validates pricing models and coordinates, as necessary, with Centene and MLTC actuaries
- Directs health plan analytics activities and coordinates corresponding reporting strategies
- Participates in Quality Committees and/or workgroups, as necessary, to ensure all contract requirements are met and to support the MLTC Goals and Objectives

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JOB DESCRIPTION

State Position Title: **Program Integrity Officer**
Health Plan Position Title: Vice President, Compliance
Reports to: Chief Executive Officer

Position Purpose: Administers and oversees health plan Compliance and Fraud and Abuse Programs, including HIPAA oversight and fraud, waste and abuse investigation. Develops and implements appropriate compliance policies, procedures and training; and assesses progress and reports key results and the status of initiatives to senior management.

Knowledge/Experience: Bachelor's degree in Public Policy, Government Affairs, Business Administration or related field (Master's/Law degree preferred). Minimum of eight years of compliance program management and contract experience in health care and/or risk management required. Extensive knowledge of and experience with state/federal insurance, managed care, HIPAA, Third Party Administration (TPA), credentialing, provider contracting, prompt pay, and program integrity laws and regulations; as well as knowledge of Federal rules on fraud and special investigations and reporting required. Experience with state and federal government agencies, accreditation bodies, Medicaid populations also required.

Competencies: *Critical Thinking/Execution, Adaptability/Flexibility, Communication/ Relationship Development, Technical and Professional Knowledge, Culturally Astute*

Position Responsibilities:

- Monitors health plan compliance with all Contract requirements, and State and federal laws, regulations, rules and requirements; develops or oversees development of policies and procedures to ensure compliance with same. Chairs the Compliance Committee
- Plans, directs and oversees all Compliance and Fraud, Waste and Abuse (FWA), Erroneous Payment and HIPAA Compliance Program activities (including monitoring and enforcement) pursuant to State and Federal laws, rules and regulations; ensures timely, consistent notification/reporting of incidents Serves as the health plan Privacy Officer and primary liaison with MLTC regarding Compliance Program and related matters. Reports to the Board of Directors on Compliance and FWA issues
- Develops/oversees methods for prevention, detection and reporting incidents of potential FWA and erroneous payments
- Develops policies and procedures, investigates unusual incidents, and designs/implements any resulting corrective action plans
- Oversees and collaborates with Centene's Special Investigative Unit (SIU) on all MLTC, State and federal investigations, including those regarding FWA. Oversees/coordinates with the SIU and local FWA Investigators on all investigations and communications with the State's Medicaid Fraud Control Unit, ensuring accurate and timely issue notification. Reviews records and refers suspected Member FWA to MLTC and other duly authorized enforcement agencies
- Oversees/coordinates health plan reporting to MLTC, State and federal entities; and oversees compliance with the timeliness, accuracy, and completeness of reports and data submissions
- Conducts and/or participates in health plan and subcontractor compliance audits and oversees the implementation of CAPs when indicated; reports progress on CAPs to senior management and the Board of Directors
- Monitors/tracks laws, regulations, Contract amendments, and Program metrics to ensure ongoing compliance. Advises management/staff on impact of changes; identifies the need for new P&Ps where necessary, and guides/trains staff on implementing new requirements
- Oversees staff Compliance training and education
- Maintains all Compliance records

nebraska total care

JOB DESCRIPTION

State Position Title: **Grievance System Manager**
Health Plan Position Title: Manager, Grievance & Appeals
Reporting Relationship: Director, Quality Improvement

Position Purpose: Ensures appropriate processing of Member Grievances and Appeals (G&A), Provider appeals, or requests for a State Fair Hearing. Performs duties as the point of contact with the State for G&As. Oversees the Grievance & Appeals Coordinators.

Knowledge/Experience: Bachelor's degree in related field or equivalent experience. Minimum of three plus years' experience in healthcare or managed care required; experience in healthcare law or Grievances and Appeals preferred. Previous experience as a functional area lead, managing cross functional teams or supervisory experience required including hiring, training, assigning work and managing staff performance. Experience working with Medicaid populations is required.

License/Certifications. None required.

Competencies: *Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge, Cultural Competency*

Position Responsibilities:

- Manages/adjudicates Member grievances, appeals and requests for Fair Hearings; and manages/ adjudicates Provider Grievances and Appeals (both administrative and medical necessity appeals) according to mandated timeframes and other contractual/legal requirements
- Monitors Member G&As and Provider Appeals and provides senior management with monthly reporting on trends. Actively monitors and investigates trends and works with health plan staff to develop and implement Corrective Action Plans to address identified issues and prevent recurrences
- Performs G&A file audits to ensure all documentation is present and all adjudication timeframes are in compliance with contractual, legal and regulatory requirements
- Integrates federal and state law changes related to G&As into the health plan's policies, procedures and compliance system
- Assists Provider Engagement Representatives in educating Providers on the correct procedures for preparing and submitting Provider Appeals

nebraska total care

JOB DESCRIPTION

State Position Title: **Business Continuity Planning and Emergency Coordinator**
Health Plan Position Title: Emergency Response & Business Continuity Specialist
Reporting Relationship: Centene Chief Information Officer

Position Purpose: The single point of contact to coordinate response and recovery of business functions in the event of a disaster, power outage or other event that causes a significant disruption in service delivery or business operations.

Knowledge/Experience: Bachelor's degree required in related field or equivalent experience; Master's degree preferred. Minimum of five years related experience including at least three years in a public sector Managed Care setting; at least three years' experience working with first responder organizations and agencies required. Familiarity with federal, State, regional, and local resources **preferred.**

License/Certifications. None required

Competencies: *Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge, Sense of Urgency, Ability to Act under Pressure*

Position Responsibilities:

- Facilitates the development and maintenance of a Business Continuity and Recovery Plan and emergency response to manage unexpected events that may negatively and significantly impact operations
- Conducts local disaster recovery readiness testing on a regular basis and oversees its monitoring to identify and remediate gaps or failures as well as to identify strengths. Actively participates in the annual testing of Centene's Business Continuity and Recovery Plan
- Develops and maintains relationships with all regional and local community emergency service providers throughout the counties served to foster collaborative Disaster Preparedness planning and resource sharing. Participates in all local community disaster preparedness meetings and efforts.
- Manages/oversees health plan emergency management plan/response during critical incidents, including incidents in any county served under Contract. Collaborates with health plan staff to ensure continuity of benefits and services for Members, including those evacuated out of their service area
- Provides 24/7 availability during high profile situations and assists with on-call responsibilities as required. Proactively mobilizes staff, as necessary, to respond to disasters or power outages.
- Assists local community efforts to safeguard Members and therapeutically address any trauma associated with critical events.
- Provides relevant resource materials including Business Continuity and Disaster Recovery Plans at all health plan office locations, as well as at network provider locations.
- Consults in the design and delivery of training to key staff regarding the Business Continuity and Recovery Plan and the Plan's emergency response.

nebraska total care

JOB DESCRIPTION

State Position Title: **Contract Compliance Coordinator**
Position Title: Manager, Compliance and Reporting
Reporting Relationship: Vice President, Compliance

Position Purpose: Primary contact with MLTC on all Contract Compliance issues. Designs and implements programs, policies and practices to ensure compliance with all MLTC, State, federal, legal and regulatory requirements.

Knowledge/Experience: Bachelor's degree in related field. Minimum of four years of compliance/regulatory experience in a health care and/or managed care setting. Previous experience as a functional area lead managing cross functional teams, or supervisory experience including hiring, training, assigning work and managing the performance of staff is required. Expertise working with the Medicaid population is required.

Licensure/Certifications. None required.

Competencies: *Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge, Culturally Competent.*

Position Responsibilities:

- Oversees implementation of day-to-day health plan policies and procedures to ensure MLTC, federal, State, and regulatory compliance
- Validates MLTC, State and federal deliverable reports for completeness and ensures timely submission to appropriate agencies; oversees the process for ensuring accuracy of all submissions and obtaining necessary certifications. Tracks the submission of all Contract deliverables
- Reviews and analyzes health plan reporting deliverables and data to identify trends in performance and opportunities for improvement
- Ensures timely, accurate and appropriate submission of all State licensure and regulatory filings
- Acts as a resource to all health plan staff related to Contract and reporting requirements and compliance with contractual and regulatory requirements
- Acts as a resource for State and/or federal regulatory agencies in response to inquiries and requests for information. Interacts with Centene Compliance and Special Investigative Unit staff related to fraud and abuse issues
- Conducts oversight audits of health plan procedures and processes to ensure compliance with contractual and regulatory requirements. Coordinates ad hoc regulatory visits
- Coordinates with Vendor Oversight Manager on applicable oversight activities and initiatives
- Conducts/manages Compliance training programs for all health plan staff as required by contract and applicable regulatory requirements. Provides guidance to staff regarding compliance issues and implementation of new contractual and regulatory requirements
- Attends and participates in Compliance Committee meetings
- Oversees the Compliance Analyst; coordinates preparation for meeting and executing contract requirements
- Investigates unusual incidents and/or areas of non-compliance and implements corrective action plans where necessary

nebraska total care

JOB DESCRIPTION

State Position Title: **Quality Management** (QM) Coordinator
Health Plan Position Title: Director, Quality Improvement
Reporting Relationship: Chief Medical Officer

Position Purpose: Ensure systemic and individual quality of care and plan, direct and oversee processes that integrate Quality throughout the organization. Lead/direct the identification and implementation of process improvements throughout the organization.

Knowledge/Experience: Must be a licensed registered nurse, physician or physician's assistant (PA); 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. Familiarity and experience with the elements of 42 CFR Part 438, Subpart D required. Minimum of five years' experience in healthcare quality management and improvement managing a Quality Management/Improvement function in a Medicaid environment required. Master's Degree and Lean Six-Sigma training preferred.

License/Certificates: Current Nebraska Registered Nurse, physician or MD or PA License. CPHQ or CHCQM required.

Competencies: *Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge, Culturally Competent*

Position Responsibilities:

- Facilitates the Quality Assessment and Performance Improvement (QAPI) Program Annual Evaluation and oversees development of the Annual Work Plan and resulting revisions to the QAPI Program Description
- Oversees identification of clinical/service performance improvement opportunities and resulting development of Performance Improvement Projects (PIPs) that address opportunities
- Tracks and presents results of health plan quality improvement efforts, PIPs, Member outcomes, and health plan performance on key Quality measures, such as HEDIS, to senior management, the Performance Improvement Team (PIT) and Quality Assurance and Performance Improvement Committee (QAPI)
- Oversees HEDIS and other performance measure data collection, audit, analysis and reporting processes, including the development of methodologies to increase member compliance and improve Provider reporting mechanisms
- Plans/directs/oversees plan-wide activities to pursue/retain National Committee for Quality Assurance (NCQA) Accreditation
- Facilitates plan-wide preparation for the External Quality Review Organization review
- Serves as an active member of the QAPIC; chairs the PIT; and serves as a member/ad hoc member on other quality committees. Oversees the Performance and Quality Improvement Coordinator
- Tracks and trends quality of care grievances and concerns and facilitates resolution
- Oversees the credentialing process to ensure a network of credentialed providers

nebraska total care

JOB DESCRIPTION

State Position Title:	**Performance and Quality Improvement Coordinator**
Health Plan Position Title:	Performance and Quality Improvement Coordinator
Reports to:	Director, Quality Improvement

Position Purpose: Lead and focus organizational efforts on the improvement of clinical quality performance.

Knowledge/Experience: Bachelor's Degree in Nursing or other clinical degree, plus CPHQ or CHCQM certification or comparable experience and education in data and outcomes measurement as described in 42 CFR 438.200-438.242. A minimum of five years of experience in healthcare quality, including relevant experience with Medicaid populations required; and Master's Degree preferred.

License/Certificates: Nebraska Registered Nurse Licensure, and/or CPHQ or CHCQM certification preferred.

Competencies: *Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge, Cultural Competency.*

Position Responsibilities:

- Serves as the MLTC's primary health plan contact person for performance on quality measures.
- Supports the Director, Quality Improvement (QI) identifying and implementing process improvements throughout the organization designed to improve clinical quality performance
- Focuses and controls activities, methods, and procedures to achieve improvement in clinical quality performance
- Utilizes data to develop targeted intervention strategies to improve outcomes
- Collaborates with the Director, QI to identify opportunities for clinical quality outcomes, and implement performance improvement projects, internally and with other MCOs
- In conjunction with the Director, QI, presents results of improvement efforts and ongoing performance on Quality measures to MLTC and senior management
- Participates in the QAPIC and other Quality committees, and attends/participates in external MLTC Quality meetings
- Formulates and establishes Quality policies, operating procedures, and goals in compliance with internal and external accreditation and regulatory guidelines
- Supports the Director, QI in the HEDIS reporting and EQRO Audit processes
- Supports the Director, QI in plan-wide activities to pursue/retain NCQA Accreditation status
- Supports the Director, QI in conducting the Annual QAPI Program Evaluation and Annual Workplan development
- Researches and incorporates clinical quality best practices into operations

nebraska total care.

JOB DESCRIPTION

State Position Title:	**Maternal Child Health (MCH)/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coordinator**
Health Plan Position Title:	Supervisor, Maternal Health/EPSDT/Child Care Management
Reporting Relationship:	Director, Care Management

Position Purpose: Conduct and manage the day-to-day operations associated with maternity, EPSDT and Child care management functions.

Knowledge/Experience: Master's degree in health services, public health, health care administration or other related field required or be a CPHQ or CHCQM. A minimum of three years of maternity and/or pediatric care management experience with Medicaid populations required. In addition, a thorough knowledge of care and/or utilization management and clinical practices and familiarity with Medicaid managed care policies, practices and regulations is required.

Licenses/Certifications: Must be a current Nebraska-licensed registered nurse, MD or physician assistant; CPHQ/ CHCQM certification preferred.

Competencies: *Critical Thinking/Execution, Adaptability/Flexibility, Communication and Relationship Development, Technical and Professional Knowledge, Culturally Competent*

Position Responsibilities:

- Designs and implements programs to ensure all child Members receive necessary EPSDT services
- Identifies and coordinates assistance for identified member needs specific to maternal/child health and EPSDT
- Ensures that all pregnant women are identified, assessed and stratified to identify any risk factors that may impact their pregnancy
- Plans, directs and oversees care management for high-risk pregnant members. Ensures any barriers to care are identified and resolved. Works with providers and other staff to ensure timely prenatal and postpartum services are delivered to all pregnant members
- Promotes family planning services and preventive health care strategies
- Ensures staffing is sufficient to meet quality and performance measurement goals
- Participates on the Performance Improvement Team (PIT) and other Quality Committees as required
- Develops, implements and maintains compliance with policies and procedures related to Maternal/Child health and EPSDT services
- Facilitates ongoing communication and coordination between care management staff and Members, contracted providers, community partners and subsidiary subcontractors to ensure the timely delivery of comprehensive Maternal/Child and EPSDT services
- Develops staff skills and competencies through initial and ongoing training
- Oversee the delivery of comprehensive community-based member education related to prenatal, postpartum and EPSDT services, including improving member understanding of health plan pregnancy management and EPSDT programs

nebraska total care

JOB DESCRIPTION

State Position Title:	Medical Management Coordinator
Health Plan Position Title:	Vice President, Medical Management
Reports to:	Chief Executive Officer

Position Purpose: Directs and coordinates the care coordination, case management, disease management, and utilization management functions for the health plan based on, and in support of the company's strategic plan and State goals and Program requirements. Establishes the Medical Management strategic vision and related policies and procedures.

Knowledge/Experience: Registered Nurse, physician or physician's assistant; advanced education in nursing, health care, business or public administration preferred. Ten + years of clinical nursing and/or experience in utilization management, case management, quality improvement in a managed care setting. Thorough knowledge of quality improvement practices. Experience with Medicaid, CHIP, managed care, and culturally diverse and/or medically needy populations required. Familiarity with medical information systems, medical claims payment process, medical terminology and coding, and National Committee for Quality Assurance (NCQA) accreditation process and standards.

Licenses/Certifications: Current Nebraska licensed Registered Nurse, Physician or Physician's Assistant.

Competencies: *Critical Thinking/Execution, Adaptability/Flexibility, Communication and Relationship Development, Technical and Professional Knowledge/Compassionate and Culturally Astute, Culturally Competent.*

Position Responsibilities:

- Plans, directs and oversees the provision of care coordination, case management, disease management, and utilization management functions
- Ensures staff adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria
- Monitors prior authorization functions and ensures that decisions are made in a consistent manner, based on clinical criteria, and meet timeliness standards
- Ensures the completion of appropriate concurrent review/discharge planning of inpatient stays.
- Participates in Appeals and Grievance investigations as necessary
- Monitors, analyzes, and implements appropriate interventions based on utilization data, including identifying and correcting over-, under-, or inappropriate utilization of services
- Actively oversees and participates in the development of the UM Workplan
- Determines and monitors staffing to ensure service standards are consistently met
- Reviews analyses of activities, costs, operations and forecast data to determine department progress toward stated goals and objectives; tracks and reports all MLTC and Plan metrics
- Actively engages in and supports Value Based Purchasing and Medical Home initiatives, as well as Provider education and contracting
- Actively participates in medical management auditing processes, including inter-rater reliability audits, and oversees implementation of appropriate corrective action
- Participates in the Utilization Management, QAPIC, Clinical Advisory, Provider Advisory and other Quality Committees; attends all MLTC meetings related to accountable functions
- Ensures compliance with MLTC, NCQA, State and federal standards and regulations

nebraska total care

JOB DESCRIPTION

State Position Title: **Provider Services Manager**
Health Plan Position Title: Director, Provider Engagement
Reporting Relationship: VP, Network Development and Contracting

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Position Purpose: Direct Provider Engagement and training activities to support network Providers, enhance health plan-MCO Provider communication strategies, and improve Provider satisfaction.

Knowledge/Experience: Bachelor's degree in a Business Administration, Healthcare Administration, related field or equivalent experience. Minimum of seven years of experience in managed care or insurance industry provider relations and/or contracting functions; experience with Medicaid managed care required. Previous management experience required, including responsibilities for hiring, training, assigning work and managing staff performance.

Competencies: *Critical Thinking/Execution, Adaptability/Flexibility, Communication and Relationship Development, Technical and Professional Knowledge, Culturally Competent.*

Licenses/Certifications: None required.

Position Responsibilities:

- Oversees the Provider Engagement function, including supervising and directing Providers Engagement Representatives and liaisons; ensures compliance with relevant company policies and standards, and well as contractual and regulatory requirements
- Actively participates in the Provider Advisory Committee, Performance Improvement Team (PIT) and other Quality committees. Collaborates with the Provider Advisory Committee to establish methodologies for identifying and responding to Provider concerns and implements interventions necessary to address and solve
- Plans, develops and implements the health plan's Provider engagement strategy, including frequency and type of Provider contact and communication, ensuring the enhancement of communication strategies
- Plans, directs and monitors all Provider Engagement Representative activities to ensure the appropriate frequency and quality of Provider contact, communication and engagement
- Oversees the development and execution of Provider training in response to identified needs or changes in protocols, processes or forms
- Supports the credentialing function by ensuring required paperwork is gathered to ensure credentialing and Provider setup occurs timely
- Develops Provider Forum Agendas and attends the quarterly meetings throughout the State to educate on current policies/procedures or upcoming changes
- Actively participates in the MLTC Administrative Simplification Committee; develops policies and procedures designed to reduce administrative burden
- Actively works with the Manager, Vendor Oversight to coordinate communications between the plan and subcontractors
- Notifies MLTC of correspondence sent to Providers for informational and training purposes
- Collaborates with and supports the Provider Performance Management staff by ensuring Provider Engagement staff deliver and explain Provider performance reports, and provide recommendations for how Providers can improve their performance

nebraska total care

JOB DESCRIPTION

State Position Title: **Member Services Manager**
Health Plan Position Title: Director, Member and Provider Services
Reports to: Chief Operating Officer (COO)

Position Purpose: Directs and oversees the planning, development and operation of the Customer Service function and assists in formulating and administrating related organizational policies and procedures in a culturally competent manner.

Knowledge/Experience: Bachelors' degree in healthcare, business or related field, or equivalent experience. Minimum of seven years of experience in a Customer/Member Services function required; management experience also required, preferably in a healthcare or insurance environment. Experience working with Medicaid populations and knowledge of applicable technologies, laws, regulations and industry practices required.

Competencies: *Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge, Culturally Competent.*

Position Responsibilities:

- Oversees coordination of all non-clinical communication between the health plan, its Members and Providers
- Directs and oversees the day-to-day activities of the Member and Provider services functions and staff, ensuring compliance with applicable policies, procedures, and contractual/regulatory requirements, including HIPAA
- Ensures appropriate staffing levels and sufficient culturally and linguistically appropriate services to enable Members to receive prompt resolution to inquiries/concerns and appropriate education about the Medicaid managed care program. Monitors performance metrics to ensure a high degree of compliance with internal and MLTC call center standards
- Ensures Customer Service Representatives are accountable, reliable, compassionate, patient and knowledgeable in order to promote and accomplish a high level of Member and Provider satisfaction; oversees call quality and other audit programs to ensure continuous quality improvement in Member and Provider Services
- Assists in the formulation and development of strategies and oversees the implementation of all major Member and Provider communication and support initiatives such as the Call Center, Portal, new orientation and ongoing education, satisfaction initiatives, and the development, approval, and distribution of materials
- Oversees and manages Member enrollment and disenrollment of Members between the State and the enrollment broker
- Represents the Member/Customer Service function on the Performance Improvement Team and other Quality Committees. Participates in the Member and Provider Advisory Committees, incorporates feedback into operational changes as appropriate
- Collaborates closely with the Quality Improvement and other department and health plan staff to analyze Member and Provider satisfaction data and implement interventions to improve satisfaction.
- Plans, directs and oversees all processes for referring and transferring calls to the nurse advice line, as well as Care Management and behavioral health staff as necessary
- Works with internal and external stakeholders to develop and implement culturally competent Customer Service training and training materials

nebraska total care

JOB DESCRIPTION

State Position Title: **Claims Administrator**
Health Plan Position Title: Sr. Vice President, Claims Operations
Reports to: Centene Executive Vice President, Operations and CIO

Position Purpose: Oversees the Claims Processing function, establishing and coordinating overall policy and goals; and ensuring accurate, timely and complete claim processing, payment and reporting within MLTC, State and federal requirements and Company goals.

Knowledge/Experience: Bachelor's degree in related field, advanced degree preferred. Ten plus years of experience in overseeing and developing claims operations required with experience in a Medicaid environment. Minimum five years of management experience required.

Competencies: *Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge, Culturally Competent*

Position Responsibilities:

- Develops, implements, and administers a comprehensive Nebraska Medicaid Managed Care claims processing system and function capable of paying claims in accordance with MLTC, State and federal requirements, while meeting or exceeding the terms of the MLTC contract, including claims processing timelines
- Plans, directs and oversees/coordinates cost avoidance and recovery processes
- Coordinates and supports the MLTC encounter reporting process, achieving MLTC requirements
- Monitors performance metrics for quality, accuracy, and timeliness of claims adjudication, adjustment, and payment. Achieves and maintains performance against all claims processing and expense standards, including minimization of claims recoupments
- Plans, directs and oversees all processes that achieve administrative simplification
- Assists and supports the Provider Engagement Department with Provider claims payment issues and concerns; meets with key Provider groups, when necessary, to discuss claims processing and/or address issues
- Ensures reporting required by Contract and State and federal law is accurate and timely.
- Ensures Claims Department participation in all Provider Forums
- Designs and implements change initiatives to address future-oriented business needs
- Creates effective organizational structure, roles and job accountabilities, and ensures ongoing training and development of staff
- Provides leadership to the Claims Operations team and develops leadership capacity in others
- Coordinates and communicates the work function's activities with other departmental functions
- Reviews analyses of activities, costs, operations and forecasts data to determine and project progress toward stated goals and objectives
- Responds to customer service issues that require management intervention
- Ensures all customer service functions of the department meet or exceed State and health plan expectations

nebraska total care.

JOB DESCRIPTION

State Position Title: **Provider Claims Educator**
Health Plan Position Title: Provider Claims Educator
Reports to: Director, Provider Engagement

Position Purpose: Facilitates Provider education on the health plan's claims submission and processing policies, procedures and systems; trains providers on internal systems and, through orientation and coaching, increases claims submission accuracy, claims processing performance improvement, and promotes Provider satisfaction.

Knowledge/Experience: Bachelor's degree in healthcare field preferred. Minimum of five years of management and supervisory experience in the health care field required, with experience in Provider Relations or Provider Services, particularly in a Medicaid managed care or insurance environment. Knowledge of grievance/appeals, claim processing and provider service systems required. Claims billing/coding knowledge preferred.

Competencies: *Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge, Cultural Competency*

Position Responsibilities:

- Educates network and non-network providers regarding billing and claims submission requirements, coding updates, EDI interfaces (such as electronic claims submission and electronic funds transfer), and available health plan resources (such as Provider manuals, the Provider Portal, Provider training materials, and fee schedules)
- Communicates/engages frequently with Providers (telephonic and onsite) to ensure the effective exchange of information and to obtain feedback regarding the extent to which they are informed about appropriate claims submission practices
- Identifies trends and guides the development and implementation of health plan and corporate strategies designed to improve Provider satisfaction
- Facilitates the exchange of information between internal MCO grievance, claims processing and Provider service systems and Providers
- Works with the Provider Call Center to compile, analyze, and disseminate information from Provider inquiries to determine any needs for additional Provider education or process improvements regarding claims submission practices, Provider education or health plan support
- Designs provider claims training materials and conducts initial and ongoing claims submission training sessions. Develops and implements performance standards for provider claims education.
- Monitors health plan and Provider compliance with contractual and regulatory claims processing standards and requirements.
- Works with key corporate Member and Provider Services staff to develop and implement strategies for enhanced claims submission and payment customer service opportunities.
- Researches provider claims issues and routes to the appropriate party for resolution; monitors resolution to ensure resolution closure and timely response to Providers
- Attends regional Provider forums

nebraska total care.

JOB DESCRIPTION

State Position Title: Case Management Administrator
Health Plan Position Title: Director, Care Management
Reports to: Vice President, Medical Management

Position Purpose: Defines, directs, and oversees a comprehensive Care Management Program.

Knowledge/Experience: Bachelor's degree in Nursing, related field or equivalent experience. A minimum of five years of management or supervisory experience in Medicaid managed care as well as prior experience as a case manager required.

License/Certificates: Current Nebraska Registered Nurse licensure; Certified Case Manager preferred.

Competencies: *Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge, Culturally Competent*

Position Responsibilities:

- Plans, directs and oversees the case management function, including Integrated Care Management Teams and other care management staff, to ensure optimal, cost-effective integrated care management
- Oversees the provision of pregnancy management and EPSDT services to Members
- Directly interacts with other staff members to ensure Member physical and behavioral health care management and disease management needs are identified and addressed; ensures all Care Management staff are familiar with community resources and actively refer as necessary
- Ensures Care Management policies and processes addess the social determinants of health that may effect a Member's health and wellness
- Works closely with the Medical Director and other medical management and health plan staff to ensure that care management policies/protocols comply with MLTC, State, federal and NCQA standards and regulatory requirements
- Plans, directs and oversees processes to track/follow Members through the care management life cycle
- Conducts ongoing needs analysis and planning to determine adequate staffing levels and ensure appropriate caseloads for Care Management staff
- Oversees the delivery of comprehensive community-based Member education, including improving Member understanding of the Integrated Care Management Program
- Participates in the Clinical Advisory Committee and ensures an annual review and approval of Care Management policies and procedures
- Actively participates in the discharge planning process for assigned Members to ensure post discharge follow up services are in place; monitors post discharge services to prevent inappropriate readmissions and emergency room visits
- Oversees care management staff communication with Member, families, Providers, subcontractors, vendors and other health plan staff to ensure Member needs are identified and met.
- Develops and implements methods, policies and procedures to improve department efficiency and effectiveness
- Participates in concurrent review meetings to assist with high needs cases
- Develops care management risk stratification and level of care management assignment methodology. Ensures appropriate risk assignment by staff members as well as robust tracking to monitor Members through each phase of the care management life cycle

nebraska total care

JOB DESCRIPTION

State Position Title: **Information Management and Systems Director**
Health Plan Position Title: Vice President, Information Technology
Reporting Relationship: Centene Chief Information Officer

Position Purpose: Oversees the development and operation of information systems and technology solutions to meet health plan, MLTC, State and federal requirements. Oversees all information system functions.

Knowledge/Experience: Bachelor's degree in Computer Science, Management Information Systems, related field, or equivalent experience, required. Minimum of seven years of experience in information systems, data processing, and data reporting in a Medicaid environment. Solid knowledge of Health Plan programs, operations, data reporting and IT systems.

Competencies: *Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge, Ability to Produce within Deadlines*

Position Responsibilities:

- Establishes and ensures ongoing connectivity with MLTC information systems
- Plans, directs and oversees development of required and ad hoc reports and ensures timely submission to MLTC
- Serves as primary point of contact with MLTC for information system issues; manages a direct relationship with MLTC information systems staff to answer questions, provide expertise and assist with problem solving; participates in all required MLTC committees and workgroups
- Participates in MLTC and health plan committees/workgroups to ensure reporting requirements are met related to encounter, enrollment and other data transmission requirements
- Determines the health plan's long-term systems and/or hardware needs to accomplish business and Program objectives. Analyzes the needs of health plan departments/functions and establish priorities for feasibility studies, systems design, and implementation to develop new and/or modify the company's information processing systems and policies and procedures
- Manages department staff including hiring, performance management and career development to ensure alignment with defined goals including meeting required deadlines
- Develops budgets and priorities, ensuring plans and resource allocations are consistent with those budgets and priorities. Responsible for representing departmental plans and activities to senior IT and company leaders, as well as strategic suppliers
- Applies process and business expertise to address technical and business issues and impact business results

nebraska total care

JOB DESCRIPTION

State Position Title: **Encounter Data Quality Coordinator**
Position Title: Senior Director, Encounters
Reporting Relationship: Centene Sr. Vice President, Health Economics

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Position Purpose: Oversees the operation of the Encounter Data processing and reporting team.

Knowledge/Experience: Bachelor's degree in Business Administration, Healthcare Administration or equivalent experience required. Five plus years of encounter and/or claims administration experience in a Medicaid managed care environment.

Licenses/Certifications: None required.

Competencies: *Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge, Cultural Competency.*

Position Responsibilities:

- Plans, directs and oversees efforts related to encounter data quality and reporting functions and closely coordinates with MLTC, as needed
- Serves as plan encounter subject matter expert, to answer Plan and MLTC questions, provide recommendations, and participate in problem-solving and decision making related to encounter data processing and submissions
- Organizes and coordinates services and communication between MCO administration and MLTC for the purpose of identifying, monitoring, and resolving encounter data validation and management issues
- Analyzes activities related to the processing of encounter data and data validation studies to enhance accuracy and output
- Continuously monitors encounter data performance metrics to ensure Plan meets/exceeds MLTC, State and federal requirements and regulations
- Promotes changes in claims processing and data capture to further timely and accurate encounter reporting
- Monitors staff performance to identify any process or quality gaps and develop/implement business solutions to correct issues
- Provides management with necessary data to expedite resolution of claims issues and support policy decisions related to claims and Information Technology to continuously improve encounter reporting
- Acts as health plan interface on software product upgrades/implementations that affect the encounter reporting process
- Promotes change through establishment and sharing of best practices
- Interfaces with all organizational functions to ensure accurate configuration, contract implementation, claims operations, and encounter reporting
- In support of the overall strategic plan, establishes operational objectives, policies and procedures for areas of accountability

nebraska total care

JOB DESCRIPTION

State Position Title: **Tribal Network Liaison**
Health Plan Position Title: Tribal Network Liaison
Reports to: Chief Executive Officer

Position Purpose: Expands and enhances the delivery of physical and behavioral health care services to American Indian Members.

Knowledge/Experience: Bachelor's degree or equivalent experience in mental health or related area, public health, health care administration, social work, or nursing. Three to five years of related experience with Medicaid populations, preferably including Tribal Communities. Must have a comprehensive knowledge and understanding of the American Indian culture and be able to effectively communicate with Tribal Leaders and community Members. Must be willing and able to travel to rural communities and remote areas.

Licensures/Certifications: None required.

Competencies: *Integrity, Flexibility, Communication, Critical Thinking, Customer Focus, Decision Making, Planning and Organizing, Building Strategic Working Relationships, Technical and Professional Knowledge, Cultural Competency*

Position Responsibilities:

- Plans and works with Provider Contracting and Engagement 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 MCO staff on American Indian issues and concerns
- Assists American Indian communities with prevention and awareness education, access to services and resolving barriers to care
- Advocates for American Indian Members with Care Management and Member Services staff to ensure American Indian interests are considered in program development and service delivery
- Conducts interviews and site visits to tribal communities to discuss approaches for delivering culturally competent services to American Indian Members and meeting tribal healthcare needs
- In conjunction with MemberConnections and Community Outreach staff, develops and educates tribal communities on available health care and support programs. Answers general questions regarding applicable policies, procedures, and statutes
- Provides input on Member materials, benefits and services
- Actively participates on the Member and Provider Advisory Committees, as well as other Quality Committees to represent Nebraska American Indian interests and concerns

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JOB DESCRIPTION

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

Position Purpose: Plans, directs, and oversees the prescription drug/pharmacy benefit. Aids the Chief Medical Officer in formulating and administering organizational policies and procedures related to pharmacy service quality, pharmacy utilization and management, and achievement of goals for pharmacy and medical programs.

Knowledge/Experience: Registered pharmacist with a Bachelor's or advanced degree in Pharmacy. Three plus years of clinical pharmacy experience supporting formularies, designing prior authorization requirements, and working with clinical information. Thorough knowledge of pharmaceutical care and pharmacy benefit management practices as well as management experience working with Medicaid programs and populations. Must understand clinical pharmacy and drug product information to support plan benefit design in the point-of-sale system.

Licenses/Certifications: Registered Pharmacist with an unrestricted license in the state of Nebraska.

Competencies: *Leadership skills, Critical Thinking/Execution, Adaptability/Flexibility, Communication and Relationship Development, Technical and Professional Knowledge/Compassionate and Culturally Competent*

Position Responsibilities:

- Leads and coordinates formulary and preferred drug list implementation, evaluation, training, reporting and problem solving; ensures the Nebraska PDL is followed and internal system, policy and process changes are made timely
- Consults on and coordinates Pharmacy Program changes; ensures formulary and prior authorization changes are communicated timely and clearly
- Oversees and manages Pharmacy Benefit Manager (PBM) activities and ensures key performance standards are met
- Manages prospective and retrospective drug utilization review activities
- Reviews and analyzes reports, records and directives on pharmacy program performance, pharmacy program compliance with MLTC State and federal requirements, Member drug utilization, and dispensing/prescribing trends by Providers
- Attends and participates, as required and requested, in the health Plan Pharmacy and Therapeutics Committee, MLTC's Pharmacy and Therapeutics Committee, and Drug Utilization Review Board Meetings
- Supports PBM Call Center prior authorization programs and their development/modification
- Meets with MLTC staff and the 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
- Resolves disputes, grievances and complaints involving pharmacy program issues
- Participates in medical expense initiatives, analyzing data and formulating cost control measures
- Supports provider education initiatives related to topics such as preferred drugs, prior authorization processes, and peer prescribing trends/data
- Participates in QI initiatives and other activities and facilitates development and implementation of recommendations for improvements; participate in external audit and accreditation initiatives

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IV.E. Covered Services and Benefits

IV.E. Covered Services and Benefits

(3 page limit)

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.

Definition of Medical Necessity

NTCs will adopt MLTCs definition of Medical Necessity per 471 NAC 1-002.02A, as noted in section E and within the definitions of the RFP for covered services:

- Health care services and supplies that are medically appropriate
- 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

Process of Developing, Reviewing and Revising Medical Necessity Definition

NTC's process of determining medical necessity considers the individual members needs and circumstances while incorporating written, evidenced-based guidelines and criteria, qualified, licensed health professionals, and utilization of state-of-the-art tools and technology.

In accordance with 42 CFR 438.210(a) NTC will furnish covered services in an amount, duration and scope reasonably expected to achieve the purpose for which the services are furnished. NTC's policies and procedures will prohibit arbitrary decisions to deny or reduce the amount, duration, and scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary. NTC will provide, at minimum, all benefits and services deemed medically necessary that are covered under our Contract with the State.

Developing. The Utilization Management (UM) criteria, which aids in consistent application of our definition of Medical Necessity, are nationally recognized, evidence-based standards of care, and include input from recognized medical experts. Through the Clinical Advisory Committee (CAC), appropriate practitioners are involved in developing and adopting criteria based on MLTC's definition, State Medicaid criteria, and Federal regulations.

Reviewing. The written UM criteria and the policies for application are reviewed and approved at least annually and updated to ensure accountability so that we provide the right amount of services to members when they need them. UM review of decisions will be made in accordance with currently accepted medical or health care practices, CAC annual review, and required bi-annual audit results review while taking into consideration the individual member needs, goals, and complications at the time of the request, in addition to the delivery of community-based services available for care. Utilization review criteria is used as an objective screening guide to support medical necessity and are not intended to be a substitute for physician judgment.

Revising. NTC's CAC will review updates and revisions to McKesson's InterQual Level of Care and Care Planning Criteria, along with any MLTC specific definition changes, and clinical policies annually. NTC will use McKesson's InterQual Guidelines for both physical and behavioral health and American Society of Addiction Medicine (ASAM) criteria for substance use while incorporating MLTC's medical necessity definition. InterQual provides a clear, consistent, evidence-based platform for care decisions that promote appropriate use of services, enhance quality, and improve health outcomes. NTC will use InterQual's Level of Care and Care Planning Criteria for Pediatric Acute, Adult Acute, Home Care,

Durable Medical Equipment, and Procedures to determine medical necessity and appropriateness of care. The Plan may also use the sub-acute/SNF guidelines to assist in determining medical necessity for sub-acute or skilled nursing care for members with catastrophic conditions or special health care needs. When changes occur, NTC will educate members and providers through our member and provider web portals, newsletters, and face-to-face communication.

Applying Medical Necessity Criteria to Ensure Appropriate Service Delivery

Local practitioners with professional knowledge or clinical expertise in the area being reviewed have an opportunity to give advice or comment on adoption of UM criteria and on instructions for applying the criteria. In addition, when requested, NTC will provide for a second opinion from a qualified health care professional with the network or if necessary arrange outside of the network, at no cost to the member.

Consistent Definition

NTC's definition does not differ from MLTC's Medical Necessity definition per 471 NAC 1-002.02A to ensure a member-centric approach to clinical decision making. We determine medical necessity within the framework of our UM Program for authorizing services; and detecting and addressing over and under-utilization in order to ensure a high quality, clinically appropriate, highly effective, cost-effective delivery system that takes into consideration individual member circumstances and the local delivery system.

(page limit N/A)
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.*

Value-Added Services

Nebraska Total Care's (NTC) comprehensive package of Value-Added Services (***Table Q23.A***) takes into account the priorities identified by MLTC for members of the Heritage Health program. These Value-Added Services complement the core benefits and programs offered by NTC and were selected to maximize the impact of our comprehensive approach to prevention and wellness promotion, chronic disease management, integrated primary care and behavioral health delivery, and crisis response. Additionally, our Value-Added Services consider social support services to ease some of the day-to-day pressures, enabling them to focus on their health and quality of life. Our Value-Added Services include a range of innovative and evidence-based practices that align with our commitment—and the State's priorities-- to eliminate unnecessary ED utilization, improve birth outcomes, and promote prevention-oriented integrated care. We are proposing Value-Added Services that we have found to be most effective in our other markets plus new services, developed specifically for Nebraska, in order engage members in appropriate care. As we begin serving members in Nebraska, we may also find that additional Value-Added Services would be beneficial and will add or revise services as needed. NTC understands and will provide to MLTC a description of the Value-Added services for approval a minimum of 45 calendar days prior to implementation. If any of the Value-Added services proposed below require a prior-authorization, NTC will ensure the Member receives a notification letter if the value-added service is not approved.

NTC's Value Add Information, Pages 117-146 have been redacted and can be found in the Proprietary Envelope.

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. (4 page limit)

Nebraska Total Care (NTC) will conduct education and outreach, track all services received, and follow up with members and providers to improve EPSDT screening rates and related HEDIS measures, and comply with all aspects of the Contract using the innovative mechanisms detailed below and within established timeframes. NTC will educate on the periodicity schedule and on what EPSDT services are with particular focus on "Treatment" by educating on where to get services (i.e. pharmacy for immunizations, mobile units, and school based clinics.) EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.

Approach to EPSDT Education. NTC will use a comprehensive, multi-dimensional approach, based on the best practices of our Centene affiliates, to ensure children receive EPSDT services, including dental and behavioral health services and necessary follow-up treatment and services, in accordance with the EPSDT periodicity schedule. Our targeted approach to identifying non-compliant members will use Care Gaps Alerts, Health Report Cards, the EPSDT Coordinator, and CMs whenever possible to educate. The success of our approach is demonstrated by our Georgia affiliate, where they were able to increase their CMS-416 Medicaid screening rate from 55% in Federal Fiscal Year (FFY) 2011 to 79% in FFY 2014.

Educating Families on EPSDT Services. Every contact with a member, parent, or guardian will include education on the importance of EPSDT services, including how staff can offer assistance with scheduling appointments. Our Welcome Calls to each new member, parent or guardian will include encouraging them to contact their PCP to schedule an appointment and offering assistance with addressing any barriers. New members and their parent or guardian also will receive a Welcome Packet, a Member Handbook, and orientation to the Member Portal. The information includes accessing EPSDT services and offers assistance with scheduling transportation. Each also clearly states that provided services are provided at no cost as well as how reward dollars can be earned on their CentAccount card by completing their EPSDT and other screenings. Our Customer Service Representatives (CSRs), Nurse Advice Line staff, Care Management (CM) Teams (including Community Based), and MemberConnections™ Representatives will remind members about EPSDT services during every contact, and offer needed assistance in accessing them. Ongoing EPSDT education is provided to all members and their parents or guardians through newsletters, our website, reminder postcards, health fairs, and other community events. Our affiliate health plan, Coordinated Care has recently partnered with the state of Washington as a trusted health information source to focus on education of early HPV vaccination for girls and boys ages 11 and 12. The campaign includes billboards, print material, facebook, and twitter. We will be monitoring campaign outcomes for successes we can transfer to Nebraska and our other health plans.

Assessing Parent Engagement and Understanding of the Importance of EPSDT Services. We will assess parent engagement and understanding with each contact. The EPSDT Coordinator or CM will use the patient-centered "teach-back" method, through which the parent/guardian explains the information they just received to confirm understanding. Staff will document the assessment in the member's record along with any barriers the parent/guardian notes during the conversation. We will track identified barriers and work with our MAC to identify solutions.

Maternal and Child Wellness Materials. We will outreach to pregnant members via phone, mail, text messages, podcasts, and home visits through our award-winning Start Smart for Your Baby® Program (Start Smart). Our *Start Smart Pregnancy Guide*, praised by the March of Dimes, provides information for self-care during pregnancy, and we incent mothers to complete prenatal, postpartum, and well child doctor visits. Care

Centene's health education books have won numerous national awards, including multiple National Health Information Awards and Hermes Creative Awards.

Management staff will hand-deliver Neonatal Intensive Care Unit (NICU) Kits to all mothers with babies in intensive care and assure them of our support.

We will implement Centene's successful Text4Baby and Start Smart text messaging programs, which support breastfeeding and prenatal care, and include messages about child check-ups and screenings. Start Smart materials cover all stages of pregnancy from conception through the first year of a child's life, and includes information about all health issues related to pregnancy, such as depression, nutrition, warning signs for when to call the doctor, recovering after delivery, etc. NTC will develop a *Start Smart for Your Baby® for Heritage Health Mobile Application (Start Smart Mobile)* that will offer a broad range of integrated interactive features to support members.

Provider Education and Support. We will educate, incentivize, and develop targeted interventions with providers to ensure timely services. We will provide EPSDT information via individual and group trainings, the Provider Manual, and our Provider Portal. Information will include requirements to provide all components of visits, providing referrals and ensuring needed follow up care and referring a child for Early Intervention Program services if, after an EPSDT screen, a provider suspects developmental delay and is aware that the child is not yet receiving services.

Children enrolled in Medicaid are at a higher risk for having elevated lead levels, accounting for 60% of children aged 1-5 years with 81% of those children not receiving a blood lead test. Therefore, did not receive appropriate medical case management, follow-up care, and environmental services to reduce their lead levels. NTC will work with providers to test during EPSDT visits with Medtox strips for immediate results; and put a care plan in action for those children-testing positive for elevated lead levels.

In addition, we will educate providers to avoid "missed opportunities" to perform EPSDT screenings (such as during a sports physical or sick visit). We will encourage providers to have office staff or the onsite Community Based CMs review the Provider's Member Roster (on our secure Provider Portal) for Care Gap Alerts and needed services whenever a member is scheduled for any type of appointment or when the members eligibility is being checked. Our PCP performance incentive program will provide rewards for meeting state HEDIS benchmarks, including for EPSDT services. To improve EPSDT utilization data completeness and allow us to target our outreach, providers will be able to upload to our Provider Portal any information they have showing compliance with screening visits and any EPSDT services the member received prior to NTC enrollment.

Ensuring Children with Special Needs/Substitute Care Access EPSDT Services. For members under age 21 with Special Needs, the member's CM will participate on an Interagency Team to develop a comprehensive service plan in coordination with other health, education and human services systems such as Parent Information and Training Center and The Center for Independent Living; as well as the child or adolescent, and family members. Because children with special needs often underutilize preventive services, the CM will incorporate EPSDT education and services into the care plan, and ensure that the member/guardian understands how and when to access them. If the child sees a specialist for most of their care and has a PCP for preventive care, the CM will assist with coordination of appointments to increase compliance. As needed, the CM will accompany members to their PCP's office to assist with member/guardian understanding of their health needs and goals. For members under 21 who are SSI or SSI-related, CM staff will ensure they receive an initial PCP health needs assessment, including primary and specialty care and case management services, over a period not to exceed one year. For members approaching age 21, the CM will work with the member, family, and providers to select providers who are also Medicare providers to ensure a smooth transition as the member ages out of EPSDT.

Innovative Mechanisms. NTC will provide education in multiple formats through service providers, schools, WIC, and other locations to meet the member where they are and monitor timely access to

EPSDT services. We will also recruit a pediatrician, parents/guardians of members, and representatives from the Division of Children and Family Services to participate on our MAC, which will meet at least quarterly to provide input on improving timely utilization of EPSDT services. NTC intends to partner with community providers to offer mobile health services such as OneWorld Community Health Center Inc. and Charles Drew Health Center Inc. who have school based clinics in order to facilitate access to well child visits.

Reminders and Outreach to Promote Timely Access to EPSDT Services. NTC will provide a variety of reminders and outreach to ensure members are aware of upcoming EPSDT services, including dental and behavioral health services, and to assist them in scheduling and keeping appointments.

Telephonic Birthday Cards. We will contact members with annual birthday reminders to members/guardians 45 days prior to the child's birth month, and send mailings to members we cannot reach by phone, or who are past due for services.

Targeted Outreach. Our EPSDT Coordinator and CM staff will reach out by phone to members who are due or past due for EPSDT services. CM staff will discuss EPSDT services with member's in-person at provider and other community locations.

Community Outreach. We will use community outreach events and other point-of-service opportunities to educate members. For example, we will use community health workers and our MCRs to provide EPSDT information at community events, such as Healthy Celebrations and back-to-school events. Our Start Smart staff will host quarterly Baby Showers for pregnant and new mothers where they will educate members on a variety of topics, such as EPSDT services.

Member Incentives. Our innovative incentive program, CentAccount, offers valued, financial incentives to members for achieving healthy behaviors such as receipt of EPSDT. NTC will load CentAccount onto a proprietary health care reimbursement card that can be used only at authorized retailers within our network. The card can be used to buy health-related items such as groceries, baby and personal care items, and some over-the-counter medicines. We do not allow cards to be used to purchase items such as candy, soda, or junk food. Cards also cannot be used to buy alcohol or tobacco products of any kind. CentAccount has proven successful in changing member behaviors in several of our affiliate Medicaid health plans. Rewards earned by performing pre-determined healthy behaviors, such as completing well-child visits and annual screenings. This incentive-based approach effectively increases the utilization of preventive services, while strengthening the relationships between members and their providers. For example, our Indiana affiliate found that one year after implementing CentAccount, data showed that members ages 3-21 were 33 percent more likely to get an annual well visit than before the CentAccount program was in place.

Reminders and Follow-Up for Non-Compliant Members. NTC will generate monthly reports from Centelligence™ to identify members past due for services. These reports feed TruCare (our integrated health services platform) and CRM, prompting any member-facing staff to engage the member during any call or in-person contact with a reminder and an offer to assist with obtaining services. We will provide these reports to provider-employed CBCMs to allow them to conduct outreach and provide assistance. All member-facing staff will be trained on engaging non-compliant members and identifying and addressing language, cultural, or other barriers.

The EPSDT Coordinator will conduct phone outreach to non-compliant members and will update contact information using sources such as LexisNexis. If we cannot reach a member after three phone attempts, we will send a letter requesting that he/she contact us, and may implement automated reminder calls to attempt to reach them. We will also use community health workers and our MCRs to make in-person visits to a member's home when we cannot reach a non-compliant member. When we successfully reach them by phone, our staff will attempt to schedule an appointment by conducting a three-way call with the member and the provider's office on the line together. We will use *MyHealthDirect to* facilitate scheduling appointments for a member in real time when we have them on the phone. We will contact the member's parent/guardian before the appointment to address any barriers to keeping the appointment. The member may also access these services via our *MyNTC* mobile app.

NTC will also use the Centelligence reports to send Health Report Cards (see Attachment 1_ LA_Health Report Card) around the member's birthday as helpful reminders to parents and guardians. The Health Report Cards cover scheduling an appointment, what immunizations are needed and talking to the doctor about items such as lead testing, Diet, Childproofing and Development to ensure the member is growing and developing at a steady healthy rate.

System for Tracking Member's Screening, Diagnosis, and Treatment.

Technology Support for Tracking/Outreach. Our information technology tools will help NTC track and monitor EPSDT services to ensure we do not miss an outreach opportunity.

Tracking. We will use our Centelligence™ suite of data informatics and standard as well as ad hoc reporting solutions such as the Nebraska State Immunization Information System to track and monitor receipt of services in accordance with the periodicity schedule. Centelligence integrates claim data with the EPSDT periodicity schedule along with member and provider data to support effective analysis and outreach.

Care Gap Alerts. Our providers will be able to access a consolidated list that reflects HEDIS-related Care Gaps and all EPSDT services that should be performed during a member's next visit on our secure Provider Portal. Our secure online EPSDT Planner organizes, in one table and by member, all needed EPSDT services. Providers will be able to see "care alerts," including which gap in service prompted the alert, via the EPSDT Planner, within each member's Centelligence Health Record, and within the provider's online Member Panel Roster. To further support closing EPSDT service gaps, NTC will implement *MyHealthDirect,* a web-based scheduling exchange that integrates directly with our providers' Electronic Medical Record (EMR) systems. This innovation enables staff and members to schedule EPSDT visits directly into providers' EMRs, and allow us to push Care Gap Alerts into the EMRs. members can access Alerts via our secure Member Portal or our *MyNTC* mobile app (iPhone and Android devices). Members over 18 may opt for receiving email notifications of identified gaps.

Reminders. Our Customer Relationship Management platform (CRM) integrates all member data, including information on upcoming and past due services, so we can remind caregivers (during any member contact) of EPSDT due dates for all children in a household. We will send monthly lists of members due and overdue for EPSDT services to PCPs, caseworkers for children in substitute care and juvenile detention facilities, and residential providers serving child members. We also will provide these lists to provider CBCMs to support their outreach efforts.

Dedicated MCH/EPSDT Coordination Staff. Our MCH/EPSDT Coordinator, responsible for EPSDT outreach and tracking, will compile/review monthly compliance reports and analyze/evaluate input from our Member and Provider Advisory Committees, satisfaction survey results and Member Grievance and Provider Complaint data. They will also coordinate with our Quality Management staff to conduct annual medical record audits to validate that EPSDT services were provided, assist with provider training, and provide member education and outreach. Staff conducting audits will provide real-time feedback and education to providers when we identify issues such as not completing all screening components or not following up on referrals.

Identifying Members Who Require Referral and Follow-Up Services. We will educate all providers consistently to use claim modifier codes that indicate whether an EPSDT screening identified the need for a referral. Our EPSDT Coordinator will review monthly reports (of members whose EPSDT screening claims included the modifier codes) to identify members for outreach, education, and referral to the Special Needs Unit, when appropriate. For children with Special Needs, the member's CM will track and coordinate all referrals and follow-up services resulting from EPSDT-related screens. Care Management staff will monitor these members to identify new diagnoses that require a care plan revision, such as disease management services, or connection to the BH MCO for needed BH services. Annual compliance audits will ensure that PCPs conducting screenings identify and refer members who need treatment services, including identification and referral of those needing BH treatment to the appropriate BH MCO.

(3 page limit)

25. Describe the MCO's plan to utilize telehealth for any services in the benefits package, including...

Nebraska Total Care (NTC) will build a provider network that meets access and availability standards for all provider and specialty types. Face-to-face member to provider interaction is always our preferred approach, and telehealth services will never supplant this level of care. However, our experience through our health plan affiliates demonstrates that telehealth services provide an opportunity for choice amongst multiple providers and specialists for our members; therefore, we are building a telehealth network that will enable telehealth to be an option for any service in the benefit package.

Snapshot of Affiliate Experience. ***In Texas,*** our affiliate Superior HealthPlan collaborated with the state to develop new regulations allowing the expansion of telehealth services to increase access in rural areas specifically for serving children involved in the foster care and child welfare system. This has now expanded to serve all Medicaid populations, primarily increasing access to psychiatry services in the most rural areas. ***In Louisiana,*** our affiliate Louisiana Healthcare Connections is working with the Louisiana State University medical system on a collaborative telemedicine solution to improve access to specialist providers in rural and underserved areas across the state. Both the Texas and Louisiana telemedicine programs consist of three components:

- The member (patient) in a remote area who travels to a clinical setting to receive the session
- The providing physician on the other end of the video feed in a different geographic location
- The technical and administrative team at both sites that facilitate the sessions.

In California, our affiliate California Health and Wellness (CH&W) has developed a **comprehensive strategy** to increase access to specialists, primarily in rural parts of the state. CH&W serves 19 **rural to frontier counties in California across varied geographies that create accessibility issues for members**. Collaborating with the California Telehealth Network (CTN), they have implemented a 12-month pilot program to expand access to selected specialties of dermatology, endocrinology, mental health, pain management, pediatric subspecialties and rheumatology. Our California affiliate's extensive research and development into telehealth services for rural and frontier communities indicates that comprehensive telehealth services that include live video services, Safety Net Connect's e-Consult platform, and a scheduling module in development to enable asynchronous PCP-Specialist communication create increased access that effectively reduces emergency department (ED) utilization. NTC will build upon the experiences of these programs as we collaborate with providers to solve for existing challenges and create new opportunities for telehealth.

Plan for Using and Operationalizing Telehealth in Nebraska

NTC is in active discussions with the University of Nebraska Medical Center Network (UNMCN) and their Munroe-Meyer Institute, which together have the single largest network of telehealth service providers in Nebraska. In our discussions, UNMCN reported that currently, telehealth sessions have a fail rate of 60% due to challenges with connecting technology. Additionally, they report providers are hesitant to participate due to low, or perception of low reimbursement rates for telehealth services. ***NTC will address these target areas for improvement through:***

Staffing and Resource Support. NTC will hire a **Manager of Telehealth Services** to provide flexible, support that offers logistic assistance and identifies local solutions, which could include: grant funding, arranging technological support, or recruiting additional providers or resources. For clinical support, NTC's **integrated Care Teams offer care coordination**. When we identify a member as participating in telehealth services, either through active facilitation by NTC, provider notification or through claims, staff from our Care Team will contact the member to ensure all needed services are coordinated and answer questions the member may have. We will track members using telehealth resources to validate improved health outcomes and appropriate utilization of ED. NTC's **Provider Engagement Teams will provide**

PCPs with education on the effectiveness of telehealth for specialty services including BH and reduce barriers to accessing services.

Partnership with Capstone Consulting. We are partnering with Capstone Consulting (Capstone) to support telehealth sites with technical training and assistance when needed. Put simply, our goal is to pursue marked improvements in the rate of successful telehealth encounters. Capstone is an Omaha-based information technology solutions company with 17 years' experience serving commercial as well as state and local government agencies across Nebraska. Capstone will work at the direction of our Manager of Telehealth Services to implement a "tiered" operational support strategy. Telehealth sites may contact our Call Center, where our Customer Service Representatives will engage Capstone technical support to offer assistance in basic guidance, problem identification and resolution, or onsite help for resolution if needed, along with training. We are designing our program with Capstone's telecommunications principal, who has over 20 years' experience, and has served on the Federal Communications Commission (FCC) Technical Advisory Committee (TAC), including the TAC Working Group on Telehealth.

Enhanced reimbursement rates to ensure that payment for telehealth services is par with that of face-to-face services. Additionally, we will work with originating site locations to ensure they know how to appropriately bill for their services. This could include incentive payments for providers that participate in our telehealth network. As appropriate, we will provide mini-grants to providers (like Vest Psychiatric) or identify additional funding sources, to encourage expansion of telehealth services and infrastructure.

Targeted Pilots with Enhanced Care Coordination such as connecting psychiatric nurse practitioners through **Vest Psychiatric** in Lincoln to members referred through primary care in North Platte, and coordinating services and tracking outcomes through NTC integrated Care Team staff.

Working with the Nebraska Statewide Telehealth Network (NSTN). NSTN is a collaboration of over 110 sites, including hospitals, health departments, mental health centers, physician offices and rural health clinics, with a common purpose of using video technology to extend health care resources to those in need. This includes clinical consultations, support groups, education and training, connectivity for administrative meetings among professionals and families.

Expanding Access Points. We are actively working to expand telehealth, including point-to-point live video, through experienced telehealth providers like **Avera Health**, and working with the **Great Plains Telehealth Resource Center** that services Nebraska. Additionally, because NTC is partnering with both Catholic Health Initiatives (CHI) and ENHANCE Health Network (formerly RPN), we have a robust network of physical and BH providers that are already providing or could easily be connected to telehealth and telemonitoring.

Using Technology to Increase Personal Health Management Skills. We use a variety of telehealth technologies and strategies to engage and help members develop self-management skills. We deploy telemedicine solutions, such as e-consults, video-conferencing and store-and-forward services, to extend needed services to members in rural and underserved areas by bringing services to accessible locations. Below are examples of technologies we successfully used and will deploy for Heritage Health.

Disease Management (DM) Telemonitoring. We will provide select high-risk members with the latest wireless technology to enable **real-time biometric readings** and immediate advice from our Health Coaches or Registered Nurses, and updates to providers. Examples include:

- An FDA-approved sensor for members in our asthma DM health coaching program enabling us and the member to track their symptoms and medication adherence
- Devices to monitor biometric data (e.g., blood glucose level, blood pressure, weight) for high risk members with diabetes, COPD and CHF
- **Electronic pill dispensers** to monitor medication, especially for high risk patients post-discharge

To drive self-management, we educate members on how to access their biometric data via the Internet.

Technology to Enhance Member Health Literacy and Access. NTC will provide select members with chronic conditions, such as asthma, access to web and mobile-based videoconference coaching, enabling our Health Coaches to view and educate the member via the internet. We will offer breastfeeding mothers with 24/7 video conference access to a lactation specialist, nutritionist and maternal/child nurse to

improve child nutrition and reduce emergency/urgent care services. Our MemberConnections™ Representatives will use secure videoconferencing during in-home, community, and hospital visits to introduce members to their Care Manager (CM); offer consultation with NTC staff; provide self-care videos; and demonstrate how to use **MyNTC, our mobile application platform for Heritage Health.** ***Technology for Needed Communications.*** With member consent, we will use text messaging for CM communications to members, personal reminders (e.g. appointments, required screenings), care gap and push notifications, and benefit reminders. Texting is the preferred means of communication for younger members, and about 40% of members overall request notification by text. We are exploring options to provide text and video enabled Smartphones for at-risk members who have unreliable phone service. ***Crisis Text Line.*** In addition, our affiliate in Indiana has begun a collaboration with Crisis Text Line (CTL) a national organization that provides 24/7 text support for individuals with a crisis or perceived crisis need. We will make this service available for Heritage Health.

Regulatory Limitations. NTC brings our experience working with states to expand the definition and to align statutes to support telehealth. We will work with MLTC and other State agencies to ensure optimization of telehealth and telemonitoring.

Services Offered Through Telehealth. In our experience across the country, we have seen the benefit of offering telehealth services primarily to enhance access to psychiatry and mental health services. However, in rural areas it is critical to look at a broader service range and creative use of technology for coordination, doc-to-doc consultation and expanding access to integrated services where co-location is not possible. We know in Nebraska today telehealth technology is utilized for services including:

- Mental Health Services and Psychiatry
- Burn treatment
- Oncology
- Orthopedics
- Genetics and Genetic Counseling
- Cardiology
- Surgical Follow-up
- Neurology
- Infectious Disease
- Nutrition
- Nephrology
- Wound Care
- Diabetes Clinical Services
- Dentistry
- Physical Therapy
- Smoking Cessation
- Neonatology

Reports from the NSTN indicate that over ***60% of the services accessed through telehealth in Nebraska are for BH.*** We will build telehealth solutions including a suite of services covering remote patient monitoring, tele-BH services, and online access to providers. Currently, these services are available in most Centene service areas; however, are being most highly utilized in Arizona, California, Georgia and Texas for physical medicine and for BH services. Our experience in California demonstrates strong early indications of success using telehealth services for dermatology and retinal exams.

Incorporating Member Preference. NTC understands that critical success factors in a member's treatment are engagement and adherence to their treatment plan. Telehealth offers increased choice in providers; but for those members who do not like telehealth; it is not useful or appropriate. Successful treatment plans incorporate member preference for treatment and location. NTC's Care Team will always work with the member to identify additional options that could include traveling specialists or coordination of transportation to providers outside their area. NTC will always honor member preference.

Telehealth and Utilization Management Strategies. In addition to expanding access to services, telehealth can also change utilization patterns. National studies uphold the effectiveness of telehealth in reducing emergency department (ED) visits and inpatient hospitalizations, which mirrors the results NTC's affiliates from across the country have observed. Reduction in overall healthcare utilization, particularly for high cost services like ED and inpatient admissions demonstrate the effectiveness of telehealth in directing members to the right care, at the right time in the right location. One example of how shifting patterns of care happens is improving access to appropriate screening. As referenced above, our California affiliate has had early success improving utilization for retinal exams. We can instantly improve access to care, by placing very low cost technology into PCP offices allowing connection to specialists. In California this improved screening rates related to diabetic retinopathy screening – which went from 18 to over 92 in just the first two months; demonstrating a 450% increase month to month since implementing the program. This shift helps to promote early detection and improve outcomes for members, and can offer significant cost savings for long-term disease management, while increasing members' choice in providers and treatment modalities, to improve the quality of care.

(3 page limit, excluding preliminary work plan)
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.

With MLTC approval, Nebraska Total Care (NTC) will use US Script, our URAC-accredited Centene PBM affiliate, to adjudicate pharmacy claims processed through its robust network of pharmacies. NTC's pharmacy program will integrate seamlessly with physical health, behavioral health and provider and member services through shared technology, clinically trained and experienced staff, and a network of pharmacies to meet member needs, providing coverage of all prescription and over-the-counter drugs as applicable to the Medicaid pharmacy benefit.

Established in 1999, US Script combines comprehensive drug management services with extensive Medicaid experience, functioning as the PBM for 15 Centene-affiliate Medicaid plans, representing over 4.5 million members. US Script has extensive experience implementing Medicaid prescription drug benefits for State Children's Health Insurance Programs (CHIP), as well as Aged, Blind or Disabled (ABD), Foster Care, Intellectual and Developmental Disabilities (IDD) and Long Term Services and Supports (LTSS), in addition to other state-sponsored/hybrid programs and Medicare (Special Needs Plans). US Script contracts directly with chain and independent pharmacies as well as pharmacy services administration organizations (PSAO), and is currently contracted with more than 66,000 pharmacies nationwide and over 450 pharmacies in the state of Nebraska. US Script's pharmacy network Director will work collaboratively with organizations like the Nebraska Pharmacy Association to expand NTC's pharmacy network in Nebraska to ensure a high participation of Nebraska's independent and community-based pharmacies. A public, searchable pharmacy directory will be maintained online and within the NTC member portal, providing ease of access of participating pharmacy information to all NTC members. Additionally, US Script offers 24/7/365 Customer Service Support to our pharmacy network in order to quickly address any potential challenges or issues that may arise.

US Script's comprehensive pharmacy program delivers a clinically-driven prior authorization program, in-house pharmacy network contracting and management, rebate administration, standard reporting, predictive analytics, a proprietary claims processing system, designated account management, pharmacy provider customer service centers, specialty pharmacy, Pharmacy and Therapeutics (P&T) support, mail order, pharmacy auditing, and drug utilization review and quality improvement functions, subject to NTC oversight.

NTC will offer an optional mail order program through US Script's mail order provider, which will fully integrate mail service with the retail pharmacy network through US Script's proprietary claims processing system. Subject to MLTC approval, Nebraska Total Care's specialty pharmacy program will include its affiliate specialty pharmacy partner, AcariaHealth, Inc. AcariaHealth's services are designed to provide support to reduce waste, increase adherence and improve outcomes. With US Script's support, NTC pharmacy services will promote member safety, appropriate use of use of generic drugs through data analyses, educational interventions, an online formulary, and clinical program management involving cross-organizational collaboration between NTC and US Script.
US Script's experience integrating with managed Medicaid plans enables them to deliver a member-focused, clinically driven prescription drug program. From pharmacy claims data integration to close collaboration with NTC personnel, US Script integrates its programs and services to enable the delivery of patient-centric services across the continuum of care.

Proven Systems and Capabilities to Benefit Nebraska Heritage Health

Because of the vast experience and expertise US Script has amassed serving NTC's affiliate Centene health plans, NTC is able to enter Nebraska offering proven systems and programs that meet the needs of Medicaid members and providers, including the following:

US Script proprietary claims processing system. US Script's state-of-the-art POS claims processing system is an online application package built by experienced industry pharmacy professionals. This platform, developed and supported in-house by the original development team, is built on a relational database management system (RDBMS) that follows ANSI SQL standards and connects retail, mail order and specialty pharmacies in the United States and protectorates through a highly secured, private intranet. Because it is proprietary and configured in-house, PBM1 enables rapid drug, edit and pricing updates to respond quickly to member and Provider needs, program requirements, state and federal regulations, and marketplace trends. US Script's claims processing system uses Medi-Span® alerts as its clinical database and messaging system, which continuously draws from updated, comprehensive drug information for both prescription and over-the-counter drug products.

US Script's system is "up" 24/7 and physical downtime is rare. In 2014 and 2015, US Script's system was available for 99.6% of all transactions sent, with transactions processing within four-tenths of a second. Eligibility verification and claim authorizations are handled solely within the claims processing system and in real-time.

Nebraska Total Care Access to US Script Systems. NTC staff will have access to real-time tools for updating eligibility, administering prior authorizations, viewing live claim data and running standard reports within US Script's claims processing system. US Script's application exports data in .txt format, and designated NTC users will have the ability to export and open data files in Excel.

Coordination of Care. Nebraska Total Care's delivery of person-centered, holistic member care will integrate pharmacy care across plan operations, which will support cost-effective utilization, ensure medication access and optimize member health. Our member services, disease management, care management, utilization management, provider relations and network staff will promote member and Provider use of our comprehensive pharmacy benefits and help resolve access barriers. Our Pharmacy staff will report to our Medical Director and directly participate in our Integrated Care Management Teams, case rounds, and BH MCO coordination, member assistance and Provider education efforts.

Integration of US Script and NTC Systems. Information and data from US Script's Management Information System (MIS) is bi-directionally integrated with Total Care's enterprise MIS, including most notably the TruCare and Centelligence™ components of our MIS. TruCare is our member -centric health management platform for collaborative care coordination; and case, behavioral health, disease, and utilization management. Among other functions, TruCare houses a member's TruCare Care Plan. Care Management and Utilization Management staff can access the medication utilization history of our members through TruCare's integration with Centelligence™. Centelligence™ is our data integration and comprehensive family of integrated decision support and health care informatics solutions. The Centelligence™ enterprise platform integrates data from multiple sources, including pharmacy utilization data from US Script, and provides actionable population and member level information, including our Care Managers via TruCare.

Shared Infrastructure with Affiliate Subcontractors. All of NTC's claims-paying subcontractors are also our affiliates, including US Script. US Script shares a common voice and data network, and Total Care and US Script share a common hosting environment in Centene's two, fully redundant, enterprise class datacenters. Among other benefits, this means US Script's systems enjoy the full hardware, software, and network redundancy and Business Continuity Planning and Disaster Recovery (BCP/DR) administration, controls, and continual testing programs to ensure the highest possible system availability levels. Total Care, and US Script's common communications platform enables staff from both organizations to detect when a colleague is online, whether on e-mail, or available for instant messaging or phone conference, or on our Intranet or logged into our Customer Relationship Management (CRM)

system - all of which fosters quicker communication and greater efficiencies; rapid, coordinated response to issues or requests demanding immediate attention; and multi-disciplinary teamwork.
In addition to above, US Script documents PA decisions and Provider interventions in a member Record, accessible to Total Care Pharmacy and other authorized staff.

NCQA-Compliant Portal. Our secure NCQA-compliant Member Pharmacy Portal is integrated into Nebraska Total Care's portal, providing a seamless single-sign-on experience for NTC members with questions about their pharmacy benefit regardless of their proximity to a pharmacy. This portal supports access to care by allowing Members to order a refill for an existing, unexpired prescription, identify drugs on the formulary, identify any utilization management requirements, review their previous claims history, find potential drug-drug interactions, find the location of an in-network pharmacy, and initiate the prior authorization process. Members can access the portal on a smartphone, a tablet, or a computer.

e-Prescribing. US Script partners with SureScripts, a recognized leader in e-prescribing, to ensure our proprietary claims system supports e-prescribing platforms. This interface enhances timely access to drug therapies by offering practitioners at the point of prescribing information about our formulary, patient specific medication history, and eligibility information.

Prior Authorization Submittals. US Script also offers Providers the ability to submit secure PA requests online, or by phone, or fax submissions. Our online form speeds PA decisions and reduces denials by not allowing the submission of requests that are incomplete or for Members no longer enrolled. US Script pre-programs automatic approvals into their claims system based on a Member's prescription history to avoid the need for certain requests. In our case-by-case analyses of all PA appeals, staff clinical experts consider both a Member's condition and circumstances along with recognized clinical guidelines and studies.

US Script Pharmacy Provider Portal. US Script offers our pharmacies a secure, online MAC pricing tool, enabling pharmacists to find the most recently updated MAC price for a specific drug as well as to submit pricing inquiry forms online. Additionally functionality is being developed to deliver a more robust portal for our providers. Functionality will include an enhanced MAC pricing lookup tool and the ability to submit pricing inquiries electronically.

Please see the IV.E Attachment Tab for Attachment 26 US Script Work Plan at the end of this section.

(3 page limit)
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.

Compliance with the Mental Health Parity and Addiction Equity Act

In 1996, the **Federal Mental Health Parity and Addiction Equity Act** was signed into US law in response to the increased awareness to the dual nature of these health conditions and the realization that "Mental health is essential to leading a healthy life and to the development and realization of every person's full potential."1 At Nebraska Total Care (NTC), this statement is central to our philosophy of holistic, integrated member care.

Administration of Benefits in Compliance with MHPAEA

Nebraska Total Care (NTC) is committed to compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 (45 CFR Parts 146 and 147). NTC will ensure compliance with MHPAEA requiring parity of both quantitative limits (QTLS) applied to mental health and substance use disorder (SUD) and medical benefits and non-quantitative limits (NQTLS). NTC will administer benefits for mental health and/or services for SUD as designated and approved by the state-specific contract and Plan benefits (e.g. value added services) and ensures equality in terms of QTLS and NQTLS with that of services delivered to treat physical health conditions. Compliance to MHPAEA will be evaluated and measured through a multifaceted approach, including policy review and adherence in respect to benefit authorization requirements, authorization processes, and applicable limits.

NTC will ensure that medical necessity determinations for mental health or substance use benefits are available to all members in the same manner as physical health benefits. NTC will utilize evidentiary processes to review clinical criteria for mental health and SUD services in the same way it does for medical and surgical benefits. These types of benefits are in the same classification when determining the extent of a benefit that is subject to NQTLs. With this in mind, NTC will provide out-of-network coverage for mental health and SUD benefits with the same expectations as with medical and surgical benefits. To ensure transparency in determinations, NTC providers as well as current/potential members may request benefit information to review medical necessity determination factors.
NTC will provide the reason for denial of reimbursement or payment with respect to the mental health or SUD benefits to members or requesting providers as part of our utilization management process. NTC is committed to providing services that are focused on resiliency and recovery. With parity values in the forefront, NTC will offer its members access to a continuum of care, always working with the member and provider to ensure services are delivered in the least restrictive setting, while continuing to respect and evaluate the member's safety needs.

Application of Medical Necessity Criteria in Compliance with MHPAEA

Evidence-Based Criteria. Nebraska Total Care adheres to NCQA Health Plan Accreditation requirements for UM, and will comply with federal and State requirements for medical necessity determinations, and all related RFP and contract requirements. In accordance with MHPAEA, NTC ensures that medically necessary covered services, and those additional benefits implemented by NTC, are not arbitrarily or inappropriately denied or reduced in amount, duration or scope. This begins with adopting and/or developing (with assistance as needed from Centene's Clinical Policy Committee) evidence-based clinical support criteria for use by medical necessity review staff. For both medical and mental health services, NTC proposes to use the current written/electronic version of McKesson's InterQual® Level of Care and Care Planning Criteria; for substance abuse services we propose to use American Society of Addiction Medicine (ASAM); for therapies and rehabilitation we propose to use NTC's Medical Management Guidelines; and any appropriate State of Nebraska and/or Regulatory guidelines. We will use available

[1] Issue Brief Parity: www.mentalhealthamerica.net

comparative effectiveness research (CER) data in developing our clinical policy for specific procedures. Our CER sources include, but are not limited to, Hayes Clinical Research (an internationally recognized research and consulting firm that evaluates a wide range of medical technologies to determine the impact on patient safety, health outcomes, resource utilization, and return on investment), as well as UpToDate® (an evidence-based, physician-authored clinical decision support resource), National Comprehensive Cancer Network (NCCN) guidelines, Agency for Healthcare Research and Quality (AHRQ) searches, and Centers for Medicare and Medicaid Services (CMS) guidance.

Relevant Guidelines and Consistent Application. To ensure relevance to our enrolled population, our Clinical Advisory Committee (CAC) obtains input on proposed clinical policy statements, medical necessity criteria, and clinical practice guidelines from local practicing physicians and providers familiar with the specific needs of members in the Heritage Health program. The CAC and the Utilization Management Committee (UMC) approve our criteria or guidelines. NTC will then distribute to UM staff, including Medical Directors, who attend mandatory training before the criteria are used in medical necessity (MN) appropriateness reviews. NTC will train, monitor, and provide regular feedback to staff, as well as conduct **regular inter-rater reliability audits**, to ensure that all staff understand how to apply criteria and how to document medical necessity decisions into TruCare, our integrated clinical documentation system. These proven techniques facilitate consistent application of criteria, routine oversight and evaluate the effectiveness of oversight processes.

Evaluation and Measurement of Compliance with MHPAEA

NTC will evaluate and measure compliance with MHPAEA through review of MHPAEA policy adherence in addition to benefit authorization requirements, authorization processes, and applicable limits. NTC will monitor a variety of channels to ensure compliance and detect issues early. Examples of monitoring include, but are not limited to grievances and appeals, member and provider satisfaction, and utilization reports. Additionally, NTC will regularly review key areas of our operations, financial strategies and clinical protocols to ensure compliance.

Operational Considerations. The importance of validating the operational functions of a care management organization is fundamental to ensuring access to the full benefit continuum for Nebraska's Medicaid members. NTC will validate that our operational and administrative structures are properly managed and appropriately staffed to meet the obligations of the MHPAEA. Additionally, NTC will train staff and implement oversight protocols on MHPAEA and the principles of parity to ensure understanding and compliance.

Financial Considerations. NTC is cognizant of the financial requirements and treatment limitation considerations for both mental health and SUD benefits. We compare and review our processes to ensure *parity of the processes used to determine* QTL or NQTL for both medical/surgical and behavioral health. For example, NTC utilizes a thorough review and analysis process to determine where, when and how to apply potentially limiting techniques including utilization management for outpatient services, precertification for services and concurrent review.

Clinical Considerations. NTC will regularly monitor, in a transparent way, our specific processes, strategies, and best practice standards utilized to determine how benefits are allotted. Specifically, we will validate that the processes used to determine how and when to apply limitations (e.g. prior authorizations) are par for both behavioral health and physical health related events. Our UMC reviews processes for compliance with MHPAEA annually, or more frequently should benefits or guidelines change. The CAC reviews the recommendations of the UMC to facilitate network provider and stakeholder participation in the process, thus providing an additional layer of oversight. The CAC forwards their recommendations to the Quality Assurance and Performance Improvement Committee (QAPIC) for final review and approval.

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IV.E. ATTACHMENTS

Proprietary and Confidential Information

IV.E. Attachments

Attachment 26, US Script Work Plan

12 pages

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Attachment Q.24. LA Health Report Card

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IV.F Member Services and Education

IV.F Member Services and Education

28. Describe member services processes including: (6 page limit)

Member Services Processes Focused on Outstanding Service Delivery

Nebraska Total Care (NTC) will leverage our parent company's 30 years of experience to structure a toll free Member Call Center that blends best practice Concierge Service with sophisticated telephone and information management technology to deliver accountable, responsive, patient, customer-focused service with *a single point of accountability for all member service transactions*. We train our Customer Service Representatives (CSRs) to provide *anticipatory service specific to the member's needs*, employing a host of member engagement tools. The same CSR who answers a member's call will ensure resolution of any member issue, provide all follow-up, and bring together the member and any needed NTC staff or community support. This minimizes hold time and repetition, offering "no wrong door" for any inquiry. To offer complete, integrated and personal service to both members and providers, our member call center, located in the Lincoln-Omaha corridor, will be fully staffed Monday through Friday from 7:00 a.m. to 8:00 p.m. central time with CSRs dedicated to Nebraska members. These extended hours will provide all members, including those who work non-traditional hours, with ample opportunity to receive service. During other hours, our 24/7 nurse advice and triage staff will answer our toll-free line. No caller will ever receive a busy signal, every call will be answered, and every caller may speak with a courteous and knowledgeable representative no matter when they call. For convenience, our interactive voice recognition telephony system (IVR) which responds to voice and push button prompts, and includes self-service features, such as for ID card replacement. Avaya, our state of the art automated call distribution system (ACD), is designed to complement our Concierge Service model and meets or exceeds this contract's requirements for managing, measuring, assessing, and recording calls. Additionally, to speed service to the member, our Computer Telephone Integration (CTI) platform automatically populates the member's record (call history, demographics, care gaps, etc.) on the CSR desktop screen, based on the member's home, work or cell phone number.

As an added service, NTC Customer Service will answer member calls from 7:00 am to 8:00 pm Monday through Friday, exceeding this contract's requirements.

- ***Training of customer service staff (both initial and ongoing).***

Training for Outstanding Concierge Service Delivery. We know that the best member engagement will come through staff that represents Nebraska's diverse cultures and populations. We will seek to recruit former/current Medicaid recipients via resources such as NEworks, Ticket to Work, and community career fairs. Then, we will train our CSRs locally to deliver outstanding member service, preparing them for every scenario, from the rare emergency call to the more typical request for assistance with provider appointments. We will monitor and coach their performance with full-time onsite staff Trainers and Quality Specialists dedicated to the call center.

Customer Service Core Training for New Hires. To ensure CSRs are knowledgeable and skilled before taking member calls, our full-time dedicated Customer Service Trainer (Trainer) provides *an initial three-week comprehensive training program* using Adult Learning Principles through classroom instruction, role-playing, hands on demonstrations, interactive online modules, and quizzes to ensure comprehension. Departmental experts, such as from Compliance, Pharmacy, Behavioral Health Clinical Director, and Care Management (CM), inform the coursework, stressing each department's role in the integrated, member-centric System of Care that supports each member. ***Table Q28.A*** is a brief summary of core training topics:

Table Q28.A

Nebraska Total Care Customer Service – Selected Core Training Topics
Fundamentals Module covers customer service and telephone etiquette; use of all desktop systems and documentation; Medicaid 101; all Internal Departments and Programs (e.g., Quality, Pharmacy, Tribal Liaison, and Provider Relations); claims and prior authorizations; member materials; emergency management protocols; confidentiality and HIPAA; and fraud, waste and abuse.
Programs Module covers accessing services; overview of Division of Medicaid and Long Term Care (MLTC), its policies and

contract; in-depth review of Populations and Covered Services, including limitations; exclusions and co-payments, where applicable; the member-centric, integrated System of Care approach used in our CM Team; Value-Added Benefits; role and importance of the medical home; EPSDT schedules; all federal and Nebraska regulations on marketing, including 42 CFR 428.10 ; NTC website, Member and Provider Portals, Caregiver Resource Center, and mobile applications.
Job Functions Module covers the day-to-day responsibilities such as how to: verify caller authorization, especially for children in foster care; locate providers and set appointments; provide services via a participating Indian tribe, tribal organization, or urban Indian organization (I/T/U); deliver Care Gap and Wellness Alerts; understand prior authorization process, claims look-up; transportation and provider accessibility standards; deploy protocols for immediate warm transfer to our 24/7 nurse advice and triage staff ; manage care management referrals and access physical and Behavioral Health (BH) Care Managers for immediate assistance; appropriate identification and handling of quality of care/service concerns; provide web and mobile application navigation assistance; access language interpreters, use Nebraska Relay, and deliver alternative format materials.

Meeting Nebraska Members Where They Are. Nebraska is an ethnically, culturally, religiously, and geographically diverse state with active immigration and refugee settlement sites, with more than 30 different languages spoken. We will hire CSRs from local communities representing this diversity and they will be trained to able to approach interaction with our members with the requisite base of knowledge and cultural competence to direct them to the most appropriate resources. For example, some areas of Omaha have rates of poverty among children that are among the highest in the nation and Nebraska's Native American tribes have rates of substance abuse and behavioral health issues that must be given special consideration. NTC will also work with provider and community partners such as People's Health Center, Lutheran Family Services, the Center for People in Need and other community based services for referral. Other training will prepare CSRs to:

- Assist members with special circumstances, such as those with developmental disabilities requiring long-term services and supports or with hearing and communications issues, young adults transitioning from foster care, and pregnant women, including scheduling assistance and warm-transfer to CM Team, with a focus on People First Language and disability sensitivity
- Understand the implications of limited mobility, lack of social supports, long-term social isolation, behavioral health risk and protective factors, invisible disabilities and co-morbidity, and understanding the unique needs of the LTSS population
- Understand social determinants of health, such as food and housing insecurity, poverty, sexual, physical, and domestic violence, teen pregnancy and the impact of trauma, including removal from family for children and youth in foster care and impact of cultural changes on immigrant populations.

At hire and semi-annually, CSRs must complete our Cultural Competency Training Program, based on the 15 enhanced National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards). We will train to elements of culturally sensitive care for specific Nebraska populations, such as Latino/Hispanic, Native American/Alaskan, Vietnamese, and Arabic members. This training is especially important since CSRs often help eliminate barriers and identify community resources and supports using our Community Resource Guide and Screening Tool (See below).

Monitoring and Testing for Readiness. After new hires successfully pass written and oral comprehension checks, each will spend at least one week in fully observed side-by-side calls, and then an additional 30 days of job shadowing with daily monitoring before taking member calls independently. For this contract, we will hire, train, and ready Nebraska-based Customer Service staff beginning in spring 2016, with CSRs fully prepared to take live member calls in December, 2016.

QMindShare immediately delivers "ticker banners" across our CSR desktop screens for important bulletins, such as notification that a foster child has been taken by a non-custodial parent.

Ongoing CSR Training. *Weekly*, CSRs meet with Supervisors to review call trends and new information, such as upcoming member educational events. *Bimonthly*, the Trainer refreshes understanding, such as how to encourage pregnant members to have a prenatal visit within seven days after notification of pregnancy or enrollment. *Quarterly*, the Trainer deploys a mandatory CSR training specifically designed around specialty areas such as pharmacy issues and supporting members with special needs. *Ongoing*, we will support *Nebraska-focused training* through a "train the trainer" model bringing our CSRs instruction from such programs as the Office of Health Disparities and Health Equities and League of Human Dignity.

Whenever possible, we will include local/state social service support organizations in our quarterly mandatory CSR trainings. *For information requiring immediate action*, such as changes in benefits or related issues affecting members, NTC will employ *QMindShare*, a significant enhancement to our electronic learning system, which delivers high impact communications and requires that the CSR respond to the content with a quick quiz for comprehension.

- ***Routing calls to appropriate persons, including escalation.***

One Call – Many Solutions. Upon receipt of call, our Interactive Voice Recognition (IVR) system greets callers and offers push-button and voice activated prompts in English and Spanish. The IVR also advises callers to immediately hang up and dial 911 if the call is an emergency. Callers may say "agent" for a CSR; "nurse" for nurse advice; or "behavioral health" for specialized BH assistance or urgencies. Calls normally do *not* route among call center staff because all CSRs have the same training, technology, and resources. Our CSRs increase satisfaction and first call resolution by providing anticipatory service, such as offering whatever the member needs (scheduling assistance, medication refill dates, prior authorization and claims status, etc.) and notifying members about alerts in their file (e.g., a care gap or when their Care Manager needs to speak with them). When a call transfer is necessary, all transfers are "warm," during which the CSR introduces the member to the appropriate staff person to ensure continuity and eliminate repetition for the caller. We have successfully trained and deployed the protocols below to affiliate plans.

For Crisis and Urgent Clinical Calls. We train at hire and ongoing to identify situations indicating an emergency, such as seizure, poisoning or vaginal bleeding during pregnancy. ***In an emergency***, a CSR alerts a Supervisor for assistance using an all-day open communication channel, *Open Chat*, and places a three-way call to 911, remaining on the line with the member for safety. If the member lives in an area not serviced by 911, the Supervisor connects with other emergency options (local fire or police departments, or hospital-affiliated ambulance services). CSRs are not trained in clinical triage, so their assumption must always be that a caller who seems in distress is in a potentially urgent health situation. For urgent needs, the CSR, using a best practice protocol, alerts a Supervisor, conducts a three way call with one of our Nebraska licensed physical or BH Care Management clinicians (depending upon need), and stays on the line for safety until released by the clinician. If the member's electronic record indicates the member is in care management, the CSR warm transfers to the designated Care Manager to ensure that the member receives consistent, appropriate response tailored to their medical history. CSRs practice emergency and urgency protocols semi-annually.

Escalation for Pharmacy Issues. We train CSRs to handle routine pharmacy inquiries (benefits, PDL explanation, etc.). If more expert attention is required, such as for members in foster care who leave needed medications behind during placement changes, CSRs use our *Route & Resolve Process*. Using a formulated template, CSRs provide our Pharmacy Department staff with details and the Pharmacy staff work the issue as a priority, reaching out to the local pharmacist or prescriber as necessary. Typically within 30 minutes or less, Pharmacy staff report back to the CSR with resolution, and the CSR contacts the member with results. This relieves the member of the burden of multiple contacts or wasted time.

For Non-Urgent Clinical Issues. We train CSRs in the immediate warm-transfer to our 24/7 nurse advice and triage line for non-urgent or emergent issues (how to care for feverish child, etc.). The CM Team receives a daily Activity Report from the nurse advice line staff for any needed member follow-up.

- ***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).***

Integrated Desktop Tools to Speed Accurate Delivery of Information. Virtually all information CSRs need is available at their fingertips through *Customer Relationship Management (CRM)*, which validates, integrates, manages, and provides access to all accurate, up to date member data (based on Role-Based Access Controls). This information includes, but is not limited to:

- All member eligibility and service history information, including Care Gaps and wellness alerts, call history, claims history, authorizations, etc.; and *Unified Member View* which details a member's historical relationship with NTC across eligibility spans
- Care Manager with message flag if the CM Team has been attempting to contact the member

- Pharmacy management database, including claims history, authorization status, last fill date, pharmacy name and demographics, Preferred Drug List, etc.
- All provider demographics (hours of operation, panel status, languages spoken, etc.), in our searchable database with GPS mapping to provide directions to callers as needed; and our innovative shared scheduling tool, which allows CSRs to select, set and change member PCP appointments during a member call without contacting the provider or placing the member on hold
- All educational and administrative Member and Provider materials and community events schedule
- NTC website and social media, Member and Provider Portals, Community Resource Screening Tool, Caregiver Resource Center, mobile applications; cobrowsing capabilities to assist members with screen navigation; *Click to Chat*, offering members immediate access to CSRs via the Member Portal
- Policies and procedures, work flows, scripts, training guides, important internal and external contact names and phone numbers (i.e., NEMT, Enrollment Broker)

- ***Handling calls from members with limited English proficiency and persons who are hearing impaired.***

For Callers with Limited English Proficiency (LEP). NTC's IVR greets callers in English and Spanish, and offers all self-service options, like obtaining an ID card, in both languages and routes call to the appropriate English/Spanish bilingual staff. For other languages, or if no Spanish-speaking CSR is available, the CSR immediately accesses our language service with professionals translating for more than 200 languages, including Vietnamese, Arabic, and Somali, meeting all CMS, HIPAA and ACA regulatory requirements. CSRs note all language and communication needs in CRM for future calls, and the integrated CTI notifies the CSR of members language needs as the call arrives at the workstation, speeding service. CSRs also arrange for in-person interpretation for members' provider appointments available at no cost to the member.

Our IVR uses a best practice "stay on the line" feature automatically connecting a caller who does not respond to voice or push-button prompts to a trained CSR for service.

For Callers with Hearing Impairments. We will display the Nebraska Relay TTY number prominently in our Member Handbook, member educational materials, and on our website, and train staff in the use of, and proper etiquette for, these services (such as speaking to the caller and not the interpreter). CSRs also will arrange for in-person American Sign Language interpretation for the member's health care appointments through resources such as the Nebraska Commission for the Deaf and Hard of Hearing (NCDHH) statewide interpreter referral service.

For Callers with Any Communication Issue. Our ADC uses a best practice "stay on the line" feature which automatically connects a caller to a CSR if the caller does not press phone keys or respond orally to menu options. For convenience, a caller also may say "agent" at any time and be connected to a CSR.

- ***Monitoring and ensuring the quality and accuracy of information provided to members.***

Continuous Quality Audit Program: Ensuring Quality, Accuracy and Complete Customer Service

To ensure exceptional, anticipatory service, we monitor the quality and accuracy of CSR's responses and phone etiquette through our customized *Call Quality Assurance (CQA) Program*. NTC's full-time *Quality Specialists (Specialists)* will audit a minimum of eight calls per CSR per month for tenured CSRs with excellent previous audit scores and up to 18 calls for new hires using Call Record, a platform integrated with the ADC, which records phone interactions and simultaneous use of desktop resources. Our Specialists will assess courtesy, accuracy, effectiveness (such as delivering appropriate care gap information), cultural appropriateness, and call documentation on each CSR's Audit Report Card. Any score on an individual call that falls below 90% will trigger review and retraining. Any discourteous statement to a member is an automatic fail, resulting in immediate removal from calls and retraining. Specialists will provide audit results to Supervisors and CSRs immediately. Using a Call Center Optimization Forum *best practice*, Supervisors review the Audit Report Card with each CSR monthly. We maintain recorded calls for 14 months and incorporate "live" call examples into training. Supervisors also audit calls in real time to review accuracy of delivery or to coach via *Open Chat* without disturbing the flow of the call or putting the caller on hold. Supervisors will assure inter-rater reliability with a monthly quality call calibration session using random calls. In addition, CSRs will participate in a quality

rebuttal program, reviewing and scoring sample calls, as a training exercise and to ensure accuracy and fairness.

Ensuring Quality Service to the Members with the Greatest Service Needs. While CSRs attempt to resolve issues in a member's first call, our experience shows that some members require more significant levels of service. Because of the complexity of their personal situation, they call more frequently with multiple administrative issues. Consistent with our Concierge Service model, we will proactively engage these members and encourage self-advocacy through our *NTC Service Team (Team)*. In this *best practice outreach*, Lead CSRs, who have more experience and training, call members who demonstrate complex or multiple administrative needs. Using active listening and motivational interviewing, the Team will uncover and assist with the full landscape of the member's need, resolve any remaining barriers to care, offer additional plan services, and ensure complete satisfaction with service. If necessary, the Team will refer and warm-transfer the member to CM Team for health education or an in-field visit.

Post-call, the Team staff member providing the service will send a personal, handwritten note and business card to the member, thanking them for their time and reminding the member to re-contact us at any time. Management also will use information gathered by the Team for quality improvement, individual and group CSR training, and as an "early warning" system to uncover any procedural or accessibility issues members have identified.

Using Speech Analytics to Improve Staff Accuracy and Offer Timely Information. To ensure accuracy of information across the call center, we will deploy Uptivity, an award-winning quality management solution that uses Speech Analytics software to help us identify situations in which CSRs may be inconsistent or incomplete, and to uncover areas where specific education is needed. Uptivity uses phonetic-based analytics to *word mine* calls based on spoken phrases. For instance, when Supervisors notice an increase in inquiries about pediatric measles, Uptivity can word mine all calls for "measles," and report the frequency of mention. The Trainer then quickly samples calls to determine our members' specific needs and within a few hours, delivers Medical Management "teaching points" on measles to each CSR via QMindShare to assist and educate concerned parents. Uptivity also delivers real-time reports on important metrics, such as new program requirements, by word mining all calls, not just a sampling. For example, Uptivity can word mine for key phrases after a program change and flag the Trainer, in real-time, about any CSR who requires more training for consistency and accuracy.

- ***Monitoring and ensuring adherence to performance standards.***

Processes to Ensure NTC Meets or Exceeds MLTC Performance Standards. NTC is well prepared to meet or exceed MLTC's member call center performance standards. We will deploy our innovative IEX Workforce Management System (IEX) to create a responsive, scalable call center to maintain appropriate staffing levels and monitor and report performance standards.

- IEX will deliver detailed analyses, based on years of call data from affiliate health plans with similar populations, historical call duration and patterns, including seasonal variations, market maturity, and call-type complexity and including program features specific to Nebraska, to create staffing patterns for optimal service performance.
- Ongoing, IEX will monitor performance against standards in real time and analyze volume, abandonment rate, average speed of answer, hold times, transfer and queue volume and all MLTC-required metrics as cited in IV. F. 2 Member Services Call Center. Because the same CSR will follow a member call to resolution, including outbound research, IEX will predict staffing needed for "shrinkage" caused by follow-up and post-call documentation, so we can adjust staffing in real time, for instance, by staggering breaks, or deploying additional resources, from fully cross-trained provider call center staff or Quality Specialists, to maintain all performance standards.
- Lastly, IEX predictive modeling capability also will allow us to forecast staffing needs and maintain standards, even during rapidly changing situations, such as during open enrollment.

When local business functions are interrupted for an extended period of time, such as during severe weather, we will activate our business continuity plan, which may include transfer support of all call

center lines to Centene's Regional Service Centers located throughout the country in multiple time zones to ensure we maintain performance standards.

Success with Performance in Affiliate Plans. Using IEX, our affiliate plans with populations similar to Heritage Health currently meet or exceed their state's standards. ***Table Q28.B*** is a sample of performance for affiliates in states *with the same rigorous performance standards as proposed for this MLTC contract* (90% of calls answered within 30 seconds; abandonment rate less than 5%, hold-time maximums, etc.).

Table Q28.B

Member Call Center Performance for NTC Affiliates with MLTC Standards: May – October, 2015						
Affiliate	Call Volume	Average Speed to Answer	Abandon Rate	% of Calls answered within 30 secs.	Average during-Call Hold Time	% Busy Signal
Louisiana	128,252	4 sec.	0.62%	97.9%	120 sec.	0%
New Hampshire	38,610	7 sec.	0.69	95.0%	170 sec.	0%

We will monitor call performance against MLTC standards in real-time and ongoing, and report data as required.

- ***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).***

CSRs Meet the Full Range of Member Need. In order to help address the social determinants of health (e.g., access to food, mental health services, job training, social support) which impact our members' wellness, our CSRs will provide members with access to all community and governmental resources. ***For routine referral and requests***, such as to MLTC, enrollment broker, or the Division of Children and Family Services, CSRs will provide all needed information (hours of operation, etc.) and warm transfer members to the service. ***For community-based resources,*** such as when a member reports food insecurity, or requires WIC, CSRs will use our *Community Resource Guide*, our searchable database of community supports, such as advocacy groups, local food banks, community clothes closets, housing supports, etc. Again, CSRs will provide all needed information and offer warm-transfer to the service. ***For more specific, personal needs,*** NTC will deploy our *Community Resource Screening Tool,* a dynamic service to identify, refer, and follow-up with members in need of social or behavioral services. With CSR assistance, members will take a baseline questionnaire which dynamically populates different questions based on the member's answers and then offers referrals specific to that member. For example, if a member calls with an employment need, our CSR can use the Tool to find job fairs or job training sites that meet the member's particular circumstance. Lastly, for members who report being ***in critical circumstances,*** such as immediate loss of housing, CSRs will immediately warm-transfer a member to our MemberConnections™ Representatives who will provide personal, in-field assistance.

- ***After hours procedures.***

After hours, our IVR call routing system will offer the same automated services and prompts, including advice about 911, as described above. Members may use voice or push-prompts for PCP assignment, ID care replacement and other self-service features, and may leave a voicemail message, which will be returned by NTC staff within one business day. Callers also may receive nurse advice or medical assistance by saying "nurse" or prompting the IVR for our 24/7 nurse advice line. Nebraska licensed RNs will answer questions, provide advice and triage, and have immediate access to our CM Team and Medical Director through an after-hours on-call assignment roster. The CM Team will receive a daily Activity Report from the advice line nursing staff, including inquiries requiring follow up no later than the next business day. At any time, members can access important personal health and wellness information and administrative functions on our website, our secure Member Portal, and via our mobile applications.

29. Describe the informational materials the MCO proposes to send to new members. (2 page limit)

Nebraska Total Care (NTC) will develop its Welcome Packet for new members based on best practices of our affiliate plans and extensive research with Medicaid consumers to create an engaging, culturally sensitive, and motivating introduction to NTC. All materials meet all State, Federal, and RFP requirements for member materials and communication with new members, including being written at no higher than a 6.9 grade reading level, in a 12 point font, with all NTC contact information prominently displayed, and including the date of issue or revision. The packet will include all early engagement materials and health literature designed to improve members' health and wellness in a folder for storage and reference. In a campaign orchestrated for maximum effectiveness, we will mail the Welcome Packet with Member ID card within 10 days of receiving the new member file, provide personal telephonic orientation within 15 business days of the date we send the welcome packet, and offer a single page in English and Spanish on our public website with links to all important information and materials. NTC will offer alternative formats for our written materials, including language translation, braille, large font letters, audiotape, prevalent languages and verbal explanation of written materials and will inform members about these no-cost services through our Member Handbook, our website, during the on-hold messaging, and in interactions with our Customer Service Representatives. All NTC material related to enrollment and PCP selection will advise members to verify their providers participation with NTC, and that they are available to see the member. We will submit the contents of the NTC Welcome Packet to Medicaid and Long Term Care Division (MLTC) for approval a minimum of 45 calendar days prior to contract start date.

Welcome Packet Specially Designed to Promote Early Engagement. Based on Centene research with adult Medicaid members, with MLTC approval NTC will offer new members a Welcome Packet designed to educate them about all benefits and services and encourage health literacy (***Table Q29***). The Welcome Packet will include:

Nebraska Total Care New Member Welcome Packet Table Q29	
ID card affixed to the welcome letter with explanation on how to use the card in tandem with the MLTC-issued ID card	Refrigerator magnet with *EPSDT periodicity schedule*, for easy reference
Welcome letter with our toll free Customer Service and Nebraska Relay numbers for 24/7 nurse advice and triage, material translations, administrative assistance, and to obtain a hardcopy of Member Handbook (which includes all elements described in section IV.F.5.f of the RFP) and Provider Directory, and Provider selection and appointment assistance	A *refrigerator magnet with our 24/7 number for nurse advice and triage,* and with space for the member to personalize with PCP name and number. In affiliate plans, this magnet is one of the most requested collateral items for our member households
One-page "to do" list for the member, including: select PCP, schedule a visit, complete and return Health Risk Screening (HRS) and Notification of Pregnancy (NOP), if appropriate, register for Secure Member Portal, obtain information regarding behavioral health services as needed, and contact Customer Service for personal assistance with any issue, including appointment scheduling and non-emergency transportation assistance.	A *Quick Reference Portal Flyer* to assist members with accessing our website and the information provided on it, including the New Member Welcome Tool Box and Caregiver Resource Center; Member Portal registration; *MyNTC*, our suite of mobile applications; and how to contact Customer Service for materials in hardcopy if the member does not have web access or needs assistance.
Your Benefits Formbook, an easy-to-use book with all needed forms, including HRS, PCP selection/change, and NOP, with instructions on how to complete and return either using the provided postage paid envelope or Secure Member Portal. These forms will scan directly into TruCare, our member-centric health management platform, allowing us to update the member's clinical and demographic information quickly, limit upload error, and save processing time	*Your Benefits Booklet,* a colorful, concise compendium of the most needed member information for early engagement, including on: Care and Disease Management programs and MemberConnections™ and how to access; appropriate emergency room use; 24/7 nurse advice and triage line; Start Smart for Your Baby®; CentAccount™; your Medical Home; importance of the annual physical; behavioral health services; and our *Community Resource Guide* available

	on line and with Customer Service assistance.
Preparing for Your Doctor Visit, a one page reminder of what to bring and what questions to ask your PCP	*"For Your Health"* folder, to keep the welcome contents together for future use

We selected these contents carefully and on the basis of focus group research. These materials, coordinated in style and color with culturally diverse models, are easy to read and navigate and, most importantly, *provide information the member wants and needs*. We will mail the member packet in a colorful envelope with call-to-action messaging about personal health and benefits, which received the most positive reaction from Medicaid consumers in our research. (Please see ***Attachment Q29_Welcome Packet sample materials***.)

Reaching Members with the Welcome Packet. NTC will maintain accurate member contact information through an integrated, plan-wide process of data *capture-and-verify* using these strategies:

- Prior to mailing the Welcome Packet and ID, NTC will use an address scrubbing program (SmartyStreets, a leading USPS approved validation service), as well as LexisNexis to eliminate unnecessary returns. We will augment the member record in our Customer Relationship Management system (CRM) but not delete the original state enrollment file data; we can supply updated contact information back to the state.
- During the personal telephonic orientation, we will obtain and verify member contact data. If a member's address differs from the enrollment file, we will re-mail the packet and can supply MLTC with the updated address.
- For returned packets, NTC Customer Service will use all available resources, such as pharmacy telephone records, PCP on file, claims information, personal cell phone numbers, to obtain updated contact information. We will deploy Google Analytics to search for a valid member phone number or address. We validate the address with the member and re-send the packet.
- Unified Member View (UMV) will link contact information across family members over the span of their enrollment with NTC allowing us to update all family members regardless of program type and view any information associated with a past enrollment span.

Using these strategies, our Georgia affiliate experiences a mail return rate of approximately 6.12% using these strategies, well below the industry average of 1/3 of MCO mail being returned.

Additional Avenues for New Member Engagement. In addition to the Welcome Packet, NTC will conduct ***personal telephonic orientation*** with new members, including confirmation of packet receipt and current address. Our MemberConnections™ Representatives will host ***New Member Open House*** events throughout the state to personally answer members' questions, offer materials, and facilitate engagement through demonstration of and assistance with PCP selection and scheduling, Member Portal registration, and mobile application (apps) demonstrations. ***(See our response to Q.32 for more details.)***
We also will provide an online ***New Member Welcome Tool Box*** with content organized around the materials, information, and links that a new member needs to access services and take responsibility for health, including, but not limited to:

- Links to essential onboarding information such as Member Handbook, Preferred Drug List, Benefits Summary, CentAccount incentive program, Start Smart™ for Your Baby, *MyITC* mobile apps, all early engagement forms (e.g. PCP selection), and how to obtain personal assistance through Customer Service, including with alternative formats and language support
- Link to the searchable Provider Directory, with all demographic information (hours of operation, accessibility, languages spoken, etc.) and mapping search engine including driving, walking and public transportation routes (where available)
- A scroll-by window of upcoming community and member events, including New Member Open House and locations of Community Service Centers for walk-in assistance.

(2 page limit)
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.

Member Materials: Delivering the Right Message in the Most Engaging Style

Nebraska Total Care (NTC) will provide all members with consumer-friendly, easily understood and actionable written material. We will inform our content with input from providers, members, our Member Advisory Committee, Tribal Healthcare Committee, and valued stakeholders, to develop publications that motivate each the member toward self-management and improve member health and wellness. We also will leverage Centene Corporation's (Centene) award winning publications to provide an age-leveled, culturally competent health literacy library. Using the sophisticated technology offered by Centelligence™ Engage (see below) we will deliver these materials in an orchestrated campaign across multiple communications channels, *delivering the right message in the right format at the right time for maximum impact and member engagement.* We also will use every traditional opportunity to deliver health literacy messaging from on-the-ground distribution, such as through our in-field MemberConnections™ Representatives, Care Management (CM) Teams and Health Coaches, and via mobile-friendly web files, podcasts, webinars, texts, and emails.

For members with literacy, alternative communications, or developmental needs, we will offer alternative formats, materials accurately translated in other languages, over-the-phone real-time interpretation, and reading/explaining English text to members.

We understand and will comply with federal, state, and contractual regulations pertaining to member materials and member education.

Centene Corporation's outstanding member materials have won numerous national awards, including the 2015 Hermes Creative Platinum and Modern HealthCare IMPACT Award.

Ensuring Member Materials Are Easily Understood

Centene is well recognized for developing original, engaging, high-quality Medicaid member materials. Our Marketing and Communications Department includes staff who have taken health literacy training through organizations such as America's Health Insurance Plans (AHIP) to enhance our ability to communicate effectively at all reading levels. We also collaborate on member materials with nationally recognized health literacy experts, such as Children's National Health System and Howard University, to ensure that our member materials are accurate, engaging and culturally competent. We partner with nationally known children's author Michelle Bain to create an entertaining and educational series of comic-books and graphic novels, such as *Off the Chain*, a dynamic self-management book covering all aspects of a teen's life and health, and *Darby Boingg Helps a Friend on a Foster Care Journey*, an activity book.

We "road test" these materials with Medicaid consumers to determine their efficacy, appeal and readability, developing best practices for our materials. For instance, in 2014, focus group testing demonstrated that the more action-oriented the content, the more likely members will read and respond; so we began adding checklists and schedules to member educational materials. Consumers also reported that, when faced with a form, they prefer contrasting colors and empty spaces clearly identified as "intentionally blank," which make it easier to complete the form, ideas NTC will incorporate into its design of the Health Risk Screening and PCP selection tools. We also obtain input from local member and stakeholder focus groups. For example, members in our Missouri affiliate told us that they find tracking tools for wellness appointments very useful, so we will include a refrigerator magnet with EPSDT schedule and a checklist of how to prepare for your PCP appointment in our Welcome Packet.

Providing Alternative Formats. NTC will provide member administrative and educational materials in alternative formats, including large print, braille, audio tape, and CD. NTC also will offer audio files of our Member Handbook on our website, along with downloadable member education podcasts, such as asthma and diabetes self-care, and specialty webinars (such as for foster care parents on trauma-informed

care.) Our website is 508-compliant and does not require anything beyond a reasonably up to date browser to access.

Members can obtain immediate, personal assistance 24/7 from Customer Service and nurse advice line staff, who will read, explain, or provide translation assistance for member materials, or arrange for alternative formats. *For members with low literacy skills, visual limitations and /or limited English reading proficiency*, we will train all member-facing staff to read and explain materials in a sensitive and culturally appropriate manner. *For members with hearing difficulties*, we will employ Nebraska Relay in English and Spanish, and train staff in the effective, appropriate, courteous delivery of service, such as speaking directly to the member and not the Relay Operator. Our member publications and website will display the Nebraska Relay number prominently.

Providing Member Materials in Other Languages. We will offer our Member Handbook, website, and materials in both Spanish and English, and will print materials in any prevalent language spoken by 4% or more of our members or potential members. We use certified professional translators for all material translations and maintain certificates of accuracy. When possible, we will use regional translators, such as Midwest Translation Service, to ensure that materials accurately represent regional colloquial dialogue and idioms.

In addition to real-time telephone translation of materials, NTC will provider in-person language and American Sign Language medical interpreters for members' provider appointments.

Customer Service will provide members with real-time interpretation of materials in any language through our national interpretation partner with medical expertise and meeting CMS, HIPAA, ACA and other regulatory requirements.

Making alternative and non-English materials easily accessible. We will inform members of the availability of alternative formats and materials in other languages, and how to access, on our website, Member Handbook, correspondence, and in all member touchpoints, such as via CM Team and Customer Service. The NTC Member Handbook, website and all critical plan materials will advise members in Spanish, Vietnamese, Arabic, Nuer, Somali, Mandarin Chinese, German and Kurdish to call our 24/7 toll-free telephone number to request information in other languages.

Identifying and delivering the right materials to the right members. All member facing staff inquire about and document communications needs in the member's electronic file, alerting staff to the member's needs during subsequent interactions. Then, through our Centelligence Engage system, we deliver *the right messaging to the right member in the right form.* Engage integrates the captured member data with the member's health record data (e.g. chronic conditions) so that we can target, immediately and ongoing, what information the member needs (EPSDT, health alerts, Care Management Program), the member's preferred method of receipt (e-mail, text, mail, phone), and preferred language. For instance, Engage allows us to deliver one set of language-specific coordinated messages to a Vietnamese-speaking member, focusing the member's attention on the most important information concerning their health.

Ensuring Material Accessibility through Appropriate Reading Levels

We write our member materials at a 6th grade reading level or below (no higher than 6.9) and test them for readability using the Flesch-Kincaid Readability Test. When developing member materials, we write the way a person talks; we use a friendly tone, active voice, common words, and short sentences; and provide examples. We adhere to People First Language and the National Institutes of Health Easy-To-Read Guidelines for health materials. To ensure maximum impact, we will obtain feedback on NTC materials from our Member Advisory Committee, Tribal Healthcare Committee, network providers and their office staff, and from community stakeholders, for example, the Asian Community and Cultural Center in Lincoln and the Nebraska Latino American Commission. The Vice President of Compliance will review member materials for all federal, state and contract requirements before submission to the Division of Medicaid and Long Term Care (MLTC) for final approval prior to production.

(6 page limit)

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.

Member Website for Engagement and Interactive Use

Nebraska Total Care (NTC) will employ the nationwide health care web applications design, integration, implementation, security infrastructure, and operations expertise of our parent company Centene Corporation (Centene) to offer a mobile enabled member website, Member Portal, and mobile applications, and available in both English and Spanish. Through a well-orchestrated online strategy, and with MLTC approval, we will offer communication touch points through our mobile friendly website and portal with bi-directional communication capabilities.

In 2014, Centene won the Gold Web Health Award from the Health Information Resource Center recognizing high-quality digital health resources for members and health professionals.

Ensuring Members Have Online Access to Timely Information. In the response below, we describe how we will offer online access to NTC and MLTC information resources through:

A Public Member Website with clearly organized, updated, and MLTC approved information that is visually appealing and easy to navigate and viewable on a mobile device.

A Secure Member Portal that empowers members with self-service informational tools and encourages members to submit questions and comments to NTC staff for information or help.

Mobile applications to extend access to care and equip members to stay engaged in their personal health.

Public Member Website to Exceed MLTC Requirements

Our public website will provide general information about the Nebraska Medicaid program and NTC, such as eligibility and benefits, health management, services including after-hours and emergency coverage and preventive care, incentive programs, how to file grievances and appeals, and other programmatic information for members. We will use a content calendar to ensure that our website is updated frequently and approved by MLTC in accordance with RFP IV.F.10.b, and in compliance with RFP Section IV.G (which has member marketing requirements similar to those supported by our affiliate Managed Medicaid health plans and their websites in 20 states).We will offer website visitors access to an extensive online health library with hundreds of articles on a variety of topics. Through our website, members will be able to register and login to our secure Member Portal (described in more detail below). Member-focused features on our NTC public website will include:

- A searchable **Member Handbook**
- An interactive, searchable **Provider Directory**
- A **news blog featuring new items and member information** (example topic from NTC's affiliate health plans include preventive care, health tips for reducing stress and lowering blood pressure, and medication safety)
- **Contact information** (toll-free 24/7 customer service number, information on interpreter services, and a telecommunication device for the deaf [TDD] number)
- The **toll free number and link** to the MLTC Enrollment Broker's website for enrollment questions
- A **link to http://accessnebraska.gov** for questions about Medicaid eligibility
- **Pharmacy Preferred Drug List** and **Pharmacy Conditions for Coverage and Utilization Limits**

Online Resources for Member Communications

New Member Welcome Tool Box. The best time to engage members in their health is at the beginning of our relationship with the member. In addition to the new member communications materials mailed to each new member, we will create a *New Member Welcome Tool Box* with content organized around the

materials, information, and links a new member needs to begin accessing services and taking responsibility for health, including, but not limited to:

- Links to Member Handbooks, Preferred Drug List, Benefits Summary, CentAccount health incentive program booklet, Start Smart for Your Baby materials, and link to Start Smart Mobile and MyNTC mobile applications (described in more detail below)
- A scroll-by window of upcoming community events, member events, and in-person orientations
- Explanation of the secure Member Portal's self-service features, benefits, and link to register
- A link to all forms a member may need to complete
- How to obtain all needed assistance through a call to our Customer Service Representatives (CSRs)

Please see ***Attachment Q31-A: Public Member Website*** and ***Attachment Q31-B: Member Health Library*** for some examples of information for members on our public website.

Online Provider Directory with Multiple Search Criteria. Members, providers and any website visitors can search for providers in our network by location or by doctor/facility/pharmacy name, and refine the search through additional criteria, such as provider name, distance to the medical facility, provider specialty, gender, and languages spoken. Distance to the provider's facility is calculated in real time. Public transportation access information is included, as well as a map that provides directions from the user's location to the provider. In addition, the directory will identify those PCPs, specialists, and other providers that are not accepting new patients. Provider data in our online directory is updated every 24 hours. Please see ***Attachment Q31-C: Provider Directory*** for a sample screenshot.

Provider Performance and Quality "Star" Rating. NTC's online Provider Directory will include provider performance and quality feedback so that members have the information at their fingertips to make an informed decision when choosing a PCP. Our online Provider Directory displays an overall provider "star" rating when the provider record is displayed. The star rating will incorporate, in one measure, factors for performance and quality.

Health Content Available through the Health Library. Our member website will offer an online health library with hundreds of books, health sheets, and podcasts on a variety of health topics to for members and/or their caregivers to view at their convenience. Topics will include, among others, information Asthma, Diabetes Management, Flu Prevention, and more.

Bi-Directional Communications. We encourage members to contact us if they cannot find what they are looking for on our website or Member Portal and any visitor to our public site or Member Portal can fill in an online form to contact us. The visitor or member can select the general topic they wish to contact us about by using a drop-down box in our Contact Us online form. We carefully monitor all Internet communications and inquiries and we are able to securely route member messages to the appropriate department based on topic to ensure a timely response back to the member, within one business day of receipt. NTC, like all our affiliate health plans, will have policies in place regarding Internet communications and a procedure for evaluating if the department is meeting the defined standards. All correspondence received through our Member Portal is secured, and our system maintains a history of the email correspondence for member service, operational, and regulatory reporting.

In 2015, Centene's mobile health content subsidiary won the eHealthcare Leadership Silver Award for Best Interactive Site for their Member Portal, from Strategic Health Care Communications.

Click to Chat Technology. To enhance our members' ability to communicate with us bi-directionally, we will offer Click to Chat technology on our Member Portal. Click to Chat allows Members using the Member Portal to begin a live conversation instantly with a CSR for immediate personal service.

Co-browse. We integrate our Member Portal and CSRs with a co-browsing capability. This function allows, with the member's consent, a CSR on the phone with a member to jointly access and see the "experience" the member is having with the Member Portal, allowing our CSRs to offer the best possible

service support for members with portal questions. As an increasing number of members and caregivers use our Member Portal, we have found the ability for CSRs to view what the member is viewing on the Portal increasingly helpful in providing service excellence.

Centelligence™ Engage: Using Technology to Ensure Effective Engagement. We will deploy our Centelligence™ Engage platform to help reinforce successful bi-directional member interaction – using the communications method (web, mobile, etc.) that a specific member prefers. The Centelligence™ system integrates data from multiple sources, for a wide variety of actionable information, reporting and analytic needs. The Engage component of Centelligence™ uses member data to determine what information needs to be targeted (e.g. Health Alert, EPSDT Gap, Medicaid Redetermination Due) to which member using the member's preferred method (web, e-mail, text, phone, letter), and in the most effective manner (e.g. culturally attuned for specific ethnicity, health status, time of day). Engage will orchestrate NTC's outbound communications with our members in a unified approach, so that we can focus the member's attention on the most important items concerning his health.

Communication Strategy Informed by Member Feedback. A critical part of successful member communication is ensuring that our materials are culturally, linguistically, and geographically appropriate and meaningful to all members. We will work directly with our members to capture what materials members would like to see on the member website and what topics and communications are relevant to them. We will ensure that our Americans with Disabilities Act (ADA) Section 508 compliant website and portal features provides optimal information accessibility and informs members of ways to access alternative formats of written materials. As our affiliated health plans do, we will periodically conduct usability testing of our website with NTC members and will subsequently use this feedback to enhance the website, where appropriate. We will also encourage members to provide written feedback and suggestions on how we can improve our website.

Nebraska Total Care Member Portal: Increasing Member Engagement

NTC's secure Member Portal will offer members online access to "self-service" functions, such as, the ability to view their clinical service and medication history, change PCPs, update their contact information, take an online health risk screening, view a health alert or gap-in-care, communicate with NTC staff, check the balance of their CentAccount® incentive program and set up (as an option) their electronic Personal Health Record.

We promote our Member Portal to our members at every practical opportunity, including via our Customer Service Representatives (CSRs) during member calls, in our member welcome literature and newsletters, through our field force of MemberConnect Representatives (MCRs) who meet each day face-to-face with members, during member orientations, etc.

See ***Attachment Q31-D: Member Portal Landing Page*** for a screen snapshot of our Member Portal, and see ***Table Q31.A*** for more information on our Portal features. Note that, unless otherwise stated, these features are available today on our affiliate health plan websites, powered by Centene technology.

Content Overview of NTC Secure Member Portal Table Q31.A.

Content/Function	Description
Account Profile and Email Communications	
E-mail Communications, Contact Us, and Secure Messaging	***Public Website.*** Members and visitors can fill out a contact us with a comment or question. ***Member Portal.*** Members can utilize our secure messaging capability behind the member's login.
Member Profile	Members are able to change their website registration information and preferences, contact information such as e-mail and password, and also add dependents through their member profile page.
Care and Wellness	
CentAccount® Reward Program	NTC's CentAccount® program promotes personal health care responsibility and ownership by offering our members financial incentives for certain healthy behaviors. The CentAccount® program uses leading technology to restrict card

Content/Function	Description
	purchases to health care and personal hygiene items. Our members have the ability to view their CentAccount® incentive balance and recent CentAccount® reward card activity through the Member Portal.
Personal Health Record (PHR)	NTC will provide support to those members who want to maintain their own electronic PHR through Microsoft HealthVault, one of the most prevalent PHR platforms in the market today. We view PHR's as an increasingly popular way to reinforce and empower member engagement, as well as allowing members to keep a portable online health record beyond the time of their active membership in our health plan.
Online Health Risk Assessment (HRA) and Care Gaps and Opportunities	NTC members are encouraged to complete a HRA and have the option to take the HRA on our Member Portal or MyNTC mobile application (see below for more information). All information collected on the HRA is electronically imported into our TruCare health management system and is used by our clinical staff to support care management. Additionally, HRA data is integrated into our Centelligence™ predictive modeling system, which analyzes HRA and other claims data and clinical information, to identify any potential member gaps in care or preventive services. Note that NTC members will also have the option to receive secure email alerts, related to care gaps identified by our Centelligence™ platform.
Pharmacy	This feature, available in early 2017, will offer member access to pharmacy information that support day to day management, treatment, or maintenance. Member will be able view real time cost pricing of drugs, view potential drug-to-drug interaction alerts, manage their medication adherence using calendar reminder alerts, as well as manage their drug refill orders.
TruCare Care Plan	TruCare Care Plans support collaborative care among NTC, members, and providers. With MLTC approval, NTC will offer members view access to their TruCare Care Plans (i.e., Asthma and Pediatric Asthma, Diabetes, Congestive Heart Failure, and Chronic Obstructive Pulmonary Disease) maintained in our health management platform, TruCare. These Care Plans include member health problems, goals and objectives, milestone dates, and progress designed for a "lay audience" and written at 5th grade reading level.
Choose, Change, or Search for a Primary Care Physician (PCP)	NTC members can choose or change their PCP at any time through the Member Portal. The member can search for and select a provider based on their needs (i.e., geographic proximity, languages spoken, gender, office hours, and other information). Once selected, the new PCP request from the member is electronically promulgated throughout our MIS for use in our system.
Manage Dependents Health Records	Federal and state regulations stipulate we may not provision a secure portal account for members who are younger than 18. However, through the profile function of our Member Portal, members and caregivers can create an account for their dependents. This feature helps caregivers manage the health of their family. We see this as an important factor to increase family engagement in our member's care especially in the event of statewide emergencies where ready access to NTC member information is important.
[redacted]	[redacted]
Financial Transparency	
Claims History and Explanations of Benefits (EOB)	All NTC Member Portal users are able to view claims history and access their EOB for services rendered to the member under our health plan on the Member Portal. The EOB includes what services the member received from which provider on what date – and includes the amount paid by NTC. In this way, we can convey to the member the benefits he or she is receiving and the total cost of those services, as well as allowing members to report any suspected fraud, waste or abuse (e.g. by allowing members to verify that they were given services depicted in their EOBs).

Mobile Technology to Further Member Engagement

Since 2010, Centene websites have been "mobile friendly": meaning that our websites detect if a visitor is using a mobile device to view our contents, and presents that content in a form "friendly" for that device. See ***Attachment Q31-E: Mobile Optimized Website*** for an example. Today over 30% of the member views of our affiliate health plan websites are via mobile platforms, partly as a result of our "mobile friendly" capabilities. We have augmented our mobile presentation abilities with the introduction of *mobile applications* to expand and enhance our members' "mobile experience". NTC's mobile applications combine Centene's operating experience in Managed Medicaid systems with best of breed mobile technology. NTC members will be informed on how to download and use our mobile applications through our CSRs, email/mail communication, and through instructional links on our website.

MyNTC Member Mobile Application. For NTC members, we will deploy our member-centric mobile application, MyNTC, specifically designed to provide our members and their caregivers with the informational tools they need to stay engaged in their health. MyNTC is uniformly branded as a NTC mobile application so users will know instantly where to turn to for any assistance (see ***Attachment Q31-F: MyNTC and Start Smart Mobile Application***). As a mobile development best practice, we will continue to release new functions and features to ensure increasingly compelling uses of MyNTC. As new capabilities are released, Members will be prompted (through their mobile device) to upgrade their MyNTC mobile application. Please see ***Table Q31.B*** for the MyNTC features we will offer for our Heritage Health program. We will work with MLTC for approval for all features.

MyNTC Mobile Application Features and Capabilities Table Q31.B.

Mobile Start Smart for Your Baby® (Start Smart Mobile)

An extension of our award-winning Start Smart for Your Baby® Pregnancy Management Program (see ***Attachment Q31-C: MyNTC and Start Smart Mobile Application***), Start Smart Mobile is an interactive and personalized application for new and expecting mothers. Start Smart Mobile will provide support for NTC's pregnant members from the first positive pregnancy test through the post-partum and early newborn period. The mobile application helps families stay on track with key prevention milestones, set personalized reminders, proactively identify and take action on health issues, and tap into NTC's other programs, such as, telephonic Care Management and 24/7 nurse advice line. Start Smart Mobile content is personalized based on expecting mother's due date and provides daily advice and informational photos and videos by weekly pregnancy stage. Start Smart Mobile will feature a broad range of pregnancy related interactive tracking tools, self-service functions, alerts, educational videos, and accessible resources. Using Start Smart Mobile, Members will be able to access care and support quickly and efficiently, engage with self-service tools (i.e., gaps-in-care, set custom reminders and alerts), check their CentAccount rewards balance, and interact with additional features (i.e., baby gift registry and name picker, local parenting classes, family planning tools and information to enroll their newborn in health coverage). We will offer Start Smart Mobile as a free resource for our expectant members and for support through their baby's early childhood years.

Technical Aspects of Website, Portal, and Mobile Applications

Web-based Technology Support. Our member website and portal have minimal end user technical requirements, with no specific browser prerequisites. Our website and portal are accessible on reasonably recent versions of all popular web browsers, including Google Chrome, Internet Explorer, Firefox, and Safari, and are designed using a mobile first strategy which means that all content is viewable on smartphones and tablets. Our website and portals are also designed so that users do not require significant memory, disk resources, or special software beyond a web browser.

Website Technology Supporting User Engagement. NTC's website will deliver rich multimedia content using best-in-class Adobe Experience Manager content management solution. Adobe Experience Manager enhances the optimization of our online content for mobile devices and provides an engaging platform for content delivery while adhering to Section 508 of the Americans with Disabilities Act and Web Content Accessibility Guidelines.

Security, Accessibility, and HIPAA Compliance. Since 2010, Centene has deployed secure member portals for all affiliate health plans. Centene's web architecture allows for the cost effective use of common technologies across all our health plans, including NTC, but our web portals are systematically segmented for each health plan in terms of user and data access and sub-network management. We employ HIPAA compliant security controls, safeguards, policies, and procedures throughout our Management Information System infrastructure, including our web infrastructure, and we can configure our Member Portal for privacy and security requirements beyond HIPAA if necessary (as we do, for example, with our Foster Care health programs).

Integration and Connectivity. NTC's Member Portal is architected on open standard technology, which allows us to deploy web services with a broad range of integration and connectivity options. The result is better access to more timely information from our internal applications and external systems for critical applications, such as our Care Gap alerts, which integrates with our Centelligence™ predictive modeling system to deliver care gap and health risk information specific to our members.

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. (3 pgs)

New Member Approach

Nebraska Total Care's (NTC) comprehensive New Member activities, supported by our Data Team, Member Services and Care Management Departments, are tailored to meet and exceed Nebraska's communication requirements and promote member engagement and active participation in their health and wellness. Activities include: 1) processing of daily enrollment files from MLTC's enrollment broker; 2) member data management to safeguard accurate member contact information; 3) mailing of Welcome Packets and Member ID Card within 10 business days of receiving the new member file; 4) initiation of Welcome Calls within 15 business days of the Welcome Packet being mailed; 5) PCP assignment within 30 days; and 5) Continuity of Care and Care Management outreach for members with immediate service needs. Initial contact is commenced and tracked by NTC Customer Service Representatives (CSRs) via mail and telephone, with reinforcing materials and information available on the member portal and mobile apps. All contacts are designed to engage and educate the member on their rights and responsibilities in a culturally and disability sensitive manner.

Daily Enrollment File. The first step to ensuring timely outreach and welcome materials is the timely and accurate processing of enrollment files. NTC's enrollment staff maintains policies and procedures governing the receipt, processing, and promulgation of 834 membership data across our MIS and those of our subcontractors. We currently process HIPAA 834 change transactions for our state Medicaid clients on a daily basis, processing inbound files within 24 hours of receipt via our secure file transmission system and integrated EDIFECS middleware, which validates and maps each data item in the 834 to the membership input file format of our MIS. We also support monthly (as well as weekly) membership reconciliation processes, to compare all of our member records at a given point in time with our State Agency clients to ensure complete and accurate data capture.

Member Data Management. As an integrated component of our Customer Relationship Management (CRM) platform, Member Data Management (MDM) supports all informational aspects of each member's relationship with Nebraska Medicaid, such as member identifiers, address and contact information, confirmed or potential family linkages, special needs, member preferences (e.g., communication options such as e-mail, phone, and/or mail), along with a history of any change to each attribute. In 2014, we introduced our Unified Member View (UMV) capability into MDM, which gives us an enhanced ability to link an inbound Member record with historic "eligibility spans" we may have on that member, (e.g. prior history as a Heritage Health member). UMV also features enhanced capabilities for member address standardization, through integration with SmartyStreets (a leading real time US Postal Service approved address standardization service); and Identity Verification & Authentication data services from LexisNexis®, enhancing the accuracy and quality of member data we house and analyze. However, as we do today, we will never overwrite eligibility information we receive from the MLTC's 834 Files but rather store alternate contact information we receive as a complementary attribute of the member data we store securely, notifying MLTC of updated information as appropriate.

Welcome Packets. Our New-Member Welcome Packet will be mailed to all members within ten business days of our receipt of the new member file. It will include the NTC member ID card, a welcome letter with NTC Member Services contact information, and a *Quick Reference Portal Flyer* to assist members with accessing our website and the information provided on it. For example, access to the New Member Welcome Tool Box, which includes the Member Handbook and Provider Directory; the Caregiver Resource Center; Member Portal registration; *MyNTC*, our suite of mobile applications; and how to contact Customer Service for materials in hardcopy if the member does not have web access or needs assistance. New members also receive a 'checklist' of things they need to do to maximize their health benefits and have the opportunity to opt into an educational monthly email campaign geared toward health plan benefits. Other information to educate members and engage them in their health are

included as described in Question 29. All contents of the welcome packet will be submitted for review and approval by MLTC a minimum of 45 calendar days prior to the contract's start date; all materials will comply with the requirements of the RFP and 42 CFR 438.10 (f)(6).

Welcome Calls. NTC's Member Call Center will conduct New Member Welcome Calls within 15 business days of receiving the eligibility file. With MLTC approval, NTC will conduct welcome calls upon receipt of the enrollment file (prior to go-live). In recent implementations, we have also opened our call centers 30 days prior to go-live to assist with the transition and partner with the state enrollment broker. This proactive approach helps to reduce member anxiety and uncertainty with respect to the transition from one health plan to another, integration of behavioral health and pharmacy benefits, and/or the transition to managed care. Members will better understand that they aren't "losing" their coverage, and will retain access to the care and treatment they need. As part of the welcome call, our CSRs educate members about covered benefits and their rights and responsibilities, and provide an overview of the NTC program and services available to the member. CSRs will discuss member confidentiality and provide information about how to access free oral interpretation and written translation services, if needed. Members will be oriented to the concept of patient-centeredness and integration, including the importance of having and engaging with their PCP and scheduling preventive care services. For those members who have not selected a PCP, CSRs will provide assistance in identifying a PCP and assistance in scheduling the first appointment. The CSR will use this call to perform an initial Health Risk Screening to determine if the member is pregnant, undergoing treatment or has a chronic condition, and identify barriers to accessing care (e.g., transportation needs, mobility limitations) or any special health care needs or other accommodations. Assistance in obtaining needed referrals, such as for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program, will also be provided.

PCP Assignment. If an active PCP selection is not included on the enrollment file, NTC will contact the member within 10 business days of receiving the enrollment file to assist the member in selecting a PCP. It is our goal to align this outreach with the Welcome Call. If a member does not choose a PCP within 10 days of enrollment, NTC will appropriately auto assign a PCP within 30 days. We view auto-assignment of a PCP as a last resort and will work proactively with members to encourage them to each select their own PCP. For members who were auto-assigned a PCP, NTC will conduct a proactive outreach campaign using trained CSRs to confirm the assignment meets the member's needs and if not help the member select a new PCP, explain the importance of the PCP relationship, and help schedule an appointment.

Continuity of Care and Care Management Needs. Members with immediate needs, as identified through the Health Risk Screening, a pregnancy flag on the enrollment file, historical claims and/or authorization data provided by MLTC or transitioning MCO, or risk stratification completed by NTC on all new members, and ongoing to capture any change in health status or need, will be referred to Care Management (CM) for follow up by a Care Manager. A Care Manager will outreach to high-risk members within 24-72 hours of identification, and moderate-risk members within five days of identification, to complete a comprehensive assessment of their physical, BH, functional, social and other needs and help address any immediate issues or concerns. For low-risk members, a Program Coordinator will contact the member within two weeks of identification to identify and address care coordination needs, such as assistance scheduling appointments and transportation and making linkages to community services. If indicated, the Program Coordinator will connect the member to a Health Coach to further assess for disease management support or to a Care Manager for comprehensive assessment. For members undergoing treatment,
CM staff will help coordinate care during the 90 day transition period to ensure no delay in treatment. During that first 90 days, all prior authorizations will be honored and members will be informed of their right to continue treatment with any prescribed medications and to continue to receive services from non-contracted providers. NTC will proactively solicit member information including open authorizations, two years of claims history, and members in CM, from MLTC and/or any transitioning MCO to help

identify immediate needs and prioritize member outreach to facilitate immediate outreach to those members with the highest level of need.

Alternate Plans to Welcome Members. Recognizing not all members respond to the same approach, we have developed outreach and education strategies to take advantage of every opportunity and health plan interaction and *meet members where they are*. Our member information and education program is designed to ensure all members will have knowledge of NTC operations and its organization; available services; how to access care; and member rights and responsibilities. For example, we will follow-up with members at different days and times, including evenings and weekends; flag members in our system that have been unreachable by CSRs or CM staff so when they call in we can address their needs and ensure they have been appropriately oriented or enrolled in CM; work with providers, pharmacies, and community resources to meet members at the point of service; host and/or participate in community outreach and member education events; leverage our member portal features and mobile apps; and reach out to members in their homes and communities using local community health workers in our MemberConnections® program.

New Member Open House. NTC will host New Member Open Houses throughout the state, providing needed information to access services and maximize benefits. We will hold the Open Houses in local centers, such as the Charles Drew Health Center in Omaha, the Good Neighbor Community Health Center in Columbus, and/or the Webster County Clinic in Red Cloud. Established centers, such as these, are known to the residents and are known to meet access standards for all individuals.

Local Approach. Our local approach to engagement will involve actively identifying and leveraging local community liaisons to best meet members where they are, bridge NTC resources to the most rural and frontier communities, inform solutions and educational strategies that work for each unique community, and elicit feedback about how NTC programs and services can be improved to meet members' needs in every area of the state. Targeted member education includes direct calls with members, telephonic and electronic outreach messaging, and in-person visits with our local MemberConnections® staff and Care Managers, who will be based across the state in order to provide face-to-face assessment and care planning. For example, our telephonic and face-to-face outreach via our MemberConnections® Program provides in-person support for members to help them understand and access care and needed resources. We will recruit MemberConnections® Representatives (MCRs) from within the Nebraska communities they will serve to ensure they are knowledgeable about local resources and can relate to members based on the local cultural, geographic, and demographic differences. This approach has been successful in our affiliate markets, such as Kansas and Indiana, where we have learned the value of hiring MCRs who may themselves be former Medicaid recipients from rural and urban areas.

Pre-Implementation and 24-Hour Support. Upon MLTC approval, our NTC Call Center will open thirty days before go-live for member-focused presentations and to offer in-person connections to reinforce our welcome calls and new member packets while connecting our team to the communities they serve. Clinical assistance and benefits guidance will be available to all members at all hours through our CSRs and our nurse advice line. Staff will answer members' program questions, send information, offer resources, and refer members to CM for additional education and care coordination as needed. To promote optimal member engagement, NTC will build our NTC CSR training program using the expertise of Centene's health plans serving a broad client population that includes behavioral health members who have a wide range of chronic, complex, and acute conditions.

Advanced Directives. As a part of their New Member Enrollment Packet, NTC members will receive written information on advance directive policies, including their rights under state law to make decisions concerning their medical care and the right to formulate advance directives. CSRs will be fully trained on NTC's written policies and procedures for advanced directives and will use Welcome Calls to answer any questions members may have about advance directives to ensure the members are informed about their choices.

33. Detail the strategies the MCO will use to influence member behavior to access health care resources appropriately and adopt healthier lifestyles. (5 page limit)

Overview of Member Engagement Strategy – Understanding What Drives Behavior Change

Influencing member behavior begins with understanding each member within the construct of their community, culture, supports, and personal motivations to sustain positive change. NTC's approach to direct engagement is anchored in understanding each person's unique characteristics and approaching them *at the right time with the right message.* To create this experience across our membership, we deploy best-of-breed predictive modeling through our proprietary, multi-dimensional care management analytics software, Centelligence™, which integrates data from multiple sources to analyze "all things member." We combine these analyses with personal interaction with members, their circles of support, and their social determinants of health to customize our member engagement approach. Using the framework of a culture of service excellence, we then develop and deploy differentiated, innovative strategies and communications, each designed to directly engage a particular member or micro-population. In general, our approaches work to shift the member from being a passive recipient of care to becoming a self-advocate and self-manager. **Our Commitment to Continuous Improvement.** Reflecting a deep commitment to health behavior change, our parent company Centene invests time and resources to continuously improve the effectiveness of our efforts. In a unique collaborative partnership Centene, Washington University in St. Louis, and Duke University have formed The Center for Health Behavior Change. The mission of the Center is to create, evaluate, and advance innovative methods of changing health behaviors by translating research into effective practices and programs that drive positive health outcomes, prevent disease, and ultimately reduce the economic burden of healthcare costs for individuals and society. Research conducted will meet peer review standards for publication.

The Center Research Team has developed a multi-pronged approach to address areas of preventable health risk. The Center's current research agenda focuses on –

- Using insights of behavioral economics to promote health behavior change with emphasis on diabetes
- Tailoring communications for improved outcomes
- Designing and implementing an inter-generational lifestyle change program for parents and their children

Strategies to Promote Appropriate Utilization of Services

Initial Education and Outreach. The most basic and oftentimes overlooked strategy to steer members toward appropriately accessing services is simply educating the member on the services and resources available to them ***(Table Q33.A).*** Health care language and terminology can be complicated and difficult to comprehend which may deter members from seeking the most appropriate care and services available.

Initial Education and Outreach Table Q33.A
New Member Orientation. NTC will conduct *personal telephonic orientation* with new members, including confirmation of packet receipt and current address. Our MemberConnections™ Representatives will host *New Member Open House* events throughout the state to personally answer members' questions, offer materials, and facilitate engagement through demonstration of and assistance with PCP selection and scheduling, Member Portal registration, and mobile application (apps) demonstrations. We will hold the Open Houses in local centers, such as the Charles Drew Health Center in Omaha, the Good Neighbor Community Health Center in Columbus, or the Webster County Clinic in Red Cloud. Established centers, such as these, are known to the residents and are known to meet access standards for all individuals.
Welcome Packet. **To emphasize the orientation messaging, we mail new members a Welcome Packet, designed with input from Medicaid members. With MLTC approval, the NTC Welcome Packet will include:** • ID Card • Welcome Letter • Refrigerator Magnets with NurseWise and EPSDT Periodicity Schedule • New Member Checklist • Member Portal Quick Reference Guide • Benefits Forms Booklet • Benefits Booklet • One pager – Preparing for Doctor Visit • "For Your Health" folder, to keep the welcome contents together for future use

Our local Customer Service Representatives (CSRs), are assigned to assist members in specific regions of the state, contact new members and deliver concierge-style anticipatory service. CSRs explain all benefits and Programs, assist with PCP selection and appointment scheduling, complete Health Risk Screenings, show the member/caregiver how to navigate the secure Member Portal, etc. We empower CSRs to remove any barriers to care, resolve issues, and do whatever it takes to provide a positive, impactful member experience.

Ongoing Member Engagement and Education. We continuously engage members to advance their health literacy in wellness choices and benefit management. *Table Q33.B* lists a few examples of the multidimensional member-facing approaches used by sister plans which NTC will deploy for Heritage Health members. During every contact, member-facing staff confirm and add to our knowledge base regarding a member's needs, existing supports and communication preferences, including details such as language, special circumstances and alternative contacts (caregiver, mobile phone, etc.) in case we cannot reach a member. As part of our approach to meet every member where they are, our Centelligence Engage platform integrates these data so that we can target, immediately and ongoing, what information the member needs (EPSDT, health alerts, information on Value-Added Benefits), the method in which the member prefers to receive it (e-mail, text, mail, phone), and the manner in which it will be most effective (culturally attuned for specific beliefs, current health status, time of day, for example).

Ongoing Education and Support Table Q33.B
Our local Customer Service Representatives (CSRs), are assigned to assist members in specific regions of the state, contact new members and deliver concierge-style anticipatory service. CSRs explain all benefits and Programs, assist with PCP selection and appointment scheduling, complete Health Risk Screenings, show the member/caregiver how to navigate the secure Member Portal, etc. We empower CSRs to remove any barriers to care, resolve issues, and do whatever it takes to provide a positive, impactful member experience.
NurseWise®. Our NCQA-accredited 24/7 nurse advice and triage line, accessed directly through our NTC member phone number and providing members with advice on the most appropriate level of care and self-care techniques.
MemberConnections™ Representatives (MCRs). MCRs enhance our members' experience with NTC, and serve a role in overall efforts to reduce preventable admissions and non-emergency visits to the emergency department, provide education and linkages that help increase appropriate care, particularly preventive services, and increase member satisfaction. *On average, our MCRs make 600 personal home visits per MCR per year, and meet hundreds more members personally while assisting within the community* Their key responsibilities are to provide care navigation, social supports, and advocate for the member's health needs. MCRs meet members in their home, hospital, provider and community, especially with at-risk and difficult-to-contact members. MCRs schedule appointments, arrange transportation, and remove barriers to care. They assist and advocate for members post-discharge, establishing rapport while the member is inpatient, and then maintain contact post discharge, to ensure that the member keeps post-discharge appointments, fills prescriptions, etc., to assist in reducing readmissions. MCRs also outreach to members upon notification of visit to the ER to understand any support/education the member might need to prevent inappropriate ER utilization.
NTC Public Website. We will offer website visitors access to an extensive online health library, powered by Krames, with hundreds of health articles on a variety of topics. Through our website, members will be able to register and login to our secure Member Portal. Member-focused features on our NTC public website will include: • A searchable Member Handbook • An interactive, searchable Find a Provider tool (Provider Directory) • A news blog featuring new items and member information (example topic from NTC's affiliate health plans include preventive care, health tips for reducing stress and lowering blood pressure, and medication safety) • Contact information (toll-free 24/7 customer service number, information on interpreter services, and telecommunication for the deaf [TDD] number) • The toll free number and link to the MLTC Enrollment Broker's website for questions about enrollment • A link to http://accessnebraska.gov for questions about Medicaid eligibility • Pharmacy Preferred Drug List and Pharmacy Conditions for Coverage and Utilization Limits
NTC Member Portal.: NTC's secure Member Portal will offer members online access to "self-service" functions, such as, the ability to view their clinical service and medication history, change PCPs, update their contact information, take an online health risk screening, view a health alert or gap-in-care, communicate with NTC staff, check the balance of their CentAccount® incentive program and set up (as an option) their electronic Personal Health Record.

Select Methods to Identify At-Risk Members and Ensure Access Care Appropriately. To ensure we provide timely support to members who need additional assistance to access care appropriately or to manage their conditions to prevent the need for hospital or ER

services, early identification of potential risks and redirection is critical. We accomplish this through continuous review of all available information (such as ER, inpatient, pharmacy, and other claims data) and use every member touch point as an opportunity to identify risk and assess needs. ***Table Q33.C*** describes some of the methods NTC will use to identify at-risk members. Below we describe the primary strategies underlying our initiatives to ensure members access care appropriately. ***Link the Member to a Medical Home.*** We will link every member with a medical home and promote medical home choice because members are more likely to utilize care appropriately when they choose and establish a PCP relationship. If a new member enrolls without choosing a PCP, we will auto-assign one to ensure an immediate accessible source of care, but will also educate them on the importance of PCP choice during our New Member Orientation. NTC will seize the opportunity at every member touch point to ensure the member has selected a PCP. Staff will provide assessment results, care plans, monitoring results, recommendations from other treating providers, and other member information to inform the medical home of the member's comprehensive needs. We will support the medical home provider's ability to monitor and coordinate care with an integrated family of secure, web-based tools for clinical quality improvement, administrative productivity, and operational efficiency. ***Increase Access to Appropriate Care.*** Through extensive statewide network development efforts, NTC will improve access to care for our Heritage Health members through creative partnerships and value based purchasing strategies. For example, NTC's value-based Strategic Alliance Agreement with ENHANCE Health Network will include the development of Telehealth opportunities that will assist in provider access, assistance and recruitment in rural and frontier regions, as well incentives to provide access to specialists, many of whom are willing to travel. Other partnership pilots with University of Nebraska Medical Center, Lancaster County Health Department, Vest Psychiatric Services, Community Health Collaboratives and others align with MLTC goals to expand service scale, access and utilization. ***Ensure Member Awareness Of And Compliance With Medications.*** Medications are frequently a cause of readmissions. Members receiving care from multiple providers may have duplicate medications or medications that impact other conditions. Prescribers may be unaware that the member has prescriptions from other providers, and may not be aware of the need to communicate with other treating providers, including BH providers. CMs will review the member's list of medications, and assess what medications the member feels they are taking and for what condition(s); if they know how to take the medication; and why it is important to take the medication as directed. We will educate the member and caregiver on their medications, communicate with the treating providers, and, when applicable, coordinate with our pharmacy staff. Some members may benefit a comprehensive medication review to identify all

Table Q33.C

Selected Methods For Identifying At-Risk Members
Use of the Patient Activation Measure, a validated tool, to assess member ability to self-manage and develop individualized support.
Robust data modeling tools that identify high utilizers, as well as members with low or no utilization of services, and those with risk factors, allowing us to intervene before avoidable utilization occurs. We will incorporate BH utilization data from MLTS to enhance risk and potential risk identification.
Our ER Flag on the Provider Portal enables us to notify PCPs of ER utilization when the provider checks member eligibility. This improves PCP awareness of members who may not be appropriately accessing primary and preventive services, thereby supporting the PCP's own outreach and education efforts to prevent future avoidable ER use.
In-person interaction with members by MemberConnections staff, or Care Management team members.
Member and provider referrals to Care Management
Medication reviews through our Medication Therapy Management and Psychotropic Medication Utilization Review Programs.
Using 3M's Potentially Preventable Event (PPE) software, an integrated component of our Centelligence analytics platform, we will systematically analyze claims data to identify PPEs (including Potentially Preventable ER Visits, Admissions, Readmissions) and work with providers to ensure care is delivered in appropriate settings.

medications, including over-the-counter drugs and supplements, what reminders they use, and any barriers. To remove barriers, we will educate the member and provide aids such as pill dispensers and reminders. CM staff can also assess the use of equipment such as inhalers and self-administration of injectable drugs, such as insulin. ***Connect The Member To Needed Supports.*** We understand that our role is not simply to be a payer of health care services but instead to integrate all medical, BH, social and other needed services to create a system of care around the member. Our Care Management staff and MCRs will connect members and caregivers to non-covered services and community resources (such as transportation, child care, food pantries, utility assistance, help applying for government programs), and enlist the support of friends, family, and others (such as clergy, support groups). In addition to these strategies, we will improve performance in this area by adapting targeted programs our affiliates have used to successfully control avoidable readmissions and ER use. ***ER Diversion Program***. Our multi-dimensional Diversion Program for monitoring ER services and reducing avoidable utilization relies on identification of frequent ER users, outreach and education by dedicated staff, and emphasizes primary care. Our affiliates have found this approach to be extremely successful in addressing avoidable ER use. We identify ER utilization through daily review of admission, discharge, and transfer data from our hospital partners. Designated CM staff will call the member to discuss the reasons for the ER visit, and provide education about appropriate ER use, the importance of routine visits to their PCP, use of alternative settings such as urgent care centers, and availability of our 24-hour nurse advice line. CM staff will also assist with making physician appointments, arranging transportation, and facilitating referrals to community resources as needed. If other health conditions are present or the member is experiencing significant social concerns, the member will be connected to a designated Care Manager for assistance and assessment as appropriate. The ER Program will also engage providers in decreasing avoidable ER visits by notifying PCPs (including PCMHs and Health Homes) when their members have been seen in the ER. We encourage providers to contact these members for follow-up care as well. The ER Flag functionality on our Provider Portal will timely notify providers of members accessing the ER the previous day. Providers can also view Member ER visit history on the Portal. We provide this information at a summary level showing the last 3 ER visits based on claims, or a detailed level showing individual claims for the past 18 months. **Strategies to Influence Member Behavior to Adopt Healthy Lifestyles.** Behavior change is fundamental to the welfare of our members, as well as containing healthcare costs. Accordingly, NTC will provide programs to assist members to improve health-related behaviors - from members with acute needs for change to healthy members who need to stay healthy. Moreover, we continue to invest our energies and resources in the research and development needed to continuously improve the effectiveness of our efforts.

Several tenets shape how we develop behavior change programs:

- The programs must reflect the unique characteristics of the population and environment
- To be effective, services and interventions must meet the member where they are in terms of readiness to change, the behaviors they are prepared to address, and how we interact with them
- A total population strategy is important – helping healthy members stay healthy is as important as helping acutely and chronically ill members adopt behaviors to manage their conditions
- The elements of a health behavior change strategy must be seamlessly integrated to ensure the quality of the member experience and the effectiveness of the program

Communication Strategy to Promote Healthy Lifestyles. NTC will conduct geographically balanced communications campaigns throughout Nebraska, employing traditional communications (newsletters, postcards, phone, etc.) and new media (web banner ads, blogs), opt-in texts and email, and evolving social media (Twitter, Facebook). For state-wide awareness, NTC will place advertising messages on wellness/personal responsibility in areas of high visibility, such as bus benches and billboards. For focused messaging to members, NTC will apply our new proprietary Customer Segmentation Profile to stimulate engagement. This sophisticated psychographic profiling allows us to deliver messages most likely to solicit member engagement, based on a deeper understanding of the member's likely behavior, lifestyle components, and attitudes toward health and care. Customer Segmentation allows us to reach

members with information appealing to their individuality. **Member Incentives to Promote Healthy Lifestyles.** With approval from MLTC, we will incent members for healthy choices/behaviors with CentAccount™, our innovative reward program for preventive/wellness care. Members can earn rewards for completion of activities such as: annual wellness visits and screenings. For the complete list of CentAccount rewards, please refer to Question 23 Value-Added Services. Members receive a proprietary CentAccount™ Card after their first qualified service, and subsequent rewards load automatically. Members use cards to buy health related items including groceries and personal care items. Members cannot buy junk food, candy, alcohol or tobacco. Authorized retailers will include Walmart, CVS, Dollar General, and Family Dollar. The Card will also serve as a discount card with monthly offers for special discounts. **Partnering with Providers to Promote Healthy Lifestyles.** Providers play a critical role in influencing member behavior. NTC will implement value based purchasing strategies and pay-for-performance incentives to reward high performing provider partners. NTC will also collaborate with provider groups to promote the importance of a healthy lifestyle and to ensure members are receiving needed preventive care. For example, NTC will partner with provider offices to identify members who have missed certain preventive care visits. NTC or provider staff will outreach to the member and encourage them to make an appointment for the needed service on a certain day set aside by the practice, assist member with transportation if needed, and remind members about the CentAccount reward program. NTC will have health plan staff at the providers' offices along with various community partners on these days to reinforce the importance of preventive care and answer questions about the member's health plan benefits. **Initiatives and Programs to Promote Healthy Lifestyles.** Below is a sample of programs and initiatives NTC will offer in Nebraska:

- ***Adopt a School.*** Centene's nationally recognized program for schools in underserved communities, reached thousands of students with over 200 events nationwide last year, providing literacy and reading programs, and self-care and self-esteem education. The program also provided fitness programs, support to school nurses, oral hygiene kits, backpacks of school supplies, etc.
- ***Healthy Lifestyle Events/Health Fairs*** provide fun healthy activities for all ages; colorful, age-leveled materials, screenings and demonstrations; and are always tailored to local needs. In 2014, our affiliates conducted more than 1,000 Healthy Lifestyle Events attracting more than 8,100 members, plus additional community residents.
- ***Weight Management and Fitness Initiatives.*** NTC will offer free memberships to Weight Watchers and trial memberships to YMCAs with the opportunity to extend membership.
- ***Weight Management and Fitness Initiatives.*** NTC will offer free memberships to Weight Watchers and trial memberships to YMCAs with the opportunity to extend membership.
- ***Community Resource Centers (CRC):*** NTC's Neighborhood Meeting Spot. For full-time promotion of wellness and healthy lifestyles, NTC will collaborate with local community organizations to meet members where they are by opening walk-in Community Resource Centers in selected locations in each area of the state. Staffed by CM, MCRs, Provider Engagement, and other personnel as needed, these CSCs will be located in areas of high "foot traffic" and where comparable services do not exist (e.g. through FQHCs). We will offer face-to-face CM services, special educational events, classes, support groups and organized health and oral hygiene screenings at the CSCs, and provide a welcoming atmosphere for members to view benefit and wellness management as easy and approachable. We will target locations in each area of the state where we can integrate with existing community organizations/agencies (such as housing authorities), or bring in these organizations and their services to alternate locations. Our goal will be to provide a convenient "one-stop shop" at which members can obtain a variety of services they need to direct their own healthcare. In the event a non-NTC member visits a CSC, NTC will assist them with contacting their MCO or the State.

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. (1 page limit)

Process to Ensure Provider Choice for Family Planning Services and Supplies

Nebraska Total Care (NTC) provides fully open access to family planning providers within our network. We also cover family planning services and supplies from out of network providers without requiring authorization and without any restrictions as specified in 42 CFR 431.51(b)(2). To ensure adequate choice and promote continuity of care within our network, NTC is actively recruiting a robust provider network which includes primary care practices, OB/GYNs, FQHCs, and Title X service providers throughout the state. For example, we have had face-to-face meetings with the following delegates from Nebraska Reproductive Health, the Federal Grantee administering the statewide Title X Family Planning Program:

- East Central District Health Department/Good Neighbor Community Center – Columbus, NE
- Community Action Partnership of Western Nebraska – Gering, NE
- Charles Drew Health Center – Omaha, NE
- One World Community Center – Omaha, NE
- Midtown Health Center – Norfolk, NE

Family Planning Policy. Our family planning policy fully aligns with all state and federal mandates, and Section IV.E.16 of the scope of services, and includes coverage for an annual physical examination and health history; follow-up visits; laboratory services; prescribing and supplying FDA approved contraceptive supplies, devices and methods; contraceptive counseling services; prescribing medication for specific treatment and related follow up visits, including lower genital tract and genital skin infections/disorders, and urinary tract infections, when diagnosed during a routine family planning visit; and male and female sterilization procedures and treatment of major complications from covered family planning procedures. Services also include detection and treatment of sexually transmitted infections and age-appropriate vaccination for the prevention of human papillomavirus infection and cervical cancer.

System Configuration to Ensure Claims Payment. As part of our policy, NTC will not restrict the choice of provider from whom/which the member may receive family planning services and supplies. This policy is built in to our claims system configuration rules to systematically pay these services by an appropriate Medicaid provider without authorization whether in or out of NTC's network. Our claims processing system is configured to ensure timely payment of non-contracted family planning providers at no less than the FFS rate in effect on the date of service for properly billed claims.

Member Education and Staff Training. Our Member Handbook will include information about our family planning coverage, unrestricted provider choice, and member education on reproductive health and contraception. NTC's family planning policy is built into our utilization management processes and staff training to ensure all members have open access to these services without any delay. In addition, all member and provider facing staff are trained to address family planning and access to services with member and providers at each appropriate contact. For example, our MemberConnections Representatives are trained to "continue the conversation" regarding reproductive life planning with postpartum mothers during home visits and follow up contacts.

Provider Training. NTC's provider training will address our family planning policy and promote PCP involvement in reproductive health screening and counseling, especially for male and female adolescent and young adult members. We will also provide information and training on industry best practices and American College of Obstetricians and Gynecologists recommendations and trends, such as the use of postpartum Long Acting Reversible Contraception (LARC). We will encourage family planning providers to communicate with the member's PCP when any form of medical treatment is provided. In alignment with federal Title X policy, our approach promotes responsible behavior; supports the well-being of families and healthy babies; reduces mother and infant death, unintended pregnancies, child abuse and sexually transmitted diseases; and allows timing of pregnancies when couples are in the best position to care for new children.

(10 page limit)
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.

Proposed Member Education Content and Materials

Nebraska Total Care (NTC) will combine best practices from Centene and our affiliate health plans serving Medicaid/CHIP/ABD/LTSS/IDD members for more than 30 years to develop and/or select member education content and multiple formats of presentation. Our ongoing health education program will be developed using culturally sensitive, people–first language and stress personal wellness topics, such as the importance of preventive care and how members can improve their health and wellness. Member education materials will include but are not limited to our Member Handbook, new member Welcome Packet, Member Newsletter, Member Portal, and other member mailings, and communication with NTC staff such as our customer services representatives, MemberConnections® representatives (MCRs), and care management staff. NTC aims its health education and resources at assisting members to make informed choices and be active participants in their health care. For example, our mobile application Health Tracker allows members to choose activities and personal health goals they want to track, such as nutrition, fitness, weight management, stress and sleep management, tobacco cessation, diabetes, and/or hypertension management. NTC may add or modify topic areas or material content based on quality performance measures results such as HEDIS and/or CAHPS survey results and as a result of performance improvement projects. NTC will also use information and feedback from members and providers, such as through the Member and Stakeholder Advisory Committees, member focus groups and satisfaction surveys, Provider Advisory Committee, and other communications to NTC staff to develop and improve current strategies and educational literature. NTC will collaborate with local community organizations to achieve community-wide wellness priorities and program strategy goals.

Member Education Plan. At least 45 calendar days prior to contract start date, NTC will submit its proposed Member Education Plan to MLTC for review and approval. NTC will ensure all member materials are pre-approved by DHHS prior to distribution. Our Member Education Plan will include our process for new member outreach, including welcome packets and welcome calls; ongoing member education; outreach to members identified for care management; member engagement tools such as smartphone-based supports, including the specific features of each; plans to accommodate the physical and cultural diversity of the State; and a list of all subcontractors engaged in marketing or member education activities for NTC. NTC acknowledges, as outlined in Section F.14.d. of the Scope of Work, we may not conduct member education or distribute education materials in provider offices.

Member Education Program Design and Topics

Materials used as part of NTC's Health Education program will be based on clinical practice guidelines (CPGs) promulgated by the leading academic and national clinical organizations such as the American Diabetes Association; American College of Obstetricians and Gynecologists; American Academy of Pediatrics; American Academy of Child and Adolescent Psychiatry; and National Heart, Lung and Blood Institute to name a few. Our health education materials will be easy to understand (no higher than 6.9 grade reading level), with appealing graphic elements, and will comply with the American Disabilities Act of 1990 including availability of Braille and audio tapes as indicated as well as with the 508 Accessibility Standards of the Rehabilitation Act to ensure access for those with disabilities. When writing all member materials, we write the way a person talks; we use a friendly tone, active voice, common words, and short sentences; provide examples when words might be confusing; and obtain member feedback to ensure clear messaging. To enhance our ability to communicate effectively at a low

reading level, several of Centene's Marketing and Communications Department staff have taken health literacy training through organizations such as America's Health Insurance Plans (AHIP). Centene used a certified health literacy consultant to develop certain materials, such as the Start Smart for Your Health Diabetes Book. NTC's Health Education topics will include but are not be limited to: covered benefits and services; when to use the emergency room including behavioral health emergencies, availability of our 24/7 nurse advice line; general health and wellness topics such as stress management; preventive care screenings and services for children and adults; healthy pregnancies; completing the Health Risk Screening; chronic disease management programs; and available website and smart phone based support programs. NTC will also actively solicit feedback and ideas from local organizations that serve our members such as Public Health Departments, Centers for Independent Living, Area Agencies on Aging, and the Munroe-Meyer Institute.

Ensuring Cultural Competence. NTC's member education materials will be culturally relevant and will be produced in English and Spanish and other languages upon request. NTC's staff cultural competence and disability sensitivity training is extensive. We understand that culture goes beyond race and ethnicity to encompass such issues as poverty and disability. We will involve community-based organizations in training to ensure staff are familiar with cultural characteristics (particularly those related to health care access and member engagement) of predominant groups. We will educate staff about health disparities and barriers members experience in making and keeping appointments and we will continually look for opportunities to address cultural issues. For example, members with very low income often do not trust unknown phone numbers, mistaking a health plan call for a call from a bill collector. Subsequently, several NTC affiliated health plans have either started calling from cell phones with a local phone number or worked with our telecommunications department to change our displayed phone number to the name of the health plan. Members with severe behavioral health conditions or IDD often have established relationships with their service care providers, and our experience has shown that collaborating with these professionals will facilitate completion of assessments, ensure members access needed services, and engage the member in managing their own care.

People First Language. NTC will use the People First approach for all member communications. People First language puts the person before the disability and describes what the person has, not who a person is. NTC understands that people with disabilities do not "suffer from, struggle to be normal, or fight to overcome their challenge"; they are people first. Persons with disabilities have strengths, weaknesses, feelings, and goals in life just like any other person. We will recruit MemberConnections® Representatives (MCRs) that have specialized training and experience in serving persons with disabilities.

Ensuring Quality and Maintaining an Effective Member Education Program. Our internal approval process will include a thorough compliance review and final approval by the Vice President of Compliance, including materials from subcontractors or providers. NTC will establish standards and processes for content and materials development to ensure accuracy, inclusiveness, respect for member diversity, and compliance with all MLTC requirements. Content produced by organizations other than NTC will be subject to the same policies and procedures as NTC-developed content. As part of NTC's Quality Assessment and Performance Improvement (QAPI) program, NTC will annually review all member educational strategies and materials (or more frequently if necessitated by a program change) to ensure that our approach is effective, and the content of our materials is correct and will not mislead or confuse our members. The annual review process follows the initial review process described above. Member feedback is sought during all member interactions to identify where we can improve service delivery, and to ensure members understand their healthcare benefits, and other information about the program. Additionally, during community events, our MCRs will ask members if they have any questions about the materials they have received, and gather any feedback members may provide regarding how useful and understandable the materials are. NTC will also evaluate member satisfaction data (inquiries,

complaints, grievances, appeals, CAHPS results, NTC -administered survey ratings, etc.) to identify opportunities to clarify educational information, materials, programs, policies, or other aspects of our plan with members. For example, our Missouri affiliate health plan, Home State Health, has conducted several member focus groups and surveys seeking member feedback regarding marketing and member educational materials. Based on this feedback, Home State Health made changes to their Member Handbook making it easier to read by including shorter blocks of narrative, and ensuring the most important facts, such as the toll-free Member Helpline number, are highlighted in text boxes and graphics. Focus group participants also told us they appreciated tools that help them track wellness appointments. In response, Home State Health added vaccine tracking sheets and well child check-up schedules as inserts in the Welcome Packet.

Innovative Methods to Educate Members

NTC's affiliates have identified that successful education programs require repeated contact attempts at different times of the day and different days of the week and the use of multiple modes of communication, including, but not limited to, phone calls, written, email, texting and mobile applications, web-based, social media, and face-to-face approaches. Since our core philosophy is that ***quality health care is best delivered locally***, NTC's member education program will emphasize face-to-face member contact because it more effectively engages members and allows us to provide information that meets members' specific questions and needs.

MemberConnections® Community Education Program. NTC's MemberConnections® Program will allow us to provide a level of interaction with our members that many other health plans do not. MCRs are NTC's community health outreach workers who are hired from within the communities we serve to help ensure that our outreach is culturally competent and conducted by people who know the unique characteristics and needs of each region. MCRs will receive comprehensive training and become an integral part of our care management staff, which benefits our members and increases our effectiveness. Through this program, NTC will be able to develop and implement community-based member outreach and education programs that strategically meet members where they are, and provide multiple venues through which they can receive the information they need to make informed health and wellness choices. For example, through our Adopt-a-School Program we will actively promote healthy lifestyle activities related to disease prevention and health promotion. At health fairs and NTC Start Smart Baby Showers, our MCRs reinforce the importance of a primary care/medical home provider, promote preventive care, encourage personal responsibility and accountability, and answer questions about the member's health plan benefits. NTC will develop community partnerships and co-sponsor a variety of community outreach and education events throughout Nebraska, such as health fairs and prevention screenings which allow us to provide in-person education to our members and the community. As extensions of our care management team, MCRs will also make home visits to high-risk members we cannot reach by phone and will assist with member outreach, coordinate social services, and attend community functions to provide health education and outreach.

Improving Health Literacy and Empowering Members through Technology. In alignment with the Healthy People 2020 goal to "increase the proportion of persons who use electronic personal health management tools," NTC will implement several technologies to help improve our members' health literacy and empower them to be active participants in their health. Health literacy is a member's ability to understand and act on information to make informed health decisions such as accessing preventive services and appropriate use of the emergency room. Multiple studies have concluded that member engagement in care and self-management contributes to optimal health outcomes and quality of life. Health education is a primary driver of increasing health literacy. In today's technology driven world, internet and mobile access is a primary source of health education for many individuals. Over the past

five years, Centene has dedicated significant resources into expanding our capabilities in this area including an enhanced Member Portal and deployment of Mobile Applications, further described below.

Equitable Education throughout the State

NTC will provide health education in multiple formats and will facilitate access to these formats for all members across the state. For example, we realize that not all members will have access to reliable phone service to participate in our audio reminder and text messaging campaigns or access to the internet to take advantage of our Member Portal. To address barriers such as these, NTC staff will assist members with accessing the Nebraska Telecommunications Assistance Program, offer our ConnectionsPlus® program (described below), and open Community Service Centers (described below). In alignment with our belief that healthcare is best delivered locally, NTC will not only have health plan staff located at our main headquarters along the Omaha/Lincoln corridor, but we will also hire MCRs and care management staff to provide face to face support to our members in the communities where they live. NTC will also hire provider relations staff from across the state that will support our providers.

ConnectionsPlus® Program. Based on our experience in other states, NTC will implement our ConnectionsPlus free cell phone program in Nebraska for high-risk members who do not have safe, reliable phone access. We understand that not all members will be eligible for the free cell phone program offered by select carriers under the Nebraska Telecommunications Assistance Program (e.g. members who are homeless). For some members who do qualify for the program, the minimum allotted minutes presents a barrier to successful and regular care management; decreases member likelihood of participating in a health program that requires usage of minutes; and is not enough to support the extent of care coordination of community/social needs many Medicaid enrollees require. NTC's free ConnectionsPlus phones will be made available to high-risk members who would benefit from unlimited talk and text. These phones allow members to call, text or receive calls and text messages from their PCPs/treating providers, care manager, other health plan staff, NurseWise, and 911. The objective of the program is a reduction in preventable events such as inappropriate ER use or hospital admissions through improved access to health care information. Members are educated on observing their health status and calling promptly for advice rather than waiting until the next appointment. NTC's ConnectionsPlus program empowers members to self-manage their condition and facilitates healthy lifestyles. Our Care Managers may upgrade the free cell phone to a smart phone with data plan for high-risk members (e.g. high-risk pregnancy or uncontrolled diabetes) with a condition(s) where an app exists to support the member in managing their health. Centene data indicates that ConnectionsPlus members display increased participation in various health screenings and have more provider interactions when compared to overall HEDIS rates. ConnectionsPlus phones can also be used in conjunction with our home telemonitoring program available to high-risk members for whom intensive monitoring is necessary and the condition is amenable to biometric telemonitoring, such as a blood glucose level or a diabetic or a blood pressure or weight for a member with congestive heart failure.

Community Resource Centers: NTC's Neighborhood Meeting Spot. For full-time promotion of wellness and healthy lifestyles, NTC will collaborate with local community organizations to "go to the members" by opening walk-in Community Resource Centers (CRCs) in selected locations in each region. Staffed by Care Management, MCRs, Provider Engagement, and other personnel as needed, these CRCs will be located in areas of high "foot traffic" and where comparable services do not exist (e.g. through FQHCs). We will offer face-to-face care management services, special educational events, classes, support groups and organized health and oral hygiene screenings at the CRCs, and provide a welcoming atmosphere for members to view benefit and wellness management as easy and approachable. We will target locations in each region where we can integrate with existing community organizations/agencies (such as volunteer fire departments, community centers), or bring in these organizations and their services

to alternate locations. Our goal will be to provide a convenient "one-stop shop" at which members can obtain a variety of services they need to direct their own healthcare.

Examples and Descriptions of NTC's Member Health Education Materials

NTC and its affiliate health plans offer hundreds of health education materials. In addition to our Member Handbook, Benefits Brochure, Newsletters, Member Portal and Mobile Applications, we provide postcards, pamphlets, booklets and books. Materials are available in English and Spanish and written at a 6th grade reading level or below. These materials are provided to members as part of our care management programs and during community events. Some materials have been endorsed by or co-authored with nationally recognized organizations such as the American Academy of Pediatrics, National Organization on Fetal Alcohol Syndrome, Child Health Advocacy Institute, American Lung Association, and National Urban League. NTC will submit all of our proposed education materials to MLTC for approval prior to distribution. ***Samples of our Benefits Brochure and Newsletters are included as Att.35.1 – 35.5.***

Centene's Award-Winning Health Education Book Series. NTC will use many of Centene's award winning books developed with a nationally recognized children's author to educate elementary school-aged children about a variety of health topics. *The Adventures of Boingg and Sprockette* books, feature Darby the Wallaby and his friends and focus on obesity prevention and healthy eating, asthma, diabetes, foster care, bullying, and the negative impact of smoking. Our MCRs use several titles in the series at school-based and community events, and during home visits when needed to support young members with education materials that target health issues they face. NTC will also use Centene's *Off the Chain* series that was created for adolescents and addresses a variety of health issues as a way to facilitate communication with teens. For example, the *Real Issues, Real Answers* booklet (and related parent guide), provides non-judgmental, sound advice about the issues tweens, pre-teens, and young adults face, such as peer pressure, keeping a positive attitude, healthy behaviors and choices, resume building, conflict resolution (anti-bullying), conduct for using social media, and personal hygiene. NTC will also use *Off the Chain: It's All About Asthma* to teach teens and their parents about dealing with, and controlling asthma. Our *Off the Chain: Teens & Pregnancy* book was written in collaboration with the National Urban League to provide clear, honest information about the stages of pregnancy and vital issues, such as nutrition for mother and baby, labor and delivery, breastfeeding, baby safety, what to expect after the baby arrives, and more. In addition, NTC will use Centene's *My Route to Health* adult health education series. The adult series includes topics such as nutrition and exercise as well as condition specific subjects like asthma, diabetes, and heart disease.

In October 2014, our Start Smart for Your Baby® Texting Program was awarded the Children's Health Award at the Medicaid Health Plans of America (MHPA) conference in Washington, D.C.

Samples of the following educational materials (***Table Q35.A***) have been included as Att.35.6 thru Att.35.15

Table Q35.A: Centene Health Education Book Series
Children's Educational Series – The Adventures of Boingg & Sprockette
Att.35.6 - *Adventures from Sugarland*
Att.35.7 - *The Gunky Bacteria Brothers*
Att.35.8 - *A Foster Care Journey*
Att.35.9 - *Smokey Yuckpak* (with companion Proactive Parents/Guardians Guide)
Adolescent Health Series
Att.35.10 - *Off the Chain® Real Issues, Real Answers®*
Att.35.11 - *Off the Chain® It's All About Diabetes*
Adult Health Series
Att.35.12 - *My Route to Health® ...Your "Roadmap" To Nutrition, Exercise, And Healthy Habits!*

Att.35.13 - *My Route to Health®...A Fresh View On Your Diabetes.*
Att.35.14 - *My Route to Health®...Listening to Your Heart Matters!*
Att.35.15 - My Route to Health®...My Care Planner: Getting Organized Around Your Health!

Additional condition specific materials that are available for all ages include:

- *Living Well with Sickle Cell* - Co-authored with Dr. Joseph Wright, MD, MPH, of the Child Health Advocacy Institute, our award winning *Living Well with Sickle Cell* helps affected members and their families learn about the disease, risks and how to avoid them, and how to get support. (Att.35.16)
- *The FAQs of HIV* discusses prevention, misconceptions, testing, and treatment topics on the subject of HIV and AIDS. Also offering advice on how to discuss the disease with children, the book features helpful information in tasteful and conversational language with appealing graphics. (Att.35.17)

Integration of Physical, Behavioral health and Pharmacy. Many of NTC's health education materials integrate information about physical, behavioral health and pharmacy. For example, our Start Smart program materials include information about perinatal depression and the Edinburgh depression screening tool that members can complete and return to NTC's care management staff. Health materials provided to members with chronic conditions include education on medication management as it relates to each condition. In addition, NTC's care management staff will educate members on how physical and behavioral health conditions can impact each other and encourage them to give authorization for their treating providers to share treatment plan information. A copy of our Behavioral/Physical Health Coordination Form (see Att.35.18) is available in our Member Handbook and on our Member Portal. NTC may also mail a copy of the form to members as part of our care planning process.

EPSDT Compliance. NTC recognizes the importance of EPSDT services for members 0-21 years of age. We begin educating members about these services during our initial interactions. Our member Welcome Packet will contain educational materials on EPSDT including a magnet that lists the recommended frequency of screenings. Our Member Handbook, Benefits Brochure, Member Newsletter and public and secure Member Portal also offer information on EPSDT. NTC will send audio and mailed postcards to member/parent during the month of their birthday reminding them of the importance of these services and encouraging them to make an appointment. Our care gap alerts also remind members of the need for EPSDT services. Care gap alerts are available to members on our secure Member Portal as well as through our MyNTC mobile application. Care gap alerts are also visible to Providers via our Provider Portal and to our Customer Service and Care Management staff through their respective documentation systems. Our Start Smart perinatal management program materials also include information on EPSDT screenings for infants through the first year of life (Att.35.23 - Start Smart Newborn Journey Book). Additionally, NTC incentivizes members to obtain EPSDT screenings through our CentAccount healthy rewards program as previously described in our response to Q23 – Value Added Services.

Appropriate ER Utilization. Similar to EPSDT, NTC will begin educating members about appropriate emergency room (ER) utilization as part of our new member welcome process. Our welcome materials will include NTC's benefit and program booklet that provides information on appropriate use of the ER and availability of our 24/7 nurse advice line, as well as our "important phone numbers" magnet which lists the toll-free phone number for contacting the nurse advice line. During the welcome call, we educate members on availability of our 24/7 nurse advice line and inquire about recent emergency room visits which provides an opportunity for NTC to educate members on appropriate use and alternate levels of care. NTC will include similar information regarding use of the emergency room and alternate levels of service in our Member Handbook, Member Newsletter and public Member Portal. We have provided a sample of our Emergency Room brochure and our 24/7 Nurse Advice Line brochure as Att.35.24 and Att.35.25 respectively.

Use of Prenatal Care Services - Start Smart for Your Baby® Maternity Care Program. NTC will implement Start Smart for Your Baby® (Start Smart), Centene's award winning maternity management program. Start Smart incorporates health and wellness promotion, care coordination, and population-based services to improve the health of moms and their babies. This multi-faceted approach to improve prenatal and postpartum care includes, wellness materials, and supports the appropriate use of medical resources. An essential component of the Start Smart program is the Notification of Pregnancy (NOP) process. The NOP form is a well-organized approach that aims to identify pregnant members at risk for pregnancy complications early in pregnancy and establish relationships between the member, provider, and health plan staff. Based on information obtained in the NOP, we are able to stratify and assign a risk score that determines the most appropriate level of maternal management. We may also identify pregnant women by mining pharmacy data for prenatal vitamins or other indications of pregnancy, reviewing lab data for pregnancy tests and looking at visits and coding of office visits from OB/GYN providers. The Start Smart program provides pregnant members with tools to empower them to be active participants in their healthcare team, including wellness programs, educational information and access to care management. Receipt of the NOP triggers the mailing of our Prenatal Care Packet. Members may also access pregnancy and postpartum health information on our plan website including relevant podcasts, or via our new Start Smart mobile application described below. Notification of the infant's birth triggers our Newborn Care Packet, which includes information for the mother about the postpartum period, as well as caring for her newborn. Members receive a small gift (outlet covers) when they submit their NOP assessment and are subsequently eligible to receive a diaper bag for completing their first prenatal visit within seven days of the NOP. Members are also eligible to receive a $15 CentAccount reward for every third prenatal doctor visit as well as $15 for a postpartum doctor visit between 21 and 56 days after delivery. Samples of the following materials (***Table Q35.B***) have been included as Att.35.19 thru Att.35.31

Table Q35.B Start Smart for Your Baby® Educational Materials	
Start Smart Prenatal Care Packet	**Start Smart Newborn Packet**
Att.35.19 - Start Smart Welcome Letter	Att.35.26 - Start Smart Newborn Welcome Letter
Att.35.20 - Start Smart *Your Pregnancy Book*	Att.35.27 - *Bouncing Back from Childbirth* Book
Att.35.21 - Start Smart Journey Book	Att.35.28 – *Great Beginnings with Your* Baby Book
Att.35.22 - Start Smart Depression Flyer	Att.35.29 - Start Smart Newborn Journey Book
Att.35.23 - Start Smart Depression Scale	Att.35.30 - Lead poisoning brochure
Att.35.24 - Emergency Room Brochure	Att.35.31 - *Vaccines Are Not Just for Babies*! flyer
Att.35.25 - Nurse Advice Line Brochure	

The Newborn Care Packet also includes the same emergency room and nurse advice line brochures, Depression Flyer and Depression Scale are also included as part of the Newborn Packet.

Specialized Maternity Program Materials. Subparts of our Start Smart program include identification for and education about 17 hydroxy-progesterone in the prevention of repeat preterm deliveries; Text4Baby which was recently honored by the Medicaid Health Plans of America (MHPA) with the 2014 Children's Health Award; breastfeeding support and specialized support for families of infants admitted to the NICU.

Technological Tools Including Social Media and Mobile Technology

NTC's secure Member Portal will offer the informational tools needed to help members take personal accountability for their healthcare, including important basic information (such as eligibility and benefit information); helping members understand what they have to do (care gap alerts, health and wellness reminders); and providing self-service support tools, such as the ability of the member to choose or

change their PCP online, print a temporary ID card, exchange secure bi-directional messages with our staff, and manage their Member Portal web account information and communication preferences.

Care Gap Alerts. Through Centelligence, our award-winning proprietary and comprehensive family of integrated decision support and health care informatics solutions, NTC will generate care gap alerts regarding preventive health and chronic condition care. These care gaps and health risk alerts power our online care gaps – allowing our members and providers to securely access actionable health information via our Member and Provider Portals. These alerts are also pushed to our internal Customer Relationship Management (CRM) system. Upon receipt of an inbound call, the Member Helpline staff is prompted that the member has an action that needs to be taken (e.g., complete a health risk assessment or get a preventive service). Likewise, our Care Management staff can see these alerts in TruCare, our fully integrated utilization and care management system, and educate members about needed services.

Online Health Library and Mental Health Resources. NTC will offer our free online Health Library powered by Krames. It contains information on over 4,000 health-related topics. The library is searchable by topic or keyword and easy to navigate. Materials include books, health sheets, and podcasts. Members can learn about wellness, illness, care plans, medications, and many other helpful tips and facts. Additionally, NTC members will be able to access our online, consumer-directed mental health resources at no charge through www.MyStrength.com, a website that offers a range of resources to improve mental health and overall well-being. MyStrength is not a provider location but a consumer-directed resource accessible through the internet and also through a member's smart phone. The website offers members the ability to take responsibility for their health care and learn more about their diagnoses, track their symptoms, and receive motivational ideas and information. We also encourage family caregivers of our members with behavioral health issues to enroll and use MyStrength for support and to better understand their family member's behavioral health condition and needs. Members can participate in MyStrength to increase awareness of mental health needs and engage in personalized e-Learning programs to help overcome depression and anxiety supported by tools, weekly exercises and daily inspiration in a safe and confidential environment.

Member Mobile Application. For NTC members, we will deploy our member-centric mobile application, MyNTC, specifically designed to provide NTC members and their caregivers with the informational resources and tools they need to understand their health coverage and stay engaged in their health and wellbeing (***Table Q35.C***). MyNTC is uniformly branded as an NTC mobile application so users will know instantly where to turn for any assistance. MyNTC will be available, free of charge for our members, via the Mobile App Resources section of our public website, as well as the Apple iTunes Store (for iPhone) and Google Play Store (for Android devices).As a mobile development best practice, we will continue to release new features to ensure content is kept up-to-date and to keep users engaged. As new capabilities are released, members will be prompted (through their mobile device) to upgrade their MyNTC mobile application. We will work with MLTC for approval for all features.

Table Q35.C. MyNTC Mobile Application Features and Capabilities.

Content/Function	Description
Member ID Card	Members can securely pull up their Member ID Card to present at the point of delivery of services.
Touch to Call	Members can find contact information for NTC and contact our Customer Services or our 24/7 nurse advice line via a pop-up phone number for immediate telephone call using "touch to call" technology.
Find-a-Provider	Through the Find-a-Provider feature, members can use MyNTC to search for providers, automatically obtain directions from their location to the provider, and call the provider instantly. In an urgent situation, a member will be able to locate the nearest urgent care center, obtain hours of operation, GPS-powered directions, and call the provider.
Health Library	Links to hundreds of resources, tools, and podcasts covering a variety of health

	related topics.
Health Risk Screening	Members can complete a Health Risk Screening (HRS) through the member Portal and/or mobile application. Once the user fills in their HRS, the data will be securely transmitted and loaded into TruCare for display within the member's clinical care record. HRS data will also be systematically incorporated into our Centelligence™ analytics platform for integration with other member clinical data in support of reporting and predictive modeling.
CentAccount® Rewards	Through MyNTC, members can access their CentAccount® rewards information, including account balance and reward points earned to date.
Health Alert Notification	Members will automatically be alerted when they (or their dependents) have a health alert or gap-in-care through push notifications and/or when a user logs into the MyNTC mobile app. The same health alerts are also displayed on the Member Portal and Provider Portal for care coordination.
Health Challenger	With a focus on physical activity, nutrition, stress management, and tobacco cessation, Health Challenger offers individualized action plans that leverage the fundamentals of game theory to engage members and motivate them to learn about, and improve, their health behavior.
Health Trackers	Members can use Health Tracker to choose activities and personal health goals they want to track, such as nutrition, fitness, weight management, stress and sleep management, tobacco cessation, diabetes, and/or hypertension management.
Symptom Checker	Through integration with self-care decisions, this feature will allow users to determine how sick they are, what level of care is appropriate (if any), and offers advice for self-care and/or interim symptom relief. The symptom checker is built with the same triage criteria used by Nurse Advice Line staff and offer users step-by-step advice for illness/injury management, supports them in choosing the right level of care at the right time (i.e. Urgent Care Clinic vs. Emergency Department), and supplies the tools for self-assessment.

Start Smart Mobile. Start Smart Mobile is an interactive and personalized mobile application for new and expectant mothers. Start Smart Mobile provides support for NTC pregnant members from the first positive pregnancy test through the postpartum and early newborn period. The application is free for NTC members, and content is personalized based on the expectant mother's due date. The application helps parents stay on track with key prevention milestones, set personalized reminders, proactively identify health issues and take action, and tap into NTC's other programs, such as, telephonic care management and 24/7 nurse advice line. **Start Smart Virtual Lactation Support.** We recognize that the lack of support from trained professionals is a barrier to new mothers who choose to breastfeed. As an extension of our Start Smart Mobile App, Centene is partnering with Pacify Health LLC to enroll members who are identified as planning to or are currently breastfeeding and in need for lactation support into the Lactation Consulting Pilot Program. Pacify Health LLC is the only mobile health app focused exclusively on delivering new parents unlimited 24/7 on-demand access, via video consultation, to an expert network of pediatric supports such as certified lactation consultants and pediatric nutritionists. Through this partnership, our Heritage Health members will have free access to these services that would typically require a paid subscription. Care Managers will begin to identify members for this pilot through outreach contacts made during the last trimester of pregnancy and the postpartum period.

Partnership with Community-Based Organizations

In addition to the approaches discussed above, NTC will use three decades of "lessons learned" by our affiliates to launch the most effective initiatives for our Heritage Health members and their communities. We are a true partner in the communities we serve. In 2014, our community-based MCRs conducted more than 8,000 local events across 17 states, with each event designed to impact a local population on a significant wellness need. Below is a sample of programs NTC will offer to members and consumers throughout Nebraska. We will partner with providers, social service agencies and community-based organizations across the state to provide health education on topics that align with the State Health Improvement Plan and the Division of Public Health's Strategic Plan.

Adopt-a-School Program. Centene's nationally recognized program for schools in underserved communities, *reached thousands of students with over 200 events nationwide last year,* providing literacy and reading programs, and self-care and self-esteem education. The program also provided fitness programs, support to school nurses, oral hygiene kits, backpacks of school supplies, etc. We will adopt schools throughout Nebraska, such as in Douglas County, which has the highest level of child poverty in the state.

Healthy Lifestyle Events provide fun healthy activities for all ages; colorful, age-leveled materials, screenings and demonstrations; and are always tailored to local needs. *In 2014, our affiliates conducted more than 1,000 Healthy Lifestyle Events attracting more than 8,100 members plus additional community residents*. We may structure activities and education around "healthy play" for youth with asthma in Wyoming County where 91/10,000 hospital admissions are asthma-related; while in Schuylkill County where 56/10,000 hospital admissions are due to heart failure, we may focus on healthy eating, meal preparation, and exercise.

Weight Management and Fitness Initiatives. NTC will select the best initiatives for each community from Centene's expansive national program, such as *Keep It Moving!,* our new collaboration with H3TV, now being piloted in Washington to develop activity skills in students K-5th grades. *Family Fun Fitness Program* offers group exercise classes and nutrition education to all ages in local recreation centers in Georgia. Programs like these may engage American Indians and African Americans in Nebraska who have a higher incidence of obesity than other ethnicities; almost 42% of American Indians in Nebraska were obese in 2006-10.

Children in Child Welfare System. Based on experience with children/youth receiving care through the child welfare system, including in the juvenile justice system, we will offer education for members/caregivers such as Preparation for Adult Living (e.g. employment, housing, budgeting) for those nearing transition, and for caregivers, (e.g. behavioral interventions, trauma-informed care). We will coordinate with service organizations such as the Foster CARE Closet (serving children current in out of home placement) and Hope Chest (provides services for children transitioning out of child welfare). These service organizations provide free personal care items, clothing and school supplies to children as well as education to parents, caretakers, and children. We also will collaborate with caseworkers to provide professional webinars, such as Trauma-Focused Cognitive Behavioral Training.

Families/Caregivers of Members with Behavioral Illness. Through our behavioral health Clinical Trainers, we will offer consumer-focused webinars on topics like self-harm, effects of trauma, behavioral management, and self-management of co-morbid conditions. NTC's Tribal Health Liaison will work with our tribal health providers. These courses may be especially useful to our American Indian members, whose suicide rates are disproportionately higher, particularly in the western part of the state.

Intellectual and Developmental Disabilities Training and Capacity Building. Through our Pathways program, Centene has worked nationally to develop programs and trainings designed to increase provider, family/guardian and individual capabilities, capacity, and independence within local IDD systems. In Nebraska, we will use Pathways and other best practice and evidence-based programs in conjunction with existing trainings and capabilities of organizations such as (but not limited to), the Nebraska Association of Service Providers, the ARC of Nebraska, Disability Rights Center and the Munroe-Meyer Institute, to help increase systemic capacity and opportunities for greater independence and empowerment across the state.

TECHNICAL PROPOSAL

Response to the Request for Proposal (RFP) No. 5151 Z1 for Medicaid Integrated Managed Care Program for the State of Nebraska

Submitted To:

State Purchasing Bureau
Attn: Michelle Thompson / Teresa Fleming
AS Materiel State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Opening Date:

January 5, 2016 at 2:00 p.m. Central Time

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IV.F ATTACHMENTS

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Attachment
29 Draft Member Handbook

nebraska total care.

Nebraska Total Care Member Handbook

2016

X-XXX-XXX-XXXX

TDD/TTY: X-XXX-XXX-XXXX

NebraskaTotalCare.com

XXXXXX-XXXX 2016

Other Formats Available

The information in this booklet is about your Nebraska Total Care benefits. Nebraska Total Care will make this Member Handbook, website and all critical plan materials available as needed in Spanish, Vietnamese, Arabic, Nuer, Somali, Mandarin Chinese, German and Kurdish. If you need information in a language other than English, please call Member Services X-XXX-XXX-XXXX so we can help you.

Nebraska Total Care will also provide information from this Handbook in American Sign Language (ASL), braille, large font, or video recorded ASL upon request. English and Spanish versions of this Member Handbook are available on our website.

Spanish: La información incluida en este folleto es acerca de sus beneficios del Plan de Salud Nebraska Total Care Si necesita obtener la información en un idioma diferente, llame al Departamento de Servicios para Miembros al X-XXX-XXX-XXXX para que podamos ayudarle.

This combined member handbook and disclosure form constitutes only a summary of the health plan. The health plan contract (Contract) must be consulted to determine the exact terms and conditions of coverage. To see the Contract, go to the Nebraska Total Care office during business hours**, Monday through Friday, 8:00 a.m. to 5:00 p.m**. If our Contract with the Department of Health and Human Services changes, we will send you an update. Keep this manual and any updates handy.

INSERT BABEL CARD TO BE INSERTED HERE with Spanish, Vietnamese, Arabic, Nuer, Somali, Mandarin Chinese, German, and Kurdish translations of how to obtain more Nebraska Total Care information.

Interpreter Services

For members who do not speak English or do not feel comfortable speaking it, Nebraska Total Care has a free service to help. This service is very important because you and your doctor must be able to talk about your health concerns in a way you both can understand. Our interpreter services are provided at no cost to you and can help with many different languages. This includes sign language. We also have Spanish-speaking representatives available who can help you as needed. Nebraska Total Care members who are blind or visually impaired can call Member Services for an oral interpretation. To arrange for interpretation services, call Member Services X-XXX-XXX-XXXX (TDD/TTY 1- 1-866-274-6083)

Table of Contents

Other Formats Available 1
Interpreter Services 1
Table of Contents 2
WELCOME 6
Welcome to Nebraska Total Care 6
Member Handbook 6
Your Provider Directory 7
Choice of Physicians and Providers 7
HOW TO OBTAIN HEALTHCARE 18
3 Easy Steps to Establish a Medical Home 18
PCP Responsibilities 19
Making an Appointment with Your PCP 19
Scheduling/Appointment Waiting Times 20
After Hours Appointments with Your PCP 20
What to Do if Your Provider Leaves the Nebraska Total Care Network 20
Nebraska Total Care Website 21
Member Advisory Committee 22
Quality Improvement (QI) 22
How to Contact Us 23
Other Important Phone Numbers 23
Your Member ID card 23
HOW YOUR PLAN WORKS 25
Service Areas Covered 25
Member Services 25

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Nurse Advice Line 25
Membership and Eligibility Information 26
Eligibility 26
Major Life Changes 26
Enrollment 27
When Your Coverage Starts 27
Disenrollment 27
Newborn Enrollment 29
BENEFITS 29
Covered Services 29
Benefits Grid 30
Your Medicaid Benefits Not Covered by Nebraska Total Care 39
EXCLUSIONS 39
What Does Nebraska Total Care Not Cover? 39
UTILIZATION MANAGEMENT 41
Medically Necessary Services 41
Prior Authorization for Services 41
Second Medical Opinion 41
How to Get Medical Care When You Are Out of State 42
Out-of-Network Care 42
Specialist Referrals and Standing Referrals 43
Self-Referrals 43
Urgent Care-After Hours 43
Emergency Care 44
Post-Stabilization Services 45
PHARMACY 45
Pharmacy Program 45
Prior Authorization 45

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Emergency Drug Supply 45
Over-the-Counter Medications 46
Excluded Drugs 46
Filling a Prescription 46
Specialty Pharmacy Provider 46
HEALTH MANAGEMENT 47
Health Risk Screening 47
Disease Management 47
Preventive Care 48
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) 49
Family Planning Services 50
When You Are Pregnant 50
Pregnancy & Maternity Services 51
Start Smart for Your Baby® 51
MemberConnections® 52
MEMBER SATISFACTION 52
Internal Grievance Process 52
How to File a Grievance 52
Internal Appeal Process 53
Filing an Appeal 53
Who may file an Appeal? 54
When Does an Appeal Have to be Filed? 54
Expedited Appeals 54
Medicaid Fair Hearing for Appeals 54
Fraud, Waste, and Abuse (FWA) Program 55
Authority and Responsibility 55
Other Insurance 56
Accidental Injury or Illness (Subrogation) 56

Member Rights and Responsibilities 58
OTHER PROVISIONS 61
Organ and Tissue Donation 61
New Technology 61
Advance Directives 61
GENERAL PROVISIONS 62
Records 62
Right to request a restriction 63
Examination of Members 63
Covered benefits 63
Workers' Compensation not affected 63
Non-discrimination 63
Payments to providers 63
DEFINITIONS 65
Protecting Your Privacy 71
NOTICE OF PRIVACY PRACTICES 71
Privacy Notice 71
Using Your Rights 74

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WELCOME

Welcome to Nebraska Total Care

Nebraska Total Care is your new health plan. This Member Handbook describes your healthcare benefits and is designed to make it easy for you to make the most of your benefits and services.

You became a Nebraska Total Care member because you live in Nebraska and are eligible for the Nebraska Heritage Health program. Nebraska Total Care is a health plan overseen by the Nebraska Department of Health and Human Services Division of Medicaid and Long Term Care (MLTC). Nebraska Total Care gives you choices – from establishing a Medical Home by choosing your primary care provider (PCP) to participating in special programs that help you stay healthy.

You may also visit our website at www.NebraskaTotalCare.com for more information and services.

Member Handbook

The Member Handbook is a detailed guide to Nebraska Total Care and your healthcare benefits. It is our contract with you. The Member Handbook explains your rights, your benefits, and your responsibilities as a member of Nebraska Total Care. Please read this booklet carefully. It gives you information on your Nebraska Total Care benefits and services such as:

- What is covered/not covered by Nebraska Total Care
- How to get the care you need
- How to get your prescriptions filled
- What you will have to pay for your healthcare or prescriptions
- What to do if you are unhappy about your health plan or coverage
- Eligibility requirements
- Materials you will receive from Nebraska Total Care

Call Member Services X-XXX-XXX-XXXX to receive an additional copy of the Member Handbook at no cost to you. You may also visit our website at www.NebraskaTotalCare.com to view the Member Handbook.

Your Provider Directory

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Visit the Nebraska Total Care Provider Directory at www.NebraskaTotalCare.com to find a list of providers to choose from, including information about Primary Care Providers (PCPs), Specialists, Family Planning Providers, pharmacies, Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), and hospitals. This directory gives you the names, locations, office hours and telephone numbers, non-English languages spoken by current contracted providers with Nebraska Total Care and is free of charge.

At any time, you can request an additional copy of the Provider Directory at no charge by calling Member Services at X-XXX-XXX-XXXX . Nebraska Total Care can also help you pick a PCP. Make an appointment with your PCP within 120 days of enrolling. For those under the age of 18 months, this appointment should be made within 60 days of enrolling. If you need help, call Member Services at X-XXX-XXX-XXXX . We will help you make the appointment.

Choice of Physicians and Providers

How to Choose Your Doctor, Other Providers and Hospitals

Some hospitals and other providers do not provide one or more of the following services that may be covered under your Plan Contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Member Services at X-XXX-XXX-XXXX to ensure that you can obtain the health care services you need.

Nebraska Total Care works with a large group of doctors, Specialists, pharmacies, hospitals and other health care providers. This group is called a "network."

Can I see any doctor?

Nebraska Total Care has a Provider Directory that lists the participating providers you can use. Participating providers are Primary Care Physicians, clinics, hospitals, other non-physician health care providers and facilities.

If you have questions about the professional qualifications of network doctors and Specialists, such as medical school attended, residency completed and board certification status, call Member Services.

You can get a copy of Nebraska Total Care's Provider Directory by calling Member Services at X-XXX-XXX-XXXX and asking for a provider directory. You can also view the provider directory on our website at www.NebraskaTotalCare.com

What if I was seeing a doctor before becoming a new Member?

You may have been getting care from another doctor or hospital before you were a Member of Nebraska Total Care for:

- a serious chronic condition or acute condition
- a terminal illness
- a pregnancy
- care for a child (up to 36 months of age) or
- a planned surgery or procedure

If that doctor or hospital is not one of our providers, you may be able to continue to get the care you need if the doctor or hospital agrees with Nebraska Total Care to do so.

For more information, or to request a copy of this policy, call Nebraska Total Care's Member Services Department at:
X-XXX-XXX-XXXX , *or* 1-866-274-6083 (TTY/TTD)

Can I choose my Primary Care Provider (PCP)?

Yes. Use the Nebraska Total Care Provider Directory to choose a PCP for everyone in your family who has Nebraska Total Care. You can choose a different PCP for each family member. When picking a PCP, look for one of the following kinds of providers:

- Pediatricians
- Family /General Practitioners
- Internal Medicine
- Obstetricians/Gynecologists
- Registered Nurse Practitioners
- Physician Assistants (under the supervision of a physician)
- Advanced Registered Nurse Practitioners (ARNP)

Specialists can be your PCP for special needs, upon request. Because Nebraska Total Care is always working to have the most complete provider network to serve all of its members, please check the Nebraska Total Care website at www.NebraskaTotalCare.com to see if new providers have been added. If you want to know more about the PCP before you choose, please call Member Services at X-XXX-XXX-XXXX . You may also see a list of network providers at www.NebraskaTotalCare.com .

You may also choose a doctor within the local Federally Qualified Health Center (FQHC) for your primary care.

If you are a Native American, you can get services at any Indian Health Service Facility. You can also leave Nebraska Total Care at any time and get services through the Medicaid fee-for-service program. You also have the right not to enroll in a Medicaid Managed Care plan.

For information on the availability of the FQHC and Indian Health Service Facility clinics, and how to get services at these clinics, call Nebraska Total Care's Member Services Department at:

X-XXX-XXX-XXXX , *or*
1-866-274-6083 (TTY/TTD)

Do I have to see my PCP for OB/GYN care?

Women can go to any participating doctor, family practitioner, or nurse practitioner for routine and preventive OB/GYN care. You do not need approval from Nebraska Total Care or a referral from your PCP. Women can also have OB/GYNs as their PCP, children can have Pediatricians, and those with HIV/AIDS can have HIV/AIDS Specialists, if they are available.

The following are the most common services you get from an OB/GYN:

- Breast examination
- Gynecological examinations and treatment
- Pap smear and
- Prenatal care

What if I don't choose a PCP?

If you do not choose a PCP within 30 days after you enroll, Nebraska Total Care will contact you and help you choose one.

If we cannot contact you, we will assign you a PCP. The PCP's name will be on your ID card. If you do not want that PCP, call the Member Services Department right away to choose another PCP.

What if I want to change my PCP?

If you want to change your PCP, choose another provider from our Directory. But, remember, a close relationship with your PCP is in your best interest. You cannot see another PCP without telling us first.

Sometimes your PCP may ask that you be assigned to another PCP. This may be because you do not keep your appointments, do not follow the PCP's medical advice, or disrupt the office. This request cannot be because of your medical condition.

Can I choose anyone from the Provider Directory to be my PCP?

The Provider Directory shows you which providers are taking new patients. Providers who are not accepting new patients are clearly marked as not accepting new patients. If you were with a provider before you enrolled in our plan, that provider may let you continue as a patient. If a PCP's office is closed to new patients, you will have to select another PCP.

Can I choose the hospital I want?

In an emergency, go to your nearest hospital. If it is not an emergency and you need hospital care, your PCP decides what hospital you go to. The hospitals are also listed in the Provider Directory.

Is the information in the Directory current?

The information changes often. You can call a provider to see if they are taking new patients. Or, you can call the Member Services Department at:

X-XXX-XXX-XXXX , *or*
1-866-274-6083 (TTY/TTD)

How do I get care when I need it?

When can I see my PCP?

When you feel you are in need of health care services, call your PCP and schedule an appointment.

What does my PCP do?

Your PCP:

- manages your health care services
- provides most of your health care, including preventive services
- refers you to a Specialist when you need one
- authorizes and arranges for needed hospital care

What happens at my first Doctor's visit?

Don't wait until you are sick to see your PCP. New Members should meet with their PCP for an Initial Health Assessment or check-up within 120 days (4 months) of enrolling in Nebraska Total Care. Children

18 months old or younger should see their PCP within 60 days of becoming a member. A check-up helps your PCP to get to know you and your health care needs. This will also help your PCP take care of you when you are sick.

At your first visit, your PCP will also check to see if you need to see a dentist. If needed, s/he will refer you to a dentist.

Can I see a Specialty Physician?

You can see a Specialist that your PCP sends you to for evaluation, consultation, or care. This is called a "referral".

When do I need a referral?

Your PCP will talk to you about your health care needs. If your PCP cannot give you the services you need, he/she will refer you to a Specialist or for treatment at a hospital. Your PCP will request the referral for you. You must get the referral before you see the Specialist.

What services can I get without a referral?

You do not need a referral for:

- Preventive care
- Urgent or Emergency care
- Family planning
- OB/GYN
- HIV testing and counseling First treatment for a sexually transmitted disease

If I need Specialist care for a long time, do I have to ask for a referral from my PCP each time I see the Specialist?

No. If you need ongoing care from a Specialist because of a serious or life-threatening problem, the Specialist can ask for an extended referral.

Examples of health problems that could get an extended referral are serious cases of cardiovascular disease, asthma, diabetes, MS, or HIV/AIDS.

We will make a decision about the referral within 3 (three) working days. The referral will be made to the Specialist within 4 working days after the decision is made.

If you think you need an extended referral, talk to your PCP. For more information on Specialty providers or extended referrals, call the Member Services Department at:

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X-XXX-XXX-XXXX , *or*
1-866-274-6083 (TTY/TTD)

When do I have to check with Nebraska Total Care first?

You have to get a Nebraska Total Care authorization, for:

- Hospitalization (but not for emergency and urgent care services)
- Services out of the Nebraska Total Care service area (but not for emergency and urgent care services)
- Outpatient surgery, long-term therapy, or specialized treatments

How do I get Nebraska Total Care authorization?

Your PCP or Specialist will ask us for approval before you get the services.

How long does it take to get Nebraska Total Care authorization?

We will make a decision regarding your provider's request for authorization in a timely manner, no longer than 5 working days from receiving the request and all of the necessary information. But, if the request is urgent, we will let your provider know within 24 hours.

Will Nebraska Total Care approve any care I want?

You are covered only for the health care services that you *need*. If our Medical Director determines you do not have a medical need for certain services, we will not approve those services.

If we do not approve a requested service, we will tell you why. You will receive a letter explaining why the authorization was not approved, or denied. If you do not agree with the explanation given, you may appeal the decision by filing a complaint. For information on how to file a complaint, see the "How do I file a complaint" section of this handbook.

To learn more about how we make those decisions, ask the Member Services Department for a copy of our medical necessity guidelines.

If you see a provider without our approval that does not have a contract with us, Nebraska Total Care is not responsible for the costs associated with the care you receive from that provider.

What if I want a second opinion?

You can get a second opinion from a participating provider for certain services, including:

- surgery

- treatment or diagnoses of serious or life-threatening conditions
- complex cases or cases with conflicting test results
- cases where the Member does not respond well after an appropriate amount of time

To get a second opinion, you can request to be referred to doctors specializing in that area of medicine. Most of the time, the second opinion must be from a Nebraska Total Care doctor. However, if there is not a Nebraska Total Care doctor qualified to see you, we will authorize a second opinion from a provider outside of our network.

If you do not know which doctor to see for a second opinion, ask your PCP or call Nebraska Total Care for a recommendation.

Once you decide who you want to see, ask your PCP or Nebraska Total Care to refer you. Then make an appointment to see one of these doctors. If the second opinion is different from the first opinion, you or Nebraska Total Care can ask for a third opinion.

Nebraska Total Care will let you know when your request for a second opinion is approved. For a routine condition, we will let you know within 5 working days of your request. If your case is urgent, we will let you know within 72 hours of your request.

If we deny your request, we will let you know within 24 hours of our decision. If you do not agree with our decision, you can file a complaint with the Division of Managed and Long Term Care.

There is no cost to you for a second or third opinion, if Nebraska Total Care approves it first. For more information on second opinions, call the Member Services Department at:

X-XXX-XXX-XXXX , *or*
1-866-274-6083 (TTY/TTD)

What if I need urgent care?

You do not need to ask us for approval first before getting emergency care or urgent care. You do not have to see a participating provider for emergency or urgent care.

If you need care during normal business hours, call your PCP. His or her staff will make an appointment for you, or tell you where to go for care.

If you need urgent care after hours or on the weekends you can call Nebraska Total Care Advice Nurse at X-XXX-XXX-XXXX . The nurse will help you decide what to do.

If you are outside Nebraska Total Care's Service Area and need urgent care, you must call Nebraska Total Care within twenty-four (24) hours of getting urgent services, or as soon as you are able to.

What do I do in an emergency?
Emergency services are covered inside and outside of Nebraska Total Care's service area. Emergency services do not need approval from Nebraska Total Care and are provided at no cost to you.

An emergency is a medical or psychiatric condition that could get worse if you don't get immediate care by:

- Placing your health in serious danger (or, with respect to a pregnant woman, the health of the woman or her unborn child),
- Causing serious harm to bodily functions, or
- Causing serious harm to any bodily organ or part.

Examples include:

- Active labor
- Broken bones
- Chest pain
- Severe burns
- Fainting
- Drug overdose
- Paralysis
- Severe cuts that won't stop bleeding
- Psychiatric emergency conditions

If you think you have a health emergency, call 911. You are not required to call your doctor before you go to the emergency room. Do not use the emergency room for routine (regular) health care.

What do I do after an emergency?

Nebraska Total Care must be notified within twenty-four (24) hours, or, if you are unable to notify us, as soon as you can. It is important for you to see your PCP when you get out of the hospital for follow-up care.

How do I get emergency care outside of the Nebraska Total Care Service Area?
If you have an emergency when you are not in the Nebraska Total Care Service Area, you can get emergency services at the nearest emergency facility. Emergency services do not require a referral or okay from your PCP provider. Emergency services are not covered outside of the United States.

If you are admitted to a hospital not in Nebraska Total Care's network or to a hospital where your PCP or other provider does not work, Nebraska Total Care has the right to move you to a network hospital as soon as it is medically safe to do so.

You may need hospital care after an emergency to stabilize your condition. This is called Post-Stabilization Care. If you do, the hospital will call Nebraska Total Care to ask for approval.

The hospital will ask you for your ID card. If you don't have your ID card, tell the hospital to call Nebraska Total Care.

If you do not agree to being transferred to a contracted hospital that can provide the care you need, you may have to pay for the post-stabilization services.

Your PCP must provide follow-up care when you leave the hospital.

For maternity related Emergency Services, please reference the "Pregnancy and Maternity Services" in Section 5 "What Does Nebraska Total Care Cover."

What if I can't get the services I need from a participating provider?

If no participating provider can give you the services you need, you can get those services from a non-participating provider. But first, your PCP must ask Nebraska Total Care for approval. If your case is urgent, we will let you and your provider know within 72 hours. For non-urgent cases, we will let you and the provider know within 5 business days.

What if my doctor can no longer care for me?

If your doctor is no longer part of our plan, you may be able to continue to see that doctor if the doctor agrees with Nebraska Total Care to do so and if you are being treated for:

- a serious, chronic condition or acute condition
- a pregnancy
- a terminal illness

You may also continue with that doctor if:

- You were receiving care for your baby (up to 36 months of age) Coverage limit will be the earlier of

- 12 months from the child's effective date of coverage if the child is a new Member,
- 12 months from the termination date of the terminated provider, or
- the child's third birthday.
- Nebraska Total Care approved a surgery or procedure with that doctor

Remember: the doctor does not *have* to continue caring for you. For more information, or to request a copy of this policy, call Nebraska Total Care's Member Services Department at:

X-XXX-XXX-XXXX , *or*
1-866-274-6083 (TTY/TTD)

Getting care outside of Nebraska Total Care's network

For routine (regular) care, all health care services are provided in the Nebraska Total Care Service Area. Routine care outside of the Nebraska Total Care Service Area is not covered.

In most cases, you need to get care within Nebraska Total Care's network and within the Nebraska Total Care Service Area. However, when you are not in the Service Area you can always get emergency care at the nearest emergency facility.

If you get care from a non-contracted provider (a doctor or other provider that is not a part of Nebraska Total Care's network) or outside of the Nebraska Total Care Service Area, you may be billed by the provider and you may have to pay, except for emergency care, urgent care, family planning and for sexually transmitted disease (STD) testing services. You can learn more about this under "What to do in an emergency?" section of this handbook.

If you get a bill

Nebraska Total Care pays for all covered medical costs approved by your PCP, Specialist, and for an emergency. There is no co-payment for services. You should not get a bill for any services covered by Nebraska Total Care. Please call Member Services toll-free at X-XXX-XXX-XXXX right away if you receive a medical bill. Nebraska Total Care will make sure the doctor stops sending you a bill.

You may get a medical bill if you go to a doctor that does not work with Nebraska Total Care or is located outside of Nebraska Total Care's Service Area. If this happens, then you may be billed by the doctor and you may have to pay for services that are not covered by Nebraska Total Care. If you pay the bill, keep a copy or record of your payment. Send a copy of your payment to Nebraska Total Care for review. If the bill is for covered or authorized services, you may receive a refund from Nebraska Total Care.

You should not be billed for emergency care, urgent care, the care required to stabilize an emergency condition, family planning services, or for sexually transmitted disease testing at a clinic. If you receive a bill, do not pay it. Call Nebraska Total Care right away to take care of the bill for you.

If you get a bill for covered services and need help or if you want to file a complaint, call Member Services at Nebraska Total Care.

How to Get Your Prescription Drugs

Sometimes when you are sick or have a health condition like asthma or diabetes, your doctor may give you a prescription. Your doctor will give you a prescription based on your health needs status.

Medicaid Members should not be asked to pay for prescription drugs. Call Nebraska Total Care if you are asked to pay for a Medicaid prescription.

For New Prescriptions:

If you are filling a prescription for the first time, you must get your prescribed medications (drugs) from a pharmacy that works with Nebraska Total Care. Nebraska Total Care provides prescriptions for its members through pharmacies that are contracted with US Script. You may also find a list of pharmacies in Nebraska Total Care's Provider Directory, or to find pharmacies near you, please call Member Services toll-free at X-XXX-XXX-XXXX .

For Prescription Refills:

If you are refilling a prescription that you already have, you can go to a pharmacy that works with Nebraska Total Care. You might be able to receive a 90-day supply of maintenance medications at select local pharmacies. Maintenance medications are drugs that you need to take for a long time, such as pills for high blood pressure or diabetes. You can also choose to have the 90-day supply of maintenance medications mailed either to your home or an alternate address through our prescription mail order program. Please remember to ask your provider/other prescriber to write a 30-day supply, as well as a 90-day supply plus refills, for your maintenance medication(s).

How to Get a Prescription Filled at the Pharmacy:

- Choose a network pharmacy near you.
- Bring your prescription to the pharmacy.
- Give the prescription to the pharmacy with your Nebraska Total Care Member ID card. This will help the pharmacy fill your prescription.
- Make sure you give the pharmacy your correct address and phone number.
- Make sure the pharmacy knows about all medications you are taking and any allergies you have to any medicine.
- If you have any questions about your prescription(s), make sure you ask the pharmacist.

HOW TO OBTAIN HEALTHCARE

3 Easy Steps to Establish a Medical Home

1) Choose a Primary Care Provider (PCP). If you do not choose one, Nebraska Total Care will choose one for you. You can find this information on your member ID card. You will be able to change your PCP at any time by calling Member Services at X-XXX-XXX-XXXX .

2) Make an appointment with your PCP to complete your Initial Health Assessment within 120 days of enrolling. For those under the age of 18 months, this appointment should be made within 60 days of enrolling.

3) Talk to your PCP about any health problems you are experiencing.

When you enroll in Nebraska Total Care, you must choose a PCP. Your primary care provider, or PCP, is a doctor, a nurse practitioner, certified nurse midwife or physician assistant you see on a regular basis to take care of your medical needs. You should receive all of your basic medical care from your PCP. You can call your PCP when you are sick and do not know what to do. Seeing your doctor for regular check-ups helps you find health problems early. This can help prevent going to the emergency room. If you have never seen your PCP, as soon as you join Nebraska Total Care you should call your PCP, introduce yourself as a new member and make an appointment for a preventive visit. It is best not to wait until you are sick to meet your PCP for the first time.

Changing Your PCP

You may change your PCP at any time if:

- Your PCP is no longer in your area
- You are not satisfied with your PCP's services
- The PCP does not provide the services you seek because of religious or moral reasons
- You want the same or different PCP as other family members

You must notify us when you change your PCP. You can do this by calling the Member Services Department at X-XXX-XXX-XXXX, sending us a written notification, or by visiting our website at www.NebraskaTotalCare.com .

PCP Responsibilities

Your PCP will:

- Make sure that you get all medically necessary services in a timely manner.
- Follow-up on the care you get from other medical providers.
- Take care of referrals for specialty care and services offered.
- Provide any ongoing care you need.
- Update your medical record, including keeping track of all the care that you get from your PCP and Specialists.
- Provide services in the same manner for all patients.
- Give you regular physical exams.
- Provide preventive care.
- Give you regular immunizations.
- Make sure you can contact him/her or another doctor at all times.
- Discuss what advance directives are and file the advance directives appropriately in your medical record.

Making an Appointment with Your PCP

Once you have selected a PCP, make an appointment to meet with your doctor to complete your Initial Health Assessment within 120 days of enrolling. For those under the age of 18 months, this appointment should be made within 60 days of enrolling, and at least annually. This will give you and your doctor a chance to get to know each other. Your doctor can give you medical care, advice, and information about your health. Call your PCP's office to make an appointment. Remember to take your member ID card with you every time you go to the doctor's office. **If you have difficulty getting an appointment with or seeing your doctor, please call Member Services at X-XXX-XXX-XXXX.**

Scheduling/Appointment Waiting Times

Network providers will be open at reasonable times. You will get an appointment based on your medical needs. You should be given an appointment within the following time frames:

Type of Provider Appointment	Scheduling Time Frame
Preventive Care	Within four weeks
Maternity Care	Within three calendar days of request
Non-urgent Sick	Within 72 hours of request
Urgent	Same Day
Family Planning	Within 7 calendar days
Emergency	Immediately, or refer to ER

After Hours Appointments with Your PCP

You can call your PCP's office for information on receiving after hours care in your area. If you have a medical problem or question and cannot reach your PCP during normal office hours, you can call Nebraska Total Care's 24-hour medical nurse line at X-XXX-XXX-XXXX to speak to a nurse. If you have an emergency, call 911 or go to the nearest ER.

NOTE: All services other than well visits, preventive services, immunizations, emergency services, urgent care services, minor consent services (sexual assault, pregnancy care, family planning, sexually transmitted disease services), HIV testing, and abortion must be obtained through Nebraska Total Care network providers or pre-approved for out of network providers.

IMPORTANT: If you cannot keep an appointment, please call the doctor's office to cancel at least 24 hours in advance. If you need to change an appointment, call the doctor's office as soon as possible. They can make a new appointment for you. If you need help getting an appointment, call Member Services at X-XXX-XXX-XXXX.

What to Do if Your Provider Leaves the Nebraska Total Care Network

If your PCP is planning to leave the Nebraska Total Care provider network, we will send you a notice at least 60 calendar days before the date this occurs. You can select a new PCP or we will automatically reassign you to another PCP. We will send you a new member ID card identifying your new PCP. You can also change your PCP by calling Member Services at X-XXX-XXX-XXXX, or by visiting our website at www.NebraskaTotalCare.com

Continuity and Transition of Care for New Members

If your Provider leaves the Nebraska Total Care network while you are getting covered services from them, you may be able to keep getting some services from that provider for:

- ***Acute* conditions.** Covered services will be provided for the duration of the condition.
- **Serious *chronic* conditions.** Covered services will be provided for a period of time, not to exceed 12 months from the date of the provider's termination.
- ***Pregnancy care*.** Covered services will be provided for the duration of the pregnancy, including immediate postpartum care.
- ***Terminal illnesses*.** Covered services will be provided for the duration of the illness.
- ***Care for children under age 3*.** Coverage limit will be the earlier of 1) 12 months from the child's effective date of coverage if the child is a new Member, 2) 12 months from the termination date of the terminated provider, or 3) the child's third birthday.
- ***Surgery or another procedure that is part of a course of treatment*.** The care must be recommended and documented by the provider to occur within 180 days of the date of the provider's termination.

If the terminated provider does not agree to comply with the Plan's contractual terms and conditions that are imposed upon current contracted providers, we will not approve the request for the Continuity of Care services.

To learn more and to request *services* or a copy of our continuity of care policy, call Nebraska Total Care's Member Services Department at:

X-XXX-XXX-XXXX , *or*
1-866-274-6083 (TTY/TTD)

Nebraska Total Care Website

Nebraska Total Care's website helps you get the answers. Our website has resources and features that make it easy for you to get quality care. Nebraska Total Care's website can be found at www.NebraskaTotalCare.com . It also gives you information on your Nebraska Total Care benefits and services such as:

- Member Handbook (Evidence of Coverage/Contract)
- Provider Directory
- Current news and events
- Member self-service features
- Online form submission

- Nebraska Total Care programs and services

Member Advisory Committee

You can help Nebraska Total Care with the way our health plan works. We have a Member Advisory Committee that gives members like you a chance to share your thoughts and ideas with Nebraska Total Care. At the meetings, you have a chance to talk about the way services are delivered. The group meets at least two times a year. We may ask members, parents/foster parents, guardians of children who are members, member advocates and Nebraska Total Care staff to join in the meeting. This gives you a chance to talk about your concerns with a variety of people. You also have a chance to tell us how we are doing. You may ask questions or share any concerns that you have about the delivery of services. Call Member Services X-XXX-XXX-XXXX if you would like to attend.

Quality Improvement (QI)

Nebraska Total Care is committed to providing quality healthcare for you. Our primary goal is to improve your health and help you with any illness or disability. Our program is consistent with National Committee on Quality Assurance (NCQA) and Institute of Medicine (IOM) priorities. To help promote safe, reliable, and quality healthcare, our programs include:

- Conducting a thorough check on providers when they become part of the Nebraska Total Care provider network.
- Monitoring the access that Nebraska Total Care members have to all types of healthcare services.
- Providing programs and educational items about general healthcare and specific diseases.
- Sending reminders to you to get annual tests, such as age and gender appropriate services such as physicals, cervical cancer screenings, and breast cancer screenings.
- Investigating your concerns regarding the healthcare you have received. If you have a concern about the care you received from your doctor or any service provided by Nebraska Total Care, please contact us at X-XXX-XXX-XXXX .

Nebraska Total Care believes that getting input from members, like you, can help make the services and quality of our programs better. We conduct a member survey each year that asks questions about your experience with the healthcare and services you are receiving.

How to Contact Us

Nebraska Total Care
Street
CityStateZip
NebraskatTotalCare.com

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. Pacific Standard Time.

Member Services ..... X-XXX-XXX-XXXX
TDD/TTY line ..... X-XXX-XXX-XXXX
Member Services Fax ..... X-XXX-XXX-XXXX
Nebraska Relay Services 711
Behavioral Health Services (covered by Medi-Cal program) ..... X-XXX-XXX-XXXX

Other Important Phone Numbers

Non-Emergency Transportation ..... X-XXX-XXX-XXXX
Emergency Services ..... Call 911

Your Member ID card

When you enroll in Nebraska Total Care, you will receive a Nebraska Total Care Member ID Card within 7 calendar days of enrollment. This card is proof that you are enrolled with Nebraska Total Care. You need to keep this card with you at all times. Please show this card every time you go for any service under the Nebraska Total Care program. The Nebraska Total Care ID card will show your name, ID#, and PCP name and number. You must protect your ID card. Misuse of the card, including loaning, selling, or giving it to another person, could result in loss of your Medicaid eligibility and/or legal action. If you do not get your Nebraska Total Care ID card within a few weeks after you join our plan, please call Member Services at X-XXX-XXX-XXXX. We will send you another card.

Here is an example of your Nebraska Total Care ID card

Front

- **Name**
- **ID#**
- **PCP Name/Number**
- **PCP effective date**
- **Pharmacy vendor information**

Back

- **Important Member & Provider Phone Numbers (24/7 hotline #)**
- **Paper Medical claims address**
- **Website address**

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HOW YOUR PLAN WORKS

Service Areas Covered

Nebraska Total Care is a health plan available through Nebraska Department of Health and Human Services. Nebraska Total Care's service area includes 19 counties in Nebraska.

Member Services

Our Member Services Department will tell you how Nebraska Total Care works and how to get the care you need. The Member Services call center can help you to:

- Find a PCP.
- Schedule an appointment with your PCP.
- Obtain a new ID card.
- Obtain information about covered and non-covered benefits.
- Understand how to file a Grievance or Appeal
- Obtain a list of health plan providers.
- Report potential fraud issues.
- Request new member materials.
- Obtain information about case management.

Please call X-XXX-XXX-XXXX (TDD/TTY 1-866-274-6083). We are open Monday through Friday from 7:00 a.m. to 8:00 p.m. Calls received after business hours are sent directly to our 24-hour nurse advice line. Our nurses are available 24 hours a day, seven (7) days a week.

Nurse Advice Line

Nebraska Total Care offers a free health information phone line. Nurses are ready to answer your health questions 24 hours a day – every day of the year. This line is staffed with registered nurses. These nurses have spent lots of time caring for people. They are ready and eager to help you.

The services listed below are available by calling Nebraska Total Care's 24-hour nurse hotline at X-XXX-XXX-XXXX .

- Medical advice.
- Health information library.
- Answers to questions about your health.
- Advice about a sick child.
- Help with scheduling PCP appointments.

Sometimes you may not be sure if you need to go to the emergency room (ER). You can call your PCP or NurseWise. They can help you decide where to go for care. If you have an emergency, call 911 or go to the nearest ER.

Membership and Eligibility Information

Eligibility

You must be eligible for the Nebraska Medicaid program in order to be eligible for this health plan. Nebraska Total Care does not determine eligibility.

To locate your Medicaid Office for your county you can contact Medicaid at xxx-xxx-xxxx, or visit: {insert website}

Major Life Changes

Life changes might affect your eligibility with Nebraska Total Care. If you have a major change in your life, please contact your Eligibility Source (such as your local Social Security Administration office, Office of Administration for Nebraska, county office, or Nebraska Medicaid office) within 10 days after the change happens (or within 10 days after you realize the change has taken place). You should also contact Member Services X-XXX-XXX-XXXX .

Some examples of major life changes are:

- A change in your name.
- Move to a different address.
- A change in your job.
- A change in disability.
- Pregnancy.
- Moving to a new county or out of state.

Also, you should call your Eligibility Source if you have a change in your family size. This might mean that your family got bigger because of a birth, adoption, or a marriage. You should also report when your family gets smaller. This may happen because a family member moves away or there is a death in the family. A divorce could also change family size.

Enrollment

If you are eligible for Medicaid and live in the service area, you and your eligible family members can enroll in Nebraska Total Care. During this period, you may choose another HMO health plan for any reason. If you want to change your health plan during open enrollment, please contact xxx-xxx-xxxx.

When Your Coverage Starts

Your coverage with Nebraska Total Care starts on the first day of the calendar month that MLTC adds your name to the approved list of Members given to Nebraska Total Care.

Mandatory Medicaid managed care members

MLTC says that most Medicaid members must enroll in a health plan and be in managed care. Members who must enroll in a health plan are called "mandatory members".

Voluntary Medicaid managed care members

Members who choose to enroll in a health plan are called "voluntary members". Voluntary members can leave the Nebraska Total Care plan at any time, and return to fee-for-service Medicaid. Voluntary members include:

- American Indians and their household, and others who are eligible to get services from an Indian Health Center or Native American Clinic
- Aliens who are eligible for Medicaid for an emergency condition only.
- 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.
- Beneficiaries who have received a disenrollment or waiver of enrollment
- Participants in the Program for All-Inclusive Care for the Elderly
- Beneficiaries with Medicare coverage where Medicaid only pays co-insurance and deductibles.

Disenrollment

Voluntary Medicaid managed care members may request to disenroll from Nebraska Total Care and select another managed care plan at any time and disenroll from Medicaid for specific reasons. MLTC procedures must be followed for all disenrollment requests. You must contact your local county enrollment broker location to ask for disenrollment forms to end coverage. After submission of the form, it takes up to 45 days to disenroll you from Nebraska Total Care. During this time, you can keep seeing your PCP until you get a notice that your Nebraska Total Care coverage has ended.

A member must be disenrolled from Nebraska Total Care when one of the following conditions is met:

- You no longer live in the service area.

- You are in a long-term care or intermediate facility longer than one month following the month you were admitted.
- You are in need of special health care services not provided by Nebraska Total Care, for example, some major organ transplants.
- You are already enrolled in another Medicaid, Medicare, or commercial managed care plan.
- You are in prison or jail.

Expedited Disenrollment

Nebraska Total Care will process an Expedited Disenrollment if we are not able to provide you medical services due to your condition or situation which is indicated in Nebraska Total Care' contract with MLTC. Nebraska Total Care will submit a disenrollment request to MLTC who will make a decision within 72 hours. When we receive the decision, we will notify you and your PCP of the effective date of disenrollment. Your health care condition will be covered by regular Medicaid.

Nebraska Total Care Can End Your Coverage

If Nebraska Total Care gets approval from MLTC, we can end your coverage for one of the following reasons:

- Nebraska Total Care made reasonable efforts, including assigning you to other PCPs, but you did not establish or maintain a satisfactory relationship with your provider;
- You knowingly did not give Nebraska Total Care the important information it needed, or you knowingly gave incorrect or misleading information to Nebraska Total Care or to your PCP that affects your benefits and health care services;
- You let someone else use a Nebraska Total Care identification card, prescription drug card, or any other card provided by Nebraska Total Care that did not belong to them; or you knowingly used an invalid card;
- You hurt, tried to hurt, or threatened any provider, provider's employee, or any employee, agent or representative of Nebraska Total Care;
- You repeatedly used obscene language or behaved in a destructive or disruptive way in a health care facility or in dealing with any employee, agent or representative of Nebraska Total Care; or
- You continually use non-Participating Providers for non-emergency services without getting the authorization you need. If Nebraska Total Care ends your coverage for any of these reasons, your benefits under Nebraska Total Care end on the date your coverage ended (called date of termination).

Newborn Enrollment

We cover a new baby for the month of birth plus the next month. (If you have your baby the month before you become a *Member*, we cover the baby for one month.) After that, your baby must have his or her own coverage. After you have your baby, call your county Eligibility Source right away to get your baby on *Medicaid*. It will take some time for your baby's coverage to start after you talk to your county eligibility worker.

BENEFITS

Covered Services

This section describes your Nebraska Total Care covered benefits and benefit limits. With Nebraska Total Care, you are entitled to receive medical services and benefits listed in this section. You are responsible to pay for any Non-Covered Services.

Covered benefits are listed below.

Please Note:

- Nebraska Total Care will not limit or deny services because of a condition you already have.
- For services which are medically necessary and covered by Nebraska Total Care, you will not have any co-payments (co-pays), deductibles, or other cost sharing.
- If you receive healthcare services which are not medically necessary or if you receive care from doctors who are out of the Nebraska Total Care network, you may be responsible for payment (except in the event of an emergency). If you have questions about medical necessity or which doctors are in your network, call Member Services at X-XXX-XXX-XXXX .

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Benefits Grid

This list is a sample of Covered Benefits and is not intended to be reflective of our proposed Nebraska Total Care Covered Benefits and Value Added Benefits. A draft Nebraska Total Care Member Handbook will be provided to MLTC for review and approval 120 calendar days prior to contract start date.

Service	Coverage	Details and Limitations
Abortion	Covered	In accordance with 42 CFR 441.202 and the Consolidated Appropriations Act of 2008
Acupuncture	Covered by Medi-Cal Fee-For-Service	Refer to Medi-Cal for limits here: http://www.dhcs.ca.gov/services/Pages/AllServices.aspx
Alcohol and Substance Abuse Treatment Services (including drugs used for treatment and outpatient heroin detoxification services)	Covered by Medi-Cal Fee-For-Service	Refer to Medi-Cal for limits here: http://www.dhcs.ca.gov/services/Pages/AllServices.aspx
Allergy Services (testing and desensitization)	Covered	Limits applicable when office visits billed in conjunction with allergy services
ıbulance – Emergency Transportation	Covered	Ground, Rotary Wing, Fixed Wing
Ambulance – Non-Emergency Transportation	Covered	Ground, Rotary Wing, Fixed Wing
Ambulatory Surgery Center - ASC	Covered	
Anesthesia Services	Covered	
Artificial Insemination	Not Covered	
Audiology Services	Covered	Members age 21 and older are subject to the state's Optional Benefits Exclusion (OBE) coverage guidelines Under age 21 refer to Nebraska Children's Services (CCS) guidelines here: http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx
Bariatric Surgery	Covered	Only covered in a Centers for Medicare & Medicaid Services Certified Center of Excellence Other limitations may apply
Biofeedback	Not Covered	

Service	Coverage	Details and Limitations
Birthing Centers	Covered	Limitations may apply
Blood and Blood Derivative Products	Covered	Designated providers for contract blood factors Other limitations may apply
Blood Pressure Equipment	Covered	Covered only for documented malignant hypertension or End Stage Renal Disease
Bone Density Testing	Covered	One test per year for specified diagnoses Not covered if for screening purposes only
Breast Pumps	Covered	
California Children's Services (CCS) Program medical services for children with certain special health problems	Covered by Nebraska Children's Service Program	Refer to CCS for limits here: http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx Only for members under age 21
Clinical Trials	Covered	Member and trial must meet specific medical criteria
Certified Nurse Midwife	Covered	
Chemotherapy	Covered	Under age 21 refer to CCS guidelines here: http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx
Chiropractic Services	Covered by Medi-Cal Fee-For-Service	Refer to Medi-Cal for limits here: http://www.dhcs.ca.gov/services/Pages/AllServices.aspx
Child Health and Disability Prevention (CHDP) Services	Covered	
Christian Science Practitioners	Covered by Medi-Cal Fee-For-Service	Refer to Medi-Cal for limits here: http://www.dhcs.ca.gov/services/Pages/AllServices.aspx
Circumcision	Routine / Elective: Not Covered Medically Necessary: Covered	

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Service	Coverage	Details and Limitations
Comprehensive Perinatal Services Program	Covered	Limitations may apply
Cosmetic Surgery (not medically necessary)	Not Covered	
Dental (dental providers / services)	Covered by Denti-Cal	Refer to Denti-Cal for limits here: http://www.denti-cal.ca.gov/WSI/Bene.jsp?fname=BeneSrvcs
Dental (medical providers / medical services related to dental services)	Covered	Certain prescription drugs Laboratory services Pre-admission physical examinations Facility fees / anesthesia both inpatient / outpatient
Diabetic Services	Covered	Under age 21 refer to CCS guidelines here: http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx
Dialysis	Covered	Under age 21 refer to CCS guidelines here: http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx
ectly Observed Therapy (DOT)	Covered by Medi-Cal fee-for-service and County Health Department	DOT is specific TB (tuberculosis) treatment rendered by Local Health Departments Refer to Medi-Cal for limits here: http://www.dhcs.ca.gov/services/Pages/AllServices.aspx
Durable Medical Equipment	Covered	
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Covered	Only for members under age 21
Emergency Room Services	Covered	
Enteral and Parenteral Nutrition	Covered	
Erectile Dysfunction Drugs and Therapies	Not Covered	
Experimental Services (other than those provided in covered clinical trials)	Not Covered	This includes, but is not limited to drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans
Family Planning Services (and supplies)	Covered	Limitations may apply
FQHC – Federally Qualified Health Center ervices	Covered	

Service	Coverage	Details and Limitations
Fluoride Varnish (non-dental provider)	Covered	Only for members under age 6 Covered 3 times in a 12 month period Service is provided by physicians, nurses, and other medical personnel
Gender Reassignment Surgery	Covered	Procedures that are not medically necessary are not covered Members age 18 & over
Health Education	Covered	
Hearing Aids and Repairs	Covered	Limitations may apply Under age 21 refer to CCS guidelines here: http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx
Hearing Screenings	Covered	Members age 21 and older are subject to the state's Optional Benefits Exclusion (OBE)coverage guidelines Other limitations may apply Under age 21 refer to CCS guidelines here: http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx
HIV Testing and Counseling	Covered	
Home and Community Based Services (HCBS) – Waiver Programs	Covered by Medi-Cal Fee-For-Service	Refer to Medi-Cal for limits here: http://www.dhcs.ca.gov/services/Pages/AllServices.aspx
Home Health Care Services	Covered	Limitations may apply
Hospice Care	Covered	Limitations may apply
Hospital Services – Inpatient	Covered	
Hospital Services – Outpatient	Covered	
Hyperbaric Oxygen Therapy - HBO	Covered	Limitations may apply, depending on diagnosis, frequency, and provider type Under age 21 refer to CCS guidelines here: http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx

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Service	Coverage	Details and Limitations
Hysterectomy	Covered	Not covered if performed only to make a member permanently sterile
Immunizations (adults and children)	Covered	Vaccines For Children program only for children Other limitations may apply
Incontinence Creams and Washes	Covered	Members age 21 and older are subject to the state's Optional Benefits Exclusion (OBE) coverage guidelines Other limitations may apply
Indian Health Programs	Covered	
Infertility (diagnosis and treatment)	Not Covered	
Injectable Medications	Covered	Limits apply to certain medications
Interpreter Services	Covered	
/estigational Services	Covered	Including, but not limited to drugs, equipment, procedures or services for which laboratory and animal studies have been completed and for which human studies are in progress but: Testing is not complete, and, The efficacy and safety of such services in human subjects are not yet established, and, The service is not in wide usage Other limitations may apply
Laboratory and Pathology Services (inpatient and outpatient)	Covered	
Laboratory Services - State Serum Alphafetoprotein Testing Program	Covered by Medi-Cal Fee-For-Service	Administered by the Genetic Disease Branch of Nebraska Department of Public Health
Local Educational Agency (LEA) Services	Covered by Medi-Cal Fee-For-Service	Refer to Medi-Cal for limits here: http://www.dhcs.ca.gov/services/Pages/AllServices.aspx
Local Health Department	Covered	Directly Observed Therapy (DOT) is covered by Medi-Cal Fee-For-Service

Service	Coverage	Details and Limitations
Long Term Care (LTC)	Covered by Medi-Cal Fee-For-Service	Upon acceptance by state for LTC, member is dis-enrolled from Nebraska Health and Wellness Plan Long-term care (LTC) is care in a facility for longer than the month of admission plus one month. These health care facilities include skilled nursing facilities, subacute facilities, pediatric subacute facilities, and intermediate care facilities Refer to Medi-Cal for limits here: http://www.dhcs.ca.gov/services/Pages/AllServices.aspx Please note: Hospice services are not considered LTC.
Mammography (screening)	Covered	Females only Unless medically necessary, only covered for those age 50 and older
Mental Health Services	Covered by Medi-Cal Fee-For-Service (with Exceptions *)	Refer to Medi-Cal for limits here: http://www.dhcs.ca.gov/services/Pages/AllServices.aspx *Exceptions covered by Nebraska Health and Wellness Plan include certain lab, radiology, pharmacy, Medicare/Medi-Cal crossover claims, FQHC, RHC, IHS, and out of state providers (not border states). Specific diagnoses applicable to Inpatient Hospital and Home Health
Non-Emergency Medical Transportation (NEMT) – other than ambulance	Covered	Benefit managed by LogistiCare http://www.logisticare.com Limitations may apply
Non-Medical Equipment	Not Covered	
Obstetrical/Gynecological Services	Covered	
Ostomy Supplies	Covered	
Oxygen and Respiratory (services, supplies, equipment)	Covered	
Pain Management	Covered	Limits include, but are not restricted to, specific diagnoses

Service	Coverage	Details and Limitations
Pap Smears (routine/preventative)	Covered	Age 21 & older
Pediatric Day Health Care	Covered by Medi-Cal Fee-For-Service	Refer to Medi-Cal for limits here: http://www.dhcs.ca.gov/services/Pages/AllServices.aspx
Personal Care Services	Covered by Medi-Cal Fee-For-Service	Refer to Medi-Cal for limits here: http://www.dhcs.ca.gov/services/Pages/AllServices.aspx
Personal comfort items	Not Covered	
Physical, Occupational and Speech Therapy	Covered	Speech Therapy: Members age 21 and older are subject to the state's Optional Benefits Exclusion (OBE) coverage guidelines Other limitations may apply Under age 21 refer to CCS guidelines here: http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx
Physician, Registered Nurse Practitioner, or ysician Assistant Services	Covered	
Podiatry Services	Covered	Members age 21 and older are subject to the state's Optional Benefits Exclusion (OBE) coverage guidelines Other limitations may apply
Prayer or Spiritual Healing	Covered by Medi-Cal Fee-For-Service	Refer to Medi-Cal for limits here: http://www.dhcs.ca.gov/services/Pages/AllServices.aspx
Prescription Drugs	Covered	Benefit managed by U.S. Script http://www.usscript.com
Preventive Care Services	Covered	Services for children and adults include, but are not limited to; preventative health assessment visits, well child care, screenings (e.g.: pap smears, mammograms, total serum cholesterol, etc.), and immunizations Some limitations may apply
Prosthetic and Orthotic Devices	Covered	Some limits apply Under age 21 refer to CCS guidelines here: http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx

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Service	Coverage	Details and Limitations
Radial Keratotomy	Not Covered	
Radiation Therapy	Covered	Under age 21 refer to CCS guidelines here: http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx
Radiology Services (high tech imaging)	Covered	MRI, MRA, CAT and PET Benefit managed by NIA www.radmd.com
Radiology Services (other than high tech imaging)	Covered	
Reconstructive Surgery (non-cosmetic)	Covered	Some limits apply Under age 21 refer to CCS guidelines here: http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx
Rehabilitative Services	Covered	
Rural Health Clinic	Covered	
Services not allowed by federal or state law	Not Covered	
Sexually Transmitted Diseases (STD) – screening and treatment	Covered	
Skilled Nursing Facility (SNF)	Covered	
Specialist Physician Consultations	Covered	
Sterilization Services	Covered	Only for members age 21 & older Consent form is required with claim submission (some exceptions may apply)
Targeted Case Management Services	Covered by Medi-Cal Fee-For-Service	Refer to Medi-Cal for limits here: http://www.dhcs.ca.gov/services/Pages/AllServices.aspx

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Service	Coverage	Details and Limitations
Temporomandibular Joint Disorder (TMJ) – Medical Treatment	Covered	
Transplant Services - Kidney	Covered	Under age 21 refer to CCS guidelines here: http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx
Transplant Services – Other Major Organs	Covered by Medi-Cal Fee-For-Service	Upon acceptance by approved transplant program member is dis-enrolled from Nebraska Health and Wellness Under age 21 refer to CCS guidelines here: http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx
Urgent Care Center Services	Covered	
Vision - Other than Optical Lenses	Covered	Benefit managed by OptiCare http://opticare.com Some limitations apply
ision – Optical Lenses	Covered	Benefit managed by OptiCare http://opticare.com Some limitations may apply

This list does not intend to be an all-inclusive list of covered services. All services are subject to benefit coverage, limitations, and exclusions as described in the plan coverage guidelines. Some services require prior authorization.

This list is a sample of Non-Covered Benefits and is not intended to be reflective of our proposed Nebraska Total Care Covered Benefits and Value Added Benefits. A draft Nebraska Total Care Member Handbook will be provided to MLTC for review and approval 120 calendar days prior to contract start date.

Your Medicaid Benefits Not Covered by Nebraska Total Care

There are some health care services that you can get as a Medicaid member, but you cannot get the services from Nebraska Total Care. They may be covered by the Medicaid fee-for-service program or another State or Federal program.

To get the excluded and limited services that are covered by the Medicaid fee-for-service program, you must find a Medicaid provider who offers these services and are determined to be eligible to receive these services. Contact Medicaid to determine your eligibility. If you are determined to be eligible for these services, be sure to take your Medicaid card when you go to that provider. These services include:

- **Acupuncture and Chiropractic Services**
- **Acute Detoxification Services, Heroin Detoxification, Substance Abuse Services**
- **Childhood Lead Poisoning Case Management Services**
- **Dental Services**
- **Federal or State Governmental Hospital Services**
- **Local Education Agency Assessment Services**
- **Medications for HIV/AIDS and Psychiatric Conditions**
- **Organ Transplantation**
- **Skilled Nursing Facility or Intermediate Care Facility (Long-Term Care)**
- **Direct Observed Therapy for Tuberculosis**
- **Waiver Program Services**

  If you are accepted by Home and Community Based Services, AIDS Waiver Services, or Senior Services, you will be returned to the Medicaid fee-for-service program.

For more information about Medicaid Benefits not covered by Nebraska Total Care, call the Nebraska Total Care Member Services Department at X-XXX-XXX-XXXX .

EXCLUSIONS

What Does Nebraska Total Care Not Cover?

What is and is not covered changes from time to time. When there are changes, we will send you a notice.

The following services and supplies are not covered or are limited under this plan:

- Services not received from or prescribed, referred, or authorized by your PCP and Nebraska Total Care, if needed. There are some exceptions: preventive care, emergency care, urgent care, family

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planning services, HIV testing or counseling, the first treatment of a sexually transmitted disease, and OB/GYN related services do not need to be authorized.

- Any service that is not medically necessary, as determined by your PCP and Nebraska Total Care.
- Services you received before you became a Member of Nebraska Total Care, or services you received on or after the date your Membership in Nebraska Total Care ends.
- Dental surgery, treatment or care (including treatment for overbite or underbite, maxillary and osteotomies and temporomandibular joint syndrome except if medically necessary, see Section 5. What Does Nebraska Total Care Cover?), or dental x-rays, supplies and appliances (including occlusal splints) and all associated expenses arising out of such dental surgery, treatment or care including hospitalizations. There are some exceptions: Hospital, doctor, and dental services and supplies and anesthesiology services needed to protect your health because of a specific non-dental physiological condition, if your PCP recommends them and Nebraska Total Care approves them in advance.
- Custodial care, maintenance care, respite care or rest cures (except when provided as part of Hospice Services).
- Personal comfort and convenience items or services like television, telephone, air conditioning, barber or beauty services, guest services or similar services and supplies that are not medically necessary.
- Cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance and that is not related to reconstructive surgeries otherwise covered by the plan.
- Health services for procedures intended primarily for the treatment of obesity, including, exercise programs and weight loss programs even if prescribed by a doctor. Treatment for morbid obesity is covered when medically necessary and approved by your PCP and Nebraska Total Care.
- Services that are not benefits of the Nebraska Medicaid Program
- Investigational services, unless you meet the conditions of Title XX, Nebraska Code of Regulations, Section XX and you get prior authorization from Nebraska Total Care. If a request for a service that is experimental or investigational is denied, delayed or modified, you may request an Independent Medical Review (IMR), see *Members Rights and Responsibilities.*
- Infertility services and treatment, including in vitro fertilization, gamete intrafallopian transfer (GIFT), embryo transport, and donor semen, and non-medically necessary amniocentesis.
- Reversal of voluntary sterilizations.
- Travel or transportation expenses, except ambulance service and non-emergency medical transportation as specifically provided described in this Member Handbook in the Transportation section of this Member Handbook.
- If a Member is hospitalized or undergoing treatment when coverage ends, Nebraska Total Care will continue to provide all covered services according to generally accepted medical standards until the Member is discharged or until the Member gets alternative coverage from the MLTC.
- Inpatient pain management program or any pain management that is non-medically necessary. Prescriptions for drugs and medicines which have not been approved for marketing by the FDA.

However, drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use.

UTILIZATION MANAGEMENT

Medically Necessary Services

Covered services that you get must be medically necessary. This means getting the right care, at the right place, at the right time. Nebraska Total Care uses standard guidelines to check medical necessity. Nebraska Total Care does not reward its network providers or their staff to deny or delay care.

Prior Authorization for Services

When you need care, always start with a call to your PCP, except in medical emergencies. Some covered services may require prior authorization or review by Nebraska Total Care before services are provided. This includes services or visits to an out of network provider and some Specialists. Home health services and some surgeries also need to be reviewed. Your doctor can tell you if a service needs review. The list is on Nebraska Total Care's website at NebraskaTotalCare.com . You can also call Member Services at X-XXX-XXX-XXXX to see if something needs to be reviewed by Nebraska Total Care.

Your doctor will give us information about why you need the service. Nebraska Total Care will look to see if the service is covered and that it is appropriate. Nebraska Total Care will make the decision as soon as possible, based on your medical condition. Standard decisions are made within five (5) business days. If the service is urgent, the decision will be made within three (3) business days. We will let you and your doctor know if the service is approved or denied. If you or your doctor is not happy with the decision you can ask us to make a second review. This is called an appeal. See the "Member Satisfaction" section in your Member Handbook for more information about appeals.

If there are any major changes to the prior authorization process, we will let you and your doctors know right away.

Second Medical Opinion

You have the right to a second opinion about your treatment choice. This means talking to a different doctor about an issue to see what they have to say. The second doctor is able to give you their point of view. This may help you decide if certain services or methods are best for you. If you want a second opinion for the following services, please talk to your PCP:

- Surgery
- Treatment or diagnoses of serious or life-threatening conditions
- Complex cases or cases with conflicting test results

- Cases where the Member does not respond well after an appropriate amount of time

Your PCP or Nebraska Total Care Member Services staff can help you find a doctor to give you a second opinion. You may choose any Nebraska Total Care network provider. If you are unable to find a doctor in network, we will help you find a doctor outside the network. If you need to see an out of network provider for the second opinion, it must be prior approved by Nebraska Total Care. There is no cost to you for a second or third opinion, if Nebraska Total Care approves it first. For more information on second opinions, call the Member Services Department at:

X-XXX-XXX-XXXX , *or*
1-866-274-6083 (TTY/TTD)

How to Get Medical Care When You Are Out of State

If you are out of the area and have an emergency, **call 911 or go to the nearest ER**. Be sure to call us and report your emergency **within 24 hours** or as soon as reasonably possible. You do not need prior approval. Nebraska Total Care will cover only medically necessary emergency services out of state.

If you are out of state and have an **urgent problem,** go to an urgent care clinic or you may go to a PCP. Be sure to show your Nebraska Total Care ID card prior to receiving services.

The two situations where you are covered for services out of state are as follows:

- You are out of state and you have a medical health emergency. You can go to an ER in any state if you have a true medical health emergency. If you are seen at an out-of-state hospital for an emergency, your follow up care must be with a Nebraska Total Care network provider. You may also need to contact your PCP to get a referral if you need to see a Specialist.
- It is determined that you need special care that you cannot receive in Nebraska. If Nebraska Total Care approves, the cost of the care you get in the other state will be covered.
- Members are not covered for any services outside of the United States, **except for emergency services requiring hospitalization in Canada or Mexico**.

Out-of-Network Care

Out of network emergency services do not need approval from Nebraska Total Care. All other covered services from an out of network providers need prior authorization by Nebraska Total Care. We will first check to see if there is a network provider that can treat your medical condition. If there is not, we will help you find an out of network provider. You will be financially responsible for payment of the out of network service(s) if Nebraska Total Care did not approve the visit or service. If you have questions, call Member Services at X-XXX-XXX-XXXX . Nebraska Total Care will notify you when the referral is approved.

Specialist Referrals and Standing Referrals

You may need to see a certain doctor for specific medical problems, conditions, injuries, and/or diseases. Talk to your PCP first. Your PCP will refer you to a Specialist in the Nebraska Total Care network who can diagnose and/or treat your specific problem. ***Do not go to a Specialist without being referred by your PCP.*** Generally, a Specialist will not be able to see you without approval from Nebraska Total Care and from your PCP. There are exceptions and they are listed in the "Self-Referrals" section of your Member Handbook. Always make sure you have a referral from your PCP first. If you have questions about getting a referral, call Member Services at X-XXX-XXX-XXXX .

Some conditions may need ongoing care from a Specialist. Nebraska Total Care will allow your PCP to give a standing referral to a Specialist in the Nebraska Total Care network when:

- The Specialist in Nebraska Total Care's network agrees to a treatment plan for you.
- The Specialist provides your PCP with updates on your condition and treatment plan.
- The Specialist's services to be provided are part of the benefits covered by Nebraska Total Care.

NOTE: If your Specialist refers you to another Specialist, your Specialist may need to obtain authorization by Nebraska Total Care and your PCP.

Self-Referrals

You may self-refer for certain covered services. No approval is required from your PCP or Nebraska Total Care for these services.

You may receive benefit coverage for the following services whether or not the doctor is in the Nebraska Total Care provider network.

- Preventive care
- Emergency services
- Urgent care services
- Family Planning services and supplies
- OB/GYN services
- HIV Testing and counseling
- First treatment for a sexually transmitted disease

Urgent Care-After Hours

Urgent Care is not Emergency Care. Urgent Care is needed when you have an injury or illness that must be treated within 48 hours. It is usually not life threatening, yet you cannot wait for a visit to your PCP.

Only go to the emergency room if your doctor tells you to go or you have a life-threatening emergency. When you need urgent care, follow these steps:

- Call your PCP. The name and phone number are on your Nebraska Total Care ID card. Your PCP may give you care and directions over the phone.
- If it is after hours and you cannot reach your PCP, call our 24-hour nurse advice line at X-XXX-XXX-XXXX (TDD/TTY1-866-274-6083). You will be connected to a nurse. Have your Nebraska Total Care ID card number handy. The nurse may help you over the phone or direct you to other care. You may have to give the nurse your phone number. During normal office hours, the nurse will assist you in contacting your PCP.

If you are told to see another doctor or go to the nearest hospital emergency room, bring your Nebraska Total Care ID card. Ask the doctor to call your PCP or Nebraska Total Care.

Emergency Care

Nebraska Total Care covers emergency medical services 24 hours a day, seven (7) days a week. Emergency services are required to treat an injury or an onset of what reasonably appears to be an emergency medical condition and do not need prior approval from your PCP or Nebraska Total Care. An emergency arises when the lack of medical attention could be expected by a reasonable layperson to result in jeopardy to a Member's health or, in the case of a pregnant woman, the health of her unborn child.

When to go to the ER

- Broken bones.
- Gun or knife wounds.
- Bleeding that will not stop.
- You are pregnant, in labor and/or bleeding.
- Severe chest pain or heart attack.
- Drug overdose.
- Poisoning.
- Severe burns.
- Shock (you may sweat, feel thirsty or dizzy or have pale skin).
- Convulsions or seizures.
- Trouble breathing.
- Suddenly unable to see, move or speak.

When NOT to go to the ER

- Flu, colds, sore throats, and earaches.
- A sprain or strain.
- A cut or scrape not requiring stitches.
- To get more medicine or have a prescription refilled.
- Diaper rash.

Emergency rooms are for emergencies. If you can, call your doctor first. If your condition is severe, call 911 or go to the nearest hospital. You do not need a doctor's approval. If you are not sure if it is an emergency, call your PCP. Your PCP will tell you what to do. If your PCP is not available, a doctor taking calls can help. There may be a message telling you what to do. You can also call our 24-hour medical advice line X-XXX-XXX-XXXX (TDD/TTY 1-866-274-6083) if you have questions.

It is okay if the hospital does not belong to the Nebraska Total Care network. You can use any hospital if it is an emergency. You or someone acting on your behalf MUST call your PCP and Nebraska Total Care within 24 hours of admission or as soon as reasonably possible. This helps your PCP to provide or arrange for any follow-up care that you may need. We will help you get follow-up care. Call us X-XXX-XXX-XXXX (TDD/TTY 1-866-274-6083).

Post-Stabilization Services

These are services that are needed to stabilize your condition after an emergency. They do not require prior authorization. It does not matter whether you receive the emergency care in or outside of the Nebraska Total Care network. We will still cover services to make sure you are stable after an emergency. Once you are stable after an emergency, we may transfer you to a Nebraska Total Care hospital or provider.

PHARMACY

Pharmacy Program

You can get prescriptions through your Nebraska Total Care coverage if you go to a pharmacy that takes Nebraska Total Care Members. There are some drugs that may not be covered through Nebraska Total Care. A Nebraska Total Care pharmacy can let you know which drugs are not covered, or help you find another drug that is covered. You can also ask your doctor about what drugs are covered, and what is best for you.

Prior Authorization

Some drugs have limits or require prior approval before your prescription can be filled. If prior approval is needed the pharmacy will inform your doctor. If your doctor feels you have a medical reason to get the drug, they can ask Nebraska Total Care for coverage authorization. If Nebraska Total Care does not grant the approval, you and your doctor will be notified of the decision and given instruction on how to file an appeal. See the "Member Satisfaction" section in your Member Handbook for more information about appeals.

Emergency Drug Supply

If your doctor cannot be reached to approve a prescription, you may be able to get a 72 hour (three day) emergency supply. Pharmacies that are contracted with US Script are authorized to provide a 72 hour supply and will be reimbursed for the ingredient cost and dispensing fee drug.

Over-the-Counter Medications

Some covered over-the-counter (OTC) drugs are covered through Nebraska Total Care. In order for an OTC drug to be covered, it must be written on a valid prescription by a licensed doctor. If you purchase OTC drugs without a prescription from a doctor you will have to pay for them.

Excluded Drugs

Some drugs are not covered through Nebraska Total Care. These include, but are not limited to, non-medically necessary:

- Drug Efficacy Study Implementation (DESI) drugs
- Fertility agents
- Topical Minoxidil
- Vaniqa®
- Drugs used to treat erectile or sexual dysfunction

Filling a Prescription

Nebraska Total Care covers most of the drugs your doctor says you need. Your doctor will write a prescription so you can take it to the pharmacy, or may be able to send the prescription for you. Nebraska Total Care provides prescriptions for its Members through pharmacies that are contracted with US Script. You can get your prescriptions filled at most pharmacies. It is important that you show your Nebraska Total Care ID card at the pharmacy. If you need help finding a pharmacy or have trouble getting your drugs, call Nebraska Total Care at X-XXX-XXX-XXXX (TDD/TTY 1-866-274-6083).

Specialty Pharmacy Provider

Certain drugs are only covered when they are supplied by a specialty pharmacy provider. These drugs require prior approval before your prescription can be filled. The pharmacy will inform your doctor if the drugs you need requires prior approval.

If you have questions about any of the pharmacy services, call Member Services at X-XXX-XXX-XXXX .

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HEALTH MANAGEMENT

Health Risk Screening

Nebraska Total Care wants to know how we can better serve you. One way we do this is by asking you to fill out the Health Risk Screening form found in your Welcome Packet. This form gives us information to determine your needs. Once you fill out the form, please send it back to us right away in the postage-paid envelope we have provided for you. You can also fill out this form on our website at NebraskaTotalCare.com . If you have questions about the form, please call us at X-XXX-XXX-XXXX .

Case Management

We understand some Members have special needs. In those cases, Nebraska Total Care offers our Members case management services to assist with special healthcare needs. If you have special healthcare needs, behavioral health needs, are pregnant, or you have a disability, case management may be able to help you. Our case managers are registered nurses or social workers. They can help you understand major health problems and arrange care with your doctors. A case manager will work with you and your doctor to help you get the care you need.

This service is for Members who have complex medical conditions. These Members often see several doctors. They may need medical supplies or help at home.

Conditions may include:

- Sickle Cell
- Multiple Sclerosis
- Kidney or Renal Disease
- HIV/AIDS
- Hemophilia

Our case managers are nurses or social workers that can help Members understand their health problems.

Disease Management

Nebraska Total Care has several programs to improve the health of our Members. We know this means more than just helping you to see a doctor. It also means helping you find your way through the healthcare system so you get the treatments and the social services you need. It also means helping you understand and manage your health conditions. We do this through education and personal help from Nebraska Total Care staff. The goal of this service is to add to the quality of your care and help you to improve your health. Nebraska Total Care works with Nurtur to give disease management services to our Members. Nurtur Health Coaches know a lot about conditions like:

- Asthma.
- Diabetes.
- High blood pressure.
- Heart problems.
- Weight Management.
- COPD.

All of our programs are geared toward helping you understand and actively manage your health. We are here to help you with things like:

- How to take medicines.
- What screening tests to get.
- When to call the doctor.

We will help you get the things you need. We will provide tools to help you learn and take control of your condition. For more information call Member Services at X-XXX-XXX-XXXX . You can ask to speak to a Health Coach.

Preventive Care

Nebraska Total Care recognizes the importance of good health. We offer preventive care services to help you and your family stay healthy. We encourage you to receive immunizations and health screenings to help lower your risk for chronic diseases. Health screenings provide the opportunity for early detection and treatment with possibly better outcomes. It is important for you to visit your PCP or Medical Home for such preventive care services. We will work with you and your provider to ensure access to care. Below are some of the Preventive Care services provided for you.

Covered Preventive Care Services for Adults:

- Immunizations –vaccines for adults
- Behavioral, Depression screenings
- Well visits
- Disease Management including, but not limited to:
    - Asthma
    - Heart Disease
    - Diabetes
    - Obesity

Covered Preventive Care Services for Women include, but are not limited to:

- Prenatal Care
- Educational and clinical services

- Start Smart For Your Baby
- Routine screenings and labs
- Well Woman Visits
- Breast Cancer screenings
- Cervical Cancer screenings

Covered Preventive Care Services for Children may include:

- Autism screenings
- Behavioral screenings
- Congenital screenings
- Depression screenings
- Developmental screenings
- Fluoride Varnishing – Oral health
- Height, Weight, Body Mass monitoring
- Immunizations
- Risk Screenings
- Vision Care

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Health Check (EPSDT) is a preventive healthcare program for ages birth to 21 years old. Children and young people need to see their doctor regularly even when they are not sick. This chart shows when babies, children and young adults need to see their doctor for a health check. We don't want your child to miss any key steps toward good health as they grow.

Doctors and nurses will examine your child or teen. They will give vaccines for diseases when necessary. Vaccines are important to keep your child healthy. They will also ask questions about health problems and tell you what to do to stay healthy. If there is a problem found during the checkup, your doctor can send you to a Specialist.

Age Group	Health Check Schedule
Infancy	Birth 3 to 5 days By 1 month 2 months 4 months

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	6 months 9 months
Early Childhood	12 months 15 months 18 months 24 months 30 months 3 years 4 years
Middle Childhood & Adolescence	Every year until age 21

To schedule a Health Check visit, call your doctor. If you have problems scheduling your visit, please call Member Services at X-XXX-XXX-XXXX .

Family Planning Services

Nebraska Total Care Health Plan covers family planning services. You can get these services and supplies from providers that are not in our network. You do not need a referral. These services are free for our Members. These services are voluntary and confidential, even if you are less than 18 years old.

Some examples of family planning services are:

- Education and advice from a trained personnel to help you make choices
- Information about birth control
- Physical exams
- Follow-up visits
- Immunization services
- Pregnancy tests
- Birth control supplies
- Tests and treatment of STDs (sexually transmitted diseases)

When You Are Pregnant

Keep these points in mind if you are pregnant now or want to become pregnant:

- Go to the doctor as soon as you think you are pregnant. It is important for your health and your baby's health to see a doctor as early as possible. Seeing your doctor early will help your baby get off to a good start. It's even better to see your doctor before you get pregnant to get your body ready for pregnancy.

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- Make an appointment with your dentist for a cleaning and checkup.
- Set a goal to live a healthier lifestyle. Healthy lifestyle habits include exercising, eating balanced healthy meals, and resting for 8-10 hours at night.

Pregnancy & Maternity Services

There are things you can do to have a *safe pregnancy.* See your doctor about any medical problems you have such as diabetes and high blood pressure. Do not use tobacco, alcohol, or non-prescribed drugs either now or while you are pregnant. Nebraska Total Care recommends that you see your doctor before becoming pregnant if you have experienced any of the following problems:

- You have had three or more miscarriages.
- You have given birth to a premature baby (this means the baby came before 37 weeks of pregnancy), or a "preemie."
- You gave birth to a stillborn baby.

A note about folic acid: Folic acid is a very important nutrient that can help you have a healthier baby. You should take folic acid before you become pregnant or as soon as you find out you are pregnant. Some foods that have folic acid in them include: orange juice, green vegetables, beans, peas, fortified breakfast cereals, enriched rice, and whole wheat bread. It is difficult to get enough folic acid from food alone. Ask your doctor about taking prenatal vitamins and see your doctor as soon as you think you are pregnant. If you have questions about folic acid or your pregnancy, call Member Services at X-XXX-XXX-XXXX .

Start Smart for Your Baby®

Start Smart for Your Baby (Start Smart) is our special program for women who are pregnant. Nebraska Total Care wants to help you take care of yourself and your baby through your whole pregnancy. Information can be provided to you by mail, telephone, and through the Start Smart website, www.startsmartforyourbaby.com. Our Start Smart staff can answer questions and give you support if you are having a problem. We can even arrange for a home visit if needed.

If you are pregnant and smoke cigarettes, Nebraska Total Care can help you stop smoking. We have a special smoking cessation program for pregnant women that is available at no cost to you. The program has trained healthcare clinicians who are ready to build one-to-one contacts with you. They will provide education, counseling, and the support you need to help you quit smoking. Working as a team over the telephone, you and your health coach can develop a plan to make changes in your behavior and lifestyle. These coaches will encourage and motivate you to stop smoking.

We have many ways to help you have a healthy pregnancy. Before we can help, we need to know you are pregnant. We can help you contact Medicaid to find out if you qualify for maternity coverage. Please call Member Services at X-XXX-XXX-XXXX as soon as you learn you are pregnant. We will help you set up the special care that you and your baby need.

MemberConnections®

MemberConnections is a program that promotes preventive health and connects you to quality healthcare and community social services. MemberConnections representatives are specially trained staff that provides support to Nebraska Total Care Members. They can help you determine which doctors are available in your area, find support services, and help arrange for needed services. The MemberConnections representatives work with Nebraska Total Care's Case Managers to ensure your healthcare needs are addressed. Please call Member Services at X-XXX-XXX-XXXX. They can also visit your home to help you with healthcare needs and social services.

MEMBER SATISFACTION

We hope you will always be happy with us and our network providers. If you are not happy, please let us know. Nebraska Total Care has steps for handling any problems you may have. Nebraska Total Care offers all of our Members the following processes to achieve Member satisfaction:

- Internal Grievance Process.
- Internal Appeal Process.
- External Grievance Process.
- External Appeal Process.
- Access to State Fair Hearing.

Nebraska Total Care maintains records of each grievance and appeal filed by our Members or by their authorized representatives, and the responses to each grievance and appeal, for a period of seven (7) years.

Internal Grievance Process

Nebraska Total Care wants to fully resolve your problems or concerns. Nebraska Total Care will not hold it against you or treat you differently if you file a grievance. **A grievance is an expression of dissatisfaction about any matter; such as you are not happy with the services you received or with how you were treated.** Grievances are any oral or written complaint submitted to Nebraska Total Care that has been initiated by you, or your authorized representative, including your provider, concerning any aspect or action of Nebraska Total Care relative to you. **An appeal is a request to review an action or adverse determination**; such as you requested services and got a denial letter.

How to File a Grievance

Filing a grievance will **not** affect your healthcare services. We **want** to know your concerns so we can improve our services.

To file a grievance, call Member Services at X-XXX-XXX-XXXX (TDD/TTY 1-866-274-6083). You may file a grievance online at www.NebraskaTotalCare.com under the secure Member website. You can also write a

letter and mail it to the address below or fax your grievance to Nebraska Total Care at 1-877-302-3434. Be sure to include:

- Your first and last name.
- Your Medicaid ID number.
- Your address and telephone number.
- What you are unhappy with.
- What you would like to have happen.

Nebraska Total Care
Grievance and Appeal Coordinator
[Insert Address]

If someone else is going to file a grievance for you, we must have your written permission for that person to file your grievance or appeal. You can call Member Services to receive a form or go to www.NebraskaTotalCare.com . This form is to assign your right to file a grievance or appeal to someone else. A doctor acting for you can file a grievance or appeal for you. If you need assistance in completing a grievance or an interpreter, please call Nebraska Total Care at X-XXX-XXX-XXXX .

If you have any proof or information that supports your grievance, you may send it to us and we will add it to your case. You may supply this information to Nebraska Total Care by including it with your online grievance, a letter, or by sending us an email, a fax, or by bringing it to Nebraska Total Care in person. You may also request to receive copies of any documentation that Nebraska Total Care used to make the decision about your care, grievance, or appeal.

You can expect a resolution orally or a written response from Nebraska Total Care within 30 calendar days of your grievance, except in urgent cases which must be resolved, in most cases, within three days.

There will be no retaliation against you or your representative for filing a grievance or appeal with Nebraska Total Care.

Internal Appeal Process

Filing an Appeal

You will know that Nebraska Total Care is taking an action because we will send you a letter. The letter is called a Notice of Action (Action).

Actions occur when Nebraska Total Care:

- Delays or denies the care requested.
- Decreases the amount of care.
- Ends care that has previously been approved.

- Denies payment for care and you may have to pay for it.

If you do not agree with the Action, you may request an appeal. An appeal is a request to review a Notice of Action. This review makes us look again at the Notice of Action. You can request this review online at www.NebraskaTotalCare.com , by phone, or in writing.

Who may file an Appeal?

- You, the Member (or the parent or guardian of a minor Member).
- A person named by you.
- A doctor acting for you.

You must give written permission if someone else files an appeal for you. Nebraska Total Care will include a form in the Notice of Action letter. You can also obtain this form on our website at www.NebraskaTotalCare.com . Contact Member Services at X-XXX-XXX-XXXX if you need help. We can assist you in filing an appeal.

When Does an Appeal Have to be Filed?

The Notice of Action will tell you about this process. **You may file an appeal within 90 calendar days from the date of the Notice of Action**.

You may ask to keep getting care related to your review while we decide. You may have to pay for this care, if the decision is *not* in your favor.

Except in urgent cases, Nebraska Total Care will give you a written decision within **30 calendar days** from the date of your request. If more than **30 calendar days** is needed to make a decision, we will send a letter to you. Nebraska Total Care will ask for extra time if more information is needed. The extra time may be better for your case. Nebraska Total Care will ask for the extra 14 calendar days in writing. The letter will say why we need more time.

Expedited Appeals

You or your doctor may want us to make a fast decision. You can ask for an Expedited Review if you or your doctor feel that your health is at risk. If you feel this is needed, call our Grievance and Appeal Coordinator at X-XXX-XXX-XXXX . **We will decide within 3 calendar days of receipt of the appeal request.** However, the review period may be up to 14 days. Nebraska Total Care will make reasonable efforts to contact you by phone if your appeal is denied. You will also receive a letter telling the reason for the decision and what to do if you don't like the decision.

Medicaid Fair Hearing for Appeals

What if I am still not happy?

If you are dissatisfied with Nebraska Total Care's decision, you may request a State Fair Hearing:

- At the same time that you appeal to Nebraska Total Care.
- After you have exhausted your appeal rights with Nebraska Total Care.
- Instead of appealing to Nebraska Total Care.

You or your doctor may request a State Fair Hearing within **90 calendar days** of receiving the notice of action or resolution. If you are currently receiving a medical service that is going to be reduced or stopped, you may continue to receive the same medical service until the hearing if you request the hearing within **10 calendar days** from the date the denial letter was postmarked.

To request a State Fair Hearing from Medicaid, please call or write to:

[Insert Address Here]

Fraud, Waste, and Abuse (FWA) Program

Authority and Responsibility

Nebraska Total Care is serious about finding and reporting fraud and abuse. Our staff is available to talk to you about this. **Here is the address and phone numbers:**

Nebraska Total Care
Compliance Department
[Insert Address]

Or you can call Nebraska Total Care's Fraud, Waste, and Abuse Hotline at 1-866-685-8664.

Waste, abuse, and fraud means that any Member, any provider, or another person is misusing Medicaid or Nebraska Total Care resources. This could include things like:

- Loaning, selling or giving your Nebraska Total Care Member ID card or Medicaid ID card to someone.
- Misusing Nebraska Total Care or Medicaid benefits.
- Billing Nebraska Total Care for "free" services.
- Wrongful billing to Nebraska Total Care by a provider.
- Billing Nebraska Total Care for services not provided.
- Any action to defraud Nebraska Total Care or Medicaid

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Your healthcare benefits are given to you based on your eligibility for both Medicaid and the Nebraska Medicaid Care Management program. You must not share your benefits with anyone. Nebraska Total Care's network providers must also report any misuse of benefits to Nebraska Total Care. Nebraska Total Care must also report any misuse or wrongful use of benefits to Medicaid. If you misuse your benefits, you could lose them. Medicaid may also take legal action against you if you misuse your benefits.

If you think a doctor, a hospital, another Nebraska Total Care Member, or another person is misusing the Medicaid or Nebraska Total Care resources, tell us right away. We will take action against anyone who does this. Nebraska Total Care will take your call about waste, abuse, and fraud seriously. Call Nebraska Total Care's WAF Hotline at 1-866-685-8664. You do not need to give your name.

Be sure to talk with your doctor about services that are covered and services that are not covered. You should not be billed for services that are covered, as long as you follow plan rules. If you get a bill for a service that should be covered by Nebraska Total Care, call your provider right away. Make sure your provider has all of your insurance information and knows to bill Nebraska Total Care. If you still get a bill from the provider after you give your insurance information, call Member Services for help at X-XXX-XXX-XXXX . Do not pay the bill yourself.

If you ask for a service that is not covered by Nebraska Total Care, your doctor will ask you to sign a statement saying you will pay for the service yourself. If you sign a statement saying you will pay for the non-covered service, then you are responsible for the bill. If you have any questions about a bill, you can call Member Services at X-XXX-XXX-XXXX .

Other Insurance

You must let Nebraska Total Care and Medicaid know if you have other insurance coverage with another company. Nebraska Total Care can help coordinate your other benefits with your other insurance company.

Accidental Injury or Illness (Subrogation)

If a Nebraska Total Care Member has to see a doctor for an injury or illness that was caused by another person or business, you must call Member Services at X-XXX-XXX-XXXX to let us know. For example, if you are hurt in a car wreck, by a dog bite, or if you fall and are hurt in a store, then another insurance company might have to pay the doctor's bills and/or hospital bills. When you call, we will need the name of the person at fault, their insurance company, and the names of any attorneys involved.

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Member Rights and Responsibilities

Members are informed of their rights and responsibilities through the Member Handbook. Nebraska Total Care network providers are also expected to respect and honor Member's rights.

Nebraska Total Care Members have the following rights:

- Ask for and receive information about Nebraska Total Care, our services, participating practitioners, providers, Member rights and responsibilities, and how to use Nebraska Total Care's benefits.
- Be treated in a courteous and respectful manner that reflects recognition of your privacy and dignity as a person.
- Wait no more than 30 seconds to speak to a Member Services representative during Nebraska Total Care's normal business hours.
- Upon request receive information about Nebraska Total Care staff and staff qualifications for health management programs.
- Receive interpreter services at no cost to you. You also have the right not to use family members or friends as interpreters. Minors should not be used as interpreters unless it is a medical emergency.
- Receive medically necessary covered services without regard to race, religion, age, gender, national origin, disability, sexual identity or orientation, family composition or size, or medical condition or stage of illness.
- Receive family planning services, services at Federally Qualified Health Centers or Indian Health Centers, sexually transmitted disease (STD) services, and emergency services outside the Nebraska Total Care network as stated in Federal law.
- Receive emergency or urgently needed services outside the Nebraska Total Care network or when authorized by Nebraska Total Care.
- Receive emergency care whenever necessary and wherever you need it.
- Receive Sensitive Services such as family planning or mental health care in a confidential way.
- Access minor consent services
- Choose a primary care doctor within the Nebraska Total Care network.
- To have a confidential relationship with your doctor.
- Receive information from Nebraska Total Care that you can understand.
- Upon request receive Member information materials in alternative formats including Braille, large print, and audio.
- Make recommendations about Nebraska Total Care's Member rights and responsibilities policies.

- Participate with your doctors and other practitioners in decision making about your own health care.
- Talk openly with your doctor and other practitioners about your medical condition and appropriate or medically necessary treatment options for your condition regardless of the cost or what your benefits are.
- Decide about your care, including the decision to stop treatment or services, or stop participating in health management programs.
- Decide in advance how you want to be cared for in case you have a life-threatening illness or injury.
- Be informed by Nebraska Total Care regarding advance directives and to receive information from Nebraska Total Care regarding any changes to that law. The information shall reflect changes in state law regarding advance directives as soon as possible, but no later than 90 days after the effective date of change.
- Review, request corrections to, and receive a copy of your medical records (your doctor may charge a fee for copies of records and other forms).
- Keep your personal and medical information and records confidential, unless you say differently, and know how Nebraska Total Care keeps your information confidential.
- Make complaints and appeals without discrimination about Nebraska Total Care, our providers, or your care. Nebraska Total Care will help you with the complaint and appeal process. You have the right to choose someone to represent you during the grievance process and for your complaints and appeals to be reviewed as quickly as possible and be told how long it will take. Medicaid Members have the right to request a State Fair Hearing or an expedited Fair Hearing for urgent cases. Call the Department of Social Services Public Inquiry and Response Unit at 1-800-952-5253 or TTY 1-800-952-8349.
- Request an Independent Medical Review from the Department of Managed Health Care (DMHC) if you disagree with Nebraska Total Care's decision to deny, delay, or modify a service that your doctor or other practitioner requests.
- Request an External Independent Review if a service or therapy was denied on the basis that it was considered experimental or investigational. If you have any questions about these procedures, see section *Member Satisfaction* of this Member Handbook, or call Nebraska Total Care Member Services at X-XXX-XXX-XXXX .
- Have Nebraska Total Care act as your patient advocate.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Disenroll from Nebraska Total Care.
- Request a second opinion about a medical condition.
- File a grievance with Nebraska Total Care if your language needs are not met.

- If you are a Native American Indian, you have the right to not enroll in a plan, not be restricted by a plan in your right to access Indian Health Facilities, and to disenroll from a plan without cause.
- You can contact Nebraska Total Care to get any other information you want, including the structure and operation of our plan, and how we pay our providers.
- You can report any marketing violations to the MLTC at [insert contact]

Nebraska Total Care Members have the following responsibilities:

- Be familiar with and ask questions about your health plan coverage. If you have a question about your coverage, call Nebraska Total Care Member Services at X-XXX-XXX-XXXX .
- Follow the advice and care procedures indicated by your doctor, Nebraska Total Care, and the program. If you have a question about these procedures, call Nebraska Total Care Member Services at X-XXX-XXX-XXXX .
- Request interpreter services at least 5 working days before a scheduled appointment.
- Call your doctor or pharmacy at least 3 days before you run out of medicine.
- Cooperate with your doctor and staff and treat them with respect. This includes being on time for your visits or calling your doctor if you need to cancel or reschedule an appointment.
- Understand that your doctor's office may have limited seating for patients and caregivers only.
- Give accurate information (to the extent possible) to Nebraska Total Care, your doctor and any other provider in order to help you receive the best care possible.
- Understand your health problems and work with your doctor and other practitioners in developing mutually agreed-upon treatment goals, to the degree possible.
- Ask your doctor questions if you do not understand what they are saying to you.
- Work with your doctor to make plans for your health care.
- Follow Nebraska Total Care and instructions for care that you have agreed on with your doctors and other practitioners.
- Immunize your children by age two (2) years and always keep your children's immunizations up to date.
- Call your doctor when you need routine or urgent health care.
- Care for your own health. Live a healthy lifestyle, exercise, eat a good diet, and don't smoke.
- Avoid knowingly spreading disease to others.
- Use Nebraska Total Care's grievance process to file a complaint. Call Nebraska Total Care Member Services at X-XXX-XXX-XXXX to file a complaint.

- Report any wrong doing or fraud to Nebraska Total Care by calling the Nebraska Total Care Member Service at X-XXX-XXX-XXXX or the proper authorities.
- Understand that there are risks in receiving health care and limits to what can be done for you medically.
- Understand that it is a health care provider's duty to be efficient and fair in caring for you as well as other patients.

OTHER PROVISIONS

Organ and Tissue Donation

Donating organs and tissues provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities. The Department of Health and Human Services' Internet website (http://www.organdonor.gov) has additional information on donating your organs and tissues.

New Technology

Nebraska Total Care follows changes and advances in health care. We study new treatments, medicines, procedures and devices. We call all of this "new technology." We review scientific reports and information from the government and medical Specialists. Then we decide whether to cover the new technology. Members and providers may ask Nebraska Total Care to review new technology.

Advance Directives

Advance Health Care Directives help you to make healthcare decisions for yourself now, in case you are unable to speak for yourself in later on.

You can use an Advance Health Care Directive to say *who* you want to speak for you and *what* kind of treatment you want. These documents are called "advance" because you prepare one before healthcare decisions need to be made. They are called "directives" because they state who will speak on your behalf and what should be done.

In Nebraska, the part of an advance directive you can use to appoint an agent to make healthcare decisions is called a Power of Attorney for Health Care. The part where you can express what you want done is called an Individual Health Care Instruction.

Together, you and your PCP can make decisions that will set your mind at ease. It can help your PCP and other providers understand your wishes about your health. You should talk to your doctor about your wishes. Advance Directives will not take away your right to make your own decisions and will work only when you are unable to speak for yourself. If your directive is not being followed you may file a complaint. A request can be sent in writing to:

[Insert Contact]

Examples of Advance Directives include:

- Living Will.
- Health Care Power of Attorney.
- "Do Not Resuscitate" Orders.
- POLST (Physician Orders for Life-Sustaining Treatment)

You will not be discriminated against for not having an Advance Directive.

Ask your doctor, nurse, social worker, or healthcare provider to get more information for you. You can have a lawyer write an advance directive for you, or you can complete an advance directive by filling in the blanks on a form.

For more information on Advance Health Care Directives, please call the Department of Health Care Services for a free brochure, or contact Nebraska Total Care's Member Services Department at X-XXX-XXX-XXXX .

GENERAL PROVISIONS

Records

All documents collected by the Enrollment Broker Enrolling Unit shall be given to Nebraska Total Care in order to establish coverage. Nebraska Total Care must make this information available to MLTC for inspections

By enrolling in Nebraska Total Care, you give us permission to share your information with doctors, hospitals and other medical providers who may examine or treat you. These medical providers can share this information with Nebraska Total Care so that we may pay them for the care you receive.

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Federal and state laws require that Nebraska Total Care keep your information and records private. Nebraska Total Care will use, share or ask for only as much of your information we need to do our job. This includes paying your claims and arranging for your care.

Right to request a restriction

You can ask Nebraska Total Care not to use or share your information. Nebraska Total Care cannot agree when we need to pay your claims or arrange for your care. Nebraska Total Care may also not agree if it would stop us from doing our other duties.

You can learn how we use and share your information in the Notice of Privacy Practices. The Notice is at the end of this Member Handbook. If you need another copy of the Notice, call our Member Services Department. The Notice will also tell you how you can ask us not to use or share your information.

Examination of Members

If there is a question or dispute about health care services or payment for such services under the contract, Nebraska Total Care may also reasonably require you to be examined by another participating physician acceptable to Nebraska Total Care, at Nebraska Total Care's expense.

Covered benefits

Members are never responsible to pay for benefits they receive under this contract.

Workers' Compensation not affected

The coverage under this contract does not affect a Member's eligibility for Workers' Compensation insurance.

Non-discrimination

Nebraska Total Care complies with State and Federal law, and will not discriminate on the basis of age, sex, color, race, creed, physical or mental handicap, national origin, marital status, sexual orientation, religious affiliation, or public assistance status.

Payments to providers

Nebraska Total Care contracts with a network of local doctors, medical groups, pharmacies, hospitals, and other providers to provide services to its Members. We pay providers in the following ways:

- **Capitation**: This means we pay the provider a fixed amount for each Member assigned to the provider. The payment is not affected by the number of visits or the kinds of services the provider gives the Member.
- **Fee-for-service**: This means we reimburse the provider after each service or visit. This system may include incentives to the doctors to manage the services they provide to Members in an appropriate manner consistent with the contract.
- **Per diem rate**: This is a set rate we pay to participating hospitals per day. We negotiate rates with hospitals that are outside the Nebraska Total Care service area that provide emergency or other referral services.

Any Member who wants more information about our reimbursement methodology can ask for a full disclosure. Members can call the Member Services Department at X-XXX-XXX-XXXX .

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DEFINITIONS

This list is a sample of Definitions and is not intended to be reflective of our proposed Nebraska Total Care Definition of Terms. A draft Nebraska Total Care Member Handbook will be provided to MLTC for review and approval 120 calendar days prior to contract start date.

Here are some of the terms used in this Member Handbook:

Acute

A medical condition that happens suddenly, that requires fast medical attention, and that does not last for an extended time period.

Approval or Authorization

Your PCP must get approval from Nebraska Total Care before you get certain services. Nebraska Total Care will only approve the services you need. Nebraska Total Care will not approve services by non-Participating Providers if we believe you can get comparable or more appropriate services through Nebraska Total Care providers. A referral is not an approval. You must get approval from Nebraska Total Care.

Nebraska Total Care

Managed Care Organization contracted by the state of Nebraska to provide care to Medicaid recipients.

California Children's Services (CCS)

A medical program that treats children with certain physically handicapping conditions and who need specialized medical care.

California Health and Disability Prevention (CHDP)

A public health program that reimburses public and private health care providers for early health assessments to detect or prevent disease and disabilities in children and youth. The program wants eligible children and youth to have access to ongoing health care. Your PCP can provide CHDP services.

Case Manager

Registered nurses or Social workers who can help you understand major health problems or arrange care with your Providers.

Certified Nurse Midwife

A registered nurse certified as a nurse midwife by the Nebraska Board of Registered Nursing who attends cases of normal childbirth and provides care for mothers before, during, and after pregnancy, and for the newborn right after birth.

Complaint or Grievance

When a Member or his or her representative expresses, either verbally or in writing, dissatisfaction with Nebraska Total Care. This includes complaints, disputes, requests for reconsiderations or appeals.

Contract

The agreement between California Total Care and DHCS; the DHCS/Health Care Options enrollment applications, the individual Member application and this EOC and any amendments.

Coverage or **Covered Service(s)** or **Benefit(s)**

The health care services provided to Members of Nebraska Total Care, subject to the terms, conditions, limitations and exclusions of the Medicaid Contract and as listed in this EOC and any amendments.

DHCS

We use DHCS in this EOC to refer to the California Department of Health Care Services of the State of California. This is the state office that oversees the Medi-Cal program.

DMHC

We use DMHC in this EOC to refer to the California Department of Managed Health Care. This is the state office that oversees managed care health plans.

Eligible Person

A person who is eligible for Medicaid and who lives in the Nebraska Total Care service area. This includes the counties of [insert counties]..

Eligibility Source

Your local Social Security Administration office, Office of Administration for California, county office, or Nebraska Medicaid office.

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Emergency

A medical or psychiatric medical condition with acute symptoms (including severe pain) severe enough that a reasonable person, with average health knowledge, would expect the lack of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, the health of a pregnant woman or her unborn child; or
- Serious harm to bodily functions; or
- Serious failure of any bodily organ or part.

Health Care Options

The state program that enrolls and disenrolls Members.

Health Coach

Individuals who will offer disease management assistance to Members.

Long Term Care

Care in a facility for longer than the month of admission plus one month.

Medi-Cal Fee-for-Service

A health care system for Medicaid recipients that is not managed care. Recipients may go to any doctor, clinic or provider they find who will take Medicaid patients.

Medicaid Managed Care

A Medicaid plan that uses only certain doctors, Specialists, clinics, pharmacies and hospitals for Medicaid recipients enrolled in Nebraska Total Care.

Medical Home

A model of care that will provide better healthcare quality, improve self-management by Members of their own care and reduce avoidable costs over time.

Medically Necessary or **Medical Necessity**

Means services that are:

- Provided in accordance with professionally recognized standards of practice;
- Determined by the treating physician to be consistent with the medical condition; and
- Provided at the most appropriate type, supply and level of service which considers the possible risks, benefits and alternatives.

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The fact that a doctor orders or prescribes a service does not mean it is Medically Necessary or a Covered Service.

Member

Any eligible Medicaid beneficiary enrolled with Nebraska Total Care who is entitled to receive Covered Services.

Mental Health Services Provider

Individuals, licensed or unlicensed, who perform mental health services to patients.

Non-Covered Service

A service that we do not cover.

Orthotic Device

A device used as a support or brace affixed externally to the body to support or correct an acutely injured or diseased body part and that is medically necessary for the medical recovery of the Member.

Out-of-Area Services

Services while a Member is anywhere outside of the Service Area.

Participating Hospital

A licensed hospital that has a contract with Nebraska Total Care to provide services to Members at the time a Member receives care. The Covered Services that some Participating Hospitals may provide to Members are limited by Nebraska Total Care's utilization review and quality assurance policies or Nebraska Total Care's contract with the hospital.

Participating Provider or Participating Doctor

A doctor, hospital, or other licensed health care professional or licensed health facility, including sub-acute facilities that have a contract with Nebraska Total Care to provide Covered Services to Members at the time a Member receives care.

Post-Stabilization Care

These are services that are needed to stabilize your condition after an emergency. They do not require prior authorization. It does not matter whether you receive the emergency care in or outside of the Sunflower State network. We will still cover services to make sure you are stable after an emergency.

Primary Care Provider (PCP)

The doctor or other provider you chose to give you most of your health care. Your PCP can be anyone on Nebraska Total Care's list of primary care providers or, for female Members, an OB/GYN, and for minors, a Pediatrician. Your PCP helps you get any specialty care you need from other providers.

Prosthetic Device

An artificial device attached to the body to replace a missing body part.

Psychiatric Emergency Medical Condition

A mental disorder where the symptoms are serious or severe enough to cause either an immediate danger to yourself or others or you are immediately unable to provide for or use food, shelter or clothing due to the mental disorder.

Psychiatric emergency services may include moving a Member to a psychiatric unit inside a general hospital or to an acute psychiatric hospital. This move is done to avoid or lessen a psychiatric emergency medical condition. In addition, the treating provider believes the move would not result in making the Member's condition worse.

Public Health Services

Health services targeted at the population as a whole. These include, among others, health situation analysis, health surveillance, health promotion, prevention services, infectious disease control, environmental protection and sanitation, disaster preparedness and response, and occupational health.

Qualified Provider

Doctor qualified in the area of practice appropriate to treat your condition.

Routine Care

Preventive care, well child visit, or care as routine follow-up for medical management of a Member.

Sensitive Services

Medically necessary services for family planning, sexually transmitted diseases (STDs), HIV/AIDS, sexual assault, and abortions.

Serious Chronic Condition

A serious disease or other medical problem that: 1) cannot be completely cured or that gets worse over time; or 2) must be treated so you don't get worse.

Serious Illness

A disease or condition that must be treated and could result in death.

Service Area
The geographic area served by Nebraska Total Care. This includes the counties [insert counties]

Specialist or Specialty Physician

A doctor who treats certain types of health care problems. Examples include, an orthopedic surgeon treats broken bones; an allergist treats allergies; and a cardiologist treats heart problems. In most cases, you will need a referral from your PCP to see a Specialist.

Triage or Screening

The evaluation of your health by a doctor or nurse who is trained to screen for the purpose of determining the urgency of your need for care.

Triage or Screening Waiting Time

The time waiting to speak by telephone with a doctor or nurse who is trained to screen you to determine your need for care.

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nebraska total care

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting Your Privacy

NOTICE OF PRIVACY PRACTICES

Privacy Notice

For help to translate or understand this, please call X-XXX-XXX-XXXX . If you are hearing impaired, call our TDD/TTY line at 1-866-274-6083or Relay 711.

Si necesita ayuda para traducir o entender este texto, por favor llame al telefono X-XXX-XXX-XXXX (TDD/TTY 1-866-274-6083or Relay 711).

Interpreter services are provided free of charge to you.

At Nebraska Total Care, your privacy is important to us. We will do all we can to protect your health records. By law, we must protect your health records and send you this notice.

This notice tells you how we use your health records. It describes when we can share your records with others. It explains your rights about the use of your health records. It also tells you how to exercise those rights and who can see your health records. This notice does not apply to information that does not identify you.

When we talk about your health records in this notice, it includes any information about all of your health services while you are a Member of Nebraska Total Care. This includes providing healthcare to you and also includes payment for your healthcare while you are our Member.

Please note: *You will also receive a Privacy Notice from Medicaid outlining their rules for your health records. Other health plans and healthcare providers may have other rules when using or sharing your health records. We ask that you obtain a copy of their Privacy Notices and read them carefully.*

How We Use or Share Your Health Records

Here are ways we may use or share your health records:

- To help pay your medical bills given to us by healthcare providers.
- To help your healthcare providers give you the proper care. For example, if you are in the hospital, we may give them your records sent to us by your doctor.
- To help manage your healthcare. For example, we might talk to your doctor about a disease or wellness program that could help improve your health.

- To help resolve any appeals or grievances filed by you or a healthcare provider with Nebraska Total Care or the State of Nebraska .
- To assist others who help us provide your health services. We will not share your records with these outside groups unless they agree to protect your records.
- For public health or disaster relief efforts.
- To remind you if you have a doctor's visit coming up.
- To give you information about other healthcare treatments and programs, such as how to stop smoking or lose weight.

State and federal laws may call for us to give your health records to others for the following reasons:

- To state and federal agencies that oversee Nebraska Total Care, such as DHCS or the U.S. Department of Health and Human Services.
- For public health actions. For example, the FDA may need to check or track medicines and medical device problems.
- To public health groups if we believe there is a serious public health or safety threat.
- To a health agency for certain activities. This might include audits, inspections, and licensure or enforcement actions.
- To a court or administrative agency.
- To law enforcement. For example, records may be used to identify or find someone who is a suspect, fugitive, material witness or missing person.
- To a government person about child abuse, neglect or violence in your home.
- To a coroner or medical examiner to identify a dead person or help find a cause of death. These may be needed by a funeral director to help them carry out their duties.
- For organ transplant purposes.
- For special government roles, such as military and veteran activities, national security and intelligence activities, and to help protect the President and others.
- For job-related injuries due to your state's worker compensation laws.
- If one of the above reasons does not apply, we must obtain your written approval to use or share your health records with others. If you change your mind, you may retract your written approval at any time.
- If sharing your health information is not allowed by or limited by a state law, we will obey the law that protects your health information best.

What Are Your Rights?

The following are your rights with regards to your health records. If you would like to exercise any of the following rights, please contact us. We can be reached at X-XXX-XXX-XXXX .

- You have the right to ask us to give your records only to certain people or groups and to say for what reasons. You also have the right to ask us to stop your records from being given to family

members or others who are involved in your healthcare. Please note that while we will try to follow your wishes, the law does not make us do so.

- You have the right to ask to get confidential communications of your health records. For example, if you believe that you would be harmed if we send your records to your current mailing address, you can ask us to send your health records by other means. Other means might be fax or an alternate address.
- You have the right to view and get a copy of all the records we keep about you in your designated record set. This consists of anything we use to make decisions about your health. It includes enrollment, payment, claims processing and medical management records.
- You have a right to opt out of sharing your name, address and protected health information.

You do not have the right to get certain types of health records. We may decide not to give you the following:

- Information contained in psychotherapy notes.
- Information collected in reasonable anticipation of, or for use in a court case or another legal proceeding.
- Information subject to certain federal laws about biological products and clinical laboratories.

In certain situations, we may not let you get a copy of your health records. You will be informed in writing. You may have the right to have our action reviewed.
You have the right to ask us to make changes to wrong or incomplete health records we keep about you. These changes are known as amendments. Any request for an amendment must be in writing. You need to give a reason for your change(s). We will get back to you in writing no later than 60 days after we receive your request. If we need additional time, we may take up to another 30 days. We will inform you of any delays and the date when we will get back to you.

If we make your changes, we will let you know they were made. We will also give your changes to others who we know have your health records and to other persons you name. If we choose not to make your changes, we will let you know why in writing. You will have a right to submit a letter disagreeing with us. We have a right to answer your letter. You then have the right to ask that your original request for changes, our denial and your second letter disagreeing with us be put with your health records for future disclosures. By law, we do not have to give you a list of the following:

- Health records given or used for treatment, payment and healthcare operations purposes.
- Health records given to you or others with your written approval.
- Information that is incidental to use or disclosure otherwise permitted.
- Health records given to persons involved in your care or for other notification purposes.
- Health records used for national security or intelligence purposes.
- Health records given to prisons, police, FBI, and others who enforce laws or health oversight agencies.

- Health records given or used as part of a limited data set for research, public health or healthcare operations purposes.

To receive an accounting of disclosures, your request must be in writing. We will act on your request within 60 days. If we need more time, we may take up to another 30 days. Your first list will be free. We will give you one (1) free list every 12 months. If you ask for another list within 12 months, we may charge you a fee. We will tell you the fee in advance and give you a chance to take back your request.

Using Your Rights

You have a right to receive a copy of this notice at any time. We reserve the right to change the terms of this notice. Any changes in our privacy practices will apply to all the health records that we keep. If we make changes, we will send a new notice to you.
If you have any questions about this notice or how we use or share your health records, please call. We can be reached at X-XXX-XXX-XXXX . Our office is open Monday through Friday from 8:00 a.m. to 5:00 p.m.

If you believe your privacy rights have been violated, you may write a letter of complaint to:

Privacy Official- Nebraska Total Care
[Insert Address]
www.NebraskaTotalCare.com

You may also contact the Secretary of the U.S. Department of Health and Human Services

Office for Civil Rights – Region IX
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103

Voice phone (800)368-1019 FAX (415)437-8329 TDD (800)537-7697

http://www.hhs.gov/

Authorization to Disclose Health Information

Notice to Member:

- Completing this form will allow Nebraska Total Care to share your health information with the person or group that you identify below.
- You do not have to sign this form or give permission to share your health information. Your services and benefits with Nebraska Total Care will not change if you do not sign this form.
- Right to cancel (revoke): If you want to cancel this Authorization Form, fill out the Revocation Form on the next page and mail it to us at the address at the bottom of the page.
- Nebraska Total Care cannot promise that the person or group you allow Plan to share your health information with will not share it with someone else.
- Keep a copy of all completed forms that you send to us. Nebraska Total Care can send you copies if you need them.
- Fill in all the information on this form. When finished, mail it to the address at the bottom of the page.

Member Information:

Member Name (print): _____

Member Date of Birth: ___/____/____ Member Medicaid ID Number/Member ID#: _____

I give Nebraska Total Care permission to share my health information with the person or group named below. The purpose of the authorization is to help me with my Nebraska Total Care benefits and services.

Recipient Information:

Name (person/group): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) ____ - _____

Nebraska Total Care can share this Health Information: (check all boxes that apply)

- ☐ All of my health information; OR
- ☐ All of my health information EXCEPT:
- ☐ Prescription drug/medication information
- ☐ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) information
- ☐ Treatment for alcohol and/or substance abuse information
- ☐ Behavioral health services or psychiatric care information
- ☐ Other: _____

Authorization End Date: _____/_____/_____ (date the authorization ends unless cancelled)

Member Signature: _____ **Date**: ____/____/_____
(Member or Legal Representative Sign Here)

If you are signing for the Member, describe your relationship. If you are signing for the Member or are the Member's personal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship).

Nebraska Total Care - Member Services
[Insert Address]
Toll Free: X-XXX-XXX-XXXX Fax: 1-877-302-3434
www.NebraskaTotalCare.com

DRAFT COPY

Revocation of Authorization to Disclose Health Information

I want to cancel, or revoke, the permission I gave to Nebraska Total Care to share my health information with this person or group:

_____

Recipient Information:

Member Name (print): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) ____ - _____

Authorization Signed Date (if known): _____/_____/_____

Member Information:

Member Name (print): _____

Member Date of Birth: _____/_____/_____ Member Medicaid ID Number/Member ID#: _____

I understand that my health information may have already been shared because of the permission I gave before. I also understand that this cancellation only applies to the permission I gave to share my health information with this person or group. It does not cancel any other authorization forms I signed for health information to be shared with another person or group.

Member Signature: _____ **Date**: ____/____/_____

(Member or Legal Representative Sign Here)

If you are signing for the Member, describe your relationship below. If you are the Member's personal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship).

_____

Nebraska Total Care will stop sharing your health information when we get this form. Use the mailing address below. You can also call for help at the number below.

Nebraska Total Care - Member Services
[Insert Address]
Toll Free: X-XXX-XXX-XXXX Fax: 1-877-302-3434
www.NebraskaTotalCare.com

DRAFT COPY

AUTHORIZED REPRESENTATIVE FORM

You have the right to choose someone to represent you during your Appeal with Nebraska Total Care. To designate a representative, please complete this form and return it to Nebraska Total Care. You may revoke this designation at any time by submitting a request to us in writing. Please note, if we do not receive a signed Authorized Representative Form in the timeframe for resolving your Appeal, your Appeal may be dismissed. If any such action is taken, you will be notified in writing.

1. I hereby give permission to _____ to act as my Authorized
   Name of designated representative

   Representative to Nebraska Total Care and to share information listed below in Section 2 regarding my Appeal or Grievance with Nebraska Total Care or its delegate.

2. Nebraska Total Care may share the following information (*check all that apply*):

   - ☐ Eligibility notices and information about eligibility for and access to my Nebraska Total Care benefits
   - ☐ Information about my medical treatment (including medical and psychiatric records). By giving my representative permission to share my information, I am specifically giving permission to share any information about drug and alcohol treatment that is included in such information.
   - ☐ Other: (*specify*) _____

3. Nebraska Total Care may share information listed in Section 2 above with the person or organization who is serving as my Authorized Representative.

4. Nebraska Total Care may share the information listed in Section II for the timely resolution of my Appeal.

5. This permission is good until: ____/____/_____.
   Date

6. I understand that I may cancel this permission at any time by sending a letter to:

Nebraska Total Care
[insert address]
Toll Free: X-XXX-XXX-XXXX Fax: 1-877-302-3434
www.NebraskaTotalCare.com

I have had the opportunity to read and consider this Authorization and agree to its terms.

___/___/___

_____ _____

Date Printed Name Signature

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Attachment
Q31-A: Public Member Website

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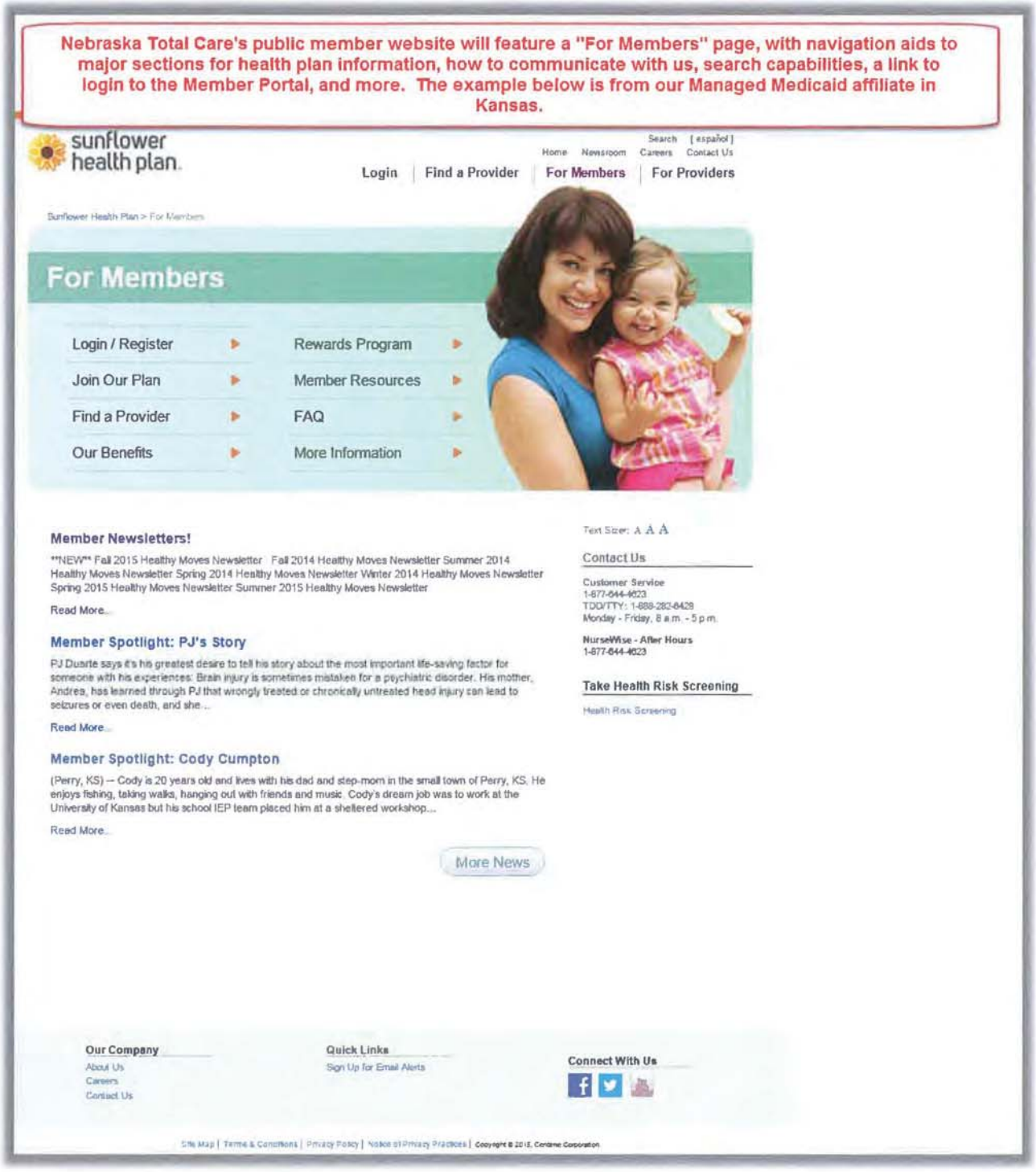
Attachment Q31-A: Public Member Website

Nebraska Total Care's public member website will feature a "For Members" page, with navigation aids to major sections for health plan information, how to communicate with us, search capabilities, a link to login to the Member Portal, and more. The example below is from our Managed Medicaid affiliate in Kansas.



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Attachment
Q31-B: Member Health Library

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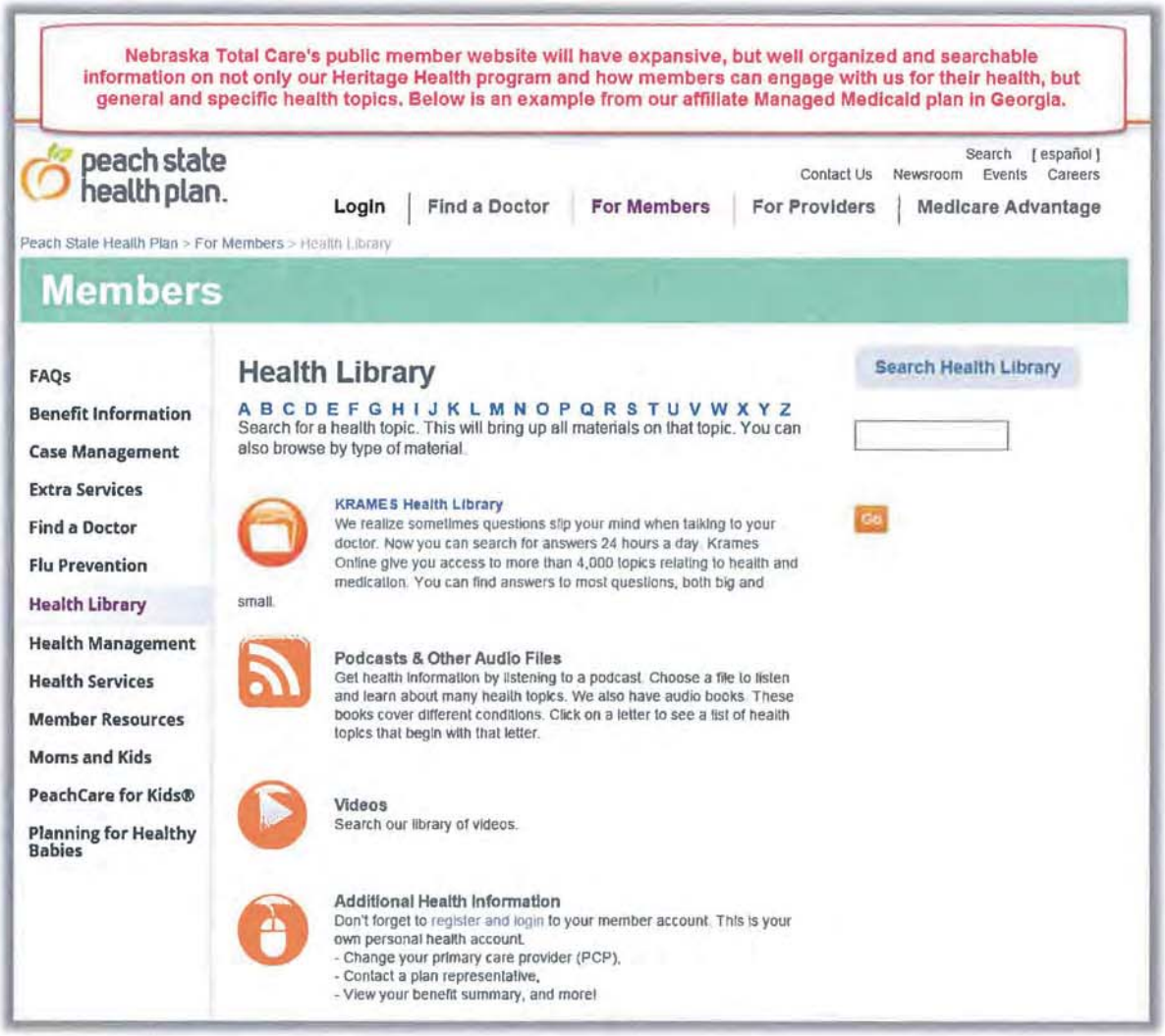
Attachment Q31-B: Member Health Library



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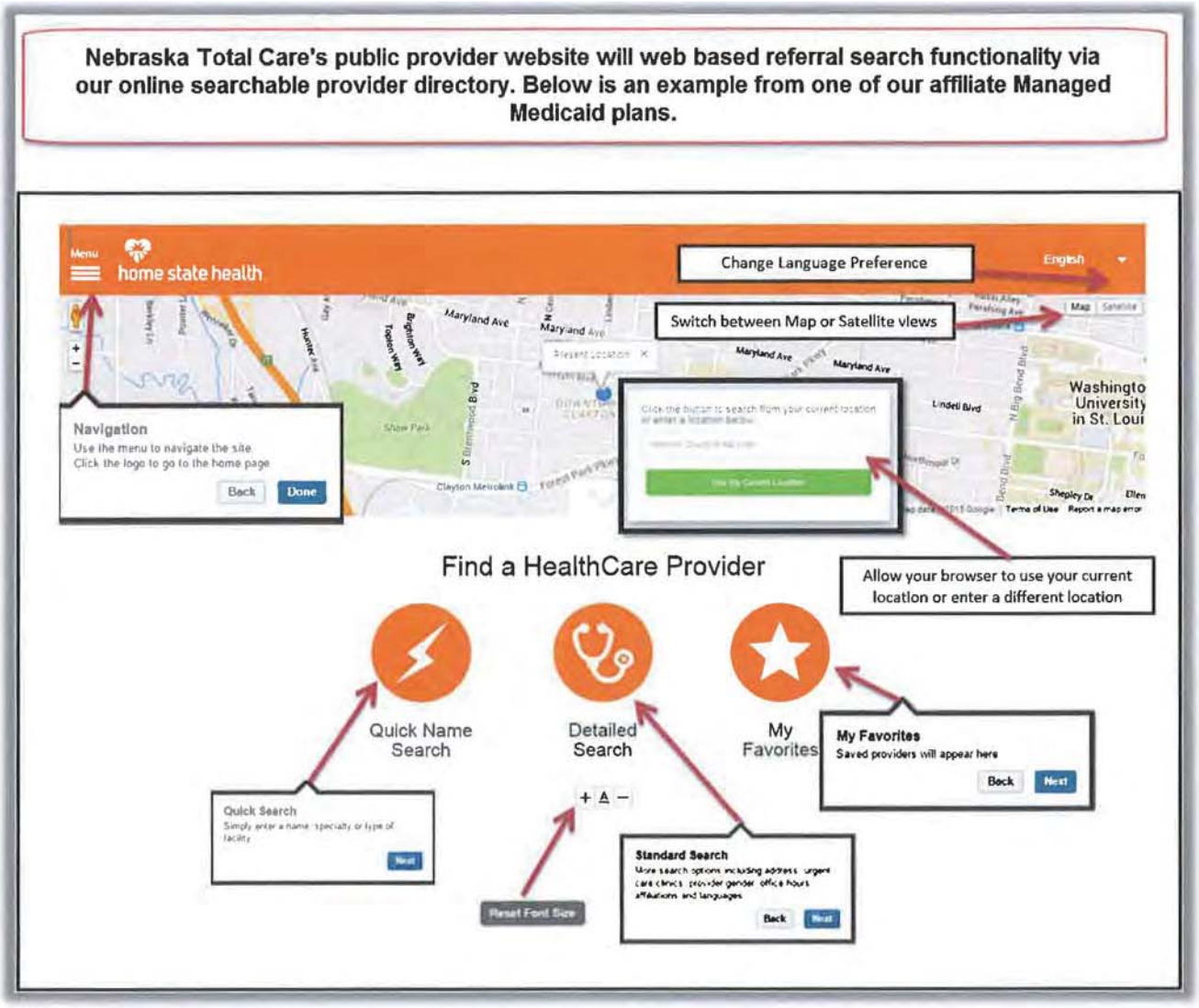
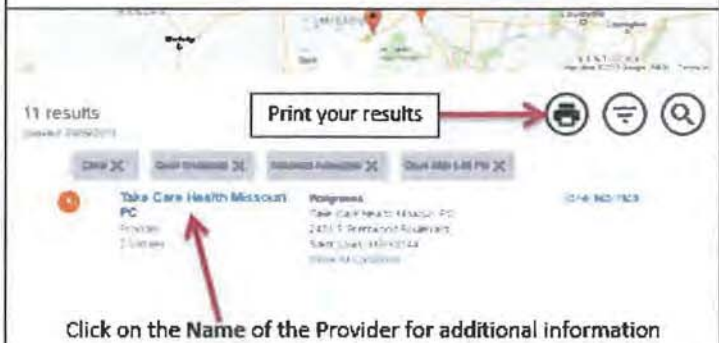
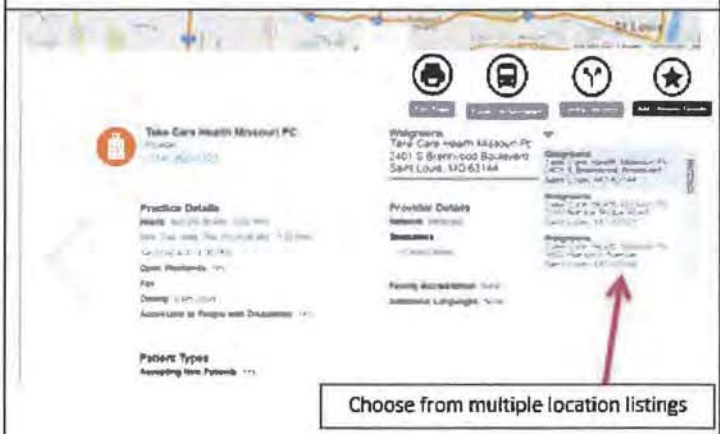
Attachment
Q49-C: Provider Directory

Attachment Q49-C: Provider Directory

Nebraska Total Care's public provider website will web based referral search functionality via our online searchable provider directory. Below is an example from one of our affiliate Managed Medicaid plans.



Below is short description of the use and functionality of our online provider directory.

Quick Name Search	For a quick search, enter a Provider name, specialty, or a type of facility.
Detailed Search	To get a more detailed search, narrow the search by selecting different criteria options.
	In this screenshot, the criteria selected from the detailed search were: 1. Clinic 2. Open Weekends 3. Handicap Accessible 4. Open After 5:00 PM Click on the X next to any of those options and the search feature will automatically update the results. Use the icons below to: To add new search options to your current search Start a new search
	Practice details for Homestate Health Plan will display: • Office Hours • Open Weekends • Phone and Fax numbers • County • Accessible to People with Disabilities • Patient Types: • Accepting New Patients • Multiple Location Listings • Network • Specialties • Facility Accreditation • Additional Languages

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Attachment
Q31-D: Member Portal Landing Page

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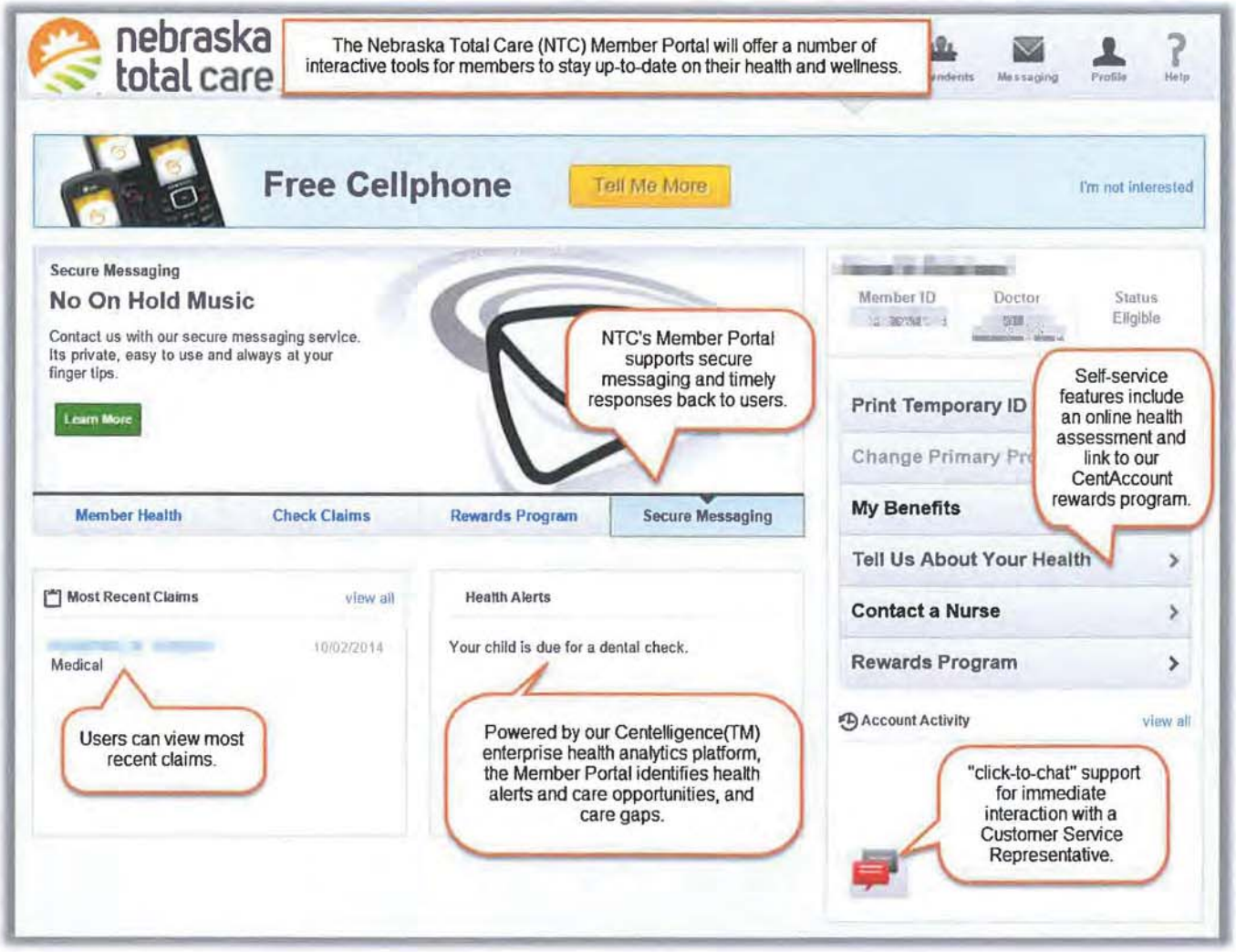
Attachment Q31-D: Member Portal Landing Page



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Attachment
Q31-E: Mobile Optimized Website

Attachment Q31-E: Mobile Optimized Website

Centene websites are "Mobile Optimized", meaning that if a user accesses our websites via a mobile device browser, our content automatically presents in a mobile friendly manner. In ADDITION, members can use our Mobile Application for a fully enhanced mobile experience.

Access via PC

Access via Mobile Device

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Attachment
Q31-F: MyNTC and Start Smart Mobile Application

Attachment Q31-F: MyNTC and Start Smart Mobile Application

Nebraska Total Care's MyNTC offers mobile information and mobile functionality, including Mobile Member ID card, benefits and eligibility information, GPS aware provider directory, health symptom checkers and more. In addition, our Start Smart Mobile offers specialized interactive functionality for expectant members. There is no cost to our members to use these mobile features.

MyNTC Member Mobile Application

Using Nebraska Total Care's Start Smart Mobile, expectant mothers can securely:

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Attachment 35.1_NTC_Sample_Benefit book

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Attachment 35.2 LHC
Fall Sample Newsletter

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Attachment 35.3 IHC
Sample Newsletter

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Attachment 35.4 PSHP
Sample Newsletter

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Attachment 35.5 BCHP
Sample Newsletter

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BEHAVIORAL/PHYSICAL HEALTH COORDINATION FORM

	Date (*month, day, year*)
Name of member	Date of birth (*month, day, year*)
Health care provider	Behavioral health provider
Address (*number and street*)	Address (*number and street*)
City, state, ZIP code	City, state, ZIP code
Telephone number ( ) / Fax number ( )	Telephone number ( ) / Fax number ( )
This form was filled out by	

The sharing of prescribed medication and treatment recommendations between this patient's physical healthcare provider and behavioral healthcare provider are essential for safe, effective coordination of care. Please complete the applicable section of this form and forward to the appropriate health care professional.

More information: www.mhsindiana.com or www.cenpatico.com

PATIENT CONSENT

Please check if you DO NOT want the following protected health information released: ☐ **Behavioral Health** ☐ **Substance Abuse** ☐ **HIV/AIDS**

This authorization will expire on _____ (Date (*month, day, year*)). I authorize the use and/or disclosure of my protected health information as described above. I understand this authorization for release of protected health information is made to confirm my wishes. I understand that I may revoke this authorization at any time by giving written notice to the person or organization that is authorized above to release information. My health care provided by _____ (Name of provider) will not be affected if I do not sign this form. This information disclosed by this release may be re-disclosed by the recipient and may no longer be protected.

Signature of member

☐ **Member declined to participate**

Signature of member

PHYSICAL HEALTH CARE PROFESSIONAL TO COMPLETE THE FOLLOWING ☐ Medication log attached

MEDICATION	DATE STARTED	PRESCRIBED DOSAGE	Allergies to medications:
1.			
2.			Current diagnosis:
3.			
4.			Comments:
5.			
6.			

BEHAVIORAL HEALTH PROVIDER TO COMPLETE THE FOLLOWING ☐ Medication log attached

MEDICATION	DATE STARTED	PRESCRIBED DOSAGE	Allergies to medications:
1.			
2.			Current diagnosis:
3.			
4.			Comments:
5.			
6.			

Please provide the following information regarding (*Member name*)	2. Is another appointment required? ☐ Yes ☐ No	If yes, date and time scheduled ☐ AM ☐ PM
1. Results of appointment, including any prescriptions ordered (*attach forms as necessary*)	3. Are there any special instructions for this member to follow? (*please describe*)	

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IV.H Grievances and Appeals

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:

- ***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. (3 pg limit)***

Grievances and Appeals Process

Nebraska Total Care (NTC) will establish, implement, and maintain a member-centric grievance system that meets all MLTC requirements. The grievance system encompasses the grievance process, the appeal process, and access to the State's fair hearing system. Our processes for identification, receipt, tracking, response, review, reporting, and resolution of Heritage Health member inquiries, grievances and appeals comply with all State, federal and NCQA requirements. Our policies and procedures govern the resolution of inquiries, grievances and appeals, and encompass internal review, expedited review, external review, and access to the State's Fair Hearing system. NTC will maintain written policies and procedures clearly describing the member grievance and appeals process and will make these policies and procedures available to providers and members. Please see ***Attachment 36_Member Grievance System Flow Charts.***

Authority and Staffing. NTC's Board of Directors will have final authority and responsibility for the grievance system process, and will delegate operational oversight and implementation to NTC's Quality Improvement Committee (QIC). The QIC will review all inquiry, appeal, complaint, and grievance summaries, including any handled by subcontractors under a delegated agreement, on a quarterly basis to identify issues requiring follow up or improvement. NTC's Performance Improvement Team will perform a monthly in-depth review of complaint, grievance and appeal data to identify trends and root causes of dissatisfaction. NTC's Grievance Manager (GM) will be responsible for ensuring all aspects of the process are documented, routed, processed, tracked, resolved, and reported per MLTC requirements. In addition, all NTC staff will be trained about the importance of the grievance process, member and provider rights, and how to assist members and providers with the grievance process.

Member Grievance Process.

Receipt and Documentation. Members, authorized representatives acting on a member's behalf, and providers (with a member's written consent) may file a grievance orally, via the Member Portal, or in writing. CSRs will document the substance of the grievance, complete a task in our Customer Relationship Management (CRM) system, and assign it to the Grievance queue for processing.

Acknowledgement. Staff receiving a member's grievance orally will acknowledge the grievance and attempt to resolve it immediately. All oral or written grievances will be forwarded to the GM for tracking, written acknowledgment, and resolution. All submitted grievances will be acknowledged within 10 calendar days of receipt. The GM will include a description of the grievance procedure in the acknowledgment letter, including the timeframe for resolution.

Investigation. The GM will conduct an initial investigative review, which may include contacting the member or the member's authorized representative for additional information or clarification of the issue and gathering applicable documentation from other NTC departments. If the grievance involves a quality of care issue, it is escalated to the QI Department for review and resolution as a part of the quality of care investigation process. Matters involving privacy concerns or potential fraud and abuse are forwarded to the NTC Compliance Officer.

Notice of Decision. NTC's GM will make a decision regarding the grievance as expeditiously as possible, not to exceed 90 calendar days of receipt. The GM will send written notice of the decision and disposition of the grievance within 90 calendar days of the receipt of the grievance. Regardless of the outcome, NTC will not discriminate or retaliate against a member for filing a grievance.

Appeal of Adverse Action. An appeal is defined as a request for review of an Action taken by a health plan. Members have up to 90 calendar days from the date of an adverse action to file an appeal. NTC's parent company, Centene, and its affiliate health plans maintain an excellent record of meeting grievance

and appeal resolution timeframes. Members, authorized representatives with written consent from the member, and the legal representative of a deceased member's estate may file an appeal orally or in writing. Oral appeals must also be submitted in writing. NTC will consider verbal inquiries related to seeking to appeal an action as appeals. **Acknowledgement.** The Clinical Appeals Coordinator (CAC) will document appeals requests within one business day of receipt. The CAC will send an acknowledgement letter that includes the subject of the appeal, explanation of the appeal process, and the member's rights, including the right to submit comments, documents, or other evidence and allegations of fact or law relevant to the appeal in person or in writing. Members are encouraged to submit documentation to support their case and are reminded of the limited time available for expedited appeals. The CAC will provide the member or his or her representative access to and copies of the member's case file relevant to the appeal at no cost. **Resolution Time Frame.** NTC will resolve appeals as quickly as the member's health condition requires. In the case of standard appeals, appeals will be resolved and the member and provider notified within 45 calendar days of receipt, and for expedited appeals, within 72 hours of receipt. The resolution time frame will be extended for up to 14 calendar days if the member requests the extension, or if the delay is in the best interest of the member and the member agrees to the extension. We also will provide the member with written notification within 2 calendar days of the reason for the delay for extensions not requested by the member and information on filing a grievance if the member disagrees with the determination. **Levels of Review.** A physician with appropriate clinical expertise will review appeals involving clinical issues or any medical necessity decisions. The individual will be the same or similar specialty, who is not a subordinate of the individual who made the initial adverse determination and who was not involved in the initial determination or any prior decision-making. **Timing of the Notice of Standard Appeal Resolution.** The CAC will provide written notice of standard appeal resolution to the member and the provider within 45 calendar days following receipt of the appeal. Appeal resolution notices will include the results of the resolution and the date it was completed. For appeals not resolved wholly in favor of the Member, adverse appeal resolution notices will include, but are not limited to, the results and date of the resolution, the right to request a State fair hearing, how to request a hearing, the right to continue to receive benefits pending a hearing, how to request continuation of benefits, and if the MCO action is upheld in the hearing, that the member may be liable to pay for continued benefits received while the appeal was pending. **Access to State Fair Hearings.** NTC members will have the right to request a State fair hearing if the member is not satisfied with the final decision after exhausting the NTC Grievance and Appeals procedure, within 90 calendar days from the date of the Notice of Action. A provider may request a State fair hearing on behalf of a member with the member's prior consent. NTC will notify members of their right to request a State fair hearing, how to obtain a hearing, and representation rules at a hearing using a variety of education to ensure that members are given access to the State fair hearing process. **Continuation of Benefits.** We will continue a member's benefits through the appeal resolution process (until the final decision by NTC or the State fair hearing decision is issued) if the appeal was filed within 10 days of the Notice of Action or the intended effective date of a proposed action and the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the period covered by the original authorization has not expired; and the member requests an extension of benefits. If these conditions are met, benefits are continued throughout the appeal process. The services will remain in place until at least one of the following occurs: the member withdraws the appeal, 10 days pass after NTC mails the notice of an adverse action, a State fair hearing decision adverse to the member is made, or the authorization expires or limits are met.

Ensure individuals who make decisions about grievances and appeals have the appropriate expertise and were not involved in any previous level of review.

Appropriate Expertise. All Customer Services Representatives (CSRs) and Care Management staff are trained to document and resolve the member's concern during the first contact when possible. All staff working with members will be trained to recognize any expression of dissatisfaction, and follow procedures to ensure the member's issue is appropriately captured and addressed. NTC's written policies will ensure that no punitive action will be taken against a provider who supports a member's complaint,

grievance or appeal, or files a complaint, grievance or appeal on a member's behalf. The NTC staff or Medical Director (MD) involved in the resolution of grievances or appeals will not have been involved in any prior level of review or decision-making. Physicians involved in reviewing any grievance or appeal involving clinical issues, an appeal of a denial based on lack of medical necessity, or a grievance regarding denial of expedited resolution of an appeal, will have appropriate experience treating the member's condition or disease (same or similar specialty), and will not have been involved in any prior level of review or decision making.

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.

Expedited Appeal Process. NTC will follow MLTC's timeframes and processes for handling expedited appeals, including extending time periods within guidelines. A member or provider may request an expedited appeal if following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

Criteria for Expedited Appeals. The CAC will immediately gather supporting documentation for expedited appeal requests and forward all information to a Medical Director (MD) (a physician with the same or similar specialty, who was not involved in any previous level of review). Prior to issuing a final adverse determination, the MD will also contact the requesting provider to obtain any additional information the provider or member would like the MD to consider. Requests related to an ongoing admission, continued hospitalization, or other health care services for a member who has received emergency services but has not been discharged will be processed as an expedited appeal request.

Resolution Process and Timeframes. For expedited appeal requests, the MD will render a decision within 72 hours of receiving the request or sooner, as the member's condition requires. The resolution time frame will be extended for up to 14 calendar days if the member requests the extension, or if the delay is in the best interest of the member and the member agrees to the extension. An oral expedited appeal request does not need to be followed by a written request for the expedited appeal. If a request for an expedited appeal resolution is denied, the appeal is transferred to the standard resolution process with a resolution timeframe of no longer than 30 calendar days from the day the MCO receives the appeal with a possible extension of 14 calendar days. NTC will make reasonable effort to provide the member with prompt verbal notice of the denial and written notice within two calendar days.

Use data from the grievance and appeals system to improve the MCO's operational performance.

Using Data to Improve Processes and Performance.

NTC's PIT will perform a monthly in-depth review of complaint, grievance, and appeal data to identify trends, root causes, or issues requiring follow up or improvement. Those areas include whether NTC and MLTC standards for timeliness and other processing issues are being met; identifying patterns related to specific issues, providers or NTC departments; and targeting any needed corrective actions. The Utilization Management Committee will review appeals data to identify trends that indicate when specific utilization guidelines should be updated, developed or clarified; or that provider education is needed. Complaint, grievance and appeal data, as well as data relating to processing standards such as timeliness, will also be submitted quarterly to the QIC for trending and analysis. NTC will incorporate aggregate data for the member and provider experience analysis for the annual QI Program Evaluation.

Table Q36 outlines how grievance and appeal data will be used to improve operational performance.

Table Q36

Performance Issue	How Data will be Used	Department
Access/Availability Deficiencies	Identifying Network Gaps; provider Wait Times, Compliance, Training	Provider Relations and Network Contracting
Quality of Care, Member Safety, Abuse of Member	Training/Re-credentialing/Peer Review	Medical Director, QI
Benefit Questions	Improvements to Written Materials	Member, Provider Services, and Marketing
Service Levels	Staffing Adjustments/Training/ Technology Enhancements	Member/Provider Services
Customer Service Deficiencies	Business Process Improvement	Applicable Functional Area
Inappropriate Billing Practices	Fraud and Abuse	Compliance/Special Investigations

37. Describe the approach the MCO will take to provide members with grievance, appeal, and State fair hearing information. (2 pages)

Member Assistance related to Grievances and Appeals

Member Notification of Grievance, Appeal, and State Fair Hearing Information and Rights

Nebraska Total Care (NTC) will utilize multiple methods to educate and notify members about their rights to file grievances and to submit appeals or request a State fair hearing. NTC will educate members about the Member Grievances and Appeals Policy through our Member Handbook, Member Newsletters, Member Portal, during telephonic and face-to-face member interactions, and via member enrollment materials, which will include: a member's right to file grievances and appeals; the requirements and timeframes for filing a grievance or appeal; the availability of assistance by NTC in the filing process; the toll-free numbers that a member may use to file a grievance or appeal by phone; the fact that, if requested by a member and under certain circumstances, (i) benefits will continue if a member files an appeal or requests a State fair hearing or external review within specified timeframes, and (ii) the member may be required to pay the cost of services furnished during the appeal if the final decision is adverse to the member; for a State fair hearing, (i) the right to a State fair hearing, (ii) the method for obtaining a hearing; and (iii) the rules that govern representation at the hearing.

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.

Availability of Grievances and Appeals Materials in Alternative Languages and Formats

NTC will provide personal assistance to any member needing support in any stage of the grievance filing or appeal filing process, including communication assistance such as translation, TTY/TTD availability, interpreter services, or alternative formats for materials. Our Customer Services Representatives (CSRs) are trained to provide assistance to members and providers as needed and to help members access materials in alternative languages and formats. We will make forms available to members, providers, and other authorized representatives to submit grievances or appeals on behalf of members. NTC will provide appeal forms for all written adverse action notices on the Member and Provider Portals, and upon request. NTC will direct member eligibility and eligibility-related grievances and appeals including termination of eligibility, effective dates of coverage, and other related issues to MLTC.

Member Grievance and Appeal Filing Assistance. NTC believes that members should have their concerns and issues heard and addressed as soon as possible. We will educate our members about how to contact NTC's Member Services Department if they have an inquiry or concern, and about the grievance process, via information made available in the Member Handbook, on the NTC website, Member Portal, and at least annually in our Member Newsletters. All materials are written in easy-to-understand language. A member or member's authorized representative may contact NTC at any time with an inquiry on behalf of a member. They may contact NTC orally, in writing, by mail, facsimile, electronic mail, through the NTC Member Portal, or by dialing NTC's toll-free Customer Services center, or in person. We take pride in our responsive customer service, and attempt to resolve the issue or inquiry for the caller at the time of the call. All NTC staff are trained to identify, document, and when appropriate, route verbal or written issues, inquiries, grievances or appeals to the Grievance Manager (GM) or the Clinical Appeals Coordinator (CAC). We have learned from our affiliates' experience that most individuals and members call the Customer Services center with their initial inquiry. When responding to inquiries, CSRs will utilize system documentation to assist them in addressing issues or provide information to the member's satisfaction. NTC will ensure that communication with designated representatives on behalf of members is HIPAA compliant. Our GM will confirm that the member has provided written consent for any representative contacting NTC on the member's behalf. When appropriate, the GM will supply a consent form for the member to complete and return. In all cases, the member has access to NTC assistance in filing member inquiries, grievances, appeals, or requests for State fair hearings.

In addition, NTC will support members through Member Advocates, staff members who will provide assistance to members with issues that require a higher level of support than is provided through the Customer Services Center. If a member calls in with an issue that a CSR feels would be best addressed by a Member Advocate, the member's call will be warm-transferred to a Member Advocate. In addition to providing other forms of assistance, a Member Advocate can help a member with the grievances or appeals filing process and can provide education about the state's fair hearing process.
Finally, NTC will also refer members as appropriate to the Nebraska Long Term Care Ombudsman Program, Disability Rights Nebraska, and other community resources that can assist members as they determine whether to file a grievance or appeal.

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IV.H ATTACHMENTS

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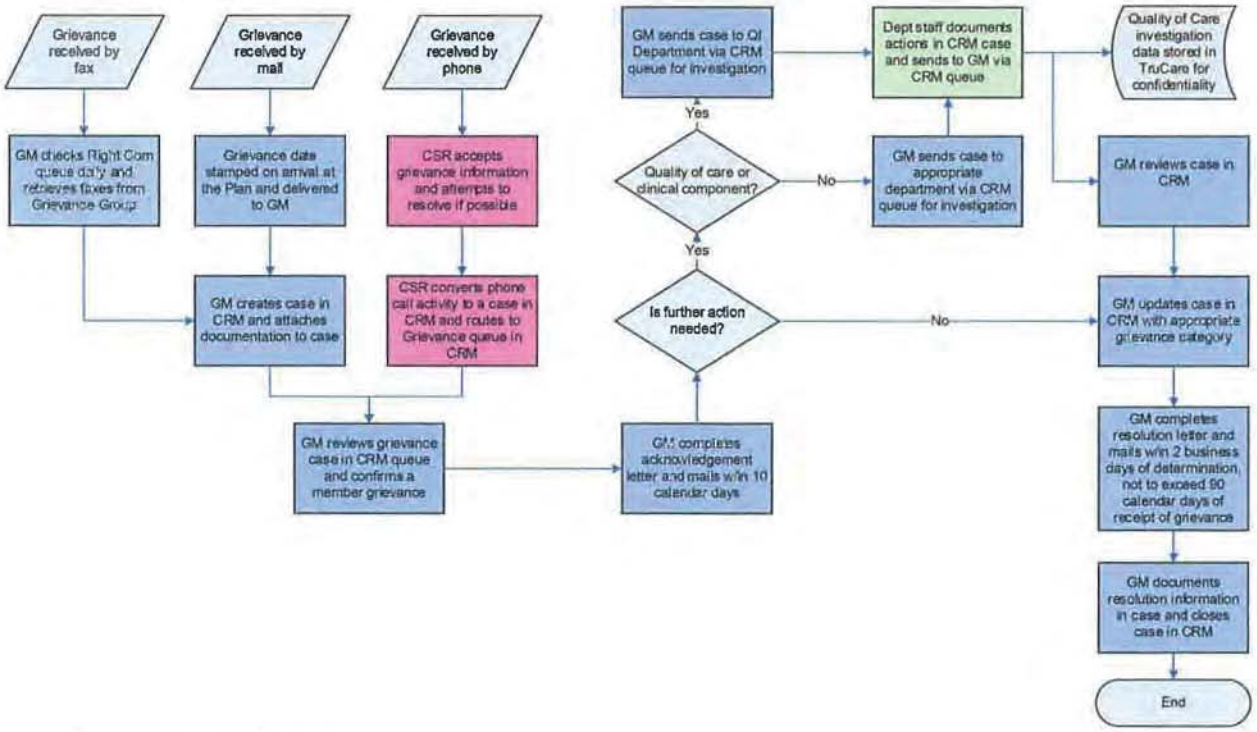
Member Grievance Process

* Grievance can be filed by a member, provider (with member's written consent), or authorized representative.



GM – Grievances Manager
G&A - Grievance & Appeal
CSR - Customer Service Representative
QI - Quality Improvement

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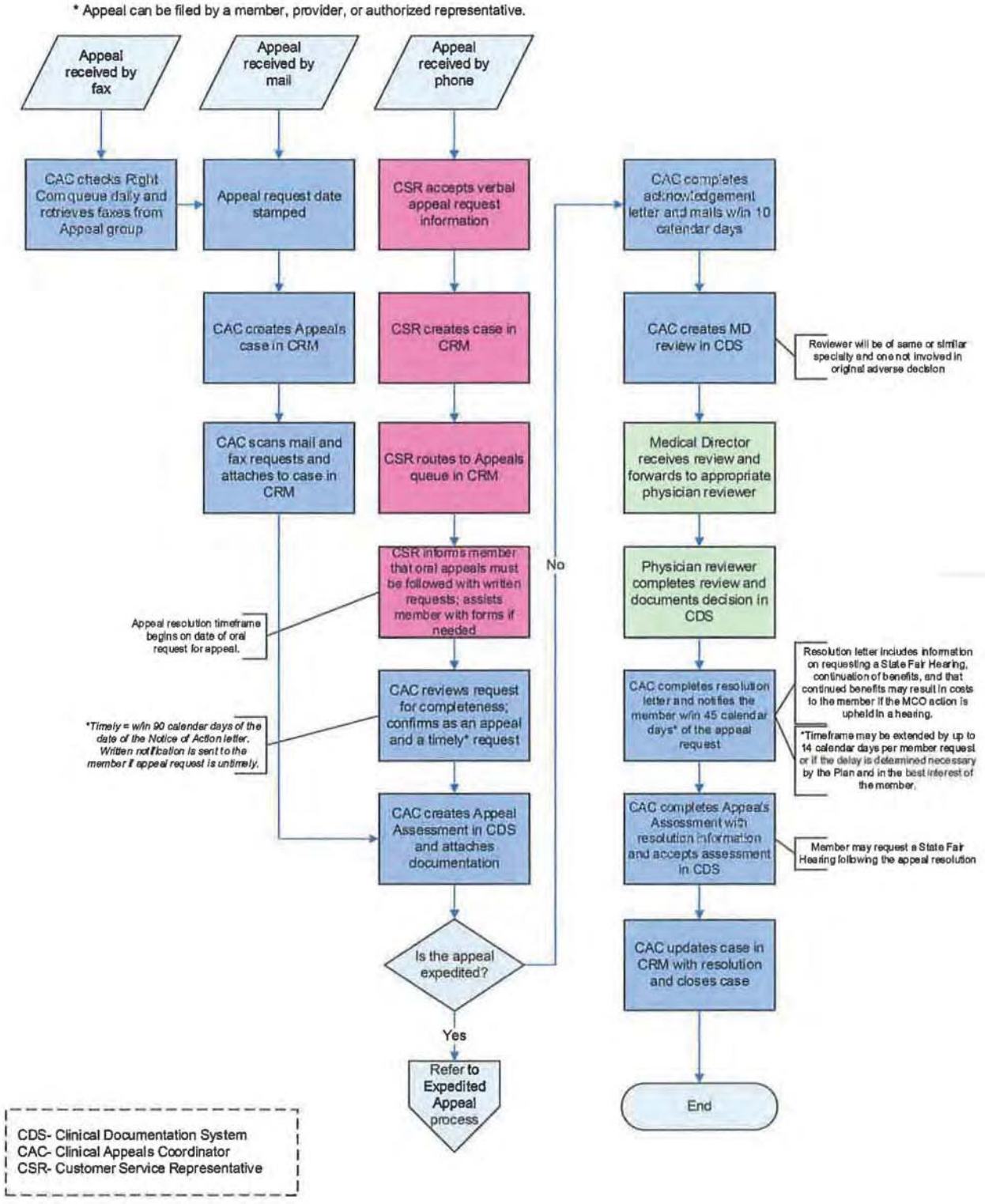
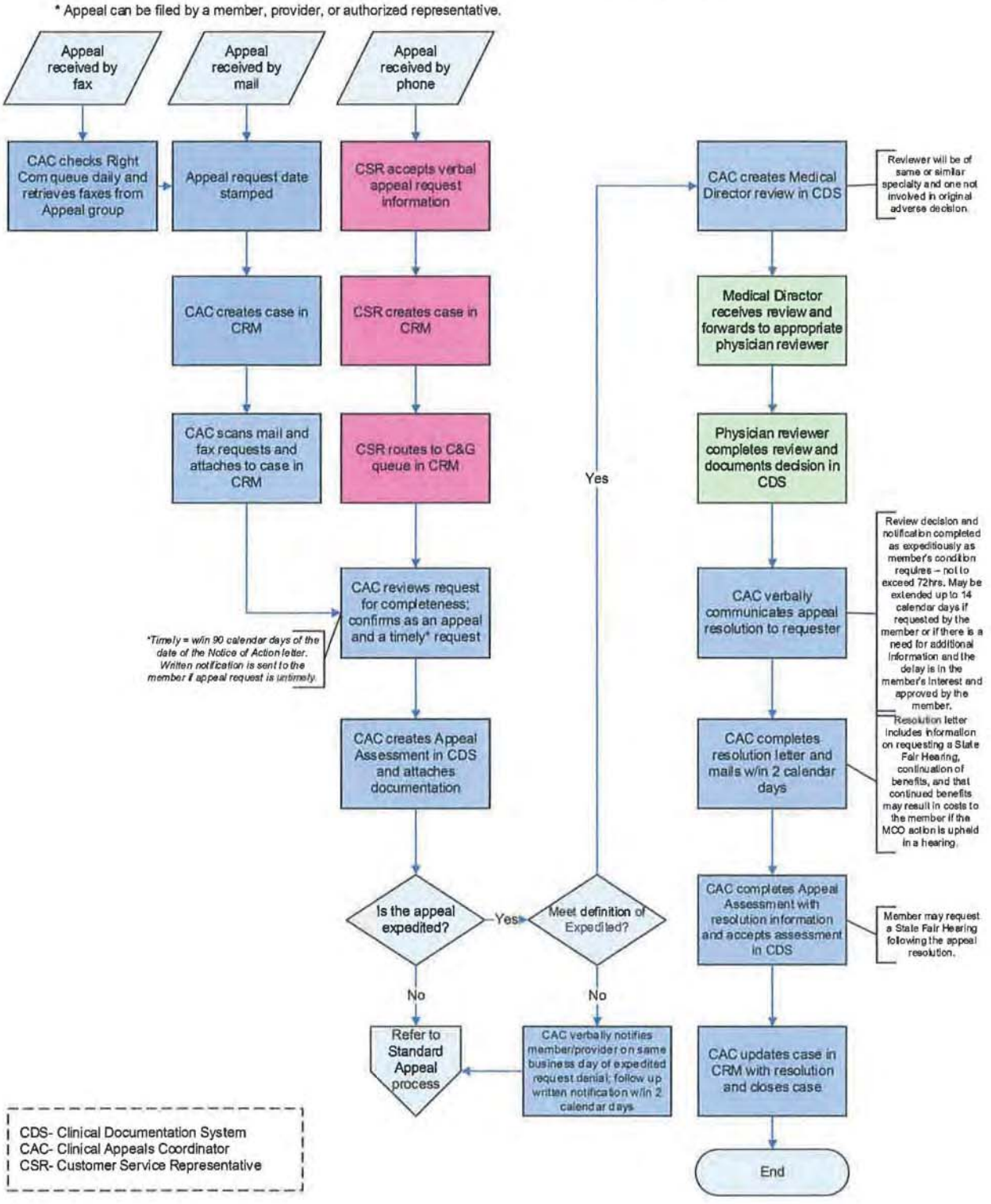
Standard Member Appeal Process



Expedited Member Appeal Process



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IV.I Provider Network Requirements

IV.I Provider Network Requirements

(6 page limit, excluding plan for developing an adequate network)

38. Describe the MCO's proposed provider network outreach approach and recruitment strategy.

Nebraska Total Care's Bold Approach to Provider Outreach and Recruitment

Nebraska Total Care (NTC) will comply with all requirements set forth in Section I. Provider Network Requirements of the RFP. NTC has actively been engaging with Nebraska's provider community for two years in anticipation of Medicaid reform that culminated in the release of an RFP for an integrated managed care model. Ensuring the success of the Heritage Health program by meeting MLTC's goals with a comprehensive network tailored to Nebraska's diverse geography and population is our focus and priority. Centene Corporation (Centene), NTC's parent company, has been managing care since 1984 and currently serves more than 4.8 million members nationwide across 23 states and has successfully grown our network to more than 248,000 Providers nationwide. Centene has built fully integrated networks in eight new states in the past five years alone; including both urban and rural markets. It is a goal of NTC's provider network strategy to capitalize upon the strength of our network provider partners in urban areas, ensure and stabilize rural networks and expand and build into frontier areas. NTC offers no less than 100% of the Medicaid FFS rate and uses value-based enhancement and incentives to engage providers in member outcome improvement. Enhanced reimbursement will incent telehealth, peer education, traveling specialist, case review, collaboration and care coordination to expand provider capacity utilization, as well as recruitment in medical and geographic areas of need. NTC's network approach and development strategy for provider outreach and recruitment includes, but is not limited to the following:

- Relationships with major health alliances and systems such as ENHANCE Health Network, Catholic Health Initiatives (CHI), UniNet Healthcare Network, and Avera Health, all of which have agreed to encourage their members to begin and/or expand acceptance of Medicaid members, expand their service areas and collaborate in recruitment of providers to add to their alliances and networks
- Active recruitment of providers who are not yet accepting Medicaid members and those providers that have not yet entered the market, including new or recent graduates
- Implementation of more efficient and expedient credentialing practices
- Partnerships with State agencies to engage providers more fully in policy compliance
- Innovative value-based reimbursement to encourage high levels of provider performance
- Partnership pilots that align with MLTC goals to expand service capacity, access and utilization, including, but not limited to collaboration with the University of Nebraska Medical Center, Lancaster County Health Department, Vest Psychiatric Services and tribal provider communities
- Collaboration with the Health Center Association of Nebraska (HCAN) and each FQHC
- Strategic alliances with Nebraska's Behavioral Health regions, network providers and the Department of Behavioral Health
- Focused Provider Engagement Model for recruitment, retention and investment to build access

Provider Partnerships. Through extensive statewide network development efforts, NTC will be prepared to meet the needs of Heritage Health members on day one of the Contract. NTC is in the process of finalizing and executing a Strategic Alliance Agreement and a value-based purchasing Quality Program Network Services Agreement with ENHANCE Health Network. ENHANCE is a health care alliance that represents upwards of 35% of the state's providers and is inclusive of nine physician hospital organizations (PHOs), over 65 individual hospitals or hospital systems, and more than 3,500 affiliated providers. ENHANCE Health Network's comprehensive, statewide regional health network provides a forum for health care system members to jointly develop capabilities and share best practices to reduce inefficiencies and improve the care they deliver. ENHANCE Health Network's 9 PHOs, the alliance's founding members, include

> ***We believe it is important to bring in payors who understand the Medicaid population and are willing to work with providers such as UniNet to provide the best care at an affordable price.***
> *-Ann E. Oasan, President, UniNet Healthcare*

Nebraska Medicine, Methodist Health System, Bryan Health, Fremont Health, Mary Lanning Healthcare, Columbus Community Hospital, Faith Regional Health Services, Great Plains Health and Regional West Health Services. NTC's value-based Strategic Alliance Agreement with ENHANCE Health Network will include, education, training, credentialing and the development of Telehealth opportunities that will assist in provider outreach, assistance and recruitment in rural and frontier regions, as well incentives to provide access to specialists, many of whom are willing to travel. Additionally, we are in the process of entering into value-based arrangements with Catholic Health Initiatives (CHI) and the clinically integrated network UniNet, which represent more than 2,800 providers and 38 hospitals. CHI/UniNet's behavioral health network is particularly notable, including as many as 80% of the state's BH providers in addition to two standalone BH facilities. NTC and Avera have agreed to enter into a contract that includes approximately 350 providers, 8 hospitals and 48 clinics. Avera will assist NTC's to further expand our ability to employ telehealth services in underserved areas of Nebraska such as the northeast region. These three agreements together comprise approximately 85% of the more than 10,000 providers in the state covering approximately 70% of the state's geographical area and providing access to over 90% of the Medicaid eligible. NTC's strategies are designed to deliver innovative access to Medicaid beneficiaries and expand provider participation and utilization without reliance upon commercial or Medicare Advantage networks. Through these proven strategies, NTC's network development team has successfully increased access to providers that have historically not been fully engaged in Nebraska to deliver complete and holistic medical care. NTC has recognized the need to deliver a fully integrated medical care plan. This has led to a collaborative relationship with the 6 behavioral health regions to better coordinate Department of Behavioral Health and Medicaid services. NTC has cited the need to work closely with providers such as Boy's Town and Boy's Town National Research Hospital for acute and behavioral care focusing on the need to address child welfare determinants. NTC has extensive national experience with Native American-Indian Health and has brought this experience and best practices to Nebraska in our efforts to develop relationships with each tribe to improve coordination of care on and off-reservation, focusing on building trust between non-Native American providers and the native community.

FQHC Collaboration and Engagement. NTC recognizes the different experiences of the state's seven FQHCs. Each Center has a unique mission due to the urban, rural, frontier nature of the state, the paucity of providers in many regions and other . NTC's network development team has met with HCAN, Nebraska's Primary Care Association on several occasions in order to develop programs that will enable greater utilization of these centers and their providers as well as to maximize their capabilities. FQHC's provide many opportunities for innovation and flexibility to expand network capabilities and provider recruitment. NTC has met with each of Nebraska's 7 FQHCs to discuss their partnership priorities and is working with each Center to maximize its effectiveness on an evidence based platform and identifying the most prominent medical needs of the community it serves and using the Center as a point of service for traveling specialists, telehealth, education and training as well as working to collaborate on recruitment of providers to employee such as physicians and nurse practitioners to meet the needs of NTC's members.

> *"We support Nebraska Total Care's plans to bid on the RFP and are committed to being an integral partner of Nebraska Total Care's should Centene/Nebraska Total Care be awarded a DHHS contract."* – ***Amy Behnke, CEO, Health Center Association of Nebraska***

Encouraging Investment to Build Access. NTC has identified many challenges to access to care related to geography and distance to primary care, specialists and specifically, behavioral care providers, cultural boundaries such as Native American health and, economic restrictions for providers to limit Medicaid members in their practice. To address these challenges NTC's strategies include investment in the collaboration and development of the infrastructure necessary to support and expand initiatives such as telemedicine and traveling specialist services. This is to be done through Value Based Purchasing and Incentive reimbursements as well as additional investment and financial support from NTC. The strategy is to expand outreach and recruitment by building access through innovations such as; a comprehensive

telehealth alliance and network through a strategic partnership with the existing services offered by The University of Nebraska Medical Center, CHI, Boy's Town, the state's six (6) behavioral health regions, seven (7) FQHC's and AVERA. NTC will invest in additional ways to utilize traveling specialists by making them available to participate in this telehealth alliance and to support providers such as FQHC's, Rural Health Clinics, Critical Access Hospitals, Native American Clinics/Centers and, frontier regions in order to provide access or additional specialty and co-opportunity care.

NTC's Provider Network Outreach and Approach to Adequacy. The network development team is led by NTC's VP of Network Development and a team of dedicated, experienced contractors on the ground throughout Nebraska. This team has built numerous statewide networks addressing the specific and complicated needs to provide a medical home and access to primary care for our members and to support this care with other needs such as access to specialists, behavioral care and services and, in some instances such as Native American health, cultural needs such as faith healers. NTC has met with and entered into working agreements with other provider associations and their members such as the Nebraska Health Care Association, the Nebraska Home Care Association, the League of Human Dignity, The Area Agencies on Aging, The Nebraska Nurses Association and the Nebraska Pharmacy Association, all of which represent multiple provider groups and individuals which are necessary to support a medical home and primary care as well as to provide special care and supportive services necessary to enhance network development and recruitment. To preserve and expand member access, we will build the most comprehensive network possible, recruiting any willing provider that meets appropriate credentialing standards interested in contracting with NTC, including physician extenders, and nurse-midwives. As the Nebraska market grows and changes, we will continuously refine our customized recruitment strategy. We will review and amend national contracts such as lab, pharmacy and DME to tailor to the needs of our members across the State of Nebraska and ensure adequacy requirements. We also will review our subcontractor recruitment plans and incorporate status reporting into our regular Joint Operating Committee Meetings. We and our subcontractors will generate frequent Quest Analytics access reports throughout the network contracting process and continuously re-prioritize our efforts. For example, we will continuously prioritize all underserved areas including the Panhandle region, Grand Island, Kearney, Hastings, South Central Nebraska, or those with identified deficiencies, such as behavioral health, specialists and providers to care for individuals with intellectual and developmental disabilities. It is sometimes necessary to identify and locate providers that are licensed and registered in Nebraska that are located outside of the state such as in Iowa, Kansas, Colorado, South Dakota and Wyoming. NTC has traveled to meet with these providers and will include them in our network and offer their services to our members as is necessary to make certain that the members medical needs are not compromised due to a lack of access to care in rural and frontier regions from Nebraska based providers. For example, Denver Children's Hospital (CO), AVERA Health (SD), All Care Health Center (IA), CHI (IA and KS), have all agreed to serve in our network and provide services to our members within the state of Nebraska as is feasible.

Our Network Adequacy Strategy for Nebraska. Our network development teams are made up of field-based Network Development Representatives, in-house Provider Outreach staff, our fully integrated affiliates for behavioral health, vision, pharmacy, and HCBS services, as well as key delegated subcontractors for radiology, diagnostic laboratory, and non-emergency medical transportation services. The NTC provider network will include local medical doctors, nurse practitioners, physician assistants, FQHCs, RHCs, local Health Departments, Walk-in Clinics, hospitals, urgent care centers, diagnostic providers, a variety of clinical facilities, and customized specialty sub-networks, including those comprised of providers with experience and expertise treating members with co-occurring mental health and substance use disorders; co-occurring mental health and substance use disorders and developmental disabilities; serious and persistent mental illness; 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.); sex-offending behaviors; eating disorders; and co-occurring serious mental illness (SMI) and common chronic physical illnesses. Although Long Term Care

services are not included in this RFP, NTC is preparing for a potential expansion of the Heritage Health service package by working collaboratively with providers such as Home Health Agencies, Nursing Homes (NH), Centers for Independent Living (CILs), and Assisted Living Centers/Homes (ALC/ALH), targeted specifically to serve I/DD, SMI and LTC members. The above-referenced strategies will also be employed in our partnerships with Native American Tribal providers, as discussed in greater detail below.

Fully Integrated Affiliates and Delegated Subcontractors. NTC will employ the services of its affiliates to build and manage fully-integrated, specialized provider networks including a fully-integrated network of BH care providers, vision care providers, and retail pharmacies. In addition to our fully integrated affiliates, NTC will augment our provider network by employing the services of nationally established service providers which include, but are not limited to, a nationally recognized provider of radiology and other medical specialty solutions and a nationally recognized provider of diagnostic laboratory services. Each of our fully integrated affiliates share Centene's philosophy of building provider networks at the local level, and our delegated subcontractors also have performed well on behalf of Medicaid beneficiaries served by Centene affiliates in other states. In addition, while all of these organizations have operations in other states, their standard business practice is to build and manage local networks. In so doing, they support local businesses, ensure continuity of care, and retain established patient-provider relationships that are conducive to patient compliance and comfort.

Understanding Community Orientation. As we develop our Nebraska provider network, as already mentioned, we have discovered certain communities where residents are accustomed to seeking care in neighboring states due to the proximity or types of services. This is especially true in the most northern and southern areas of Nebraska, as well as those in the Panhandle. This also includes services offered in Council Bluffs, Sioux City and Sioux Falls. We believe it is important to recognize these access patterns and to develop a strategy, in collaboration with the State, which aligns with established access patterns while still managing care and costs.

NTC's Hospital & Tertiary Care Network. The NTC provider network development team's strategy includes meeting with every hospital facility administrator in Nebraska in order to contract and incorporate those facilities into the network and care coordination plan. In addition, the goal is to identify the scale of providers and services offered from each facility and to develop a plan to offer many of the services available through our other provider partnerships, value based purchasing and incentive programs, telehealth, education and training and recruitment programs to maximize and expand each facilities offerings of access to care and ability to participate in a fully integrated care coordination plan for our members. This is an ongoing process which has been underway for over two (2) years and that will continue through award and the life of the contract. Our impetus for meeting and communicating with the decision-makers at each hospital early and often was to identify and overcome hurdles that could delay the development of a strong hospital and full service network, as well as to develop a local partnership and working relationship to make certain the providers are invested in collaborating in the development of the network in Their community. This includes the out of state facilities in order to guarantee their understanding of the Nebraska Medicaid program and requirements and to ensure the implementation of a practical and workable plan built upon the principle of continuity of care for our members who are accustomed to seeking or require care across state lines. Our initial efforts reinforce our belief that we have developed a strong rapport with key hospitals, hospital systems, their employed and affiliated physicians and other providers. Our goal is to attain 100% participation.

Out-of-Network and Out-of-State Providers. In the event a member's care cannot be provided in-network, NTC will arrange for care with a qualified provider located within the state, preferably within the member's community. Single case agreements solidify payment terms, authorization parameters, and treatment plans to ensure thorough care coordination of the patient's care and appropriate transition to in-network services if warranted. At times it is necessary and prudent to arrange for the member's care with out-of-state providers. This occurs mainly in a tertiary care setting or when the member has a rare illness or diagnosis that is best treated at a Center of Excellence located out-of-state. In these cases, our Care Coordination teams are at the forefront of the care coordination process (e.g. communicating with

providers, scheduling appointments, arranging transportation and lodging) until the member's health care issue is resolved and they return to their home state for follow up care with in-state providers.

Child Welfare System Providers. Building a successful provider network to serve the needs of children and youth in the child welfare system requires a comprehensive understanding of the child welfare system of care approach, a commitment to collaborating with the Office of Juvenile Services, and an intimate familiarity with the unique PH, BH and pharmacy needs of children and youth who transition in and out of home placement. NTC's affiliate health plans have extensive experience caring for child welfare system members and current offer services to more than 67,000 children in 10 states. In 3 states, we are the sole-source manager of integrated services for individuals in the Foster Care system. Ongoing, regular communication across all providers is critical for maintaining and improving health outcomes, and NTC serves as the point of connection between members and all providers across the system of care. As Nebraska's provider community receives training on Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), NTC reinforces this tool, which has proven instrumental in the treatment of children in the child welfare system, through ongoing TF-CBT provider education. NTC's success building and maintaining a network that meets the needs of children/youth in the child welfare system continues to reduce network gaps. NTC recognizes the necessity to constantly and systematically evaluate the provider network against the needs of children/youth in the child welfare system of care to ensure continued access. NTC has implemented a recruitment campaign aimed at providers identified through licensing board listings, lists of providers assigned a new Medicaid ID number, and local medical society reports of specialists new to underserved areas, as well as Child Placing Agencies and child advocacy centers to identify child welfare specific providers. NTC has strived to develop a working relationship with providers and leaders in child welfare such as Boy's Town, The six (6) behavioral regions, Nebraska Association of Behavioral Health Organizations, (NABHO), Lutheran Family Services, our FQHC partners, Native American community organizer, community assistance programs related to Foster Care, Probation/Parole and other agencies related to the various social determinants associated with child welfare concerns, multiple departments of public health including the Lancaster County Department of Health, all of which can provide data, programs, education/training and certain levels of care to be offered primarily or in support of other provider partners to meet the unique and varied needs of this population.

Tribal Community Providers. NTC recognizes that we have a responsibility to serve the Native American population in a culturally-sensitive way. In Tribal communities, our approach has been highly respectful of each tribal nation and their desire to remain sovereign and independent. Health care is no exception and that is why NTC has met one-on-one with each tribe's governing and/or health system leadership. We have visited with representatives of the four recognized tribes headquartered in Nebraska to ensure that the models we implement are consistent with the priorities of tribal leaders. We take pride in the relationship-building efforts we have succeeded in with tribal communities throughout the State and we believe this will lead to strong networks consisting of Indian Health Service, Tribal 638, and Urban Indian Health (I/T/U) providers who provide physical health, behavioral health, and long-term care services. NTC's sister affiliates in Arizona, Bridgeway Health Solutions and Cenpatico of Arizona, have been serving Native Americans since 2006 and have developed a variety of best practices that have been well-received and fully embraced by Native American providers and members throughout Arizona. These include a focus on housing, employment skills, and substance use. We are in the early stages of sharing ideas and exploring solutions that we plan on implementing in Nebraska for Native Americans of every tribal community. Tribal leaders have highlighted the importance of addressing the administrative barriers to delivering Medicaid services to their members. Our dedicated Tribal Liaison will ensure that such impediments are addressed expediently. We will further support the continuum of care for our Native American members receiving services from Native American providers by waiving prior authorization requirements, and our claims and administrative systems will be configured to accept and correctly reimburse claims from I/T/U providers regardless of the provider's participation status with NTC. We are cognizant of the need to provide access to services offered by traditional healers and other desired services on and off-reservation, and we will utilize our partnerships with other Nebraska providers to

supplement the services that are currently offered by providers under contract with IHS to ensure that our Native American members are able to access a full continuum of primary and specialty services. NTC will employ a Native American Provider Liaison who will be responsible for fostering relationships with each of the Tribes and developing our network of Tribal providers over time. NTC will also establish an **Indian Health Committee** with representatives from each of the Tribes and Tribal communities to promote meaningful communication and input to assist us in providing culturally effective services and care management approaches to the Native American population. We will also collaborate with the Urban Indian Association and Health Clinic and Cultural Coalition to recognize all Native Americans regardless of tribe and location.

Continuous Provider Network Development. NTC's network development team is constantly looking for opportunities to improve the network and expand access to our members. For example, if we identify a provider not currently in the network, we promptly reach out to inform the provider about NTC, solicit feedback and begin efforts to execute a contract. NTC has developed and is actively and aggressively implementing innovative measures to encourage provider participation, such as financial incentives and innovative contracting strategies described further below. In cases where we have confirmed there are no providers available within a specific geography, we identify the patterns of care our members follow to seek care in contiguous areas. Patterns of care are determined by claims utilization, and by speaking with the local provider community to understand referral patterns for specific specialty care needs. NTC arranges for access to services by helping arrange for telemedicine and further partnering with large systems to help recruit providers to those areas either permanently or through rotational clinics.

Ongoing Network Fortification. At times, it is necessary to build upon the existing Medicaid network by recruiting providers that have not historically served Medicaid populations. Based on discussions we have had with representatives from Nebraska's provider community, we understand that a significant percentage of providers have not previously accepted Medicaid patients into their panel. Through our extensive provider engagement efforts over the past two years, ***we have developed strategies and relationships that will be instrumental in increasing access to providers who have not previously participated in Medicaid, and those who have previously been unwilling to engage with NTC's competing MCOs.*** For example, network fortification is often necessary for certain subspecialists such as infectious disease specialist providers and high-risk prenatal care providers. NTC will recruit additional providers after all efforts to build networks consisting of traditional Medicaid providers have been exhausted and the need to complete the provider network to ensure appropriate access still exists.

For a detailed description of access standards by provider type, please refer to Attachment 38 - Network Development Plan.

Ongoing Network Adequacy Measurement. Like its affiliate health plans, NTC will continuously monitor its provider network to ensure it is made up of the right mix of providers to serve members in a timely manner and in the right setting. Our ongoing efforts to measure adequacy include reviewing monthly complaint reports, and out-of-network utilization. Our monitoring efforts are further discussed in our response to Question 41.

Rationale Used to Determine Network Sufficiency. We compare the number of members within a given geography to the total number of in-network primary care providers and required specialty providers serving the same geographic region. We also take into account those providers who have reached capacity and adjust calculations to get a true picture of network capacity for each geographic region. In Nebraska we define "geographic region" as Nebraska's 15 Core Based Statistical Areas (CBSA) defined by the US Office of Management and Budget (OMB) as urban centers of at least 10,000 people and the individual counties that fall outside of a CBSA. Key populations zones have the greatest concentration of members, but NTC will devote significant effort and resources to rural and frontier areas to ensure sufficient access throughout the State. Identified network gaps are immediately shared with the network development team in Nebraska so they can take the necessary steps to fill the gap or coordinate single-case agreements for out-of-network services in collaboration with our care management teams until the gap is filled.

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.***

Please see ***Attachment 38_Network Development Plan*** for a detailed work plan and corresponding narrative which demonstrate NTC's strong capacity for developing an adequate provider network within the timeframes prescribed in Section IV.I of the RFP, as well as the proven methods NTC will employ on an ongoing basis to assess and ensure that MLTC's network standards are maintained and exceeded.

(2 page limit)

39. Describe the MCO's required PCP responsibilities and how the MCO will verify PCPs are performing them.

Responsibilities NTC Requires of PCPs

NTC will require PCPs to comply with all requirements set forth in this RFP. In ***Table 1: Required PCP Responsibilities***, NTC summarizes the key required responsibilities all Primary Care Providers (PCPs) are expected to perfom (***Table Q39***).

Table Q39: Required PCP Responsibilities

Responsibilities NTC Requires of PCPs
Comply with Provider Contract Requirements
• Cooperate and comply with NTC's Medical Management Program including quality improvement, utilization, disease, and case management • Meet appointment waiting time standards • 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 • Track waiting times by appointment • Meet response times for returning calls After-Hours for urgent and other calls • Encourage PCPs to offer After-Hours office care in the evenings and on weekends • Supervise, coordinate, and provide all Primary Care to all assigned Medicaid Members • Maintain Medical Record, which includes documentation of all PCP and specialty services including BH • Comply with NTC's Cultural Competency requirements • Comply with all applicable provisions set forth under the Americans with Disabilities Act
Provide Services to Promote Health
• Provide preventive care and teach healthy lifestyle choices • Identify and treat common medical conditions • Assess the urgency of the member's medical problems and direct them to the most appropriate place for that care • Coordinate and initiate referrals to specialists, both in and out of network • Work with NTC staff and other providers to ensure that members receive the right services at the right time and place, to avoid serious complications and more costly levels of care • Work with NTC and other providers to identify and address gaps and implement innovative solutions to decreasing potentially preventable admissions or readmissions as well as avoidable use of the emergency department
Comply with NTC's Quality Improvement Program
• Provide physician services according to generally accepted clinical, legal, and ethical standards consistent with licensure, qualifications, training, and experience • Follow CPG and other evidence based guidelines to improve member health • Provide feedback on Quality Improvement Department Policies and Procedures • Participate in Provider Committee activities • Expect to be available for peer-to-peer review activities • Provide member Medical Record information upon request
Schedule Appointments to Comply with EPSDT Periodicity Schedule
• Provide, at the member's preventive visit, all of the EPSDT required components and those identified in the periodicity schedule • Contact the members' parents or guardians to schedule an appointment for those screens and services noncompliant with EPSDT periodicity schedule • Perform initial health and screening visit, as appropriate, for all newly enrolled EPSDT eligible children within 24 hours of birth • Refer for further diagnostic and/or treatment services to correct or ameliorate defects, and physical and Mental Illnesses and Conditions discovered during the EPSDT preventive health visits

Responsibilities NTC Requires of PCPs
Integrate Physical and Behavioral Health Services
• Send status reports to the member's BH providers
• BH Providers send initial and quarterly (more often if clinically indicated) summary reports of members' status to the PCP, with member or legal guardian's consent
• Participate in NTC's clinical education programs and education outreach designed to increase PCP proficiency in screening and identifying members for BH referral or treatment
• Coordinate with BH providers to increase attendance of members with Serious Mental Illness at a PCP office
• Become proficient in accessing and sharing member data via the Provider Portal, enabling better communication across PH and BH healthcare systems, and educating members on the importance of this data sharing
• Become a fundamental part of NTC's care planning team
• Collaborate with NTC to develop solutions to address the social determinants of health
Coordinate Care with Specialists and Other Providers
• Create a treatment plan for members who need a course of treatment or regular care monitoring as part of System of Care
• Create plan with member participation, and in consultation with the member's specialty providers
• Maintain continuity of each member's health care
Adopt and Utilize Electronic Health Records
• NTC recognizes its obligation to send and receive specified member health information to/from MLTC for the purpose of care coordination and member management

NTC Processes to Verify PCP Performance. NTC verifies that PCPs are performing their required responsibilities through quarterly Access and Availability Audits, member education and feedback, member satisfaction analysis and monitoring, PCP education on responsibilities, and PCP performance improvement processes. An important component of the PCP performance verification process will be regularly communicating with providers that performance results are directly tied to value based purchasing initiatives, and that high levels of PCP performance correspond with earned incentives and bonuses.

Conduct Access and Availability Quarterly Audits. NTC will use quarterly Access and Availability Audits to verify that PCPs are performing their required responsibilities related to open/closed panel status, appointment availability, and in-office wait times. Additionally, NTC will use "secret shopper" calls to confirm provider compliance with all contract requirements. NTC will promptly take corrective action measures to remediate provider noncompliance.

Educate Members and Monitor Member Satisfaction with PCPs. NTC will educate members about PCP responsibilities and monitor member satisfaction to verify that PCPs are performing required responsibilities. NTC will include information about the PCP's role and services provided, choosing a Medical Home, and the PCP's role in the Member Handbook. In addition, NTC includes the PCP's name, address, and telephone numbers on member ID cards. NTC will also monitor member Grievances and Complaints to verify that PCPs are performing their required responsibilities, described in Question 36.

Educate PCPs on Responsibilities and Conduct Performance Improvement Process. NTC will educate PCPs about their responsibilities and conduct performance improvement processes, including provider profiling, peer comparisons, and PCP Report Cards, to verify and assist PCPs in meeting their responsibilities. For example, NTC will provide to PCPs ongoing education and training on culturally and linguistically appropriate service delivery. NTC will include PCP responsibilities on the provider website and Provider Portal, and in the Provider Handbook. NTC's description of PCP responsibilities in the Provider Handbook will address the role of the Medical Home; PH and BH Coordination including the requirement for PCPs and BH providers to send each other status reports; information about how NTC and MLTC will use HIE information; an explanation of any service limitations or exclusions from coverage; information regarding practice protocols; and other provider responsibilities.

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. (3 page limit)

NTC recognizes that Nebraska's provider community includes available specialty providers who do not have capacity to serve or simply do not accept Medicaid members. We further recognize that the urban, rural and frontier makeup of Nebraska poses a further challenge to specialty service access. NTC will engage in a comprehensive analysis of service accessibility that considers geographic and social obstacles and pinpoints the community resources capable of helping us identify inadequacies and develop solutions. To bridge the barriers we identify, we will employ a range of innovations to increase the number of specialists within the specialty types to which access is limited and ensure that we are prepared to mitigate any hurdles that our members face in accessing specialty care. Our multi-faceted analysis process, the menu of solutions we will employ to enhance provider participation as well as our approach to assure member access to specialty service are described below.

Innovative Strategies to Identify Specialty Types for Which Access is Limited

The **Specialized Targeted Analyses** outlined in detail below, identify specialty types for which access is limited through sophisticated data analytics as well as through input solicited from the community through our committee structure and health plan staff.

- ***Quest Analytics Analysis Based on Disease State.*** Quest Analytics, the same tool employed by CMS to measure geographic access, will help NTC identify limited access specialties and other network gaps. The tool is capable of conducting condition specific analysis and providing a "heat map" functionality to help us to evaluate our network to ensure we are providing appropriate access to specialty care for conditions such as diabetes or STDs.
- ***Data Analyst Team (DAT) Analyses.*** Our DAT will review outliers in claims utilization associated with certain disease states and drill down to determine the root cause. In some cases, this outlier may be caused by a lack of contracted providers in a particular specialty and geographic area. In such cases, the DAT will notify the Contracting Team so they can initiate recruitment activities to contract with targeted specialty providers.
- ***Member, Provider and Stakeholder Feedback.*** NTC will routinely solicit input from our **Member Advisory Committee (MAC)** on the challenges related to accessing care at the regional and county level. We anticipate that they will also help us better understand the root causes of member complaints and member satisfaction survey results related to specialty care limitations. Our **Provider Advisory Committee (PAC)** and its **Behavioral Health and Indian Health Advisory sub-committees** will include representation from around the state and play essential roles in helping NTC identify barriers to specialty access and collaborate with us in developing solutions. We also work with **community resources**, including first responders, waiver service case managers, advocacy groups for persons with disabilities, public health advocates, judges, and CASA. This multidimensional analysis is augmented by day-to-day input by our **Customer Service staff,** who track and report member inquiries and Complaints related to specialty access, and our **Care Management staff,** who report on barriers to coordinating care caused by limited access to certain specialists.

Initiatives to Increase Network Participation among Specialty Types for Which Access is Limited.

NTC recognizes that a multi-faceted approach to addressing specialty provider network participation is essential. The strategies described below are consistent with the diversity of the state's geography and provider community.

Employing Traveling Specialists. NTC will expand access to travelling specialists. Some partners, like CHI and the University of Nebraska Medical Center already offer a robust selection of travelling specialists. However, independent development will be required in many cases. For example, Chadron Community Hospital in the Panhandle and Franklin County Memorial Hospital in South Central Nebraska

publish a monthly traveling specialist calendar, which will be shared with NTC's member and provider services teams as a tool to connect members in rural Nebraska with access to specialty care. NTC has also developed incentive programs to for specialists to improve access to members in rural and frontier areas where desired time and distance standards are not achievable.

Approaching Existing Specialty Providers to Expand Access. NTC will approach select specialty Provider partners to encourage them to consider traveling to/expanding into areas where access is limited. Facilities such as Fillmore Community Hospital and Morrill County Community Hospital, are expanding access to rural members by expanding their physical sites to increase capacity for outpatient clinics. By partnering with these facilities to gain an understanding of high-demand & low-supply specialty services, NTC will ensure that clinics are utilized and members are served locally.

Contracting with Border Providers. NTC recognizes that in some cases, especially in rural and frontier areas, specialty providers are not available within the distance standards and, in such cases, we identify the nearest provider available based on the patterns of care. NTC will work with providers across state lines in Kansas, Iowa, South Dakota, Colorado and Wyoming to provide specialty care based on members' needs. For example, NTC has secured agreements with Avera Health in South Dakota to serve members in northeast Nebraska as well as Colorado-based Denver Children's Hospital and HCA Healthcare to serve members in western areas of the State.

Ensuring Member Transportation to the Appropriate Specialist. NTC is committed to balancing provider access guidelines with member needs. If, for example, a Care Manager recommends that an I/DD member visit an OB/GYN with experience serving patients with intellectual or developmental disabilities that falls outside of the prescribed access distance parameter, NTC will ensure access to and cover the cost of appropriate transportation to and from the specialist identified as the provider who can provide the most specialized service to the member.

NTC's Telehealth & Tele-Consults. NTC recognizes that there are areas within Nebraska that lack certain specialty providers, (i.e., psychiatry in rural and frontier areas). In an effort to address these gaps and improve access to holistic, person centered specialty care, NTC will use telehealth strategies to expand capacity for provider-to-member encounters and provider-to-provider consultation. We are actively engaged with partners like CHI and UNMC already offering telehealth services and we are expanding service by collaborating with providers like **Vest Psychiatric Services.** Our partnership with Vest in North Platte area will provide grant funding for infrastructure development and enhanced Care Coordination services. Vest will provide psychiatric nurse practitioners and licensed clinical social workers (or other licensed BH professionals) to help support PCPs in the North Platte area and expand member choice for BH service providers. Some PCPs are reluctant to refer to telehealth because they do not fully understand the service and the value of telehealth. Therefore, we will provide resources and support to all PCPs during provider orientation to educate providers about telehealth. For those in North Platte this education will specifically focus on referral and participation in the Vest Psychiatric program. Our Telemedicine Program is described in further detail in our response to Question 25.

NTC's Pathways Program Increases Specialty Access to I/DD Members. 25 years after the passage of the Americans with Disabilities Act in 1990, individuals with intellectual and developmental (I/DD) disabilities commonly do not have access to quality specialty medical care professionals because of fear and misunderstanding of disability. NTC, in partnership with Munroe-Meyer Institute at the University of Nebraska Medical Center, will support the provision of a whole-person approach to managed care that focuses on, among other objectives, building network capacity to support specialty access needs of I/DD members. NTC will support building capacity to ensure quality supports and specialty services that meet the needs of I/DD members are available to these members by assisting with the provision of specialized education courses to all stakeholders involved in the provision services for people with I/DD such as medical personnel, school personnel, families, I/DD providers and health plan personnel; identifying and encouraging the use of best practice examples as models; and connecting resources for ongoing growth, support and sustained access to specialty services among the I/DD population.

Provider Incentives Encourage Participation and Increase Specialty Provider Participation.

NTC will offer a variety of incentive programs to encourage specialty physician participation in our network (as discussed in our response to Question 97) and improve quality outcomes. For example:

- ***Ear, Nose and Throat (ENT) Pilot Incentive Program***. Partnerships with ENT specialists in an incentive program to meet ENT quality targets and cost reductions.
- ***OB Incentive Program.*** Collaborations with one or more PHO to develop an OB Incentive Pilot Program reduce unnecessary Caesarian Section (C-Section) deliveries. This incentive will offer obstetric providers an opportunity to share a percentage of the savings when two quality metrics are met: Elective C-Section delivery rate at or below the national average and postpartum visit rate at or above the NCQA Medicaid 90th percentile.
- ***Notification of Pregnancy (NOP) Incentive***. Early submission of NOPs allow for earlier member screening and enrollment into Care Management services. NTC will encourage providers and office staff to submit NOPs as early as possible during the member's pregnancy. Providers and office staff are eligible to receive incentives for the facilitation and timely submission of notification of pregnancy forms to our Care Management Department.
- ***Additional Value-Based Purchasing (VBP) Specialty Incentives.*** As part of our VBP Incentive Program, NTC will offer a per service payment to specialists who identify and provide services that address or close identified gaps in recommended member care, including gaps related to VBP measures.

Challenges to Member Access to Specialty Services and Mitigating Strategies.

Beyond assuring provider participation, we recognize the need to ensure that members do not face barriers to specialty service access. Included below are anticipated obstacles to access and the steps we will take to make certain that they are removed.

Geographic Limits to Specialty Service Access. Nebraska's urban, rural and frontier geographies contribute to specialty access challenges. To overcome these challenges, NTC employs a number of programs intended to *meet members where they are*, despite the member's location. Strategies include the use of traveling specialists and telehealth services discussed above, as well as Community Health Collaboratives and partnerships with PCPs with assistance from specialty provider types through our care coordination program.

Specialty Access Among Native American Members. NTC partners with off-reservation specialist providers to engage members via on-reservation care coordination staff through our traveling specialist and telehealth programs. For example, our agreement with Avera includes access to BH specialists through telehealth capabilities, exclusively directed toward meeting the needs of tribal members.

County/Region Resource Constraints that Limit Specialty Service Access. NTC recognizes that counties and regions lack the assets and economic resources necessary for supporting specialty practices. Through value based purchasing arrangements, NTC incentivizes specialty providers groups and organizations to recruit and hire specialists into their practices.

Specialty Access Limitations due to Improper Credentialing Processes. NTC is aware that deficiencies in properly credentialing certain provider types, such as nurse practitioners, to provide specialty services, such as behavioral health care, limit members' specialty service access. We mitigate this by customizing our credentialing and re-credentialing practices to make these processes more practice-friendly, thereby increasing our network's delivery of services and simplifying the process for providers, such as nurse practitioner behavioralists, to gain proper credentialing to deliver specialty services, as long as providers continue to meet state requirements.

Single Case Agreements (SCAs) with Non-Participating Providers. In a situation where a provider offering a necessary specialty service is accessible to a member but not in-network or amenable to joining NTC's network, we will make arrangements, either through standing authorizations or SCAs that allow our members to access services on an out-of-network basis. Such options will allow otherwise non-participating providers to see our members for services for a specific length of time without the requirement to fully join the network.

(2 page limit)
41. Describe the MCO's process for monitoring and ensuring adherence to MLTC's requirements regarding appointment availability and wait times.

Ensuring and Assessing Appointment Availability Access Standards

In accordance with the requirements set forth in the RFP, including those in "Attachment 2 – Access Standards", NTC will ensure compliance with all appointment availability and wait time access standards. NTC will audit compliance with appointment access and wait time standards, as well as physician 24-hour availability, through our formal quarterly audit program. We will conduct all audits in a non-punitive way, using primarily outside vendors with follow-up education and remediation conducted by NTC Provider Relations (PR) staff. In addition, we will monitor compliance using other approaches, such as through our Post Primary Care Physician (PCP) Appointment Survey Program; during onsite provider office visits performed by PR Representatives; through the analysis of CAHPS member satisfaction (for both appointment availability and wait times) and Provider Satisfaction Survey, member and provider Complaint/Appeal, utilization management and other data; and from input received from our members and providers through call center inquiries and Advisory Committee feedback.

NTC has entered into incentive-based agreements with providers that are willing to offer extended office hours. NTC will educate providers about appointment access and wait time standards during our New Provider Orientation and ongoing training programs, in our Provider Manual, and on our website. In addition, NTC will use regular e-mail "blasts" and Provider Newsletters to remind network providers of the appointment availability, wait time and after-hours access requirements as specified in the provider contract. All provider communication efforts emphasize the critical connection between provider performance based on quality measurement review and results, including appointment availability and wait time standards, and incentives earned through our value based purchasing initiatives. Our PR Representatives will educate providers during face-to-face visits and inquire about their knowledge of and ability to meet standards. When there is an obvious barrier to meeting standards, they will work closely with the provider to identify reasonable interventions to bring them into compliance.

Overall Approach to Auditing Provider Network Accessibility. NTC will follow the same approach to audit compliance with standards for urgent and non-urgent PCP, Pediatric, OB/GYN, specialty provider appointment availability and wait times, as well as physician 24-hour availability. In addition, our behavioral health (BH) subcontractor will conduct quarterly appointment availability audits and will report all results to NTC on a quarterly basis. Our BH subcontractor will implement quarterly Wait Time Audit Programs that align with the same protocols that NTC has established for our providers. In addition, NTC will include Urgent Care and Emergency Providers for appointment availability, and we will audit hospitals for compliance with appointments for non-emergency hospital stays. NTC will explore developing a collaborative auditing approach with other MCOs to minimize duplicate contacts with providers.

In November 2015, NTC's Louisiana affiliate, LHCC, collaborated with a pilot group of providers to enhance the reimbursement for after-hours CPT codes, allowing practices to staff for extended hours. This offers providers and members the opportunity to increase access in the evenings, weekends and holidays in their medical home.

Quarterly Appointment Availability Audit Program. NTC will retain a third-party vendor to administer our annual member and provider satisfaction surveys to identify access-to-care strengths and opportunities, along with other key information.

Method and Frequency of Audits. Our third-party vendor will audit 25% of our contracted provider network to assess provider compliance with one or more of the appointment availability standards. NTC's PR staff will conduct secret-shopper calls at least quarterly, in collaboration with our vendor, to ensure that at least 25% of contracted Providers are audited each quarter. As part of the audit process, auditors will verify contact information such as address, phone, fax, e-mail, and open panel status. Our BH team also conducts quarterly appointment availability audits.

Addressing Deficiencies. Within 14 days of receiving audit results, PR Representatives will visit non-compliant providers face-to-face and re-educate them about all access standards, specifically discussing

any area in which the provider failed to meet requirements. In a collaborative fashion, our PR Representatives will solicit feedback from the provider and their staff to identify barriers to maintaining timely access for appointments and agree on specific interventions. They will instruct the provider to implement proposed interventions within seven calendar days, and our vendor/PR staff will re-survey the provider in the following quarter to determine if they demonstrate compliance with standards.
If a Provider fails to demonstrate compliance after the second audit, NTC will provide written notice to the Provider within 14 days of receiving audit results documenting the area of non-compliance and requesting that the Provider submit a written Corrective Action Plan (CAP) within seven days. The CAP must outline the steps and processes they will implement to bring the practice into compliance with the specific standard(s). Our PR Representatives will conduct secret shopper calls to monitor all providers under CAPs to assess compliance within 60 calendar days from the implementation of the provider's CAP. Our Peer Review Committee will review providers who remain non-compliant and provide recommendations, such as focused monitoring. They may also refer providers to the Quality Assessment and Performance Improvement Committee (QAPIC) for consideration of continued network status.
NTC's QAPIC will review results on a quarterly basis and as part of the annual Quality Assessment and Performance Improvement (QAPI) Program Evaluation. These Committees will analyze results to identify plan-wide trends indicating access problems and, if access is found to be an issue, they will provide recommendations to Contracting and other NTC staff for resolution.

Quarterly Wait Time Audits.

Method and Frequency of Audits. NTC will include in-office wait time audits as part of our Quarterly Audit Program. Our third-party vendor will conduct statewide quarterly audits of 25% of NTC's contracted primary care, pediatric, specialty, and OB providers to identify those who are non-compliant with the in-office wait time access requirement. The surveyor will ask provider office staff whether they update members on current wait times and offer to reschedule the appointment if the member has been waiting 45 minutes or longer for scheduled appointments.

Wait Time Audit Program. NTC will implement a program among certain provider groups (representing all provider types) with practice management systems in place that allow them to capture patient wait times. The groups participating in the program will submit reports to NTC that include their internal average wait time. These reports will enable NTC to identify individual practice wait time patterns, better understand the reasons for the non-compliant wait times, and develop interventions that address the underlying issues resulting in office wait times exceeding the standard.
Program participants will submit their reports to us within 30 calendar days. Within 14 calendar days after we receive the wait time reports, NTC will analyze the data to determine if there are any trends in non-compliant wait times. PR staff will then schedule a meeting with the group to review findings.

How Deficiencies Will Be Addressed. The process for addressing non-compliance with wait time standards mirrors the process and timeframes described above for appointment availability, including the re-audit, CAP, post-CAP monitoring, and peer review processes.
For providers participating in the Wait Time Audit program, in the event a provider group is found to be non-compliant with standards, PR staff will discuss possible barriers to compliance; request provider feedback on challenges meeting wait time standards, and brainstorm possible interventions that will reduce patient wait times. PR Representatives will submit the agreed upon interventions to the provider, in writing, within 7 calendar days. The provider will implement interventions and monitor wait times for the next 30 calendar days and will submit a new Wait Time Report which NTC will evaluate to determine if interventions were successful in reducing wait times. If the Provider is still found to be non-compliant, NTC will follow the same CAP, CAP Monitoring and Peer Review processes described above until the provider demonstrates compliance with standards.

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. (3 page limit)

Approach to Promoting and Facilitating Capacity of Nebraska Providers.

To enhance our network's ability to deliver patient-centered care and improve outcomes related to health, behavioral health, and wellbeing, member compliance, and member satisfaction, we must partner with community-based providers and other stakeholders. Our approach to facilitating provider capacity involves meeting each provider where they are and strategically filling gaps to strengthen capacity using a calibrated combination of tools and strategies. For example, claims data and members assignment reports allow us to ensure patterns of care align with member PCP assignment and make updates as necessary. The diverse array of Nebraska providers and stakeholders we have engaged includes ENHANCE Health Network, Catholic Health Initiatives (CHI), the six Behavioral Health (BH) Regions, the Nebraska Behavioral Health Organization (NABHO), the Nebraska Community Based Health Providers, the Health Center Association of Nebraska (HCAN), the State's seven Federally Qualified Health Centers (FQHCs), League of Human Dignity, Aging Partners, Nebraska's four recognized Indian Tribes, the Nebraska Urban Indian Health Coalition, the Nebraska Hospital Association, the Nebraska Nurses Association and the Nebraska Health Care Association around their current capacity and needs related to the provision of patient centered care. In response, we will bring a comprehensive package of provider supports to Nebraska, including training and technical assistance, tools and technological supports, and provider incentive strategies. We will use a continuum of support, evaluate provider resources in place, readiness to provide comprehensive person centered care and then providing training, technical assistance, and other supports to fill any gaps. Many of our affiliates use Patient Centered Medical Homes (PCMHs) and other related models (i.e., health homes) to deliver patient-centered, holistic, and coordinated care, and we are well versed in supporting providers to achieve these designations and implement care that is informed by these models. Provider Training & Technical Assistance. NTC's experienced staff members, including our Provider Engagement and Clinical Training Teams, offer both high touch, face-to-face interaction with providers and their office staff, as well as virtual, web-based training and technical assistance. NTC's multi-dimensional training approach partners with entities already engaged in training activities around the state in order to leverage work that is already occurring. For example, we will partner with the University of Nebraska, which is currently working to augment Nebraska's network of health professionals in rural and frontier areas of the state through their Rural Health Education Network (RHEN) to enhance their current training program in ways that facilitate patient centered care.

In addition to leveraging current activities, NTC's overarching approach for enhancing provider capacity to deliver person centered care in all regions of the state (urban, rural, and frontier) includes:

(1) Training and Technical Assistance that is conducted, at minimum, upon provider orientation and quarterly thereafter with each provider. NTC's patient-centered provider training includes topics related to whole-person screening and assessment tools, engagement practices like Motivational Interviewing, and Cultural Competency related to care provision for unique subpopulations, is focused on equipping providers with the tools, information, and knowledge needed to successfully provide quality, person centered care. Additional topics for training and technical assistance will be identified through NTC's continual assessment of provider capacity and member outcomes (via our Provider Report Cards), selected by representatives on the Provider Advisory Committee (PAC), or requested by individual providers/associations themselves. We can provide in-person or web-based training on an individual provider, group, or network-wide basis. In addition to formalized training, clinical staff, including those working within the Case Management, Quality Management, and Provider Engagement teams, actively identify provider training needs, provider education and connect providers to the appropriate NTC Team Member who can provide necessary education. ***(2) Collaborative Learning Opportunities,*** will include an annual PCMH Provider Summit (described in more detail in Question 43) at which practices from across the state will come together to discuss patient centered best practices within the context of the Patient Centered Medical Home (PCMH) model. In addition, as we do in other markets, NTC Trainers will

partner with a variety of provider associations across the state (including ENHANCE, CHI, HCAN, the Nebraska Urban Indian Health Coalition, and the Nebraska Association of Behavioral Health Organizations (NABHO) to provide training to their members on topics that they self-select, including those related to patient centered care, improving health outcomes, member compliance and member satisfaction. NTC will work work with League of Human Dignity, Independence Rising and Aging Partners to identify providers who are currently delivering patient centered care in line with the needs of consumers receiving LTSS to support a strong medical home. We want to leverage best practices and ensure HCBS services are integrated as a critical component of the members medical home.

(3) NTC Care Managers Embedded within Provider Sites. NTC will place Care Managers who are Registered Nurses within selected provider locations to provide additional support for those that are working towards transitioning to a PCMH and that do not have community based care management services in place. The embedded NTC Care Manager will participate as a member of the practice's care team, providing face-to-face care management to members served by the practice, as well as consulting with the provider team on complex cases and helping to ensure all member needs are appropriately addressed. **Provider Portal & Technological Supports.** Written reference manuals and resources for providers and their staff will reinforce the training and technical assistance described above. Our ***Provider Portal*** will contain on-demand webinars and training recordings, as well as links to scheduled teleconferences, workshops, and other educational events. Our interactive Provider Portal is a secure web-based platform that also supports a number of provider administrative "self-service" capabilities to allow providers to offer more efficient and effective services to members. Poor communication between providers often results in service duplication and uncoordinated care. Our Provider Portal will facilitate integrated information sharing and collaboration among all treating providers through Online Care Gap Notifications (i.e., a missed refill or needed lab testing), Comprehensive Health Risk Assessments, individual treatment plans, and practice-level clinical, quality and cost reports. Providers with Electronic Medical Record (EMR) capabilities can also have a member's clinical data transmitted from the portal directly to their EMR. In addition to Provider Portal tools, topically relevant quarterly ***Provider Newsletters*** will ensure providers are aware of available resources and remain up to date about relevant policies and best practices that are relevant to person-centered care. ***Clinical Practice Guidelines (CPGs)*** related to a variety of conditions (e.g., asthma, depression, diabetes, ADHD, obesity in children) and ***Preventive Health Guidelines*** will be shared with providers electronically via the Provider Portal, as well as in hard copy for providers who lack consistent internet access, in order to improve member outcomes associated with these topics. We will also provide ***Quick Reference Guides*** as one-page reference cards covering topics such as appointment access and availability standards, claims guidelines, the Provider Portal, and community resources to facilitate care provision, (e.g., translation/interpreter services, transportation options). Finally, in order to facilitate successful member referrals, our ***Provider Directory***, accessible via our online portal and mobile application, includes names, locations, telephone numbers, clinical specialties, non-English language/cultural specialties, hours of operation, and indicates if providers are accepting new patients. This directory is easily searchable by location using a map feature (geo-mapped). ***Telehealth & Tele-Consults.*** Provider capacity is limited in many of Nebraska's rural, frontier and even urban regions. To address these gaps and improve access to holistic, person-centered care, NTC will use telehealth strategies to expand provider capacity. Telemedicine is an essential component of our member-centric approach, allowing Provider-to-Member as well as Provider-to-Provider live interactions and consultation. Providers often use telemedicine to consult with each other and share their expertise, which benefits member care and enhances outcomes. We will encourage the use telehealth to facilitate these interactions. For more information on NTC's telemedicine strategy, see Question 25 above. **Provider Incentives.** In addition to the above strategies to enhance provider capacity, we will also use both financial and non-financial incentives to encourage providers to provide patient-centered care, as well as improve health outcomes, member compliance, and member satisfaction. We begin by meeting each provider where they are, and then provide incentives that will help them move to the next level of care provision. Providers will be incentivized to attend integrated care trainings or incentives for achieving PCMH recognition and improved member outcomes (i.e., reducing avoidable

hospitalizations). Through value-based purchasing agreements with many of key provider providers such as the ENHANCE network, CHI and FQHCs, NTC has identified and is implementing quality measurements to emphasize and monitor patient-centered care and incent development of patient-centered models. NTC's newly created Community Health Collaborative in Norfolk and each Value Based Enterprise Zone will support our practices of PCP participation in behavioral health and other co-existing conditions and to utilize NTC's fully integrated care coordination methodology. ***Please see Question 97 for more details*** on our plan to move providers into value based payment arrangements that reward the provision of person centered care and improved outcomes.

NTC's Previous Successes & Lessons Learned that will be Leveraged in Nebraska

NTC, through its parent company Centene Corporation (Centene), has over 30 years of managed care experience serving over 4.8 million members across 23 states. NTC recognizes that by enhancing the ability of our network providers to deliver person centered care, we are able to achieve enhanced outcomes for our members and the system at large. We will leverage and utilize lessons learned from our affiliates working in other markets in our approach to Nebraska, including:

(1) Implementing Local Approaches to Care that Leverage Provider Capacity to Improve Outcomes. Our Illinois affiliate identified a very high readmission rate for psychiatric admissions among a group of individuals living with Serious Mental Illness (SMI) living in the Chicago area. In response, they reached out to Thresholds, a high performing, outpatient provider group in Chicago that specializes in Assertive Community Treatment (ACT) and the provision of intensive person centered services for the SMI population. When our affiliate identifies a member who would benefit from these intensive services, they notify Thresholds. To enable Thresholds to successfully find and support these high risk members, our affiliate waives authorization requirements. This initiative has resulted in a significant *increase in outpatient care, decrease in inpatient care, and reduction in cost for "super-utilizers."* NTC recognizes that payer-provider partnerships can result in collaborative, innovative solutions, and we will engage in these strategic partnerships where appropriate to improve outcomes for all Nebraskans.

(2) Cross Sector Coordination and Communication to Enhance Person Centeredness. Our Kansas affiliate implemented the Rapid Crisis Response System (RCRS) for members with intellectual and developmental disabilities (IDD) after identifying that the lack of communication skills resulted in behaviors and observations being misunderstood as behavioral health symptoms, resulting in a prescription for an unnecessary psychotropic medication. Through this initiative, our affiliate's RCRS team establishes a person-centered case conference with the member's caregivers and their social supports to collaboratively evaluate the trigger for behavior related to the critical incident and strategize solutions outside of medication. As a result, our Kansas affiliate's RCRS clinicians presented recommendations that *reduced psychotropic medication use by 39% for IDD members* last year alone. NTC acknowledges the importance of full communication and coordination in the development of an appropriate, person centered plan of care, and we will implement this strategy on behalf of Nebraskans that are utilizing multiple services across sectors. **(3) Onsite Care Management Support to Enhance Person Centered Care and Improve Outcomes.** Our Georgia affiliate developed an initiative to embed Care Managers (CMs) within a partner FQHC site that is serving a large number of high-risk pregnant members living in rural areas of the state to improve pregnancy outcomes for both mother and child. The CMs partner with the FQHC to provide these women with an array of person-centered services such as assessment, care planning, education assistance with addressing barriers related to social determinants such as housing and transportation, and in home visits for members who are "non-compliant" with their treatment plans. As a result, our affiliate achieved a 56% decrease in the NICU rate, an 82% increase in the Postpartum Visit rate from 2010 to 2014, and the 2014 Case in Point Platinum Award for innovative strategies to improve pregnancy outcomes in rural areas. As described above, NTC will site CMs within selected Nebraska provider locations to support their ability to deliver person centered, coordinated care.

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: (5 page limit)

- ***Promoting and facilitating provider capacity to meet PCMH standards.***

Promoting and Facilitating Provider Capacity to Meet PCMH Standards

Nebraska Total Care's (NTC) PCMH philosophy is to meet providers "where they are" in their journey towards practice transformation and provide a wide range of tools and support that vary depending on the provider's level of interest, readiness, and size of practice. Our program will build on the knowledge gained from the Nebraska Medicaid Patient-Centered Medical Home Pilot Project, while leveraging our experience in other states. Centene currently has more than 4,400 network PCMHs and Health Homes nationwide that have a record of success in care integration and community-based care management focused on individual member needs. Based on our experience and findings from the Nebraska PCMH Pilot, we will provide a comprehensive, flexible PCMH support program is that is tailored to the level of need and capabilities of each practice. This approach increases provider participation and improves success while supporting holistic, person-centered, community-based care. Our program will support providers of varying sizes in rural, urban and frontier areas, and includes all types of primary care providers, including pediatricians, in solo or group practices, Indian Health Services and Tribal providers, Rural Health Centers and Federally Qualified Health Centers. NTC will provide MLTC with aPCMH implementation plan within 90 days of the start of this contract. Following is an overview of the specific types of assistance we will provide to assist providers in attaining the highest level of PCMH recognition/accreditation.

NTC is working with FQHCs to identify types of assistance we will provide to support their PCMH activities. Services we have proposed include transportation support, improved access to data, funding for home monitoring pilots, on-site Care Managers, enhanced Behavioral Health coordination support, and nutrition/cooking classes for diabetic or obese members.

Technical Assistance, Training and Education. Because we want all our providers to have the knowledge and tools they need to be effective partners in providing patient centered care and coordinate with other providers and our care coordination teams, all providers participate in a comprehensive training and education program that emphasizes our expectations and resources for managing members' care; the importance and process of care coordination; how to obtain information on members' health status and services; and how to communicate effectively with members and their families. Our goal is to support all practices at various stages of practice transformation and, transition them towards pursuing full PCMH recognition.

Advocating PCMH Adoption. To encourage providers' interest in the PCMH model, we will host **Medical Home Summits** to educate network providers about the improved patient outcomes and improved work satisfaction possible with the PCMH model. The Summits will be held in urban, rural and frontier areas and will include a discussion of the resources and tools we provide to help providers attain PCMH recognition. The Summits also provide an opportunity for Providers to discuss regional challenges, best practices and strategies for improving care, and communicate to NTC problems or concerns they may have related to providing effective care. We also will partner with professional medical organizations and societies to promote the PCMH model. Similar to activities in other states, we will provide financial assistance to organizations who are working with providers to support PCMH initiatives, and have already begun identifying opportunities for collaboration. For example, in Georgia, we awarded $50,000 to the Georgia Chapter of the American Academy of Pediatrics and another $50,000 to the Georgia Academy of Family Practice to support PCMH initiatives.

PCMH Champions. Once we determine a practice is interested in pursuing PCMH status, we will identify a provider to serve as the PCMH Champion for the practice. We will provide ongoing assistance to enable that individual to guide the practice staff and providers through the transformation process.

Supporting Practices Throughout the Transformation Process. For all providers working towards PCMH status, we will provide enhanced support based on their specific needs and situation. Our NCQA Content Expert Certified PCMH Coordinators will develop a work plan for the practice, develop a timeline for staff training, assess current workflows, and help the practice develop policies and procedures to support revised patient flow and work processes. Coordinators meet with the practice on a regular basis to help assess progress, provide additional direction and assist with problem solving. All services and training will be easy to access, consistent with findings in the Nebraska PCMH Pilot study that noted services must be easily accessible to ensure physician and staff engagement. We also will provide two years of paid access to the American Academy of Family Physicians PCMH Program Planner. This web-based interactive tool helps the practice staff manage the work plan, learn how to adopt electronic health records into the practice, and assess progress in PCMH transformation.

Regional Small-Practice Support. Because Nebraska has such a large number of small provider practices that need additional support, we will provide a dedicated **small-practice support team** that will be assigned to multiple providers within a common geographical area. These teams will provide one-on-one practice assistance and joint training among several offices, who can benefit from the common experiences and challenges. Regional Care Managers will work with providers and their staff to provide more intensive technology support and training to meet providers "where they are" and ensure they understand and can effectively utilize the tools we offer to manage their practice and support care coordination. Providers will also participate in **Regional PCMH Learning Collaboratives** to discuss PCMH training, share experiences, lessons learned and identify best practices.

Data Sharing and Electronic Health Record Support. As noted by many providers we have spoken with, and also in Nebraska's PCMH Pilot program, providers currently struggle to obtain the comprehensive, timely information they need to effectively manage their patients' care. To address this need, *all* network providers will have access to Centelligence™, our integrated decision support and health care informatics system that includes secure administrative and clinical applications necessary for an effective care management program. *Administrative features* include eligibility inquiry; authorization request and response; electronic claim submission and status inquiry; interactive Preferred Drug List and formulary search; interactive authorization requirement search; and a searchable Provider Directory to assist with referrals. *Clinical Information* includes member health records, clinical practice guidelines, Online Care Gap Notifications (OCGN), member panel rosters, disease registries, and an electronic copy of the TruCare member's care management service plan displaying the member's health problems and diagnoses, treatment goals and objectives, milestone dates, and progress. The Portal includes an overview of the members' service utilization activity, including laboratory and pharmacy information, inpatient visits, emergency room visits and provider office visits. Information is also integrated with our Member Portal (see discussion below).

EHR Support and Incentives: For providers who have not transitioned to Electronic Health Records (EHR), our Centelligence™ Health Information Exchange (CHIE) allows for other types of data connectivity as the provider begins to adopt their own EHR, and/or connect to a Health Information Exchange (HIE). CHIE securely delivers expanded, member-level clinical information via several complementary electronic "channels," including web-based online access, mobile platforms, and health information data exchange capabilities. CHIE data interchanges include Health Level 7; CCD Data; Admission, Discharge, Transfer (ADT) data; Emergency Department notifications, and other standardized health information transactions. We will also offer a variety of EHR incentives including subsidies, bonus payments and increased PMPM payments to "meet providers where they are" technologically and enable them to share in the ongoing cost savings gained from EHR use. We also will assist providers in identifying and applying for available grants to fund EHR implementation, which we have found to be especially helpful for small practices that do not have the resources to pursue application of these funds.

Behavioral Health Integration and Coordination. To support providers' efforts to meet PCMH and MLTC standards regarding integration of Behavioral Health into primary care, our Clinical Trainer will

provide training that includes practice guidelines, principles of Recovery and Resilience, and the use of screening tools for behavioral health conditions that are commonly encountered in primary care settings. This includes:

- PHQ-9: to screen for depression
- Edinburg Depression Screen: to screen for postpartum depression
- CAGE: to screen for issues related to alcohol use
- SBIRT: to identify substance abuse and appropriately refer for treatment.

Provider Relations Specialists will help identify behavioral health providers with which they can establish formal agreements for coordinating behavioral health services. We will encourage larger practices to hire mid-level practitioners or physicians with behavioral health experience to improve the integration of behavioral services into primary care. In addition, our integrated Care Managers will teach-by-example as they work with practice coordination staff to coordinate behavioral services for our members. Our Care Manager Teams are fully integrated and cross-trained in physical and behavioral health issues.

Provider Incentives. We will implement a multi-dimensional provider incentive program that includes the following components to reward and encourage providers at various stages of transformation:

- One-Time Payments for Attaining and Maintaining PCMH Recognition: NTC will provide a one-time payment per practice site when a practice is initially accepted into the PCMH program. We will provide another one-time payment once the practice attains PCMH status. To encourage practices to maintain their PCMH status, practices that attain recognition through our assistance will receive an additional one-time payment upon renewal of recognition status.
- Performance Based Incentives: practices that meet or exceed pre-established performance targets will be eligible to receive enhanced incentive payments
- Incentive to Address Health Disparities: NTC will encourage practices in medically underserved areas or that primarily serve populations with identified health disparities to pursue PCMH status. Realizing that many of these Providers may be resource-poor, we will offer enhanced incentives and expertise to support these Providers through the PCMH transformation process. We also will provide enhanced technical support to help build the infrastructure needed to transition to a PCMH model.
- Preferential assignment of new members through the auto assignment process
- Enhanced payments for certain services provided during extended office hours.

Maintaining contact with members throughout their interactions with the health care system

Maintaining Member Contact

We understand the importance of keeping our members engaged in their care, and will coordinate with our PCMH providers to use all appropriate strategies and targeted interventions for maintaining ongoing contact with members. Depending on the individual and the type of information we are conveying, we will contact members by phone, mail, e-mail, or in person via home-visits. Our approach will be adjusted to meet each individual "where they are," and will reflect variations in cultural preferences and personal circumstances. For example, when appropriate, we will provide cell phones to individuals with certain conditions so they can communicate regularly with their PCP and Care Manager. For example, when appropriate, we will provide cell phones to individuals with certain conditions so they can communicate regularly with their PCP and Care Manager and we will send text messages or call these members to remind them of upcoming appointments or to get their prescriptions refilled. These services assist our providers by reducing no-shows and ensuring members receive appropriate services. We also communicate regularly with members through our Member Portal, which provides extensive information regarding their benefits, health care status, reminders, and educational information to help them manage their care. Members can check on upcoming appointments, review their care plan, and communicate with their providers and care management team. Frequency of communication will depend on the individual, diagnoses, and health care needs. Our Care Management team will work with providers to target members

at greatest risk for escalating problems, and will engage in more frequent contacts as indicated based on the member's diagnoses, severity of illness and upon admittance for inpatient services or emergency services when appropriate.

Managing referrals

Facilitating and Managing Referrals

NTC will work closely with PCMH providers to facilitate referrals for services requiring authorization. Through our Provider Portal, providers can access a list of referral services requiring prior authorizations, and may submit requests through the Portal, by phone or by fax. Referral requests will be processed by our Referral Specialists, and many requests are approved automatically. All referral or service authorization requests are documented in TruCare and are available to the PCMH provider through the Provider Portal, allowing access to all referral information regardless of which provider submitted the request. We use TruCare tracking and alerts to ensure referral requests are processed quickly by Referral Specialists. We also will prioritize requests based on the urgency of the case or other issues, such as enabling members to obtain services immediately without scheduling another appointment.

Illness and disease prevention

Activities to Prevent Illness and Disease

Our Nebraska Care Team will engage members, PCMH providers and community organizations as partners in motivating members and their family to adopt healthy behaviors and comply with recommended disease and illness prevention activities. Care Managers will coordinate with providers to monitor members in need of specific prevention services based on their age, gender, or health factors, and can target outreach to members who need more intensive support to modify behaviors and comply with disease and illness prevention efforts. We will use predictive modeling to target broader, community-wide initiatives, such as educational and screening events, to those members and communities most at risk for specific illnesses or disease. For example, we may offer home screenings to members in a certain area to identify issues such as mold or lead, or offer flu shots or immunizations in a neighborhood setting where members have transportation challenges. We will work with our PCMH provider partners to identify the most effective strategies and support their outreach and education priorities. We also will provide technical assistance and training to ensure compliance with and understanding of our evidence-based clinical practice guidelines and preventive and health promotion services. We will provide outreach and education through our member newsletter, in reminders and notices we distribute by mail, email or text messaging, in materials provided on our Member Portal, and through our wellness events.

Encouraging active participation of the member or family/guardian/authorized representative in health care decision-making

Member and Family Engagement in Health Care Decisions

Our Care Managers receive extensive training on how to engage members and will work with our PCMH providers to encourage their patients and family/guardian/authorized representative to actively participate in their health care decisions. NTC will work with members to:

- develop an individualized service plan that addresses physical, behavioral health and community support services in the least restrictive setting, and in a way that promotes member responsibility
- support the member in understanding medications and provider instructions
- follow-up with members after visits to identify any issues that need to be addressed, and
- monitor member progress and results to identify and implement any changes in the care plan.

Members and authorized family will have access to their service plan through the Member Portal, and can view or update the plan at any time. This secure environment supports member and family engagement, provides automatic follow-ups and alerts, and provides flexibility to make it easy for our members to communicate with providers and the NTC care team when it is convenient for them to do so. Providers and their staff will also receive training on techniques to effectively engage members and their families. The training will include strategies for establishing trust and rapport with members, developing a

partnership with members through motivational interviewing, and empowering members by helping them focus on their strengths that will help them better manage their health.

Encouraging the use of specialty services and supports

We understand that the appropriate use of Specialty Services and Supports is critical to an effective PCMH program that provides "the right care at the right time," and will provide training and tools to ensure providers can quickly and efficiently identify and arrange for the appropriate level of specialty care and supports. All providers will have online access to and receive training on NTE's clinical practice guidelines and utilization management requirements, which help determine when and what type of specialty services and supports are appropriate. To minimize administrative burdens on providers, we encourage (but do not require) providers to submit and manage referral requests electronically through our Provider Portal. The Portal includes an Interactive Provider Directory with multiple search options to assist PCMH providers in identifying referral providers that are most appropriate for their patients' needs based on location, specialty, gender, language spoken, and whether they are accepting new patients.

Providing access to care outside normal business hours

Providers seeking PCMH status are required to offer access to routine and non-routine care outside of regular business hours, including early morning, evenings, and/or weekends. We encourage providers to develop an after-hours schedule that is responsive to their patients' needs and minimizes time-off from work or school. In recognition of the benefits extended hours offer our members, we will provide enhanced payments for services delivered during the extended time periods. NTC will promote the availability of "after hour" appointments in our directory and will direct enrollees who have problems accessing care during normal office hours to providers with extended hours. For small practices pursuing PCMH status, we will work with providers participating in our Regional Small-Practice Support program to develop a shared after-hours practice. As noted in a study of the use of after-care, such collaborative efforts are especially beneficial for small providers, who reported significant reductions in time spent on after-hour calls, increased job satisfaction and reductions in ED utilization.[2]

Facilitating Open Scheduling and Same-Day Appointments Where Possible

All PCMH providers are required to provide same-day appointments for urgent/acute care services. We do not prescribe a specific number of same-day appointments but encourage providers to track the number of requests for same day appointments to determine the appropriate number of slots. We also expect providers to adjust the number of slots available based on actual utilization and requests. Policies must ensure all patients have access to same day appointments as needed. We will verify compliance based on telephonic checks, monitoring of member complaints and member satisfaction survey results. If we determine members are using ER services because they were unable to obtain a same-day appointment, in addition to providing member education on alternatives, we also will work with providers to determine whether the practice needs to increase the number of same-day appointments.

[2] Journal of General Internal Medicine, "After Hours Care and its Coordination with Primary Care in the U.S.," November 27, 2012. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3475839/

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: (3 page limit)

Through our affiliates' extensive experience operating across 23 states, NTC has established policies and procedures designed to effectively and efficiently manage the network termination or loss of a large-scale provider group or health system. NTC will proactively monitor and manage our network to reduce the risk of losing a health system, while also remaining prepared to implement a comprehensive response that emphasizes and ensures continued member access and continuity of care should this type of event occur.

Proactive Risk Management & Continuous Network Monitoring. Throughout implementation, NTC will build excess capacity into our Nebraska network, keeping in mind access needs related to an array of factors, including geography, cultural/linguistic diversity, and disability/condition. ***As described in Question 38***, NTC's Network team will continually monitor the composition of our network, including the results of access and availability surveys (i.e., using our Quest Heat Maps, through which we are able to align our members' place of residence with provider availability), engaging and contracting with new providers where access issues are identified. NTC's Provider Engagement Representatives, who are "on the ground" throughout the state, will alert NTC leadership at the first sign of provider network abrasion, and our Provider Satisfaction surveys will enable us to identify and address provider (dis)satisfaction. NTC's leadership team will also be cognizant of media reports that address financial, legal, or quality concerns that could compromise the viability of a network hospital or group practice. To ensure compliance with the State requirements and contract standards, and to protect the health and safety of members, NTC may increase the frequency of routine monitoring, conduct onsite visits, and, as appropriate, institute corrective action plans for facilities with a known viability problem or potential for closure. We will perform all of these activities in order to avert losses within our network that could threaten the continuity of care for our members.

- ***Notification to MLTC.***

Notification to MLTC. NTC will not wait until a large-scale provider group or health system termination is formalized to notify MLTC of what has occurred. Instead, we will contact and engage in a dialogue with MLTC as soon as we become aware of the potential for a termination or large scale loss within our network so that we can, in partnership, resolve any significant impact of the loss on our members. NTC will also notify the Nebraska Medicaid Program Integrity Unit (NMPI) in writing within three (3) business days of learning of the potential for any significant changes to the provider network, including in cases where we sever a relationship with a previously debarred or excluded individua/ entity. NTC will notify MLTC when we learn of any termination or loss of a large-scale Provider group or health system.

- ***Coordination with the Pharmacy Benefit Manager (PBM).***

Coordination with the PBM. US Script is NTC's internal Pharmacy Benefit Manager (PBM), and an affiliate company that is also managed by Centene Corporation (Centene). Based on this corporate connection, NTC and US Script work within systems that are already built to communicate pertinent information, making notification of a large scale loss within our network seamless and rapid. US Script team members will be integrated within NTC teams, convening regularly around issues of all types, including those having to do with network adequacy, through a variety of methods (i.e., regularly scheduled meetings, telephonically, and through instant messaging). US Script's POS electronic system feeds directly into NTC's MIS and TruCare systems, making pharmacy-related information exchange with NTC and our provider network simple at all times, including after a network loss.

- ***The automated systems and membership supports used to assist affected members with provider transitions.***

Automated Systems to Assist with Provider Transitions. Should a largescale loss occur within our network, NTC's automated technology systems support our ability to quickly respond and ensure access to care. The Network Data Management component of our integrated MIS automates NTC's provider relationships through continuous data management, including managing termination dates and other data changes arising from the loss of a provider, in an integrated fashion. TruCare, our member-centric health management platform for collaborative care coordination and utilization management provides an integrated clinical record that supports development of a member-level Transition Plan, described in more detail below. Each affected member's Transition Plan includes the member's identified health, behavioral

health, and specialty issues, treatment goals and objectives, milestone dates, and progress in a well-organized online format within TruCare. Further, TruCare also makes the member's integrated care plan available to authorized Provider Portal users. A consumer friendly version of the member's Care Plan is available for the member to access as well, via our secure, web- and mobile-based Member Portal. The Member Portal also allows members to review and select a new provider (that are geomapped within the system for ease of use), and Member Connections Representatives are available to assist members in using this system and/or selecting a new provider through our member call center ***(see Question 28)***.

- ***Systems and policies used for continuity of care of members experiencing provider transitions.***

Systems & Policies for Member Continuity of Care.

NTC will swiftly and effectively take action to correct any network deficiencies associated with this large scale loss, should they occur. NTC will work with MLTC to notify affected members and engage in Transition Planning to ensure continuity of care for affected members.

Member Notification. NTC will provide written notice of a provider's disenrollment from our network to any member that has received services from that provider in the past 12 months. If the network loss involves the member's primary care provider (PCP), notification will also encourage the member to select a new PCP within thirty (30) days and inform the member that NTC will assign the member to a new PCP if the member does not select one. In addition, NTC will contact impacted members who are currently receiving services from an affected provider by phone to assist with the member's transition to a new provider and to provide additional assistance with the provider selection process (alerting members to the availability of resources within the Member Portal and providing information about available resources in their area). If an impacted member with a chronic condition in case management cannot be reached by phone, a Member Connections representative will visit the member at home to explain their options for selecting a new provider and help schedule an appointment or transportation. Following the member's first appointment with their new provider, NTC's Member Services team will follow up with the member by phone to ensure the member is satisfied with the service(s) received.

Member Transition Planning. Our first priority during a large scale provider loss is to ensure that member health, behavioral health, and specialty needs (including pharmacy) continue to be met. To immediately identify the need for a Transition Plan and member support after a network termination, and to obtain information needed to ensure continuity, NTC uses the following sources of information:

- Enrollment data to identify members with a provider who is part of the terminating group or system
- Existing authorizations of ongoing covered services, including data related to members who are currently receiving inpatient-level services and those with an authorization for service at a future date
- Available claims data that identifies specialists and other providers who are part of the terminating provider group or health system and provided services to members within the past 6 to 12 months
- Pharmacy data to identify members with prescriptions written by providers who are part of the terminating provider group or health system, with a focus on medications that indicate a chronic or complex condition that may require ongoing services, including short- or long-acting beta agonists which would indicate asthma or psychotropic medications which would indicate mental illness.

Once we have identified members in need of a Transition Plan to ensure access and care continuity, we use TruCare, our integrated clinical system, to share information with relevant staff and help to develop a member-centric Transition Plan. We use this information to stratify transitioning members for outreach and additional continuity of care supports based on risk. Member Connections and Care Management staff use information available in TruCare to assist members who call the Member Call Center or who are working with Care Management staff during the transition.

Member Information Transfer. NTC uses automated technology systems to facilitate continuity of care for members impacted by provider transitions. NTC's Provider Portal gives new providers access to information about the member's care history, including identified needs, services received, and pharmacy information. In order to ensure there is no gap in care, NTC's Care Management teams coordinate with the member, the existing provider who is leaving the network, and the new provider to assess the member's needs; develop a plan for safely transitioning care to the new provider; and ensure the

Transition Plan and/or Care Plan continues to address the member's needs and preferences. Care Managers use TruCare to support these continuity of care-focused activities, documenting the Transition Plan, adjustments to treatment goals, and other case management actions within TruCare. Case Managers assist with medical record transfer as needed, educate the member about the Transition Plan, and assist as needed with scheduling appointments with the new provider and transportation to services where appropriate. When disruption of services could potentially jeopardize the member's health or mental health, we require and train our Care Management team to prioritize outreach to the receiving provider within one business day of becoming aware of the transitioning member, including but not limited to the following circumstances:

- Pregnant women who are high risk, in their third trimester, or are within thirty (30) Calendar Days of their anticipated delivery date
- The member has a significant medical or behavioral health condition
- The member needs an organ or tissue transplant
- The member is receiving ongoing services such as chemotherapy or radiation
- The member has open authorization for services including but not limited to ongoing outpatient behavioral health services, scheduled surgeries, post-operative follow up, or out-of-area specialty care
- The member is currently in an inpatient facility
- The member is engaged in care management and requires significant and/or complex care coordination support services
- NTC will allow 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.

- ***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.***

Impact of Region-Wide Loss & NTC's Response. NTC's first priority is to make sure that our Members have access to all needed services within the timeframes that are appropriate to their condition and circumstances. If the loss is in a geographic area where other providers of the same type are not available, we will take the following actions:

- Identify and/or attempt to ***recruit providers in close proximity*** who are willing to provide care to transitioning members. NTC will utilize ***local leads*** (i.e., NTC advisory group members, advocates), who can help to target and recruit additional providers to the network, and we will deploy ***local contracting teams*** that will prioritize areas with identified deficiencies
- Arrange for ***non-emergency transportation*** for high risk members for critical treatment
- Utilize ***persuasion strategies*** to attempt to keep the provider in the network, for example, direct outreach from NTC's Medical Director
- Provide an ***Out of Network (OON) authorization***, or enter into a Single Case Agreement with a terminating provider or another OON provider. We will also attempt to engage and contract with the OON provider.
- Implement initiatives to extend the network's current capacity and provide access to specialty care that is no longer available in the member's local area, such as ***telemedicine*** and ***member transportation support***.

The following case study illustrates how one of our affiliates successfully implemented these strategies. NTC's Georgia affiliate experienced a large scale termination of a physician provider system in 2012, a loss that would have caused a PCP deficiency within its network. In order to address these circumstances, our affiliate partnered with a local physician to identify and recruit PCPs in the area who were not employed by the terminating system. As a result, our affiliate was able to recruit the necessary providers to comply with GeoAccess standards and ensure access and continuity of care for its members. Since that time, NTC's Georgia affiliate has successfully negotiated an agreement with the terminating provider system using persuasion strategies, and this health system is once again a valuable member of their network. This reinstatement, along with the new providers recruited into the network, further enhances their network and provides expanded access for their members.

45. Describe the MCO's credentialing and re-credentialing process including: (3 page limit)

Nebraska Total Care's (NTC) credentialing program is built on Centene Corporation's (Centene) extensive experience with credentialing providers in our affiliate programs throughout the country and includes comprehensive written policies, procedures and standards for credentialing, re-credentialing, and ongoing monitoring in full compliance with all applicable federal and State standards, including those required in 42 CFR 438 and 455, Subpart E, and applicable standards of the National Committee for Quality Assurance (NCQA). Our procedures address program oversight, provider types, provider nondiscrimination, the application process and timelines, communication with providers, tracking of credentialing activities, the recredentialing process and oversight of delegated credentialing and recredentialing.

Application Process

To participate in the NTC provider network, providers must submit a completed application and applicable supporting documentation and meet all participation requirements. NTC accepts applications submitted directly by the Provider or via the Council for Affordable Quality Healthcare's (CAQH) Universal Credentialing DataSource. Applications are reviewed to ensure all required fields are completed and required documentation is attached. Providers are promptly notified if applications are incomplete and instructed to provide missing information before the application can be processed. Once the application is complete, we conduct a query of the National Plan Provider Enumeration System (NPPES) to confirm that the practitioner has a current, valid NPI. NTC will confirm with MLTC that the provider is currently enrolled as an approved Medicaid provider, or is in the process of enrolling as a Medicaid provider. We also collect and provide Disclosure forms to the Centene Corporate Compliance department for exclusion checking. Upon notification from the Corporate Compliance department of a ***verified exclusion status*** of an individual or entity with an ownership or controlling interest in the provider or a managing employee of the provider, our Provider Data Management system will terminate the contracting process. In addition, NTC will communicate with MLTC, DHHS Division of Behavioral Health, and DHHS Division of Public Health regarding any incidents or audits that potentially affect provider licensure for any applicable provider type.

Applications with satisfactory inquiry status are forwarded to the Credentialing Department for processing. Credentialing staff will ensure all provider-specified data elements and documents are included, are verified, and are consistent with established thresholds. Credentialing verifies data using primary and secondary source verification, all of which comply with NCQA, State, and federal requirements. Query images and other documentation reviewed (including those retrieved via oral sources) during primary source verification are saved, date stamped, initialed, and placed in the applicant's file prior to the credentialing decision. Applications meeting thresholds for "clean files" will be presented to the Chief Medical Director for review and approval. Applications failing to meet "clean file" credentialing thresholds are submitted to the Credentialing Committee for review, further research as needed, and a decision.

NTC's Quality Assurance and Performance Improvement Committee (QAPIC) will have direct responsibility for the credentialing program, activities and policies. The Credentialing Committee will report to the QAPIC, which reports to the NTC Board of Directors. The Credentialing Committee, chaired by the Chief Medical Director (CMD), will oversee the credentialing process and evaluate credentials and professional conduct and will be responsible for acceptance, deferment, or denial of a provider's application. The Credentialing Committee is also responsible for reviewing monthly reports to measure compliance with credentialing standards. Through the Credentialing Committee, we will also incorporate local best practices and ensure that any issues expressed by the provider community are expediently addressed. For example, as a part of our wider partnership with Vest Psychiatric Services, described in detail in the answer to question 40, we will provide training to our staff to streamline the credentialing process for Nurse Practitioners. We will address concerns, such as the inconsistencies experienced by tribal community providers completing the credentialing process, by ensuring that our application process is accessible and configured appropriately for Native American providers.

Ensuring that providers are enrolled in Medicaid and have a valid identification number

Medicaid Enrollment Verification

NTC will require that all contracted providers be enrolled with MLTC as an approved service provider. Upon receipt of a credentialing application, we will confirm the provider has a valid Medicaid Identification number. We understand MLTC has implemented new provider enrollment processes beginning December 1, 2015 and we will follow whatever procedure MLTC requires for obtaining confirmation of enrollment. Providers who have submitted an application as a Medicaid provider but have not yet been approved will be allowed to begin the credentialing application process while they await a decision by MLTC. Applications will go through the standard credentialing review process and, if necessary, may be pended until the Medicaid provider application is approved or denied. Once approved, NTC can confirm a Valid Identification Number has been issued.

Obtaining information on ownership and control

Obtaining and Reviewing Information on Ownership and Control

In compliance with federal and State requirements, we obtain information from contracted providers and any individuals and/or entities having a 5% or more direct or indirect ownership or a controlling interest in the entity and all other requirements delineated in 42 CFR 455.104, which we use to determine whether any individual has federal sanctions that would prohibit us from reimbursing the provider for services provided to a member. NTC collects and provides disclosure forms to the Corporate Compliance department for monitoring of exclusion checking. Upon notification from the Corporate Compliance department of a verified exclusion status of an individual or entity with an ownership or controlling interest in the provider or a managing employee of the provider, the contracting process will be terminated.

Identifying excluded providers and persons convicted of crimes searches

Identification of Excluded Providers

Searches will be conducted on all credentialing and recredentialing applicants and compared against the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) list of Excluded Individuals/Entities and the System for Award Management (SAM), the Social Security Death Master File (SSDMF) and the National Practitioner Data Bank (NPDB). During initial credentialing, recredentialing, and as part of monthly ongoing monitoring between recredentialing cycles, we consistently monitor providers for loss of licensure, exclusions, as well as other sanctions and fraud and abuse violations.

Criminal History and Abuse Checks. Member safety and security is a top priority for NTC, and conducting thorough background checks of our providers is an important tool for ensuring our providers are qualified to treat our members. As part of the assessment and reassessment for participation process and in accordance with NCQA requirements, all applicants are required to provide information on any criminal convictions. We also require criminal background checks, abuse registry lookups, and other required checks for all Long Term Services and Supports (LTSS) providers. This includes LTSS providers who are not employees of a provider agency, such as self-direction service providers. On an ongoing basis, we continually monitor for loss of licensure and OIG exclusions as well as other sanctions and fraud and abuse violations.

Credentialing Committee Review and Decision. Nebraska Total Care's Quality Assurance and Performance Improvement Committee (QAPIC) will have direct responsibility for the NTC credentialing program, activities and policies. The Credentialing Committee will report to the QAPIC, which reports to the NTC Board of Directors. The Chief Medical Director (CMD) will have direct responsibility for the credentialing program and participate in monthly credentialing meetings and other activities related to the credentialing and recredentialing programs. The Credentialing Committee will include network physicians and will oversee the credentialing process and evaluate each applicant's credentials and professional conduct and will be responsible for acceptance, deferment, or denial of a provider's

application. The Credentialing Committee is also responsible for reviewing monthly reports to measure compliance with credentialing standards.

Credentialing Cycle Time. NTC will complete the credentialing process and will load approved providers in our electronic provider file within 30 days following receipt of a complete credentialing application. This information will be included in NTC's weekly electronic provider file submitted to MLTC. Denied applicants will receive written notification of the decisions with a description of his/her appeal rights. To accommodate periods of heavy demand, such as prior to and immediately following implementation, Credentialing will utilize additional staff typically dedicated to other markets. Additionally, Centene has agreements with Credentialing Verification Organizations (CVOs) that may be used to assist in handling heavy volumes. NTC will seek MLTC approval prior to utilizing these CVOs. To ensure ongoing compliance with required timeframes, the QAPIC monitors key credentialing indicators quarterly to ensure that we are compliant and complete initial credentialing and recredentialing within required timelines. NTC will recredential all providers at a minimum of every 36 months. A series of recredentialing notices will be sent to providers at 180, 120, and 60 days prior to the due date, as needed. Our Provider Relations staff will also call any Providers who fail to respond to credentialing notification where there is a potential for recredentialing failure which would result in network termination.

Ongoing Monitoring. To ensure we are compliant with all federal, State and organizational requirements, we will record credentialing activities for all provider types in our Provider Data Management software platform. Credentialing staff will conduct ongoing monitoring and reporting to ensure continued compliance with credentialing and re-credentialing timeframes and compliance with all credentialing standards and policies. Staff will ensure that network providers have not incurred exclusions, licensure sanctions, legal activity, or other negative indicators in between or prior to their standard recredentialing through routine monitoring of all providers in the network.

Acceptance of CAQH Application Submissions. NTC also accepts credentialing applications submitted via the standard Council for Affordable Quality Healthcare's (CAQH) Universal Credentialing DataSource, which simplifies the administrative process for providers who choose to participate. Providers may contact CAQH or NTC for assistance with submitting through CAQH. Applications submitted through CAQH are subject to the same review and data verification process as applications submitted directly to NTC.

Using quality and utilization measures in the recredentialing process

Using Quality and Utilization Measures in the Recredentialing Process

Upon recredentialing, NTC will review member complaints and appeals, utilization management, and Quality of Care performance. Our Quality Improvement staff will submit detailed logs of complaints, related quality review site visits/results, and corrective action plans, all of which are updated on regular basis. We also will review annual and/or quarterly profile reports for high volume PCPs, specialists, and acute care hospitals. Examples of profile measures include:

- **Member Access to Care:** Appointment availability, after-hours access, after-hours linguistic access
- **Member Satisfaction:** Member Complaints; average months of enrollment
- **Quality:** QOC complaints; % of 0-15 months old/3-6 year olds/adolescents receiving appropriate well visits; outpatient follow-up visit within 7 days after inpatient mental health event discharge
- **Utilization:** ED, outpatient, PCP, specialty office visits/1,000; inpatient admits/1,000; timeliness of screenings; readmission rate; average length of inpatient stay

For providers not identified as high volume, QI and Credentialing staff monitor member and Quality of Care complaints on an ongoing basis and for the 36 month period preceding recredentialing.

(2 page limit)
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.

An Integrated Management Information System (MIS) Enabling Provider File Data Integrity. Nebraska Total Care (NTC) will maintain its provider file through the use of our Provider Relationship Management (PRM) system: an integrated component of our enterprise MIS supported by our parent, Centene Corporation (Centene). PRM collects, stores, and exchanges provider data to and from internal and external sources (including State Medicaid systems such as Nebraska's MMIS). Our Provider Data Management Department (PDM) enters and updates provider data solely in PRM, ensuring that all Provider data comes from one governing source in our MIS to support claims processing, provider payment, encounter data production, reporting systems, care and utilization management, online provider directories, and Provider and Member Portals and Mobile Applications. PRM accepts credentialing information from providers electronically through an interface with the Council for Affordable Quality Health's (CAQH) ProView Universal Provider Database, and PRM can also be configured to receive credentialing information in other formats, should the Administrative Simplification Committee and/or MLTC adopt an alternative credentialing form. NTC's affiliate Health Plans maintain full NCQA Health Plan Accreditation for Medicaid and state-funded health programs in 15 states, which includes NCQA approved processes for Provider credentialing and requisite data management, the same NCQA best practices that NTC will employ for Heritage Health.

Nationwide, our Provider Relationship Management (PRM) system manages the integrity and completeness of over 230,000 Provider records, supporting accurate payments for over 60 Million Managed Medicaid claims/year.

Ensuring Sufficient Information to Pay Providers. As part of our contracting and credentialing process, PDM staff enters all information in PRM outlined in the RFP IV.I.15.a, including provider demographic, specialty, location, affiliation and related information, provider name, group name, W-9 form showing legal entity name and tax identification number (TIN), taxonomy code, address, effective date, end date, specialty, Medicaid ID number (e.g. Nebraska's 11 digit Provider ID number), Service Location(s), payment information, NPI number, and licensing/credentialing information. The provider's financial affiliation(s), license status, specialty/practice type, and pay class (which incorporates the provider's contractual relationship with NTC) support our claims payment processes. We also regularly perform ongoing reconciliation with CMS' NPPES (National Plan and Provider Enumeration System) to ensure accuracy in NPIs and we can use MLTC provider data files for ongoing validation of Nebraska Medicaid IDs, in a process very similar to what our affiliate health plans do routinely for Medicaid across the nation. We can also support Nebraska Medicaid provider types and specialty codes in PRM.
PRM is fully capable of sending weekly electronic provider files to MLTC (per RFP IV.I.14.b) and supports similar processes today in our affiliate health plans.

Issuance of 1099 Forms. PRM is completely integrated with our claims processing and payment system, which enables our Finance Department (as required by Federal Law) to issue 1099 forms for all providers (network and out-of-network) who received claims payment of $600 or more in the previous tax year. PDM staff review and validate the accuracy of our master provider file at regular intervals throughout the year, which allows for an efficient and timely 1099 issuance process in January. NTC's Chief Financial Officer (CFO), in conjunction with the Centene's CFO, will be responsible for ensuring accuracy and overseeing proper issuance of NTC 1099 forms by January 31st of each year.
Provider Service Support. PRM is also integrated with the Customer Relationship Management (CRM) component of our integrated MIS. CRM offers enterprise level call center support for provider inquiries, outbound campaigns, targeted outreach, and unified provider communications across all the venues in

which providers interact with NTC (phone, fax, email, mobile platforms or web). Providers will be able to contact the NTC provider call center for prompt assistance on any topic, including questions concerning 1099s, claims payments, or other administrative matters.

Meeting Federal and MLTC Reporting Requirements. NTC will use the Centelligence™ reporting component of our MIS to meet all Federal and MLTC reporting requirements, including reporting mandates related to provider information. Centelligence™ is our family of integrated decision support and health care informatics solutions, integrated with all other core components of our MIS, including PRM and our master provider file, CRM, and our claims processing system. Centelligence™ provides expansive business intelligence support, including flexible desktop reporting and online Key Performance Indicator Dashboards with "drill down" capability. Centelligence™ also includes integrated geo-mapping capability allowing us to regularly monitor and report on our provider network adequacy, as well as ensure that we meet or exceed access standards. We also integrate provider information from our subcontractors in Centelligence™, including pharmacies, Behavioral Health (BH) providers, and vision specialists, enabling us to report on these providers as well.
PDM also collects provider ownership disclosure forms as part of our provider enrollment process and our compliance department checks the owner names, which allows us to capture and report on information related to 42 CFR §455.104 Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.

Cross Referencing State and Federal ID Numbers. PRM uses the National Provider Identifier (NPI) as its Internal ID for Providers. This allows PRM to link multiple Provider identifier types (e.g. state specific Medicaid ID's such as Nebraska's 11 digit Medicaid ID) to one NPI. Having the NPI as the "master identifier" in PRM also allows us to link the NPI to multiple financial affiliations, TINs and billing address information and specialties. Integrating provider IDs in this manner allows us to efficiently, regularly, and accurately monitor Federal and State based agencies for excluded providers. During credentialing, PDM Analysts validate that NPI numbers submitted on applications (or listed in the applicant's CAQH registry) match the NPI in NPPES. Our NCQA credentialing process also includes a search of Federal and State exclusions lists, such as the US Department of Health & Human Services Office of Inspector General's List of Excluded Individuals and Entities (LEIE), General Services Administration's (GSA) Excluded Parties List Service (EPLS, also known as the System of Award Management (SAM)), CMS' Medicare Exclusion Databank (MED), State Board of Examiners, State Licensure Units (such as DHHS' Licensure Unit) and the National Practitioner Data Bank (NPDB) to discover if any sanctions or practice/licensure restrictions have been implemented against the applicant. In between credentialing and recredentialing cycles, we obtain sanction-related information through PRM's systems interface with CAQH. As a part of recredentialing, our NTC Provider Relations team will verify that each provider is properly licensed in accordance with Nebraska law and regulations.

Providers excluded from participation with Medicare or Medicaid, or who have a revoked/suspended Medicaid/Medicare ID number, will not be eligible to participate with NTC. Safety features built into our PRM system ensures no provider on an Exclusion List is eligible to treat patients or receive payment.

Preventing Payment to Excluded Providers. Our Claims Processing Subsystem contains adjudication logic that intercepts and prevents claims from advancing to payment status for providers found to have Federal or State exclusion status.

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IV.I ATTACHMENTS

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Attachment 38
Network Development Plan

Network Development Plan

Submit plan for developing an adequate provider network within the timeframe described in Section IV.I - Provider Network.

Overview

The following detailed work plan and corresponding narrative demonstrate NTC's strong capacity for developing an adequate provider network within the timeframes prescribed in Section IV.I of the RFP, as well as the proven methods NTC will employ on an ongoing basis to assess and ensure that MLTC's network standards are maintained and exceeded. NTC acknowledges and agrees that, from the date of contract award and then every two weeks until the contract effective date, NTC will be expected to provide updates about our network development activities to include, in detail, NTC's network status, corresponding Quest Analytics reports, descriptions of any provider network gaps, and NTC's remediation plans. Further, NTC acknowledges that future network development plans must be submitted by November 1st of each contract year, and that such documents serve as an assurance of the adequacy and sufficiency of NTC's provider network. NTC will also submit, as requested by MLTC, an updated plan when there has been a significant change in operations that would affect adequate capacity and services such as, but not limited to, changes in services, covered benefits, payments, or eligibility of a new population. NTC will include in such future network development plans all components set forth in Section I.16 Network Development Plan of the RFP.

In Nebraska we will prepare the Network Development Plan using the following materials to ensure compliance: MLTC contract templates, RFP requirements, Covered Services, and MLTC access standards. We will train all network staff to ensure competence and knowledge of all Nebraska requirements and continue our meetings with our key Nebraska partners such as ENHANCE Health Network, CHI, the Nebraska Hospital Associations, the Behavioral Health Regions, and FQHCs to understand practice and referral patterns, Provider needs/concerns and any population nuances throughout the state.

Tasks and Timeframes

The following table describes our network development plan to ensure that the NTC provider network satisfies MLTC, NCQA, and internal access and availability standards for Nebraska Medicaid members:

Task Name	Start Date	Finish Date	Status	Accountable Team
Network Development / Provider Credentialing / Provider Relations				
Network Development				
Customize Policy & Procedures for NE Requirements including non-discrimination and mainstreaming of NE Medicaid members	3/15/2016	6/1/2016	On Target	Network Contracting
Hire, train local contracting staff / mobilize business development contracting resources	1/1/2016	4/5/2016	On Target	Network Contracting
Obtain current NE provider list from MLTC / purchase lists, as needed	Current	3/1/2016	On Target	Network Contracting
Meetings / Relationships with Key Provider Associations/community agencies/advocacy groups	Current	Ongoing	On Target	Network Contracting
Develop Network Development Plan & Strategy specific to NE Requirement (key providers, expertise & commitment to BH principles, adequacy requirements)	Current	6/1/2016	On Target	Network Contracting
Primary Care Provider / Specialist strategy (include direct access for members with SHCN criteria)	Current	6/1/2016	On Target	Network Contracting
Behavioral health provider strategy	Current	6/1/2016	On Target	Network Contracting
Hospital / Facility strategy	Current	6/1/2016	On	Network

			Target	Contracting
FQHC / RHC strategy (notify MLTC if contract cannot be reached)	Current	6/1/2016	On Target	Network Contracting
ACO / Health System strategy	Current	6/1/2016	On Target	Network Contracting
PCMH strategy and requirements (submit PCMH implementation within 90 days)	Current	6/1/2016	On Target	Network Contracting
Methods to improve ability of BH provider s to meet all health needs / integrated care	Current	6/1/2016	On Target	Network Contracting
Pharmacy network (Medicaid network in good standing with MLTC)	Current	6/1/2016	On Target	Network Contracting
Specialty pharmacy (MLTC review and written approval 45 days of designated specialty drugs)	Current	6/1/2016	On Target	Network Contracting
Establish value based contracting strategy (30% by 3rd year)	Current	Ongoing	On Target	Network Contracting
Develop network tracking and reporting (CRMP system)	11/1/2015	3/1/2016	On Target	Network Contracting
Implement Contract Processing System and Resources	1/1/2016	3/1/2016	On Target	Network Contracting
Configure systems / Geos to track adequacy (Attachment 2 - Access standards); Submit exception requests to MLTC, if needed	1/1/2016	1/1/2017	On Target	Network Contracting
Provider Contracting Adequacy Completed	1/1/2016	10/1/2016	On Target	Network Contracting
Draft Contract packet approved by MLTC (standard documents, contract, credentialing, FAQ)	1/1/2016	4/1/2016	On Target	Network Contracting
Provider Contracts developed / approved with all State requirements	1/1/2016	3/1/2016	On Target	Network Contracting
Implement Contracting Strategy (mailing, telephonic, face to face, key provider)	3/15/2016	1/1/2017	On Target	Network Contracting
Monitor and Track Progress / Adjust Resources and Methodology, as needed	3/15/2016	1/1/2017	On Target	Network Contracting
Develop and Implement special contracting for behavioral health requirements and commitment	3/15/2016	1/1/2017	On Target	Network Contracting
Develop and Implement National Contracting Strategy (state specific contract amendments)	3/15/2016	1/1/2017	On Target	Network Contracting
Develop and Implement Subcontractor strategy including contracting and oversight--Vision, Lab (CLIA), Radiology	3/15/2016	1/1/2017	On Target	Network Contracting
Develop transportation strategy	3/15/2016	6/1/2016	On Target	Network Contracting
Develop chiropractic strategy	3/15/2016	1/1/2017	On Target	Network Contracting
Develop P4P Incentive Program	3/15/2016	1/1/2017	On Target	Network Contracting
Network Adequacy Provider file to MLTC via provider enrollment file minimum of 90 calendar days prior to start	3/15/2016	1/1/2017	On Target	Network Contracting
Audit Find a Provider (FAP)	9/1/2016	Ongoing	On Target	Network Contracting
Customize Credentialing Policy & Procedures (30 calendar days to complete, include subcontractor) - submit to MLTS for approval	1/1/2016	4/1/2016	On Target	Provider Data Mgmt. (PDM)

Assure all providers enrolled with MLTC	1/1/2016	Ongoing	On Target	Network Contracting
Hire and train new staff	3/15/2016	10/1/2016	On Target	Provider Data Mgmt. (PDM)
Configure Emptoris (contract management system)	3/15/2016	5/1/2016	On Target	Provider Data Mgmt. (PDM)
Create credentialing NE packet (State specific and non-standard requirements / state validation sources)	1/1/2016	4/1/2016	On Target	Provider Data Mgmt. (PDM)
Configure Portico (provider management system / hierarchy & business unit configuration)	3/5/2016	5/1/2016	On Target	Provider Data Mgmt. (PDM)
Load Provider information into Portico with required information (evaluate loading state data provided, as contracts received)	3/15/2016	1/1/2017	On Target	Provider Data Mgmt. (PDM)
Audit Provider Load Information	8/1/2016	Ongoing	On Target	Provider Data Mgmt. (PDM)
Portico to Amisys interface configuration complete	5/1/2016	10/1/2016	On Target	Provider Data Mgmt. (PDM)
Conduct Credentialing Committee meetings (increased frequency as needed)	5/1/2016	Ongoing	On Target	Provider Data Mgmt. (PDM)
Provider Relations				
Customize Policy & Procedures for NE Requirements (including appointment availability and referral access)	3/15/2016	6/1/2016	On Target	Provider Relations
Hire and Train Provider Relations Staff (available 7 am - 8 pm for PR; 8 to 8 for clinical RX, anytime for non-routine/ emergent)	5/1/2016	10/1/2016	On Target	Provider Relations
Define Provider Engagement / Relations Strategy (including BH integration)	3/15/2016	7/1/2016	On Target	Provider Relations
Configuration of provider call center, separate RX line or menu option	3/15/2016	1/1/2017	On Target	Provider Relations
Identify key providers and associations (collaborate with contracting)	3/15/2016	5/1/2016	On Target	Provider Relations
Develop Provider Training and Outreach Plan (includes website)	5/1/2016	7/1/2016	On Target	Provider Relations
Develop Provider Handbook with all requirements, MLTC approval calendar days prior , post to website	6/1/2016	10/1/2016	On Target	Provider Relations
Provider Billing Manual updated	6/1/2016	11/1/2016	On Target	Claims/Config
Develop additional provider training materials, State review / approval	6/1/2016	1/1/2017	On Target	Provider Relations
Turn on online provider directory and print directory	10/1/2016	10/1/2016	On Target	Provider Relations
Conduct Provider "town halls" provider forums	9/1/2016	Ongoing	On Target	Provider Relations
Conduct Provider Orientations within 30 days of contracting(welcome packet / orientation materials)	9/1/2016	1/1/2017	On Target	Provider Relations
Conduct provider " Open Mic " calls and/or other implementation provider outreach, as needed	9/1/2016	Ongoing	On Target	Provider Relations
Establish Provider Advisory Committee (RX, BH providers included)	3/15/2016	1/1/2017	On Target	Provider Relations
Establish monthly provider newsletter	8/1/2016	Ongoing	On Target	Provider Relations

Provide encryption software on request to provider to allow exchange of member data via email	9/1/2016	1/1/2017	On Target	Provider Relations
Establish provider complaint system (submit to MLTC 45 days prior)	6/1/2016	10/1/2016	On Target	Provider Relations

Ensuring and Assessing Geographic Distance Access Standards. In accordance with the requirements set forth in "Attachment 2 – Access Standards", NTC shall ensure compliance with the geographic distance access standards set forth below. NTC acknowledges that the classification of counties as urban, rural and frontier is included in "Attachment 3 - Nebraska Counties Classified by Urban/Rural/Frontier Status", with classifications based upon data from the most recent U.S. Census.

Provider Type	Access Standard
Primary Care Physicians	Two or more contracted PCPs within 30 miles of the personal residences of members in urban counties; one or more contracted PCPs within 45 miles of the personal residences of members in rural counties; one or more contracted PCPs within 60 miles of the personal residences of members in frontier counties.
High-Volume Specialists (including cardiologists, neurologists, hematologists/oncologists, OB/GYNs, and orthopedic physicians)	One or more high-volume specialist within 90 miles of the personal residences of members
Retail Pharmacies	Through its fully integrated affiliate, NTC shall provide one or more network retail pharmacies within five miles of 90% of members' personal residences in urban counties; one or more network retail pharmacies within 15 miles of 70% of members' personal residences in rural counties; and one or more network retail pharmacies within 60 miles of 70% of members' personal residences in frontier counties.
Behavioral Health Inpatient and Residential Service Providers	NTC will 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. In the event MLTC determines that no inpatient providers are available within the access requirements, NTC will develop alternative plans for accessing comparable levels of care, instead of these services, subject to MLTC approval.
Behavioral Health Outpatient Assessment and Treatment Providers	NTC will provide adequate choice of behavioral health outpatient assessment and treatment providers within 30 miles of members' personal residences in urban areas; two or more providers within 45 miles of members' personal residences in rural counties; and two or more providers within 60 miles of members' personal residences in frontier counties. In the event rural or frontier county access requirements cannot be met due to lack of behavioral health providers, NTC will utilize telehealth options.

Measuring and Monitoring Compliance with Geographic Distance Access Standards. Using our best-in-class network access mapping tool, NTC will ensure compliance with geographic distance access standards primarily through regularly-scheduled network mapping exercises and ongoing monitoring activities. NTC's Network Leadership will generate Quest Analytics tables and maps to plot member and provider locations by zip code and analyze the information, considering the prevalent modes of transportation available to members against our distance standards and those developed by the State. Quest Analytics is a "best in class" network access mapping software that enables us to measure access using multiple variables and to quickly assess travel distance issues. Prior to the program start date, we will conduct access mapping on a weekly basis for the provider types most relevant to members. After implementation, we will conduct such network accessibility mapping at least monthly until six months after go-live or until travel distance standards are met. At that point, we will begin network access

mapping every quarter (or per State requirements) as a component of our broader semi-annual Access and Availability Evaluation and to submit required network reports to the State. The Director of Provider Relations and Network Development will lead the scheduled departmental reviews of Quest Analytics tables and maps. The maps provide a visual, high-level view of any gaps. The tables use actual member residence data and allow us to identify at the zip code level any coverage gaps. The tables also will show the municipality and county in which each zip code is located. At a minimum, the provider specialties we will review include, but are not limited to:

- Allergy
- Cardiology
- Dermatology
- Endocrinology
- Family/General Practice
- Gastroenterology
- General Surgery
- Internal Medicine
- Neonatology
- Nephrology
- Neurology
- Neurosurgery
- Obstetrics and Gynecology
- Occupational Therapy
- Oncology/ Hematology
- Ophthalmology
- Orthopedics
- Otolaryngology
- Pathology
- Pediatrics
- Physical Therapy
- Psychiatry (adult)
- Psychiatry (child and adolescent)
- Radiology
- Reconstructive Surgery
- Rheumatology
- Speech Therapy
- Urology

Ensuring and Assessing Appointment Availability Access Standards. NTC will ensure compliance with appointment availability access standards in accordance with all requirements set forth in "Attachment 2 – Access Standards". As further described in our response to Question 41, NTC will audit compliance with appointment access and wait time standards, as well as physician 24-hour availability, through our formal quarterly audit program. We will conduct all audits in a non-punitive way, using primarily outside vendors with follow-up education and remediation conducted by NTC's Provider Relations (PR) staff. In addition, we will monitor compliance using other approaches such as through our Post Primary Care Physician (PCP) Appointment Survey Program; during onsite Provider Relations (PR) Representative Provider office visits; through the analysis of CAHPS member satisfaction (for both appointment availability and wait times) and Provider Satisfaction Survey, member and provider Complaint/Appeal, utilization management and other data; and from input received from our members and providers through call center inquiries and Advisory Committee feedback. A formal, comprehensive analysis of PCP service hours is performed annually, the results of which are reported to NTC's Quality Assessment and Performance Improvement Committee (QAPIC). Although an undesirable outcome, consistent failure to meet approved standards is grounds for dismissal from the NTC provider network.

Ensuring and Assessing Cultural Competency among Network Providers and Subcontractors. NTC will build upon the *experience* and *successes* of our parent company, Centene, whose health plans have provided culturally competent services to all members, including those with Limited English Proficiency (LEP), those with disabilities, and those with diverse cultural and ethnic backgrounds for more than 30 years. NTC will meet State and federal requirements (per 42 CFR 438.206), but is also committed to fostering a culturally competent environment among our network providers and subcontractors. Building upon this foundation, NTC will support the delivery of services in a culturally competent manner, with the expectation that all members be treated with dignity and respect. These values are fostered through provider and subcontractor training to ensure a network that reflects the diversity of our membership.

NTC analyzes population data available through the U.S. Census, the FQHC Uniform Data System, and utilization of our free interpretive services and translation requests to ensure our network reflects the culture of our members. We recruit providers from within communities we know have a high prevalence of non-English speaking members. Although language is one measure of diversity, NTC recognizes the

importance cultural competency has in engaging and retaining members in care and providing services that meet their needs.

Promoting Culturally-Appropriate Care through NTC's Provider Network. Culturally-appropriate care by its very nature is delivered by a provider who can relate to the member, beyond language, and provide services and support with ***sensitivity, understanding, and respect for the member's culture***. We have designed our care management and service delivery model and processes to identify and respond to what is important to each individual, including strengths, goals and cultural considerations, so each member understands how and why to access appropriate care, feels comfortable, and is empowered to do so. Our MemberConnections Representatives, staff hired from the communities we serve to provide on-the-ground member service, offer invaluable insights unmet community needs which may have the potential to be resolved at the provider level. When developing provider outreach and engagement strategies, we take into account all cultures. For example, NTC is committed to serving our Native American members through engagement with and inclusion of Tribal providers; we continue to communicate with each of the tribes headquartered in Nebraska to ensure their awareness of service availability. Additionally, we are aware of the Somalian and Micronesian refugee populations located in Lincoln, and that refugees are eligible to receive eight months of Medicaid coverage. We are committed to ensuring these members receive culturally-appropriate care through our provider network. In speaking with providers across the region, an FQHC in Omaha shared that its ZIP code, 68111, has a very high level of child poverty, a 26% unemployment rate, and that the significant migrant and refugee populations result in 25 different languages spoken among their patient base, 16% of which speak English as their 2nd language. The top notable languages outside of English that have been mentioned by providers across Nebraska include Spanish, Kurtish, Vietnamese, Sudanese, Somalian, Syrian and the Micronesian languages. NTC will create an environment of cultural awareness by implementing the NCQA Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards), as well as the Americans with Disabilities Act standards for the basis of programs and policies. Our policies and procedures, administration and service practices the value of providing culturally competent care, including honoring members' beliefs, sensitivity to cultural diversity, and fostering in providers and subcontractors attitudes and interpersonal communication styles which respect to members' cultural backgrounds. These policies and procedures are communicated to all providers and subcontractors to ensure we are creating an environment of cultural competency for the member. Implementing CLAS standards provides us clear direction to ensure that we provide culturally competent services to our members. We will implement and conduct continuous quality improvement for the CLAS standards, through implementation of our Cultural Competency Plan and provider and subcontractor training in collaboration with local advocacy and community groups. Adhering to the CLAS standards, we will work to minimize physical, mental, and cultural barriers to care and to preserve the dignity of our members. Additionally, we encourage our providers to assess their practice using CLAS standards and offer our provider network training resources on culturally competent health care such as the *Physician Toolkit and Curriculum: Resources to Implement Cross-Cultural Guidelines for Medicaid Practitioners* available at https://www.thinkculturalhealth.hhs.gov/Content/ContinuingEd.asp. This will be located in the located in the Practice Improvement Resource Center on the Provider Portal. Building on best practices established in our affiliate health plans, NTC will establish a CLAS Task Force that will be responsible for the oversight and maintenance of our framework and commitment to ensure that members receive care and services that are delivered in a culturally and linguistically sensitive manner. Chaired by our Vice President of Compliance, the Task Force will include management staff from our Customer Services, Provider Services, Contracting and Network Development, Medical Management, and Quality Departments, as well as our Chief Medical Officer (CMO) and other senior leadership staff. The Task Force evaluates the effectiveness of our cultural competency strategies and initiatives, and reports results to our Quality Assessment and Performance Improvement (QAPI) Committee, which incorporates relevant data and information in our annual QAPI Work Plan and subsequent QAPI Evaluation. The

CLAS Task Force will meet quarterly, and will annually update the Cultural Competency Plan and evaluate the effectiveness of cultural competency strategies, including interpreter services provider training.

Ensuring and Assessing After-Hours Provider Access Standards. NTC will ensure that members in all areas of the service region have access to providers who offer morning care before 8:00 AM, evening care after 5:00 PM and weekend hours, in addition to scheduled daytime hours. Our approach includes promoting physicians to become PCMH certified where extended hours are a requirement of that program.

NTC Encourages Providers to Expand Service Hours. During provider contracting and orientation, NTC staff will solicit information regarding available office hours. NTC will proactively support and monitor providers in their efforts to ensure or expand access through increased hours of operation. For our members' convenience, providers' morning, evening and weekend hours are noted in the Provider Directory and online via Find-A-Provider functionality. One of the best examples of an NTC affiliate engaging with providers to develop creative solutions for expanding service hours comes from Louisiana Healthcare Connections (LHCC). During regular meetings with closely engaged practices in LHCC's network, they brought up the concern of patients visiting the Emergency Room (ER) and Urgent Care (UC) clinics instead of calling or coming to their PCP's office/medical home. Some members simply used these alternatives because their PCP's office was closed after normal business hours. The practices expressed interest in remaining open for longer hours, but not being able to cover the cost of staffing to do so. The LHCC finance team worked with one of Centene's corporate actuaries to research usage of ER and UC amongst our members since 2014. In November 2015, a financial model was developed that determined if LHCC enhanced the reimbursement for after-hours CPT codes, the practices could choose to staff and remain open. Additionally, LHCC could keep members connected with their medical home after hours and reduce unnecessary costs (testing, inaccurate diagnoses, inaccurate prescriptions) attributed to care in the ER and UC's. Not only does this provide access to working families who cannot schedule routine appointments during normal office hours, it gives our providers and members the opportunity to increase access in the evenings, weekends and holidays in their medical home.

NTC Requires 24-Hour Accessibility And After-Hours Coverage. Regardless of whether PCPs offer morning care before 8:00 AM, evening care after 5:00 PM, or weekend hours, NTC requires that a PCP or designee must be available via an answering service, pager, or instructions that provide members with access to an on-call medical professional any time of day. NTC will arrange for members to receive transportation services to and from after-hours and weekend provider appointments. NTC will monitor compliance with accessibility and after-hours coverage standards by conducting regular "secret shopper" access surveys, the results of which are reported to NTC's QAPIC.

Ensuring Network Inclusion of PCPs. NTC shall consistently demonstrate that each member has an ongoing source of primary care appropriate to his or her needs and a person formally designated as primarily responsible for coordinating the health care services furnished to the member. NTC's Primary Care Provider (PCP) program will include all of the traditional specialty options for the provision of primary care services (internal medicine, family practice, general practice, pediatrics and OB/GYN) plus the inclusion of additional physician specialties based upon the individual member's health status, chronic health conditions, and/or individual care plan. Thus, an individual member who might benefit by having a cardiologist, oncologist, pulmonologist, endocrinologist, psychiatrist or other specialist effectively serve as his or her primary medical provider can choose a specialist as their PCP that best understands and can meet their needs. Additionally, with the enactment of recent legislation, NTC is committed to expanding member access to primary care through the inclusion of nurse practitioners, with oversight from a PCP, in to our provider network.

Ensuring Network Inclusion of Behavioral Health Providers. NTC's behavioral health (BH) team has managed behavioral health services for numerous state Medicaid, CHIP and special needs populations for more than 20 years. To ensure network adequacy in anticipation of additional membership and varying

groups of Medicaid enrollees in Nebraska, our BH team has developed partnerships with appropriately credentialed behavioral health providers to assure the availability of behavioral health services to both adults and children and to meet the access requirements as described in "Attachment 2 – Access Standards". Our BH team has secured agreements with regularly utilized BH provider groups including Boy's Town and each of the state's six BH regions, and is currently reaching out to all mental health authorities within Nebraska. Our Nebraska BH provider network will consist of:

- BH Outpatient Facilities
- BH Hospitals
- BH Outpatient Therapists and Prescribers
- FQHCs
- Substance Use Disorder (SUD) Facilities

The BH Outpatient therapists (groups and individuals) are comprised of MDs, ARNPs, Physician Assistants (PAs), PhD Level and Master's Level Psychologists, and Social Workers/Professional Counselors/Marriage and Family Therapists.

BH Telemedicine Services in Nebraska. Our BH team is developing innovative partnerships with Nebraska BH providers in collaboration with medical providers to address the needs of children in rural areas who have historically had limited access to both physical and behavioral health services. Specifically, NTC has been working with CHI Health's network of providers to make behavioral health services available to members in rural areas. NTC also will utilize telemedicine to serve both adult and pediatric populations effective January 1, 2017.

Ensuring Network Inclusion of High-Volume Specialists. NTC's specialist physicians will include a robust network of specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical and behavioral health needs of the Nebraska populations we will serve without imposing excessive travel requirements on our members.

Ensuring Network Inclusion of Federally Qualified Health Centers and Rural Health Clinics. Because NTC recognizes that each Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) throughout the state has different needs, NTC has individually met in-person on multiple occasions with and is working to formalize partnerships with all seven FQHCs in Nebraska, in addition to All Care, located in Council Bluffs, Iowa. The NTC team has also met with many RHCs located throughout Nebraska. In the event a contract cannot be reached between NTC and any FQHC or RHC, NTC will notify MLTC. Additionally, NTC has entered into a formal partnership with HCAN, Nebraska's Primary Care Association. NTC's partnership with HCAN will serve as the lynchpin of efforts to facilitate collaboration and explore synergies between Nebraska's FQHCs. We will also seek to facilitate collaboration between the FQHC community and other partners such as the behavioral health regions. For example, we learned during a visit to Midtown Health Center in Norfolk that the Midtown would like to explore ways to better coordinate services and share data with Region 4 Behavioral Health and Faith Regional Health Services. NTC recognizes that as the common denominator in partnership with all three parties, it has a unique opportunity to broker communication and ongoing collaboration to support fully integrated care.

NTC is committed to working with all FQHCs to achieve and/or maintain the highest level of PCMH accreditation. Below are examples of the FQHC-specific programs and pilots NTC plans to support for each:

Charles Drew Health Center (Omaha)

- Assistance with funding a Healthy Homes Assessment Officer
- Assistance with interpretive services
- Support for additional transportation needs

Community Action Partnership of Western Nebraska Health Center (Gering)

- Support for a Chronic Disease Manager to help serve the Panhandle

- Strengthening their ED/Hospital relationship
- Provide more access to data, in addition to defining the results
- Effort toward innovative solutions to educate diabetics in the area, including group visits
- Support of diabetic education initiative specific to the Hispanic population in the Panhandle
- 1-on-1 behavioral health focus

Good Neighbor Community Health Center

East-Central District Health Department (Columbus)

- Support of their language line
- Funding for home monitoring pilot
- Nutrition courses/cooking lessons for diabetic/obese members (very high obesity rate among kindergarteners locally)
- Support of telemundo novella pilot

Heartland Health Center (Grand Island)

- Support for language services
- Support in reaching members who have incorrect phone numbers and addresses on file with DHHS

Midtown Health Center (Norfolk)

- Assistance with collaboration between Faith Hospital and Behavioral Health Region 4
- Provide more access to data, in addition to defining the results
- Coordinate introduction of Midtown to Avera Health to expand BH services

OneWorld Community Health Centers, Inc. (Omaha)

- More frequent Provider Relations/Engagement meetings
- Support with education and outreach surrounding the chlamydia crisis
- Provide more access to data, in addition to defining the results

People's Health Center (Lincoln)

- Support for a social worker/case manager on-site
- Assistance with language line

Ensuring Network Inclusion of Urgent Care Centers. NTC is committed to ensuring that members have access to services when they need them, and we believe that ensuring access to urgent care is critical. NTC recognizes its responsibility to do whatever it reasonably can to prevent an urgent health care matter from becoming an emergency. Thus, we will utilize all available resources within our network, including CVS/pharmacy's seven Minute Clinics throughout Nebraska, to share information with our members about and facilitate access to urgent care services such as immunizations and extended office hours when our members need them. NTC will work with urgent care centers to administer immunizations as a way to expand access and share data through our provider portal.

While we encourage our primary care physicians (PCPs) to offer flexible and extended office hours, we know that many urgent health care conditions arise during after-hours or on weekends. Accordingly, we will use established utilization management guidelines in encouraging and evaluating the availability and utilization of urgent care services. We also encourage members to seek emergency services when they believe a medical emergency exists, and we will educate our members regarding the appropriate use of urgent care through the Member Handbook, articles in our Member Newsletter, and engagement with Customer Service Representatives.

Ensuring Network Inclusion of Retail Pharmacies. NTC's pharmacy program will integrate seamlessly with physical health, behavioral health and provider and member services through shared technology, clinically trained and experienced staff, and a network of pharmacies to meet member needs, providing coverage of all prescription and over-the-counter drugs as applicable to the Medicaid FFS pharmacy benefit. NTC will subcontract with our affiliate US Script, Inc.® as our pharmacy benefit manager (PBM). Established in 1999, US Script combines comprehensive drug management services with extensive Medicaid experience, functioning as the PBM for 15 Centene-affiliate Medicaid plans in 15 states,

representing 4.5 million members. Populations include State Children's Health Insurance Program (CHIP), as well as Aged, Blind or Disabled (ABD), Foster Care, Intellectual and Developmental Disabilities (IDD) and Long Term Services and Supports (LTSS), in addition to other state-sponsored/hybrid programs and Medicare (Special Needs Plans). US Script contracts directly with chain and independent pharmacies as well as pharmacy services administration organizations (PSAO), and is currently contracted with more than 66,000 pharmacies nationwide and over 450 pharmacies in the state of Nebraska, including those pharmacies embedded in Nebraska's FQHCs. We are working in conjunction with the Nebraska Pharmacists Association to expand our current pharmacy network. NTC will keep an up-to-date pharmacy directory online for public access. US Script offers 24/7/365 Customer Service Support to our pharmacy network.

Ensuring Network Inclusion of Hospitals. NTC recognizes the importance of having quality hospital services available when our members need them. Accordingly, NTC will be entering into value-based contracts with Nebraska's two major hospital systems, CHI Health and ENHANCE Health Network, who serve the highest density population areas along with rural communities. In addition, NTC has distributed LOAs to all hospitals in Nebraska. Based upon LOAs returned thus far, we anticipate an extremely high hospital participation rate with NTC.

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IV.J Provider Services

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: (4 page limit)

Provider Services Program Structure

Nebraska Total Care's (NTC) provider service model structure provides a strong foundation with multiple functional areas supporting providers, including, but not limited to: Provider Services, Provider Engagement, Network Development and Contracting, Quality Improvement, Medical Management, Compliance and Finance. Our provider services team meets regularly with each functional department that supports providers to ensure cross-functional communication, internal training and to address provider needs related to billing and other issues. The Provider Services Manager will play a key role in coordinating communications between NTC and our network providers, managing the Provider Services staff, and working collaboratively with the Provider Advisory Committee to establish methodologies for processing and responding to provider concerns. The Provider Services Manager will also be responsible for developing provider trainings in response to identified needs and participating in the MLTC Administrative Simplification Committee.

Our internal provider services staff handle research, analysis, and coordination of updates and provider needs with internal departments. This allows our external provider services staff to take the time necessary to meet with the providers. While external Provider Engagement specialists provide face-to-face education and training to providers and billing staff, each of these areas work together collaboratively to support provider needs in a timely and efficient manner. At the heart of NTC's provider services and communications strategy is a belief that local provider services staff delivering regular, meaningful information results in a provider community that is best equipped to meet the complex needs of Nebraska's most vulnerable populations, and comply with MLTC and NTC processes and systems. NTC will use a variety of communications mechanisms, coupled with carefully developed, well-tested content to ensure that providers receive the information needed to work with us successfully, maintain high performance standards, and achieve optimal outcomes for our members.

- ***Information available in the provider handbook or other media.***

New Provider Orientation. Once a provider has contracted with NTC, we will provide comprehensive education that addresses all aspects of plan operations, the Heritage Health program and MLTC requirements. A detailed description of NTC's initial and ongoing provider training efforts may be found in our response to Section 50. This information is then reinforced through provider materials, including the provider welcome packet and provider handbook. NTC's pre-implementation provider outreach incorporates interactive training sessions for providers, which we believe are critical in establishing strong, lasting relationships, and ensuring use of the most effective preventive care and disease management strategies and best practices. Partnering with the state medical society, physician groups, primary care association or hospitals to host provider orientation sessions encourages a broader attendance, as does using convenient, familiar locations. NTC appreciates that providers have multiple demands on their time, so we will make every attempt to *meet providers where they are*. For example, NTC will offer supplemental online interactive and presentational training to all providers and staff, accessible 24/7. **Provider Welcome Packet.** After completing initial credentialing, NTC's Provider Services Department will mail all new providers a Provider Welcome Packet (*Table Q47.A*). We distribute these materials in Provider Welcome Packets and during initial orientations; both in hard copy and CD formats, and providers are informed that they may obtain copies free of charge, 24/7, through our website. This packet contains all of the materials and information a provider will need in order to participate in NTC's network, including: *Table Q47.A*

• Welcome Cover Letter • Provider Manual • Provider Quick Reference Guide • Prior Authorization Requirements List • MemberConnections® Brochure and Referral Form	• EPSDT Tools • PaySpan Brochure (Information and registration for electronic transactions) • Referrals for Case Management Services • Panel Requests (Pre-birth, Full, Hold, and Disenrollment)

• Pregnancy Notification Form • Medical Prior Authorization Form	

Provider Handbook. The Provider Handbook (submitted to MLTC for approval 90 days prior to contract start date) describes the manner in which NTC manages its Medicaid program, as well as operational procedures necessary for providers to be familiar with in order to maintain compliance with Contract requirements. Our Provider Handbook (***Table Q47.B***) will include all of the information required in RFP Section IV.J.3 and is organized in an easy-to-reference format, and covers topics including, but not limited to: ***Table Q47.B***

• NTC and MLTC address and phone numbers • Provider non-discrimination information • A Description of the Nebraska Medicaid and CHIP programs, including benefits and limitations • Member and Provider Grievance and Appeals System policies and procedures • Medical Necessity standards (DHS and practice guidelines) • Medical record standards • Claims submission protocols and standards • Provider Rights & Responsibilities • Cultural competency information • Value added services and benefits • Primary Care Physician responsibilities • Prior authorization and referral procedures	• ICT Prompt Pay requirements • Medical Management Programs (including guidelines for treating chronic and complex conditions) • Eligibility verification process • EPSDT standards • Credentialing and re-credentialing information • Quality Improvement program • Providers' rights for advising or advocating on behalf of his or her patient • Definition and requirements pertaining to urgent and emergent care • Cost sharing requirements • Policies and procedures for third party liability and other collections

The Provider Billing Manual, a separate document from the Provider Handbook, is NTC's guide for providers that describes the manner in which providers are expected to bill for services covered by our program. The Provider Billing Manual is comprehensive and addresses all aspects of claims submission and billing requirements. NTC's Provider Quick Reference Guide is a "crib sheet" summarizing the operational policies and procedures that govern our program, and includes information about billing requirements. In addition to these materials, Clinical Practice Guidelines (CPG) and related educational materials are available on our website and in printed form upon request to promote convenient access. examples of conditions for which we will provide CPGs include ADHD, adult preventive care, asthma, bipolar disorder, diabetes, major depressive disorder, pediatric preventive care, schizophrenia, sickle cell, and congestive heart failure.

- ***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.***

Engaging Providers in Program Development. NTC believes strongly in active involvement of its providers in designing and implementing a clinical and quality program that builds value among providers, members and the plan. In order to introduce this collaborative foundation in Nebraska, NTC will act on Centene's experience implementing new health plans in other states by eliciting provider participation early in the planning, design, and implementation process as well as on an ongoing basis to foster long-standing relationships. In each state where Centene operates a Medicaid managed care plan, we institute a multipronged approach to ensuring that we develop relationships with the providers in our network, engage them in providing feedback, and actively utilize the input they provide, all the while remaining acutely aware of the multiple demands on their time. Our approach in Nebraska will mirror our approach in other states and will be supported by our providers' participation in NTC Quality Assurance and Performance Improvement Committee (QAPIC). The QAPIC will be supported by the Credentialing, Peer Review, Pharmacy & Therapeutics, Utilization Management, Joint Operating, Corporate Compliance, Performance Improvement Team, Member Advisory, Provider Advisory, and Clinical Advisory committees and subcommittees including the Behavioral Health, Hospital, and Tribal Healthcare Advisory Committees. Except for the Member Advisory Committee, all external committees

actively involve a broad range of provider types. NTC has developed a partnership with HCAN (Healthcare Association of Nebraska, Nebraska's primary care association), and the HCAN members which include 7 Federally Qualified Community Health Centers (FQHCs) (representing 11 sites) and also one affiliate member in Council Bluffs, Iowa. NTC plans to actively engage them in the planning and design of our clinical and quality model, placing particular emphasis on our approach to physical and behavioral health integration. Providers from several FQHCs have already committed to serving on several of our committees.

Soliciting Provider Feedback. Through our commitment to and culture of service excellence, NTC will employ comprehensive, integrated processes to engage providers' and assess their satisfaction such as soliciting feedback directly from Providers, analyzing results of provider satisfaction surveys, monitoring operational performance metrics that indicate opportunities for improvement in service delivery, analyzing complaint and appeal data and analyzing provider network participation. In addition, NTC will hire a Chief Medical Officer (CMO), an outward facing physician executive, who will be responsible for engaging providers and identifying/removing barriers to satisfaction. The CMO will chair our Provider Advisory Committee (PAC), described in more detail below, which will serve as a primary vehicle through which we will solicit input on issues providers consider most important.

The QAPIC is responsible for ensuring formal satisfaction surveys are conducted and provide guidance and oversight in the development of ad hoc and standard surveys. SPH Analytics (formerly The Myers Group) will conduct NTC's annual Provider Satisfaction Survey, which assesses degree of satisfaction with, for example, credentialing, utilization management, claims processing, and staff professionalism and level of knowledge. The survey also asks, "What can NTC do to improve its service to your organization," which will help NTC identify and appropriately address common themes. Our **PAC** will review all survey results and recommend interventions for improving satisfaction to the QAPIC.

In addition to the annual survey, NTC will survey newly contracted providers within an appropriate time after their effective date, to identify concerns that NTC can address early in the relationship. We also will conduct ad hoc surveys and provider focus groups to identify and solicit feedback on targeted issues that may impact satisfaction. Findings and feedback received as a result of these provider engagement activities guide our ongoing enhancement of provider education, feedback, and monitoring activities. For example, NTC's Georgia affiliate, Peach State Health Plan, successfully **improved** the satisfaction rate of network OB/GYNs by **16 percentage points from 2013 to 2014.** Peach State's annual Provider Satisfaction Survey Report revealed a decrease in OB satisfaction rates. After conducting targeted focus groups, our affiliate determined that OBs were dissatisfied with rates and prior authorization requirements for ultrasounds. Our affiliate approached the State to improve the reimbursement rates, revised the ultrasound clinical review program, and solicited input from Maternal-Fetal Medicine OB/GYN sub-specialists to refine the prior authorization process.

- ***Description of how the MCO will develop, establish and maintain its provider advisory committee, with representation as identified in this RFP.***

Provider Advisory Committee (PAC). NTC will establish a PAC that is comprised of both major providers from across Nebraska as well as individual providers and will include physical health, behavioral health and pharmacy providers, as well as providers who primarily serve individuals with intellectual and developmental disabilities. Through our extensive provider and stakeholder engagement and on the ground outreach, we have already identified providers to participate on the PAC, including Dr. Joseph Evans, Monroe Meyer Institute; Paul Utermark, CEO, Filmore County Hospital, Robin Stuart, CEO, Morrill County Community Hospital. Nebraska Total Care continues to work diligently to identify other providers and stakeholders to participate on our committees. The PAC will be chaired by the CMO. Other internal participants will include the Director of Contracting and Network, Director of Member & Provider Services, and Provider Services Manager. The PAC will be convened at least quarterly at locations to be determined by the membership to encourage consistent participation. PAC agendas will be relevant and meaningful to providers, promoting two-way communication and resulting in key takeaways. For example, participants will provide input on NTC's provider profile, incentive programs, other administrative practices, and support development of the physician scorecard indicators, useful analyses

of the data, and effective means of helping providers improve their performance, in alignment with our value-based purchasing programs and quality goals.

In addition, NTC will establish a Hospital Advisory Committee, Behavioral Health Advisory Committee and a Tribal Healthcare Advisory Committee to provide input to the Provider Advisory Committee. For example, the Tribal Healthcare Advisory Committee will be chaired by our Tribal Liaison to ensure regular coordination with IHS, 638 providers, Urban Indian Centers, and other involved agencies. The PAC will report to the QAPIC at least quarterly.

Provider Services Manager. NTC's Provider Services Manager will serve as the provider network liaison, and will work collaboratively with the PAC to establish a formal process for responding to and tracking provider concerns; develop provider trainings in response to identified needs or changes in protocols, processes, and forms; and, enhance MCO-provider communication strategies.

- ***Sample provider outreach methods.***

Examples of Provider Outreach. NTC's community-based Provider Services Specialists will provide pre-implementation and ongoing Provider Orientation for PCPs, LTSS providers, specialists, hospitals, and ancillary providers, usually held at physician offices for large practices, and at hotel conference rooms or community facilities for group sessions, with scheduled follow-up training to be conducted following implementation.

Our face-to-face pre-implementation provider education and training provides a forum within which we receive feedback and answer provider questions in real-time. To reinforce our training, we provide written manuals and guides for providers and their staff to use as reference materials, and use peer support, web-based communication, standing committees, and a provider call center to round out a communications system that has proven to be highly successful. For instance, in Louisiana, our affiliate health plan Louisiana Healthcare Connections, recently conducted provider trainings on specialized behavioral health integration. We will also conduct conference call lunch and learns, where providers can ask questions about specific topics and get immediate answers from provider services staff.

We have met with and sponsored association conferences for provider and consumer advocacy organizations across Nebraska, including the organizations listed in ***Table Q47.C***. We find it critical to obtain immediate and ongoing support from these types of organizations and engage them early and often.

Table Q47.C NTC Provider Engagement Meetings: Participating Organizations	
Nebraska Nurse Association	SPEAKOUT
Nebraska Hospital Association	Nebraska Nurses Association
Nebraska Medical Association	Great Plains TeleHealth Resource & Assistance Center
Nebraska Rural Health Association	Rural Partners in Medicine
Nebraska Academy of Family Physicians	Nebraska Action Coalition
Nebraska Medical Group Management Association	University of Nebraska Medical Center
Nebraska Association of Local Health Directors	UNMC Behavioral Health Education Center
Health Center Association of Nebraska	UNMC Monroe Meyer Institute
Nebraska Healthcare Association	UNMC School of Allied Health
Nebraska Association of Behavioral Health Organizations	Metro Omaha Medical Society
Children and Families Coalition of Nebraska	Lancaster County Medical Society
All Behavioral Regions	Lancaster County Health Department
Foster Care Closet in Lincoln	Douglas County Health Department
Community Action Partnership of Western NE	Nebraska Pharmacy Association
Panhandle Partnership for Health and Human Services	Munroe-Meyer Institute at UNMC
Community Action Mid Nebraska	Disability Rights Center
Disability Rights Nebraska	Region V Services
ARC of Nebraska	ARC Board Member
Autism Center of Nebraska	Nebraska Association of Service Providers
UNMC Center for Reducing Health Disparities	VODEC
East Central District Health Department	Omaha Healthy Kids Alliance
Lutheran Family 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. (3 page limit)

Providers can speak to a live person at Nebraska Total Care's (NTC) Provider Call Center any time day or night, 24/7. NTC's Provider call center will provide best-in-class technology, innovation and resources that ensure our CSRs have, at their fingertips, all the information they need to assist Providers. We have created a Customer Services Representative (CSR) career ladder program that builds on the extensive training our member call center CSRs receive and we provide additional skills and content training to high performing call center CSRs to prepare them to take Provider calls. We train our Provider CSRs to answer inquiries across all products, programs, and populations in Nebraska, and empower them to resolve Provider issues during the Provider's first call.

We provide seamless Provider call center operations for behavioral health, vision, and pharmacy, as well as for our dental value added services. Our Provider Services Helpline will be staffed by CSRs Monday through Friday, 7:00 a.m. to 8:00 p.m. Central Standard Time. For provider calls received after-hours, and calls received on State-designated holidays, providers may speak with representatives from our 24-hour nurse advice line to coordinate emergency prior authorization requests and discuss urgent or emergent member issues with a Registered Nurse. Our Provider Services staff will also include a clinical pharmacist who will be available to take pharmacy related calls between 8:00 a.m. and 8:00 p.m. Central Standard Time, Monday through Friday. Providers who would like to speak with a Clinical Pharmacist can select that option through the Integrated Voice Response (IVR) or CSRs may also warm transfer a provider to a Pharmacist.

Maintaining a Fully Staffed Line. To maintain appropriate staffing that will meet or exceed MLTC performance standards, NTC will use our innovative IEX Workforce Management System (IEX) to create a responsive, scalable call center. Based on years of call data analyses from other Centene health plans with similar populations, IEX factors in historical call duration, call patterns, seasonal variations, market maturity, and program features specific to Nebraska to adjust staffing. These capabilities enable us, for example, to accommodate longer call times for Providers new to managed care. Our IEX model also accounts for variations in call-type complexity, allowing us to create better service performance to standards than using static CSR to Provider ratios. This predictive modeling capability allows us to forecast staffing needs and maintain standards, adjusting for both the size and type of membership and size of network, even during rapidly changing situations, such as during open enrollment and network expansion. Because the same CSR follows a Provider call to resolution, including outbound research and re-contacting the Provider, we use IEX to predict staffing needed for "shrinkage" caused by follow-up, post-call documentation, and staff training.

When local business functions are interrupted for an extended period of time, such as during severe weather, we activate our business continuity plan, which may include transfer of all call center lines to Centene's Regional Service Centers located throughout the country in multiple time zones to maintain performance standards.

• How the MCO will ensure that provider calls are acknowledged and resolved within three business days of receipt.

Timely Call Resolution. NTC's will make available an IVR solution to all provider callers, affording providers 24/7 access to information such as eligibility, primary physician information, and claim status, including paid date and amount. Providers can use the IVR to identify the topic of their call, e.g., eligibility, claims, prior authorization request and authorization status, pharmacy services, behavioral health, dental services, vision services, care management, if they are a provider interested in joining our network, and lastly "something else." Providers may by-pass all options by pressing "0" at any time during the call; this immediately connects them with a Provider CSR ready to assist. In the event of an after-hours call providers will have the option to leave a voice mail message. If the provider chooses to

leave a voicemail, it is NTC's policy to return their call by close of the next business day, and CSRs will check voicemail three times a day to ensure compliance with this NTC policy.

Nebraska Total Care is committed to first call resolution, resulting in optimal customer service and easing the administrative burden placed on our Providers.

Trained CSRs to Support Accurate, Timely Resolution. NTC strives for first call resolution for the vast majority of our calls. To ensure all calls are acknowledged and resolved, as quickly as possible, but no longer than three business days, our CSRs are trained to have an in-depth knowledge of covered services, programs, populations, and how to access specialty services. Before our CSRs can begin taking Provider calls, *they must* first complete core Member call center training and *demonstrate competency handling Member calls.* Our core Member call center CSR training includes a four week classroom training program focused on service to Members, including our **Back to Basics** training on courtesy, cultural competency, and phone and web etiquette; **Fundamentals** training on all systems, documentation, workflow, and understanding of all internal departments; **Programs** training on covered services, populations and programs, copayments as applicable, enhanced benefits, members rights and responsibilities, etc.; and **Job Functions,** which covers the day-to-day responsibilities of the CSR. Our CSR training also includes **Cultural Sensitivity** topics tailored to the specific needs of the Nebraska population we will serve. For example, NTC plans to partner with the League for Human Dignity and the Office of Health Disparities and Health Equities to review materials and conduct trainings on disability etiquette and ensure CSRs can connect members and providers with local resources to support populations with special health care needs. We will regularly involve local organizations in our quarterly mandatory CSR trainings, including our Tribal Council partners, Nebraska Disability Rights Center, and Nebraska Methodist College Cultural Competence Instructional Programs. For additional details on core and ongoing Member CSR training, ***please see our response to Question 28.***

Provider CSR Training After training, Member CSRs must demonstrate six or more months of servicing member inquiries with a Call Quality Audit score of more than 95%, including on accuracy and call etiquette, before becoming eligible for advanced training to take Provider calls. We train all new Provider CSRs to deliver personal service and accurate, timely attention to all Provider inquiries. Provider CSRs learn to educate Providers and their staff on referral and claims payment procedures, claims disputes, eligibility verification, covered services, authorizations, the Provider complaint system and a broad range of other topics. CSRs also learn how to access Nebraska's online Medicaid eligibility verification portal from an icon on their integrated desktop information system to verify a Member's eligibility.

Ensuring CSRs Have the Most Current Information. Centene uses Count 5's **Q Mindshare** change management tool to assist the Service Center leaders in getting the correct information to the right CSRs at the appropriate time. The Q Mindshare application pushes appropriate information about policy changes and other updates directly to CSRs' desktops. CSRs receive a notification that new information needs to be reviewed. Content can be created within the application or accessed externally, such as from Centene's Cornerstone Learning Management System (LMS). Supervisors are able to view their team's participation rates, see their scores on assessments and use feedback as an opportunity to engage with their CSRs. CSRs have the ability to provide feedback in the form of both ratings and comments. In addition, CSRs are able to access the information at a later time for reinforcement, if needed. Also, NTC's Provider Service Representatives (PSRs) will be committed to working in partnership with NTC providers and Provider CSRs. If a provider requests clarification of a process, PSRs are available to educate them on the processes, as applicable. If the provider's concern is outside of the PSRs scope, the PSR will escalate the issue to the assigned Provider Relations Representative or the Claims Liaison (for Claims issues), as applicable. PSRs understand the busy environment in which our providers work, and will be committed to assisting them in resolving all matters at hand efficiently.

Using Speech Analytics to Improve Staff Accuracy and Offer Actionable Information. To ensure accuracy across the call center, we will deploy Uptivity Discover (Discover), a quality management solution that uses Speech Analytics software to help us identify situations in which CSRs may be inconsistent or incomplete, and to uncover areas where specific provider service or education is needed.

By *word mining* calls based on spoken phrases. For instance, if Supervisors notice that providers inquire about a specific issue related to reimbursement for Native American members, **Discover** can word mine all calls for "Native American," and report the frequency of mention. The Trainer then samples the calls to determine our providers' needs and within a few hours, each CSR has Medical Management talking points at the desk-top via QMindShare to educate concerned providers.

- ***The location of operations, and if out of state, describe how the MCO will accommodate services for Nebraska.***

NTC's toll-free Provider Services Helpline will be operated from our Provider call center, which will be located in NTC's Nebraska headquarters office in Lincoln.

- ***How the MCO will measure and monitor the accuracy of responses provided by call center staff, as well as caller satisfaction.***

Multi-Dimensional Approach to Call Center Monitoring. An effective call center operation requires daily monitoring and data-driven decision making to maintain excellent performance on a wide range of performance standards. NTC will monitor call center performance standards by recording all calls and employing daily, weekly, monthly, and ongoing monitoring activities. At a minimum, NTC will monitor Average Speed of Answer, Abandoned Call Rate, Blocked Call Rate, Average Hold Time, Timely Response to Inquiries, Accurate Response to Inquiries, and Phone Etiquette. Our Director and Supervisors will analyze and monitor an array of call center standards and performance measures using reports from Avaya, IEX, Uptivity, Customer Relationship Management system and a number of enterprise-level reports.

Monitoring in Real Time to Meet or Exceed MLTC Call Center Standards. Our Work Force (WF) Analysts use ***IEX Workforce (IEX) Management*** to monitor performance against standards in real time and ongoing. IEX analyzes call duration, volume, IVR use, hold times, and all needed metrics down to five-second increments, when necessary. The WF Analyst uses this real-time activity and analysis of historical and recent trending data to adjust staffing. The IEX predictive approach notifies the Analyst of rapidly changing situations in volume or call duration so that we can deploy additional resources, for example, from fully cross-trained Member call center staff or other staff such as Member Advocates and Quality Specialists. For additional details on IEX, see *Maintaining a Fully Staffed Line* above.

Continuous Quality Audit Program: Ensuring Accuracy and Complete Service to Providers. To ensure each CSR is delivering accurate information and exceptional service, we monitor the accuracy of CSR responses and phone etiquette through our customized *Call Quality Assurance (CQA) Program*. Each CSR will receive 8 to 10 evaluations of live or recorded calls per month and must maintain a monthly average of 93% or higher, based on defined criteria. Any score on an individual call that falls below 90% triggers review and retraining. **Call Record** records phone interactions and simultaneous use of desktop resources, allowing Quality Specialists to conduct a complete review of the CSR's performance against criteria. The Quality Specialist completes an Audit Report Card for the CSR assessing their courtesy, accuracy, effectiveness, thoroughness of delivery, and complete call documentation. Using a Call Center Optimization Forum *best practice*, Supervisors review the Audit Report Card for and with each CSR monthly to compare individual performance to department performance goals. NTC will incorporate recorded calls, as "live" call examples, into training. We will submit our CQA criteria and protocols to MLTC for review annually or more frequently if needed to reflect a change in specific business need of NTC or MLTC.

Provider Satisfaction Surveys. NTC will conduct new provider surveys and an annual comprehensive provider satisfaction survey to solicit regular feedback from providers in our network. The annual provider satisfaction survey will include questions about our providers' degree of satisfaction with NTC's services including the professionalism and level of knowledge demonstrated by NTC Provider Call Center staff. In addition, within 90 days of a newly contracted provider's effective date, the new provider will be sent a short survey designed to identify concerns that can be addressed early in the relationship.

(5 page, excluding sample resources, tools and materials)
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.

Provider Web Resources Focused on Managed Medicaid

Nebraska Total Care (NTC) will employ the health care internet applications design, integration, implementation, security infrastructure, and operations expertise of our parent company Centene Corporation (Centene) to deploy an integrated suite of web enabled tools configured specifically for our Heritage Health program. We will offer access to resources, information, and tools for Providers through:

Using Centene web technologies, Nebraska Total Care's affiliated health plans support over 1 million website sessions per month, with approximately 9 million Provider Portal page.

- A public provider website with concise, organized, and MLTC compliant information, including a web-based referral search system via a fully searchable online provider directory.
- A secure Provider Portal that promptly supplies authorized providers with web-enabled transactional capabilities and a number of provider administrative "self-service" capabilities, such as provider/member inquiry support, initial authorization submission and inquiry, the ability to submit claims through our Real-time Editing and Pricing (RTEP) module, and a growing family of clinical applications including care gap alerts, member panel roster, online care plans, and more.
- Our Centelligence™ Health Informatics Platform & Health Record which securely delivers expanded, member level clinical information to both physical *and* behavioral health (BH) providers.
- Drill-down reporting capabilities to help PCP and PCMH Providers become aware of the status and outcomes of their patients, in line with our Value Based Purchasing strategies.
- HIPAA compliant controls to ensure web content is appropriately secured and that are audited regularly to ensure ongoing compliance. In addition, our Provider Portal is compliant with 42 CFR Part 2 Confidentiality of Alcohol and Drug Abuse Patient Records.

Public Provider Website

Our NTC public provider website, available to all NTC website visitors, will offer providers information on electronic transactions, network participation, helpful resources and links, training guides, important contact information including a "Contact Us" form, an informative web blog, and link to login or register for the secure Provider Portal. See ***Attachment Q49-A: Public Provider Website***, for an example based on one of our affiliated Centene health plans.

Timely Provider Communication. NTC will communicate regularly with providers in person, via teleconferences, and online webinars and with written materials, such as, newsletters and web blogs. We will post Provider Newsletters on our Public Provider Website. Our Provider web blog will be updated monthly with relevant topics (i.e., policy updates and new processes).

Content for all Providers. Thanks to our use of industry standard web technologies such as HTML5, and best in class web content management systems such as Adobe Experience Manager (AEM), we can rapidly update content on our websites while maintaining a consistent provider user experience. Our implementation of AEM and our web content versioning capabilities, along with a best practices approach to change management, allows us to prepare new and modified web content to review with MLTC, prior to posting on the web at least 90 calendar days prior to the contract start date, and to remain compliant with RFP requirements, while ensuring all content is up-to-date and accurate. As do our affiliate sites today, our public provider website will include:

- A searchable Provider Handbook, updated on a regular basis, with all NTC Policies & Procedures
- Provider training manuals, and training session information, including dates, content and location of training events.
- MLTC bulletins that pertain to NTC

- Information on when to obtain prior authorizations and referrals, and how to request such authorizations. Please see ***Attachment Q49-B: Prior Auth Needed Tool*** for an example.
- Easy to find links to our NTC main website, as well as to the MLTC website and other websites related to Nebraska Medicaid and the Heritage Health program.
- Prominently displayed information on how to contact NTC's Provider Services Department, as well as other general customer service and contact information
- Provider Directory, with full web-based referral search capabilities, including those enumerated in the RFP Section IV.J.4.c.iii. Please see ***Attachment Q49-C: Provider Directory*** for an example.
- Through integration with our affiliated subcontractor and Pharmacy Benefits Manager (PBM), US Script, we will provide an entire set of pharmacy related information resources on our provider website, along with MLTC-approved changes to formulary, prior authorizations (PA), and clinical criteria at least 30 days prior to change effective date. The pharmacy section of our provider website will include:
- How and whom to contact for prescription filling questions.
  - The NTC Formulary List and Nebraska Preferred Drug List
  - NTC Pharmacy Prior Authorization (PA) requirements, including how to submit PA's (forms, online submissions, etc.)
  - Updated and searchable NTC Maximum Allowable Cost (MAC) pricing information.
- NTC's provider appeals and grievance process and complaint system.

Practice Improvement Resource Center (PIRC). Our NTC provider website will include the PIRC: a searchable compendium of information modules on evidence-based practices, guidelines, and tools to help providers manage the clinical, operational, and technology aspects of their practices. The NTC PIRC will offer online toolkits from recognized authorities, with features such as cultural competency training, materials addressing prenatal care from the American College of Obstetricians and Gynecologists, American College of Pediatricians, treatment and guidelines for Sickle Cell Anemia (NHLBI), depression management tools, and links to anti-hypertensive guidelines. The PIRC will also include tools, resources, and links in support of PCMH practices. For example, the PIRC will include information on NCQA and JCAHO requirements for PCMH Recognition and Certification, respectively. The PIRC will have information on NTC's support for the Nebraska Health Information Initiative (NeHII) and how the provider can work with NTC and NeHII for meaningful clinical data exchange, contingent on our successfully coming to a mutually beneficial agreement with NeHII, which we expect to do in 2016. The PIRC will also invite providers to contact one of our Provider Relations staff to learn more both about our support of NeHII as well as information on our support for Electronic Health Records (EHR) adoption and applications such as automated HEDIS care gap closures.

In 2014, Centene won the Silver Web Health Award from the Health Information Resource Center recognizing our work with online health risk assessment web-based resource tools.

Integrated Provider Portal for Administrative and Clinical Tools

As shown in ***Attachment Q49-A: Public Provider Website***, providers can login to our HIPAA compliant, secure Provider Portal from several locations on our public website, including our public provider website. The Provider Portal offers authorized **physical health *and* BH** providers online access to a number of self-service administrative and clinical applications, such as, Care Gap notifications, Centelligence™ Health Record, TruCare Care Plan, secure messaging with NTC, online member panel rosters and practice-level clinical quality & cost reports. ***Table Q49*** offers an overview of the secure, web-enabled transactional capabilities our NTC providers will be able to perform. Note that all of these functions are currently supported at our affiliate Managed Medicaid health plans today, using the same Centene powered web technology.

Table Q49

Provider Portal Function	Description
Provider Practice Information	Providers have the option of updating their contact information including address on our Provider Portal. All updates or changes are reflected on the Provider Directory within 24 hours.
Member Search	Search for Member by last name, date of birth, date of service, or by Member ID and date of service.
Secure Messaging	Users can securely message with NTC Customer Service Representatives (CSRs), Care Managers, and other staff via an "inbox" and "outbox" capability on the Provider Portal.
Claims Submission, Status, Payment History	Today, electronic claim submission directly to our Portal is the *second most popular method* of claim submission to us, exceeding all but one of the over 80 clearinghouses Centene supports. We offer providers individual and HIPAA EDI batch file claim submission and the ability for providers to request adjustment to claims online, search for claim status using member information, claim information, and/or provider name, and view and download payment history information. Providers may also submit claim reconsiderations for real time processing through the portal and view the status/outcome of reconsideration requests. See ***Attachment 49-D: Claims Processing on the Provider Portal.*** In 2016 we our introducing our **Real Time Editing and Pricing** module (described in more detail below) for real-time claim editing, including clinical code editing, and estimated pricing for professional claims submitted through our portal.
Claims Filing Assists	Providers can access detailed billing instructions, including claims submission time frame requirements, claim dispute and State Fair Hearing information, via our electronic Provider Manual on the Provider Portal. In addition, providers have access to our online EDIFECS Ramp Manager EDI testing system, which allows interested providers to "on board" through interactive file testing and certification of direct (to NTC) EDI submission (see discussion above).
Claims Audit Tool	The Provider Portal will also provide access to NTC claims adjudication logic using our Clear Claim Connection software. This software essentially allows our providers to understand our administrative and clinical claim edits at a detailed coding level, to both offer claim processing transparency and to help ensure claim coding accuracy.
Authorization/Referral Status	Providers can enter and view authorization requests and status
ER Flag	This functionality allows facilities to indicate in the Provider Portal if a NTC member is in the ER. If the facility activates the ER Flag, the data is automatically transmitted to TruCare, our member-centric integrated health management system accessible by all staff on our Care and Utilization Management teams. In TruCare an ER follow-up task is generated for follow-up by the Care Team staff the next business day allowing us to provide timely notification to PCP and other relevant providers as needed.
Member Panel Roster, Care Gap Report	View, print, or export a listing of all members under the PCP or PCMH's care including alerts generated through our Centelligence's™ predictive modeling system. Through Centelligence™, our proprietary health informatics platform, we analyze claims, assessment, demographic, and other member data to provide Care Gap, Disease

Provider Portal Function	Description
	Management, and Emergency Department high utilizer alerts. These alerts notify a provider about the potential need for interventions, diagnostic tests, and labs for certain conditions, or for EPSDT and preventive services. Additionally, PCP and PCMH providers can quickly review and filter on detail level information through the Member Panel Roster and can export and print a Care Gap Report. NTC Provider Representatives will be available to educate providers on how to retrieve and interpret the Care Gap Report. See ***Attachment Q49-E: Member Panel Roster and Care Gap Report*** for examples. Closing Member Care Gaps: we are enhancing our Provider Portal for use at NTC with a Quality Attachment tool which will allow providers to demonstrate that a Member Care Gap has been satisfied. Providers will have the ability to upload clinical documentation through the portal which will then be automatically transmitted to our Quality Department for review and Care Gap closure.
Centelligence™ Health Record	The Centelligence™ Health Record (CHR) offers a well-organized view of a member's cursory clinical "face sheet" and detailed clinical tabs for each member for whom we have supporting data. The CHR is based on current and historic medical, BH and pharmacy claims information, lab test results, health risk assessments, and other information systematically received from multiple sources and processed in Centelligence™, our proprietary health informatics platform. We provide an actionable, detailed breakdown of the data so that providers know who to reach out to for what services, and when, to potentially improve outcomes. Providers can access a detailed level of claim based utilization showing all member level claims, including medical and pharmacy data for the past 18 months. This comprehensive view of the member's utilization and care needs offers insight into the services obtained by the member outside of the provider's practice including emergency room and inpatient services. Please see ***Attachment Q49-F: Detailed Patient Record on the Provider Portal.***
Care Management Referrals	Our Provider Portal allows a provider to refer a member for physical or behavioral health care management services online. Please see ***Attachment Q49-G: Care Management Referrals.***
TruCare Member Care Plan	We integrate care plans created by Care Management staff and other clinical professionals on our integrated Care Team in TruCare (our member-centric health management platform for collaborative care coordination; and case, behavioral health, disease, and utilization management) with our Provider Portals so that providers have access to one Care Plan for monitoring treatment goals, objectives, milestone dates, and progress for a member's identified health problem in a well-organized online format. Additionally, select TruCare Care Plans are available in a consumer-friendly format on the secure Member Portal further engaging members in their care and treatment plans. Please see ***Attachment Q49-H: TruCare Care Plan on Provider Portal.***

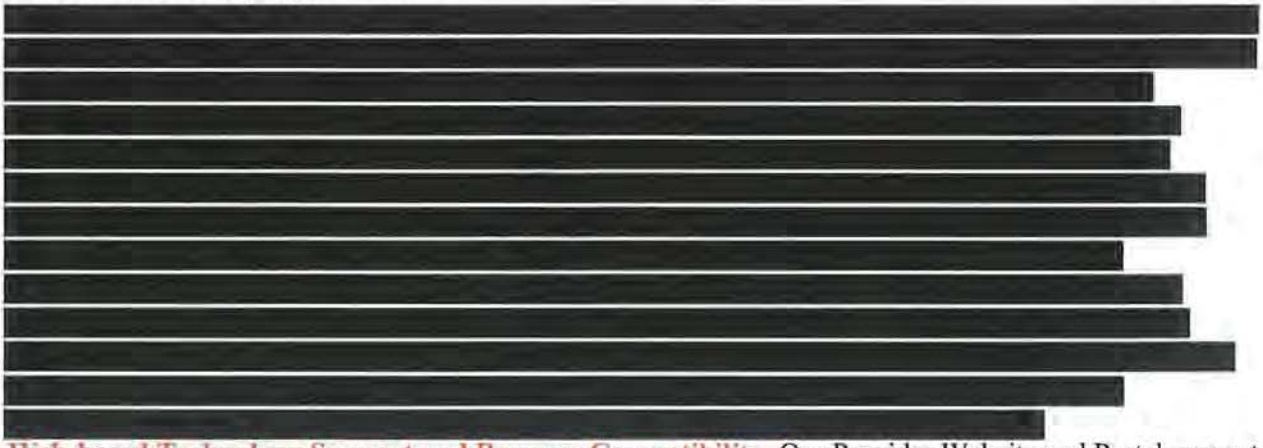
Real-time Editing & Pricing Claims Module (RTEP). RTEP will provide the NTC Provider Portal with real-time claim editing, including clinical code editing, and estimated pricing for professional claims submitted through our Provider Portal. When a Provider enters a Professional claim online on our portal RTEP will instantly apply our adjudication process steps: validating member and provider eligibility for the dates of service, matching prior authorizations applicable to the services on the claim, identifying "other insurance" and applying Third Party Liability / Coordination of Benefits amounts, determining if

benefits apply, enforcing other advanced edits and NTC's Heritage Health business rules, applying clinical edits, and finally pricing the claim - all performed during the provider's online session. Our Provider Portal will then display back to the provider, whether we will pay the claim and an estimated amount to be paid, with clear notice that the estimated paid amount displayed is subject to adjustment after our Fraud, Waste and Abuse (FWA) checks, where we subject the claim to a comparison of a nationwide database of FWA billing patterns. As always, our objective is to lower administrative burdens for providers without sacrificing program integrity. Additionally, NTC providers will have the ability to sign up for expedited payment options if submitting claims through our web portal. We will offer two business day claim payment turnaround time from claim finalization to provider payment for submitted professional claims. This latter enhancement means improved cash flow for providers, as well as an incentive for providers to submit their claims to us as soon as possible after the date(s) of service – which ultimately translates to timelier, more accurate, and more complete encounter data to MLTC.

Expanded Provider Portal Analytic Capabilities. In 2016, Centene is incorporating two significant functional enhancements with Centelligence™ Patient Analytics and Centelligence™ Analytic Insights. Both of these capabilities support the evolution of provider contracting arrangements towards increasing levels of Value Based Purchasing arrangements, by allowing providers to monitor their performance against pay-for-performance and other innovative payment strategies.

Centelligence™ Patient Analytics (CPA). CPA builds upon our existing Member Panel Roster, evolving the roster into a *patient registry* by allowing providers to instantly view critical information to better identify evidence-based care gaps, understand quality improvement opportunities, and improve their care management functions. CPA offers providers diagnoses, medication, lab, and care team data on an individual member level, while also offering prospective gaps in care to fulfill specific quality measures.

Centelligence™ Analytics Insight (CAI). CAI is a suite of the most important medical cost and utilization, pharmacy, emergency department, clinical, population health, and quality data to help health plans and providers form a cohesive understanding of provider performance and membership trends. CAI dashboards provide varying levels of information to providers. Dashboards will allow for, among other uses, provider performance analysis, provider peer group comparisons, cost and utilization trending, quality measure performance, active and non-active member pattern analysis, disease state prevalence, readmission analysis, and population health trend analysis. Users are also offered many of these metrics on a risk and severity adjusted basis.



Web-based Technology Support and Browser Compatibility. Our Provider Website and Portal support Google Chrome, Internet Explorer, Safari, and Firefox browsers and are designed using a mobile first strategy which means that all content is viewable/usable on smartphones and tablet devices. Providers do not need additional software to use our Provider Website or Portal. Both our Provider Website and Portal are compliant with Section 508 of the Americans with Disabilities Act (ADA).

50. Describe the MCO's proposed provider education and training program, including: (5 pages)

Provider Education and Training Program

Nebraska Total Care (NTC) will offer provider education and training in a variety of ways. Our Provider Handbook, Resource Toolkits, webinars, and newsletters will be available to the network on our Provider Portal, and live trainings and provider forums will be accessible throughout the state. Individual provider outreach will be a core feature, as we will assign a Provider Services Specialist and/or Trainer to each provider for orientation and to provide ongoing support by phone and in person. Accessible quarterly town hall forums will be open to all providers statewide, facilitated by our use of community venues and provider sites. The goal for these forums will be to educate staff on credentialing, contracting, billing, utilization management, and care planning, etc. Ongoing operational and clinical trainings reinforce individualized training and empower participants to learn from one another. Our training calendar will include four to eight offerings each month, based on tracked and trended provider interest, and trainings will be recorded and catalogued in our searchable topics library for providers to access any time. In addition, NTC as part of its Value Based Purchasing Agreements with ENHANCE, CHI, FQHCs and Native Tribes will include quality measures and requirements for regular and ongoing provider education and training. This will be a collaborative program that NTC and providers will develop and execute.

- ***A description of the training program.***

Program Description

Our program will include initial orientations, webinars, online training and resources, conference calling, and provider office visits. Our approach will be customized for providers of different types and responsive to urban, rural and frontier needs. Trainings will be developed and scheduled based on provider input and will leverage material developed by Centene's Clinical Training Team, as well as the available expertise of the providers and the community-based organizations within our network. NTC will collaborate with our Value Based partners to schedule and present education and training on site and developed to address population, specialty and systematic programs and materials. Those in rural areas can join by webinar. Programs with Native Americans will be conducted at Tribal facilities. All staff such as NTC's tribal liaison and other provider related staff will be required to assist in development and attend all programs. NTC will submit a copy of our provider training materials and training schedule to MLTC for review and approval a minimum of 90 calendar days prior to the contract start date. Documentation of training sessions and attendance will be available to MLTC upon request.

Orientation. NTC's Provider Services (PS) team will provide initial training within 30 calendar days of contracting. Provider orientation will address 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 behavioral health emergencies.

Our Provider Claims Educator will educate our in-network and out-of-network providers on claims submission requirements, coding updates, electronic claims transactions and electronic fund transfers, and available NTC resources, including our Provider Manual, Provider Portal, training materials, and fee schedules. This comprehensive orientation will be provided via both in-person and via webinar. Provider orientation will be held individually at provider sites and in groups at convenient, familiar locations.

In-person Training and Webinars. Training will be offered in geographically strategic locations to ensure easy access statewide. We will partner with the State medical society, physician groups, primary care associations and hospitals as well as each of our Value Base partners to host these sessions in easily accessible locations. NTC also will offer supplemental online interactive and recorded training to all providers and staff, accessible 24/7, and peer-to-peer training through Internet options, including self-paced modules and interactive webinars. Trainings will be promoted via our Provider Portal and through direct communication, informed based on tracked and trended needs that are identified by our Provider Services Representatives, our Provider Training Team, and our Provider Advisory Committee (PAC).

Our core training will be customized for NTC to include educational opportunities appropriate for the full array of needs identified by primary care, behavioral health, other specialists, and hospital providers, including specific issues that already known, such as training and education for nursing facilities regarding billing procedures for when a member transitions from a skilled to a custodial level of care.

Town Hall / Open Invitation Trainings. Ongoing trainings and community Town Hall forums will expand on orientation basics, cover program and policy changes, address particular education needs, and provide cyclical "refresher" training. NTC will conduct group training events and host live interactive webinars and trainings via video conferencing to facilitate access. Our Florida and Louisiana affiliates had success using Town Halls to support wide scale orientation to promote rapid uptake of new processes and establish ongoing relationships with providers in those markets. We have typically offered both live and open-conference line/WebEx access, to ensure that all relevant staff from the agencies might attend, despite conflicts with clinic operations. This includes our continued outreach to refugee and Native American populations which will require special attention to cultural sensitivity and needs.

Additional Training Offerings. NTC will provide written training and educational materials electronically and via our provider resources web page (hard copy provided upon a provider's request). In addition to our comprehensive Provider Manual, online training resources will include the Provider Directory for referrals, provider newsletters, clinical practice guidelines, disease management information, user guides for Provider Portal functions (claims, care gap alerts, member records, etc.); claim and other forms; and quick reference guides with key phone numbers and community resource information. These will conform to any vision, hearing, language or cultural necessity.

Examples of Training Content. Initial orientation and ongoing training topics will include all elements found in the Provider Manual, particularly covered services and provider responsibilities for coordinating medical and behavioral health (BH) services contract requirements; quality assurance and performance improvement programs and the provider's role; and policies and procedures specific to each line of business (*Table Q50*). Training will also address state priorities, including strategies for accessing and coordinating NTC and community resources to facilitate reduced use of Emergency Departments, address health disparities, and promote wellness. Diversity and social determinants will be included in the curriculum. **Staff Accountability.** Our Provider Services Manager will design the training program for NTC. Provider Relations team members will proactively outreach to providers to provide individualized in-person or telephonic training to address issues identified through provider/staff requests, monitoring, training evaluation, provider analysis, and analysis of claims submission errors or member complaints. Our Provider Training team will conduct trainings and recruit necessary experts, as needed.

- ***A work plan that outlines education and training activities, including frequency of office visits to conduct activities.***

Table Q50 Nebraska Total Care Provider Training Work plan

Category	Topics	Timeframe	Responsible Entity
Orientation	Covered Benefits and Levels of Care; Outpatient Treatment Requests; Clinical Documentation; Titrating Outpatient Services; Medical Necessity Criteria; PCP Tool Kits; Referral and Screening; Integrated Healthcare; Enrollee Outreach/Member Connections; 24-hour Nurse Advice Line Services; Pharmacy Services Overview (including formulary); Case Management, Prior Authorization Process Policies and Procedures; Billing and Claims Submission (including sample claims and review of remittance advice form); Claims Dispute Resolution processes; Preventative Services: Medicaid Policies (including updates); Person-Centered Planning Process, HCBS settings per CMS regulations; Information Technology, Billing, and Systems Operations; Critical Incident Policies and Procedures, Provider Requirements and Responsibilities; Eligibility Verification Process; Provider Portal; and The Role of the	30-45 days prior to go live; ongoing is within 30 days of providers' effective date with the health plan; office visits will occur within 30 days of new contract and then at least quarterly, or as needed	Network and Clinical Provider Training team

	Care Manager and the importance of notifying a member's Care Manager of any significant changes in the member's condition or care		
Specialized Training for BH Primary Care FQHC/RHC/PCMH **Pharmacy**	SMART Goals, BH Screening Tools (PHQ2 and PHQ9 {Depression}, CAGE-AID {Substance Abuse}, GAD-7 {Anxiety}, Vanderbilt {AHDH}), Diagnostic Manuals (DSM-5, ICD-10), Mental Health First Aid, SBIRT, Suicide Assessment and Intervention, Motivational Interviewing, Stages of Change, Positive Psychology, Strengths Based Model, BH 101, Diagnosis Specific Disorders, Psychotropic Medications, Social Determinants, Co-Occurring Disorders, Recovery Model, Trauma Informed Care for Providers and Caregivers, Adverse Childhood Experiences, Resiliency Training, Cultural Competence, Poverty Competence, Stress Management for Caregivers, and Behavior Management Strategies. Targeted training to support traditional LTSS providers in transitioning to rendering services under the IHQHI program through assistance with features, such as abuse and neglect procedures and requirements	30-45 days prior to go live – ongoing as needed; office visits will occur within 30 days of new contract and then at least quarterly, or as needed	Network and Clinical Provider Training team
Community Stakeholders	Community stakeholders are invited to all of our town hall provider trainings and are frequent hosts for our trainings	30-45 days as well prior to go live and ongoing as needed	Network and Clinical Provider Training team

Education and Training Activities. NTC's Provider Training and Education Program includes initial orientations, webinars, online training and resources, conference calling, provider office visits, and workshops and other educational events. We also collaborate with professional associations and community-based organizations to offer additional educational opportunities including input and consultation with advocacy groups, Tribal communities and other organizations that can assist in inclusion of concerns, needs and information that will assist providers in maintaining understanding, communication and best practices to deliver care.

Method of Education and Training

Newsletters and E-blasts. NTC will send out banner messages on our Provider Portal as well as routine newsletters and E-blasts for our providers to communicate changes in policies or processes that may impact claim submission or payment.***Provider Forums.*** These will be large scale, quarterly provider education meetings where we discuss NTC operations for the network. We will share claim payment information and review claims-related data, such as quality metrics, claims payment, turnaround time, denial reasons, and health plan policy updates. The target audience for these meetings will be practice and billing managers, hospital account managers, and clinicians. ***General information included in provider meetings includes:***

• Claims Payment Summaries (billed, allowed, and paid amounts) • Claim Adjudication Summaries, by provider type (hospital, specialist/primary care practices, and ancillary) showing claims received, paid, pended, and denied • Claim Payment and Denial Rate Summaries (showing % of claims paid, pended, and denied)	• Average Claim Adjudication Turnaround Times (paper vs. electronic) • Trends in denials that may require provider education • Health Benefit Ratio (HBR) • Provider Incentive Programs

Ongoing and Targeted Provider Education. This effort will address new requirements or initiatives, program priorities, such as physical/BH coordination requirements, and compliance issues. Ongoing and targeted provider education will be conducted in various modes, including office-based and group

training. We also will provide e-learning, including on-demand web-based training and webinars conducted by PS Specialists. Topics will vary based upon:

• Provider satisfaction survey results • Trends in provider call center inquiries • Trends in member grievances and provider complaints	• Changes in DHHS or NTC policies and procedures • NTC quality improvement initiatives • NTC priorities such as cultural competency and incentives

Frequency. We will conduct provider orientation training sessions within 30 days of placing a newly contracted provider on active status, and we will invite all providers to attend Town Hall/Ad Hoc trainings and other training events, which will comprise a training calendar of four to six trainings per month, within reasonable proximity of every provider at least quarterly. Our PS Directors set yearly "touch goals" for individual PS Representatives/Managers (PSRs). A "touch" is a significant interaction (face-to-face visits, telephonic, webinar, etc.) that involves education, information sharing, and/or issues resolution. To support our PSRs in meeting these goals, we provide continuous training that emphasizes peer support and recognition of achievement. For example, PSRs who significantly exceed standard goals become "role models" who receive recognition and share their strategies at monthly PS all-staff meetings.
Frequency of Office Visit. Our PSRs' office visits will occur within 30 days of a new contract and then based on need/request. We visit all network providers at least quarterly, or more often based on their preferences. For more than two years NTC has been on the ground in Nebraska creating opportunities to build relationships, learn about local community needs, and has listened to our providers regarding their recommendations to implement our processes. In NTC's affiliate markets, such as Louisiana, Indiana and Florida our PS Teams engage more than 90 percent of unique network providers annually, and continually remind all providers (network and nonparticipating) that they can contact us via our provider call center or PS staff at any time.
Evaluation and Improvement. We will track participation and follow up with providers to help them complete needed training. Every training has a pre- and post-test and an 80% score is the NTC threshold for passing. In addition, a survey from each training also will track improvement, and providers are routinely surveyed to elicit additional topics for training. NTC's Value Based partners such as ENHANCE, CHI and the seven FQHC's will collaborate monitor and identify necessary and/or beneficial training opportunities.

- ***A listing of the types of materials and content the MCO will distribute (include three samples of materials).***

Provider Materials

In addition to NTC's Provider Manual, we will distribute a packet of resources and educational materials at all provider training sessions and post updated educational and resource materials online for providers' convenient for access anytime. Provider training packets will include, at a minimum, recent provider newsletters; pertinent bulletins; instructions regarding filing claims, copayment, and member cost-sharing responsibilities; disease management support materials; user guides for website features; and quick reference guides with key phone numbers and community resources. Each quarter, NTC will distribute a provider newsletter containing information about upcoming changes, new programs, announcements, reminders, and similar topics of interest to the provider network as a whole.

Overview of Content. Provider Manual. Submitted to MLTC at least 90 calendar days prior to contract start date and approved prior to publication, the NTC Provider Manual will describe the manner in which we manage our Medicaid program as well as operational procedures followed by our Company. It covers a broad array of topics, including those listed to the right.

- A description of the Medicaid Care Management program
- Member and provider grievance and appeal process
- Medical necessity standards Medical record standards
- Billing and payment protocols and standards
- Credentialing criteria
- Provider rights and responsibilities
- Care Team core benefits and services
- Cultural competency information
- Value added services and benefits
- Primary Care Physician responsibilities
- Utilization Management policies and procedures
- Prior authorization and referral procedures
- Prompt pay requirements
- Medical Management programs (including guidelines for treating chronic and complex conditions)
- Eligibility verification process
- EPSDT standards
- Credentialing and re-credentialing information
- Quality Improvement program and requirement

The manual will be distributed to all new network providers with the welcome packet, and it will updated regularly and distributed in whole or in part to network providers at least 30 days in advance of any material policy or procedure change.

Provider Billing Manual. This is NTC's guide for providers that describes the manner in which providers are expected to bill for services covered by our program. The Billing Manual is comprehensive and addresses all aspects of claims submission and billing requirements.

Provider Quick Reference Guide. This is a provider "cheat sheet" summarizing the operational policies and procedures that govern our program that includes information about billing requirements.

Clinical Practice Guidelines. NTC will educate providers on clinical practice guideline (CPG) application, our Care and Disease Management Program support for CPGs, and how these guidelines dovetail with clinical initiatives such as NCQA. CPGs and related educational materials are available on our website and upon request. Examples of clinical practice and preventive guidelines we will provide include ADHD, adult preventive care, asthma, bipolar disorder, diabetes, major depressive disorder, pediatric preventive care, schizophrenia, sickle cell, and congestive heart failure. Please see the following Attachments for Samples of Material and Content NTC will tailor and distribute: ***Attachment 50.A_Provider Orientation, Attachment 50.B_Quick Reference Guide, Attachment 50.C_Guidance for Prior Authorization***

- ***How the MCO will evaluate usefulness of educational sessions and utilize feedback to influence future training sessions.***

Evaluation and Oversight

Our approach to evaluating the effectiveness of provider training material is two-pronged. First, we establish a cross-department feedback loop with providers to ensure the material is current, relevant, and understandable. Secondly, we monitor compliance to further evaluate provider's awareness and understanding. NTC uses multiple approaches to this end:

- Provider satisfaction surveys and training evaluations
- Provider Advisory Committee (PAC)
- Member surveys and secret shoppers
- Value Based measurements and partner input
- Medical record audits
- Member & provider complaints and grievances
- Provider profiling – report cards
- Provider Incentives
- Provider care gap alert system

Tracking Provider Participation. We will track participation and follow up with providers to ensure they complete needed training. PS team members will reach out to providers who have not participated in personalized New Provider Orientations. Our Value Based partners will assist in this process and will monitor participation as well as provide reports on follow up.

Evaluation. Every training has a pre- and post-test with a required 80% pass threshold. In addition, we will ask training attendees to complete a seven to nine question survey, with space for comments and a request to identify additional training topics. Feedback will be aggregated and reviewed by our PS leadership quarterly to identify needed revisions to training. Web-based training will include a similar online form. Feedback on pre-implementation training will be reviewed weekly to ensure quick identification of issues. Value Based agreements will require collection and reporting as part of the quality measurement and compliance.

Utilizing Feedback to Improve. Our PSRs will educate and obtain feedback from providers to inform our training plan. For example, as we were implementing the BH benefit carve-in to the Louisiana Bayou Health Plan, a significant number of BH providers were not accustomed to billing private insurance companies for the services they rendered. Our team developed training materials and scheduled a series of town hall meetings throughout Louisiana to build awareness. **To date, these trainings have been attended by over 1,000 BH providers, and a similar training in our Florida market has been attended by over 15,900 providers.**

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. (2 page limit)

Provider and MCO Communication and Collaboration

Our Provider Services (PS) approach emphasizes personal connections. We meet providers prior to go-live and reinforce these relationships during orientation *and* as we learn about and respond to their needs via on-going meetings, calls, emails, and trainings. Our website, information technology, monthly provider newsletter, and provider forums all provide additional venues for communication, routinely evaluated to ensure effectiveness and efficiency. We will support email communication, collecting and storing provider email addresses for communicating changes, available materials, and upcoming events, and provide encryption software on request from a provider to allow the exchange of member data via email. Our PS model provides a supportive infrastructure across multiple departments (medical management, call center, contracting, quality, etc.), and a no wrong door for receiving provider input and feedback. Our NTC Provider Network Liaison will establish and work collaboratively with our Provider Advisory Committee (PAC) to ensure that an effective feedback loop is created between NTC and its provider network. We have already identified providers to participate as representatives on our PAC, as well as our Credentialing, UMC, QAPIC, and Clinical Advisory Committee (CAC) to ensure full provider representation when policies and plans are made. At go-live, Value Based Purchasing agreements with ENHANCE, CHI, seven FQHCs, Tribal 638s and Avera Health, will include measures to promote communication and address administrative efficiencies and monitor clinical policies and operational issues to focus on efficiencies and refine a response to provider concerns through training and communication strategies.

Effective Communication Forums and Methods

Face-to-face interaction with our providers is the cornerstone of our model. Regional Provider Services Representatives (PSRs) are assigned to engage each provider and their staff at their offices, as we build relationships and learn first-hand about their needs and concerns. To maximize the impact of our outreach, we stratify providers into groups based on factors that influence the level of support they need: Level/amount and types of services provided (e.g. specialty or high-volume providers); Total number of members served; Regional differentiators (e.g. areas with critical needs); Participation in initiatives or programs; Level of familiarity with Medicaid; and time in network (e.g. support for new providers). Our efficient outreach model is tailored to meet needs, improve administrative efficiencies, and engage providers in developing and monitoring clinical policies and operational issues.

Goals of Communication and Collaboration

Our success hinges on our network providers and their ability to efficiently and effectively serve our members. We rely on our providers to tell us how we can best support their efforts in achieving our shared goal of ensuring that the right high-quality care is provided, in the right amount, where and when our members need it. Our goal is to effectively engage our providers as partners.

Improving Administrative Efficiencies. Our collaboration with providers to improve administrative efficiencies has already started through our active, on-the-ground, outreach with providers and provider associations. Over the past year, we have met with hundreds of providers and associations throughout the state to identify opportunities for improved efficiencies, explicitly asking for provider input. For example, Charles Drew Health Center identified transportation as a significant pain point. They identified issues such as lack of timely access to transportation, lack of appropriate transportation such as wheelchair accessible vans, and lack of transportation providers who can work with the large non-English-speaking population that utilizes services provided by Charles Drew. NTC is committed to working through these and other identified provider issues to improve administrative efficiencies. On an ongoing basis, our Performance Improvement Team (PIT) and Senior Leadership Team (SLT) will monitor, daily, weekly,

and monthly indicators, including claims processing timeframes, prior authorization processes, and credentialing timelines, and feedback received through Provider Services and quality committees. Both NTC and Centene's *Compliance teams* will monitor provider satisfaction indicators and compare them to previous results, benchmarks, and targets. All of these activities will inform and help design interventions and process improvements and subsequent monitoring and oversight.

Engaging Providers in Developing and Monitoring Clinical Policies and Operational Issues

Our PAC and CAC are designed to solicit input from providers in developing, reviewing, approving, and monitoring clinical policies and operational issues. Providers also participate on our UMC and other quality committees to facilitate input from a range of providers representing different populations and disciplines, such as persons with disabilities and behavioral health. Our provider engagement strategies are designed to support, be responsive to, and collaborate with providers. For example, calls to our PSRs, input shared in trainings and forums, and comments and complaints are all tracked and trended to inform policy and practices changes, trainings, and administrative processes. Trainings and quarterly town halls/summits will be designed to further promote these activities and maximize communication between NTC and its providers. They will be open to all network providers and meeting agendas and minutes will be made available to MLTC on request. We will report information from these meetings and forums to our SLT and MLTC. Value Based agreements with providers will include quality measures incentivizing development and monitoring of clinical policies and operational issues. SPH Analytics will conduct NTC's annual Provider Satisfaction Survey, which will assess degrees of satisfaction with, for example, credentialing, utilization management, claims processing, and plan support. Additional formal and ad hoc survey activities are conducted throughout the year. More extensive initiatives, such as our cross-market Provider Journey Mapping project, are designed to thoroughly elicit input from our providers ***at each touch point*** to learn from their experience of our services as we continually adapt our model.

Role of the Provider Network Liaison

Our Provider Network Liaison will establish our process for responding to provider concerns, develop trainings in response to identified need or protocol changes, processes, and forms and enhance our provider communication strategies. Our PAC will meet monthly to identify organization-wide and individual provider issues and develop strategic remediation initiatives.

Working with the Provider Advisory Committee. Our Provider Network Liaison will solicit provider input from the PAC regarding provider materials and support, plan performance, clinical programs, quality initiatives, value-based payment, and other clinical and operational activities. The PAC will represent feedback and guidance from a spectrum of local network providers, including the major provider organizations in the State as well as individual providers, including BH and pharmacy providers and providers who primarily serve individuals with disabilities. Our Provider Network Liaison will coordinate with the PAC to ensure providers have a direct voice in developing and monitoring clinical policies and operational issues. This liaison is also responsible for coordinating input from the PS Team to ensure that the Provider Training Plan reflects provider input and addresses Statewide needs and overseeing the feedback loop to facilitate provider communication. Information from the PAC is reported up to the QAPIC quarterly, including information from our Hospital, BH, and Tribal Sub-Committees.

Examples of Successful Collaboration with Providers to Identify and Implement Change

When Home State Health Plan, our affiliate in Missouri, initially began visiting providers and offering data and reports about billing and claims performance, they were providing information from a broader regional level. They listened and learned that providers wanted information about their own billing and claims payment performance. Home State's external PS Specialists now come equipped with 90-day Provider Claims Reports that include a claims payment summary; a denial report that includes reasons for each denial; and a Turn Around Time report so providers can see how quickly they bill and how long claims processing takes. These reports are a tool for PS Specialists to tailor billing and claims education to meet the specific needs of the provider. Similarly, in Massachusetts and New Hampshire, we proactively raised provider satisfaction rates by using a report card that educates providers about the number, types, and top reasons for provider claim denials and appeals.

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. (3 page limit)

Provider Complaints Process

NTC is committed to ensuring that providers are satisfied with our management. We work hard to avoid complaints through maintaining an open dialogue with providers to ensure multiple opportunities for communication and creative problem-solving. Provider complaints are processed through our Complaint System which is an integral component of our Quality Assessment and Performance Improvement (QAPI) Program. We will track the receipt and resolution of any and all verbal or written complaints originating from in- or out-of-network providers related to dissatisfaction with NTC policy, procedure, or payment. Our call center based Provider Service Representatives (PSR), field-based PSRs, senior management, and clinical staff are all involved in the QAPI Program and empowered to respond immediately, creatively, and flexibly to rapidly resolve complaints and route them for ongoing review.

Receiving and Processing Complaints

Every provider in our NTC network will have a field-based PSR who will be notified of and responsible for ensuring that provider complaints, when they do occur, are resolved thoroughly and rapidly. Our provider services staff are trained to distinguish between a provider complaint and a member grievance or appeal for which the provider is acting on the member's behalf. Our call center staff (CSRs) are trained to document and route complaints from providers based on the division best able to resolve the concern quickly and efficiently:

- Member-specific events are routed to the Grievance System Manager for expedited resolution
- Access and availability complaints are routed to Network Development and Contracting teams
- Payment complaints will be routed to the designated PSR
- Resource Needs complaints will be routed to our Network Development team
- Personal concerns will be directed to our Provider Network Liaison
- Quality of care, denials, suspension, authorization, and member utilization complaints will be tracked and resolution monitored directly by our Quality Department

Compliance Coordinator. If a call turns into a complaint, the formal complaint is forwarded to NTC's Compliance Coordinator. The Compliance Coordinator will research all provider complaints, regardless of how received, phone, mail, fax, email, or in person. Research activities involve contacting providers via telephone, e-mail, or fax to obtain additional information to thoroughly investigate the complaint. The Compliance Coordinator reviews the complaint, identifies any potential barriers to timely and complete resolution, and works with the applicable departments to thoroughly investigate observing applicable statutory, regulatory, and Contractual provisions, collecting all pertinent facts from all parties and applying Nebraska MLTC written policies and procedures. The Compliance Coordinator corresponds with providers using written acknowledgment letters and resolution notices as described below. Providers may bundle complaints regarding multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint. Each provider complaint will be fully investigated using applicable statutory, regulatory, contractual, and provider subcontract provisions, collecting all pertinent facts from all parties and applying NTC and MTLC's written policies and procedures.

Oversight and Escalation. The Compliance Coordinator presents the proposed resolution to the Compliance Department leadership team and appropriate executive level staff, including the Vice President of Operations/COO and Director of Provider Services, to approve the proposed resolution and determine if corrective action is required. NTC executives with the authority to require corrective action

will be notified and involved in the provider complaint escalation process. Names, telephone numbers, and e-mail addresses for these responsible individuals will be provided to MLTC within 15 calendar days of Contract signing. Our policies and procedures will include a description of the complaint filing process, and the resolution timeframes. Written policies and procedures that describe our provider complaint system will be submitted to MLTC for review and approval 45 calendar days prior to our start date.

All complaints will be reviewed by our Quality Management Department where complaints are trended and issues are identified for systems level adjustments, targeted training, or policy change. For example, we may review the prior authorization lists to see if there are trends in services which are always approved and for which the required prior authorization requirement can be eliminated. Provider complaint trends and associated recommendations for improvement or intervention will be reported up through the QAPIC.

Provider Notification of Process. NTC will distribute all policies and procedures, via approved summary or appropriate web link, to in-network providers at the time of contracting and to out-of-network providers with the remittance advice, including how to file an appeal or complaint. Providers will be informed about our complaint process during their orientation and via multiple resources, including the Provider Handbook and the Provider Portal, which includes specific instructions regarding how to contact provider services staff and contact information for the NTC Complaints Coordinator who receives and processes provider complaints. While there is no wrong door, providers will be advised to contact their PSR via telephone, e-mail, regular mail, and in person, to ask questions, file a provider complaint, and resolve problems. Our NTC BH Provider Liaison will be an additional conduit for BH providers. NTC will interact with providers through telephone, e-mail, fax, and in person with our provider services staff when handling inquiries and complaints. Providers will be educated as to when they may file a complaint directly with MLTC for those issues that are not a NTC function. Providers may also always file a complaint through our call center.

Provider Interaction and Correspondence

If the outcome of a Provider Complaint Review is adverse to the provider, the Compliance Coordinator will send a Notice of Adverse Action to the provider within 30 calendar days. The Notice informs the provider of their rights and options of requesting arbitration regardless of the type of action. For example, if the Action relates to a claim, the provider may request binding arbitration before a certified private arbitrator with experience and expertise in the healthcare field after exhausting NTC's Administrative Review Process.

Timeframes. Providers can submit a written complaint within 30 days of an incident. The Compliance Coordinator will manage the timely acknowledgement and resolution of provider complaints, in writing, and resolve all provider complaints within the timeframes indicated below. Our grievance response timeframe, upon approval of MLTC, will be:

- Complaint filed within 30 calendar days of the incident or action
- Acknowledgement of receipt within 10 business days of receipt of the complaint
- Response/written Notice of Adverse Action within 30 calendar days of receipt of the complaint
- Follow-up/resolution as indicated

Tracking of Provider Complaints and Grievances

Our Compliance Coordinator will receive and process provider complaints and monitor timeliness of acknowledgement and resolution. Provider complaints are captured, tracked, reported, and managed (to completion) through our Customer Relationship Management (CRM) system. CRM is built on Microsoft Dynamics CRM technology and enables us to identify, engage, and serve our members and providers in a holistic and coordinated fashion, across the breadth of their wellness, clinical, administrative, and

financial matters. CRM's inquiry tracking functionality enables unified communications (phone, e-mail, fax, mobile device, web and interactive messaging) between NTC and our members and providers. All contacts, whether by phone, e-mail, etc., with a provider become part of that provider's online CRM record. CRM's tracking and reporting capabilities ensure that CSRs can route inquiries to appropriate staff (e.g. eligibility specialists, claims processors, clinical staff) and allows CSR staff and management to manage all inquiries to successful completion in the fastest possible timeframe.

How Information is Used to Improve Provider Services. Through our QAPI Program we will use information collected internally to improve operations. Our internal tracking system, reporting processes, and influence on provider services activities, plus our use of measureable provider satisfaction information allows us to learn from provider complaints and inquiries and engage providers in identified opportunities for improvement. We will use Provider Complaint System data for improvements in areas, such as business process, staff training, identification of network gaps, improvements to written materials, additional provider training, fraud and abuse, subcontractor performance, and staffing adjustments. For example, in our Missouri affiliate plan, Home State, the health plan received complaints from providers that after appropriate collaboration and due diligence resulted in the removal of a prior authorization requirement for obstetrical ultrasounds. Our Massachusetts affiliate, CeltiCare, saw appeals related to Pharmacy spike to 48 (64% of all appeals). Nine (19% of pharmacy appeals) were related to Suboxone treatment. The appeal trends indicated that CeltiCare's Suboxone policy was potentially too stringent and also there was difficulty obtaining clinical info needed to support medical necessity. CeltiCare updated the policy by removing a 6- month time limit on the medication to meet the needs of the population and ensure that all provider notifications clearly articulated what was needed to obtain approval. Following the intervention, total Pharmacy related appeals declined to only 18 and have remained low based on continuous monitoring. Information is also used to prevent complaints. For example, to address high claim denial rates for select providers in our Washington health plan affiliate, Provider Relations and the Medical Director conducted targeted outreach and education for an identified list of providers with the highest denials on claims.

Internal Reporting

Provider complaint data will be presented to the QAPIC at least quarterly. The QAPIC will review these reports to identify trends and areas of concern, including whether timeliness standards are met; identifying patterns related to specific issues or MLTC departments; and targeting any needed corrective actions. Trend data will also be presented to the Corporate Compliance Committee. The PS team will report on provider complaints during monthly calls with Quality and Provider staff from other NTC-affiliated health plans. These calls are an opportunity to share and develop best practices and flag complaints that require systemic response. Our Quality or Compliance Department will provide monthly provider complaint reports to the Provider Relations Department for the purpose of prioritizing the activities of PSRs, including targeted education and outreach, updates to training curriculum and/or provider materials, and revisions to policies and procedures as appropriate and approved.

How Reports are Used to Improve Performance. The PS Department will review provider complaint data and trends to identify opportunities to improve individual provider performance and provider materials and training that support superior performance. Reports out of CRM can be filtered by provider to identify individual trends, or by billing code or process, to target system deficiencies. Information is monitored and shared through our continual face-to-face presence with providers, monthly and quarterly provider training, reimbursement policy clarifications and changes, and internal PS staff training. Information is also used to target individual provider interventions, including corrective action as necessary, improve provider materials, and suggest topics for our monthly provider newsletter. Systemic changes are overseen by the QM Department to ensure appropriate evaluation and continuous improvement.

(1 page limit)

53. Describe the MCO's plans and ability to support network providers' "meaningful use" of electronic health records and current/future Federal IT requirements.

Promoting Meaningful Use by Meeting Providers Where They Are

Nebraska Total Care (NTC) will promote, incent, and support the meaningful use (MU) of electronic health records (EHR) through a coordinated, four pronged strategy, recognizing that our network providers are at markedly different stages in EHR implementation:

1: Expanding MU with Providers Already Using EHRs. In meetings with Nebraska providers, including CHI Health, the ENHANCE Health Network (formerly RPN), and the University of Nebraska Medical Center (an EHN member), we have discussed impactful data exchanges. We will offer these providers mutually beneficial MU applications, for example: the sending of Admission, Discharge, Transfer (ADT) data from providers with the waiving of Inpatient Admission Notifications by NTC, offering a major administrative efficiency. We will also support the receipt of HEDIS care gap closure data from EHRs, eliminating the need for manual "chart pulls", as well as additional MU applications.

2: Integrating MU with our PCMH Incentive Program. We will deploy resources and incentives (including financial incentives) for providers to achieve NCQA Patient Centered Medical Home (PCMH) Recognition (see Section 43). Our NCQA Certified PCMH Coordinators will help providers develop a plan for Recognition status, including EHR MU requirements, and help the practice develop procedures to support patient work processes confluent with EHR deployment, including EHR connectivity via NeHII.

3: Identifying and Engaging Providers. During routine provider contact (e.g. service inquiries, site visits) we will collect, trend, report and act upon the EHR MU status of all our network providers. We will target providers with no EHR, and engage them with an understanding of resources available to them, including ours as well as other assets in Nebraska, such as NeHII and Wide River, LLC, which has served as the state's Regional Extension Center (REC) and continues to support EHR efforts. Using this approach our affiliates have seen marked impact: for example, over the past 18 months, our affiliate in Florida has found that 50% of the providers they engaged on this topic are now deploying EHRs. Our providers will also have access to our Provider Portal, which offers a number of secure online clinical applications, including member roster with health registry functionality, care gap alerts, online member health records and care plans, and much more – including a Practice Improvement Resource Center with information on EHR use and opportunities to contact us.

4: Collaborating with NeHII. In November 2015, we began work on a comprehensive participation agreement with the Nebraska Health Information Initiative (NeHII) and expect to execute this agreement in 2016. We believe we can help drive EHR MU through NeHII by contributing clinical data, including medical, behavioral health, and pharmacy claims data, lab test results, assessments, and other information to NeHII and in so doing, help enhance the usefulness of NeHII's query based and Virtual Health Record offerings. We are also partnering with local county public health departments and other DHHS agencies, including DBH, for data sharing arrangements (see Section 12), and will drive the use of NeHII as the fulcrum for these efforts.

Ability to Support MU through Connectivity. NTC's enterprise Management Information System (MIS), developed and operated by our parent, the Centene Corporation, includes Centene's Centelligence™ Health Information Exchange (CHIE) system, an integrated part of our MIS that uses and maintains compliance with US Department of HHS Office of National Coordinator (ONC) standard interchange technology to send and receive meaningful information securely.

In 2013, Grant Thornton, LLP, a leading independent auditor, gave Centene's MIS its highest possible score for HIE readiness.

Centene currently uses CHIE to connect to HIEs and support clinical data exchanges for a variety of applications in Washington State, Texas, Indiana, and, in 2016, in Georgia and in Arizona. Centene subsidiaries become an active HIE participant wherever we can. In Arizona, for example, our affiliate is represented on the Arizona Health-e Connection (AzHeC) Board of Directors and Planning Board by Cenpatico's Senior VP of IT and Operations.

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. (2 page limit)

Nebraska Total Care (NTC) seeks to extend the capacity of Primary Care Providers (PCPs) to provide integrated behavioral health (BH) services and coordinate member's co-existing conditions through ***NPACT (Nebraska PCP Access Coordination and Training Program)***. ***NPACT*** promotes integrated care across our network using a provider centered approach, whereby we first assess provider capacity, and then offer tailored provider trainings, system-wide supports, and engagement strategies to fill identified gaps and move providers further along the integration spectrum relative to their goals (***Table Q54***). NTC supports partners like Catholic Health Initiatives (CHI), Midtown Health Center (FQHC-Norfolk, NE), Vest Psychiatric and the University of Nebraska Medical Center already engaged in programs utilizing PCPs in an integrated practice with behavioral health to enhance capacity to treat co-existing conditions and provide expanded education, training and member engagement opportunities. NTC will also utilize Telehealth services to engage and educate PCP's as part of a webinar program to equip PCPs with the tools necessary to offer BH services, support case management and confer and participate care and coordination of co-existing conditions.

Table Q54 A Selection of Integration Initiatives NTC will Support	
UNMC Munroe-Meyer Institute	Places pre- and post-doctoral psychology interns and licensed BH providers in pediatric primary care settings
People's Health Center	Recently partnered with Lutheran Family Services to co-locate BH
Charles Drew Health Center	Fully integrated onsite BH services; PCMH certified

Assessing PCP Capacity. Partnerships with local stakeholders are critical to enhancing care for members. Our Network Development and BH leadership representatives have engaged with PCPs and other stakeholders across the state around their existing capacity related to integrated care provision, and we have formed collaborations and identified opportunities for customization of ***NPACT.*** There is a spectrum of integration currently occurring across Nebraska. The first step of ***NPACT*** will be to meet with PCPs across the state to discuss their definition of integration using the SAMHSA-HRSA Center for Integrated Health Solutions six levels of collaboration/integration[3] as a guide. While some PCPs will reach Level 6 (fully integrated care), we know this type of integration is not right (or possible) for every practice. We meet PCPs where they are, assessing their current referral practices, member patterns of care, and the use/availability of tools and resources that enhance integration (i.e., NeHIE, BH partners, staff resources for care coordination), and engage and support them to move toward the right approach for their practice, members, and community. **NPACT Engagement and Education Strategies.** Based on our assessment of where each PCP is and wants to go within the spectrum of integration, create ***NPACT Support Plans*** that contain customized arrays of supports, including a comprehensive training package, educational supports, a Psychiatric Access Line, reimbursement for Screening, Brief Intervention, and Referral to Treatment (SBIRT), access to telehealth, and ongoing monitoring and incentives to support integration. **PCP Training.** NTC provides primary care practices (PCPs and their clinical and administrative staff) with a customized array of trainings that are directly responsive to identified gaps and integration goals. For PCPs who are just beginning to think about integrating BH services, evidence based screening tool and local BH referral source identification education is often a good starting place. Others, who are more ready to integrate care may be ready to implement (or improve in the implementation of) an evidence based model of integration that meets the needs of the populations that they serve (i.e., Collaborative Care) or move towards becoming certified as an integrated Primary Care Medical Home (PCMH), as described more fully in Question 43. NTC's integration-related training topics, which are provided both in person and virtually, include: Screening tools such as PHQ-9 (depression), Edinburg Depression Screen (post-partum), and CAGE-AID (alcohol and other drugs), to assist PCPs in identifying BH issues, SBIRT, an evidence based practice (EBP) for

[3] http://www.integration.samhsa.gov/integrated-care-models/CIHS_Framework_Final_charts.pdf

identifying/responding to co-occurring substance issues, Mental Health First Aid (MHFA), an EBP targeted for staff at all levels of the PCP's practice to educate them to support individuals experiencing mental health conditions and crises, Integrated Care Planning, to support PCPs in caring for the "whole person" and utilizing actionable BH data available through NTC's Provider Portal moving into this integrated environment, Collaborative Care Model, an EBP to assist PCPs in integrating BH services within their practice. NTC continues to engage a variety of stakeholders, including the Nebraska Division of BH, ENHANCE Health Network, CHI, the Children and Family Coalition of Nebraska (CAFCON), University of Nebraska Medical Center (UNMC), and the State's Native American tribes, in identifying training topics that support PCPs in the delivery of integrated BH services and supports. **Additional Educational Supports.** To support training efforts, we offer written materials and resources (i.e., a Mental Health Severity Guide that summarizes key behavioral health indicators and Provider Toolkits that relate to specific behavioral health disorders and integrated care practices) in hard copy and electronically (via our Provider Portal), maintain an e-library of Relias Learning courses on a variety of BH topics that relate to the provision of integrated care for providers to access "on demand" directly through our website, facilitate connections between PCPs who are at various stages of integration for peer-learning opportunities (i.e., Learning Collaboratives), and facilitate connections via teleconference, using specific patient case studies as a tool for discussion and group learning, teach by example via integrated care management teams that with PCPs and their teams within practices to assist in coordinating and providing integrated BH services, embed Care Managers within PCP offices to support development of integrated care infrastructure. **24/7 Psychiatric Access Line.** To offer PCPs continued support to meet their patients' co-occurring BH needs, NTC offers a 24/7 Psychiatric Access Line to our network. PCPs can call this phone line at any time to reach a licensed mental health clinician for consultation to interpret member screening results, diagnose behavioral health conditions, and identify appropriate intervention and prescription protocols. **Support for SBIRT.** In addition to SBIRT training modules, NTC will cover the initial SBIRT service code to incentivize PCPs to engage in implementation. Recognizing that the success of SBIRT is directly proportional to the PCP's referral network, NTC's Provider Services Team will assist each PCP to identify behavioral health providers within their region to establish formal referral agreements. We encourage the formation of multiple referral channels for each PCP to assure member choice and access to an array of culturally congruent, developmentally- and acuity-appropriate service providers. **Telehealth & E-Consults.** To augment the ability for PCPs in the rural and frontier regions of Nebraska (where nearly half of Nebraskans reside but behavioral health practitioners are scarce[4]) to deliver integrated behavioral health care, NTC offers telemedicine services. Through telehealth, NTC can support PCPs to virtually "integrate" BH practitioners into their practices. These BH clinicians can utilize telehealth to provide both direct services to members and consultation to the PCP around BH issues (for which NTC offers reimbursement). For a description of our telehealth strategy, see Question 25. **Integration Incentives.** From the moment we engage with each PCP, we identify what integration related performance measures are being tracking and other appropriate measures that, based on their current capacity, could support integration. We support PCPs in the early stages of integration to track process metrics (i.e., increased number of BH referral relationships, staff participation in BH training), and over time (or when working with PCPs who are further along the spectrum) move towards measurement of integrated care outcomes. As appropriate, we offer financial and non-financial incentive arrangements to PCPs that engage in integrated care practices (i.e., improving on HEDIS measures such as depression screening and referral, achieving Patient Centered Medical Home status). PCPs who are seeking to integrate behavioral health care can participate in one of our "Gold Card programs," a non-financial incentive program that streamlines administrative requirements to effectuate coordinated care. Throughout implementation, NTC works closely with our network and the State to explore additional opportunities for incentives for integrated care practices (i.e., purchasing needed equipment for professional practices). See Question 97 for a complete description of how NTC engages in Value Based Payment (VBP) arrangements with providers.

[4] Evans, J. (2014). Integration of BH into Primary Care: What's Happening in NE? UNMC.

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. (5 page limit)

Nebraska Total Care (NTC) is dedicated to the satisfaction of our provider partners and the fourth leg of the Quadruple Aim (as stressed by Bodenheimer and Sinsky in 2014[5]): improving the work life of our network providers and their staff. Therefore, we value and emphasize the collection and utilization of actionable direct feedback from providers, and strongly believe in the parallel process (i.e., providers that are satisfied with the supports they are getting from NTC will provide higher quality services to their consumers). We regularly obtain provider feedback through a comprehensive, integrated process that includes soliciting feedback directly from providers, analyzing results of provider satisfaction surveys, monitoring operational performance metrics that indicate satisfaction or dissatisfaction, analyzing complaint and appeal data, and examining provider turnover. Across NTC and our affiliate health plans, there is an ingrained sense that direct provider feedback is among the most valuable information that we can receive, as it often relates to a specific concern or question that, by addressing, NTC can proactively resolve across our entire network. Upon the identification of any provider satisfaction issue, NTC will conduct root cause analyses to determine the key drivers of the identified dissatisfaction, develop targeted action plans to address findings, and continuously monitor progress toward reversing dissatisfaction with the ultimate goal of becoming every network provider's health plan of choice.

Tools that NTC will use to Assess Provider Satisfaction.

Provider Advisory Committee. Our multi-disciplinary **Provider Advisory Committee** (PAC) will serve as a primary vehicle through which we will solicit input on issues Nebraska's providers consider most important. The Committee will include representation from the major provider network organizations in the State as well as individual providers from across service sectors (i.e., behavioral health and pharmacy providers, and providers who serve individuals with disabilities). The PAC, led by the **Medical Director**, will meet on a monthly basis. The **Provider Services Manager** will work collaboratively with the PAC to refine and adapt our time-tested methodologies for processing and responding to provider concerns to meet the needs of Nebraska providers. Recognizing the unique needs of the behavioral health and Native American provider communities across the state, NTC will establish a **Behavioral Health Advisory Committee** (BHAC) and **Indian Health Advisory Committee** (IHAC), consisting of entities that are specifically working in Nebraska's behavioral health sector and in tribal communities, who will provide input to the PAC on network and management concerns and cultural considerations related to network, service and access enhancement. *NTC continues to identify committee members – several members already identified include those in **Table Q55**:*

Provider Advisory Committee	Behavioral Health Advisory Committee	Indian Health Advisory Committee
• Representation from major provider network organizations (ENHANCE Health Network, CHI, etc.) • Joseph Evans, MD – Director Psychology, Monroe Meyer Institute • Joe Lohrman – CEO, Annie Jeffrey Memorial County Health Center • Joni Thomas – Executive Director, Independent Rising	• Administrators from each of Nebraska's 6 BH Regions • Annette Dubas - Executive Director, NABHO • Pat Connell - VP, Behavioral Health, Boys Town	• Ricky Trobaugh - Winnebago Tribe • Vietta Swalley - Santee Sioux Tribe • Jan Henderson - Ponca Tribe • Crystal Appleton - Omaha Tribe • Donna Polk - CEO, Nebraska Urban Indian Coalition

Provider Satisfaction Surveys. NTC adheres to the belief that regularly soliciting and acting on the valuable feedback received by providers will result in our ability to improve the services and supports that we provide to providers, members, and MLTC. Based on this belief, NTC will use a variety of survey tools to assess provider satisfaction. Our annual Provider Satisfaction Survey includes questions about our providers' degree of satisfaction with all aspects of their experience working with NTC, including:

[5] Bodenheimer and Sinsky, From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider, Annals of Family Medicine 12:6 Nov Dec 2014 pp 573-576

- provider credentialing
- service authorization
- NTC staff courtesy and professionalism
- network management
- appeals
- referral assistance
- coordination
- perceived administrative burden
- provider communication
- provider education
- provider complaints
- claims reimbursement
- utilization management processes

The survey also asks, "What can NTC do to improve its service to your organization," which will help NTC identify and appropriately address gaps in the supports that we are providing to each provider. A Provider Satisfaction Survey report will be developed that contains a priority matrix of common issues for follow up and correlates provider attributes (i.e., type of provider such as maternal and child health, behavioral health, or extent of provider knowledge) with overall satisfaction. **NTC's Network and Quality Improvement teams**, in collaboration with the PAC (and BHAC for issues related to satisfaction of behavioral health providers within our network), will use the highly correlated items and the priority matrix to develop Action Plans that focus on resolving critical satisfaction issues.

Nebraska Total Care Affiliate in Action...

NTC's Louisiana affiliate utilizes feedback from Provider Satisfaction Surveys to develop improvement processes. Each year, opportunities for improvement and specific action items are identified and assigned to different department and teams depending on the nature of the need Each assigned team develops and implements an Improvement Initiative and reports status updates to the Quality team on a monthly basis.. Current Louisiana initiatives include reimbursement fee consistency assurance, claims processing, pre-certification, referral, and authorization timeliness improvement and other strategies to support LA providers to provide appropriate clinical care to their patients.

In addition to our annual Provider Satisfaction Survey, within 90 days of each newly contracted provider's effective date, NTC's Provider Network team will send the new provider a short survey designed to identify concerns that can be addressed early in the relationship. In our experience, this type of early outreach can help to build provider-plan rapport and alleviate the "snowball effect" that may occur when provider concerns are not addressed early on, oftentimes avoiding significant dissatisfaction and frustration later down the road. NTC will also conduct periodic focus groups and attend existing provider associations' meetings and Town Halls to capture more general provider concerns and obtain provider feedback on specific issues identified through Provider Satisfaction Surveys and associated Action Plans for improvement. NTC's Provider Network Team is responsible for ensuring provider satisfaction surveys are conducted. The Network team works in close collaboration with the Quality Improvement team, that provides guidance and oversight related to NTC's overarching Quality Assurance and Performance Improvement (QAPI) strategy. We will utilize a third-party vendor, SPH Analytics (formerly The Myers Group), to conduct our annual Provider Satisfaction survey and assist in the analysis of the survey results. The PAC (with input from the QAPI Committee, and the BHAC, where appropriate) will review these survey results and provider satisfaction data and assist in the development of interventions ("Action Plans") for improving provider satisfaction.

Soliciting Direct Provider Feedback. In addition to the provider surveys and focus groups, NTC will regularly and intentionally solicit actionable feedback directly from providers through frequent, face-to-face interaction between network providers and NTC representatives, including those from Network, Provider Engagement, Provider Services, and Training teams. Upon contracting, each provider will be assigned a **Provider Engagement Representative**, who can connect them to appropriate resources within NTC should questions or issues arise. Our Provider Services Call Center, described in detail in Question 48, will provide an additional forum for providers to share feedback. We will also offer providers the option to directly communicate with us through our secure messaging feature on the Provider Portal. Our

PAC/BHAC and QAPI Committees will review and monitor these data as well, and assist in the development of Action Plans to mitigate identify trends. As part of our Value Based Purchasing measures with provider partners such as ENHANCE, CHI and the seven FQHC's, we will collaborate to solicit, collect and address provider concerns and overall satisfaction in order to work toward solutions.

Provider Inquiries and Grievances System. NTC further maintains systems and procedures for the receipt, investigation, and resolution of Provider Inquiries and Grievances, which we utilize as yet another way to solicit and respond to feedback in order to enhance provider satisfaction.

Figure Q55.A Provider Complaint System Process

Our approach to provider Inquiries and Grievances, i***llustrated in Figure Q55.A and described in more detail in Question 52***, reflects our core business strategy of continuous quality improvement. The complaints and appeals that NTC receives from providers allow us to improve our processes and continually enhance our level of provider satisfaction and support outside of formalized satisfaction surveys. NTC will closely monitor Provider Complaint/Appeals data on a monthly basis, and our dedicated **Compliance Coordinators** will receive, process, track and trend complaints and appeals by functional (i.e., primary care, behavioral health, pharmacy) and specialty (i.e., Tribal serving provider, frontier/rural/urban-based) areas, measure the number of complaints against established thresholds, and compare the data to historical benchmarks. All data will be presented to the PAC/BHAC and QAPI for their review and recommendations.

Provider Turnover. In addition, NTC recognizes that provider turnover is often a reliable indicator of provider (dis)satisfaction. Therefore, NTC's Network Team will regularly monitor and review the number and type of provider contract terminations, identifying the cause of the termination to determine if it was avoidable and analyzing overall retention rates and trends on a quarterly basis. The Network Vice President (VP) will report all findings to the QAPI Committee and PAC for their feedback.

Use of Survey Results to Implement Quality Improvements and Improved Outcomes.

Overarching Strategy for Addressing Identified Issues. When low satisfaction rates are identified through any of the above strategies, NTC's Network and Quality Improvement teams will utilize the Plan-Do-Study-Act methodology (***Figure Q55.B***) to conduct root cause analyses to determine the key drivers of the dissatisfaction and develop a targeted action plan to address the identified root causes.

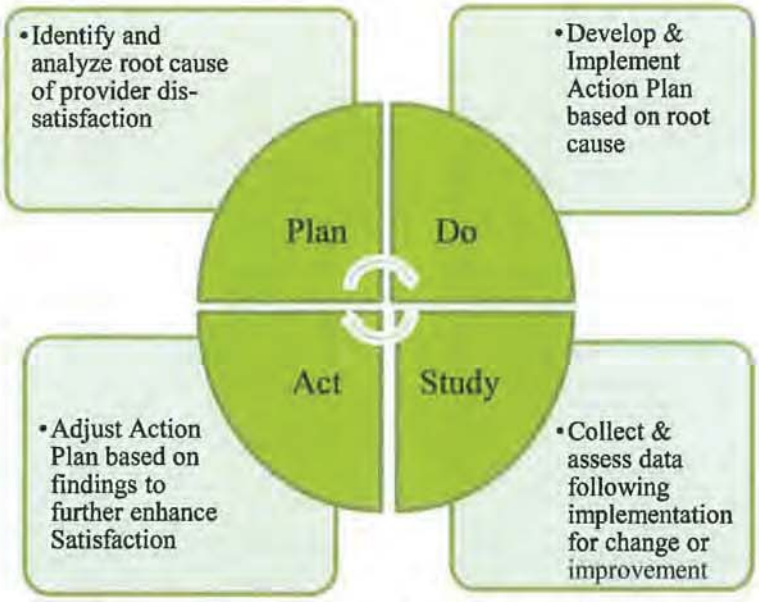


Figure Q55.B PDSA Process for Provider Satisfaction

For example, based on the identified root cause of the issue, action plans could involve updates to NTC's provider education process regarding clinical criteria (should the issue be a gap in provider knowledge) or the process of training and testing inter-rater reliability for Utilization Management (UM) or Prior Authorization (PA) staff (should the complaint be

related to uneven UM/PA criteria being applied). As part of Action Plan development, NTC will solicit input from the PAC and QAPI Committee. Following the development of the Action Plan, NTC's Performance and Quality Improvement Coordinator will assign accountability to a specific department or team for implementation, and monitor progress on a monthly basis to determine whether the intended impact of the Action Plan was achieved and make adjustments where necessary.

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.

The following are examples of how NTC's 23 affiliates across the United States have utilized surveys and our satisfaction assessment processes to improve quality and outcomes.

Enhancing Standardized Provider Reimbursement Rates.

NTC's Louisiana affiliate recently identified a critical reimbursement issue among independent pharmacists within their network. When pharmacy benefits were carved back into Bayou Health, our affiliate (and other MCOs) were challenged with the expressed dissatisfaction from independent pharmacies due to carve in-associated low reimbursement rates. Upon identifying the issue, NTC's affiliate quickly began working with the state's independent pharmacies to address these reimbursement and formulary issues and collaboratively develop a solution. Ultimately, after exploring a variety of solutions in partnership with the affected pharmacies, NTC's affiliate decided to pay the affected pharmacies a dispensing fee and established ongoing transparent communications that encouraged independent pharmacies to become active participants in the network. As a result of its quick action, NTC's affiliate was able to build a strong pharmacy network across the state of Louisiana. Today, our affiliate continues to work closely with the state's independent pharmacies, using our process of bi-directional communication and provider feedback provision that helps to ensure a robust network of satisfied pharmacy providers who are able to provide medication-related support and services to members living across the state.

Formalizing a Point of Contact for Providers. Recently, after an Annual Satisfaction Survey, NTC's parent company, Centene Corporation (Centene), identified an issue that many providers working within its local networks across the country felt as though they didn't have a direct point of contact with their local plan. In response, Centene established a formalized process for its local plans to assign Plan representatives to every provider within its network. These representatives now serve as the "face" of the plan for their assigned providers. The result of this initiative is that providers now feel that they have a personal connection and point of contact at the Plan, who can field their questions and connect them to appropriate resources (including Provider Training and Education, Referral Resources, engagement and support tools to leverage) to mitigate any issues they may experience, resulting in increased provider satisfaction. NTC will extend this initiative to Nebraska, assigning each provider an NTC point of contact upon contracting.

Changes to Prior Authorization. NTC and our affiliates strive to use provider feedback to identify and (if appropriate) remove any unnecessary administrative barriers from our process. For example, our Louisiana affiliate received feedback from its local OB/GYN providers that prior authorization (PA) for OB ultrasounds were unnecessary and excessive. At that time, our affiliate had waived the PA requirement for high-risk obstetricians previously, but they still required general practice OBs to obtain PA for anything beyond the baseline assessments. However, after hearing this feedback from the OB/GYNs, our affiliate reviewed the associated UM data, which did indicate an extremely low rate of denials for general practice OB ultrasounds. After additional consultation with their network OB/GYNs and evaluating the potential benefit of early diagnosis for reducing prenatal complications, NTC's Louisiana affiliate decided to remove the PA requirement for all OB providers.

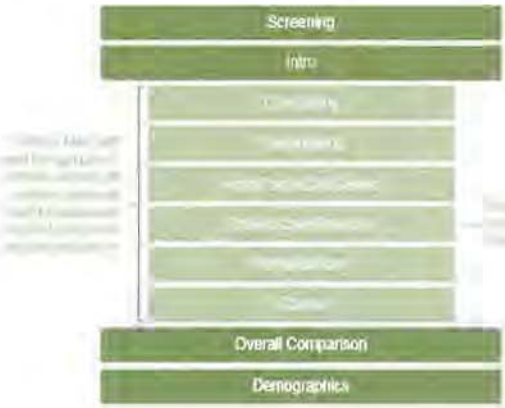
Engaging Stakeholders to Identify Solutions. Through their Provider Satisfaction Survey, NTC's Indiana affiliate identified that satisfaction with claims payment was a key driver of provider (dis)satisfaction. Based on this identified correlation, our affiliate implemented a service team approach that brought their local Claims Liaisons and Regional Network Specialists together to provide in person, coordinated support to providers to address identified challenges related to claims. These team based efforts resulted in a 6.5% improvement in the number of providers who indicated that they would

recommend our affiliate to others, significantly outscoring the Myers Group's Medicaid Summary Response Rates.

Provider Journey Mapping

In the spring of 2015, NTC's parent company, Centene Corporation Inc. (Centene) began its Provider Journey Mapping initiative, a provider satisfaction assessment process across a subset of our affiliate health plans in Florida, Texas, California, and Arkansas that is examining the provider experience at each point of plan-provider interaction. Centene is using this Provider Journey Mapping process to assess the provider experience across its entire workflow, from the initial network engagement and contracting process to claims submission to provider experience with our clinical/administrative training and other supports. The overall objective for this research was to uncover solutions to streamline or improve the process, and ultimately increase satisfaction with Centene and its local affiliate Plans. By following healthcare providers from initial contact with Centene through the claim and payment process, pain points, moments of truth, and highly effective innovations can be identified and learned from. To date, Centene has conducted over 450 interviews with cross sector providers in the selected markets (i.e., hospital systems, Federally Qualified Health Centers (FQHCs), group practices, and PCP offices) in order to learn about their experience with the local Centene health plan. The process of these interviews is illustrated by ***Figure Q55.C***.

Figure Q55.C: Quantitative Questionnaire Flow



A selection of results from this Journey Mapping process include the following:

- Engaging in clear and direct communication with the right people at each practice (who are often not the doctor) is critical
- Providers are interested in, and feel that they benefit from, Centene's ongoing educational opportunities (including webinars and in person trainings). Local Plans can (and should) leverage Centene's corporate opportunities and share educational events and opportunities across the entire Centene community.
- Interviewed providers ranked "solves problems in a timely manner" and "easy to contact and speak with someone about questions" as the most important features for Centene Plans to have.
- A vast majority of providers across sectors and localities who were interviewed stated that they had used the Provider Portal, and the majority found it straightforward and easy to use. However, a small subset (approximately 3%) of providers who have used the portal's features experienced some difficulty in leveraging its features, meaning for some, additional training may be beneficial.

Quote from Journey Mapping interview on the most beneficial features of the Provider Portal: "That I can actually correct my claim right there and then and I will get a reference number and my claim will actually be processed in 5 days or within 1 day and we will get paid." – TX, Individual

Centene's corporate leadership team is currently in the process of working with a cross functional group to develop Practice Improvement initiatives that are associated with its findings that will result in a smoother process for providers overall. Nebraska Total Care (NTC) will leverage these lessons learned and initiatives from the Provider Journey Mapping process that are related to improving provider satisfaction to Nebraska, in partnership with State-providers, where appropriate.

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IV.J ATTACHMENTS

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Attachment Q49-A: Public Provider Website

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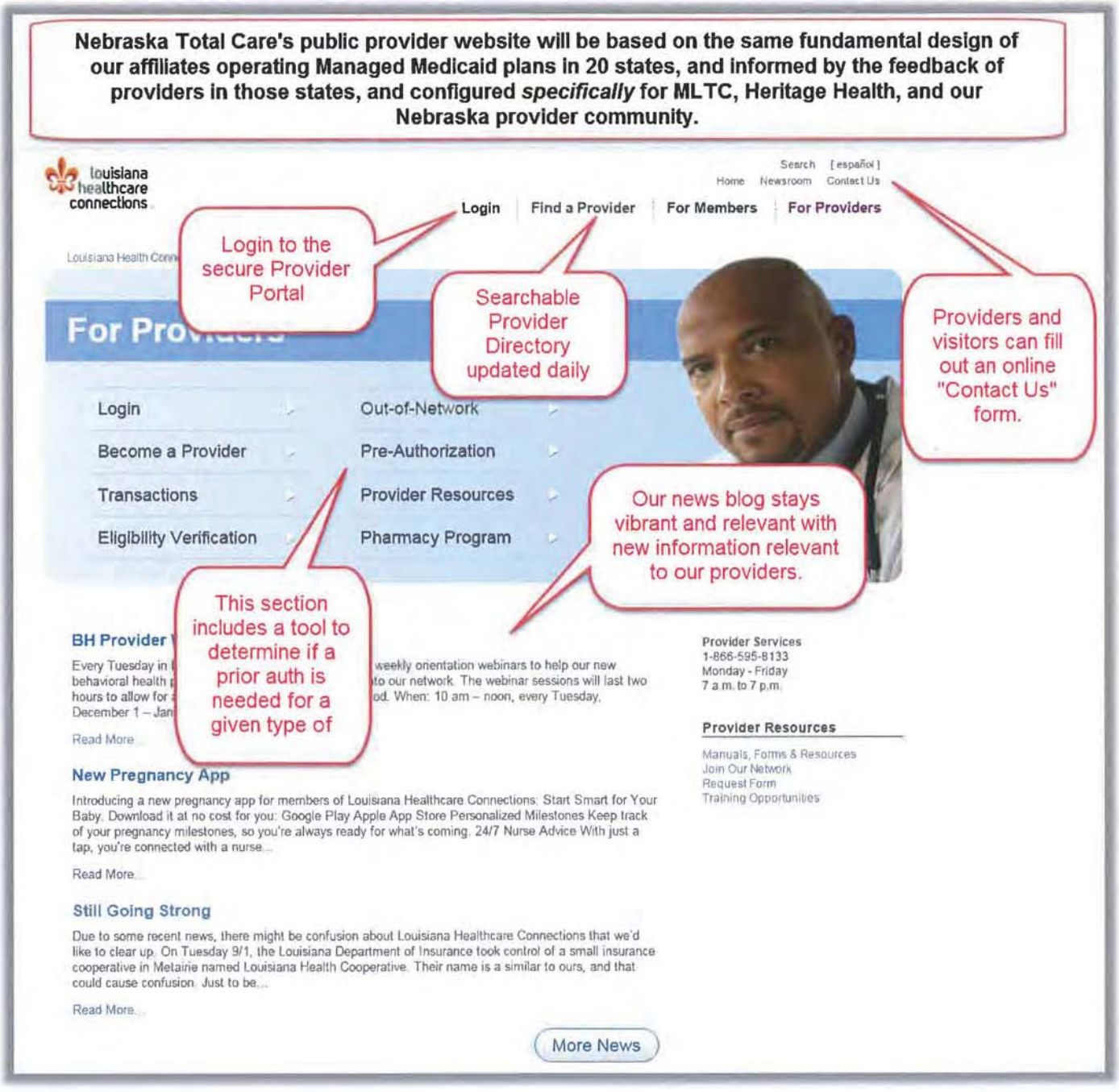
Attachment Q49-A: Public Provider Website



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Attachment
Q49-B: Prior Auth Needed Tool

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Attachment Q49-B: Prior Auth Needed Tool

Nebraska Total Care's public provider website will include an efficient tool for providers to determine when - and how - they should and can file a prior authorization or referral request. Below is an example of this functionality from one of our affiliate Managed Medicaid health plans.

Louisiana Health Connect > For Providers > Pre-Auth Needed? > Medicaid Pre-Auth Needed?

Medicaid Pre-Auth Needed?

- **Pre-Auth Needed?**
- DME Authorization List
- Medicaid Pre-Auth Needed?
- **Electronic Transactions**
- **Eligibility Verification**
- **Grievance Process**
- **ICD-10 Overview**
- **Integrated Care**
- **Join Our Provider Network**
- **Marketing Regulations**
- **National Imaging Associates Inc. (NIA)**
- **Out-of-Network Providers**
- **Patient Centered Medical Home Model**
- **PaySpan – EFT/ERA**
- **Pharmacy Program**
- **Prior Authorization**

DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to your Provider Manual (Nov. 2014). If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Out-of-network providers must submit a pre-authorization for all services, excluding family planning, emergency room and table top x-ray service. If you are not in the Louisiana Healthcare Connections provider network, you can learn about Joining Our Network.

Vision Services need to be verified by Opticare.
Dental Services need to be verified by DHH.
Complex imaging, MRA, MRI and CT scans need to be verified by NIA.
Behavioral Health/Substance Abuse need to be verified by Cenpatico.
Outpatient Physical, Occupational and Speech Therapy Services need to be verified by Cenpatico *STRS*.
Pharmacy services need to be verified by US Script.

We will configure the functionality depicted here specifically for our Heritage Health program, and review and seek approval from MLTC per RFP requirements.

Are Services being performed in the Emergency Department or Urgent Care Center or FQHC, DOH, RHC, Family Planning services billed with a contraceptive management diagnosis?
YES ☐ NO ☐

Types of Services		
Is the member being admitted to an inpatient facility?	YES	**NO**
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	YES	NO
Are anesthesia services being rendered for pain management or dental surgery	YES	NO
Are plastic or oral surgeon services being rendered in the office?	YES	NO

To submit a prior authorization Login Here.

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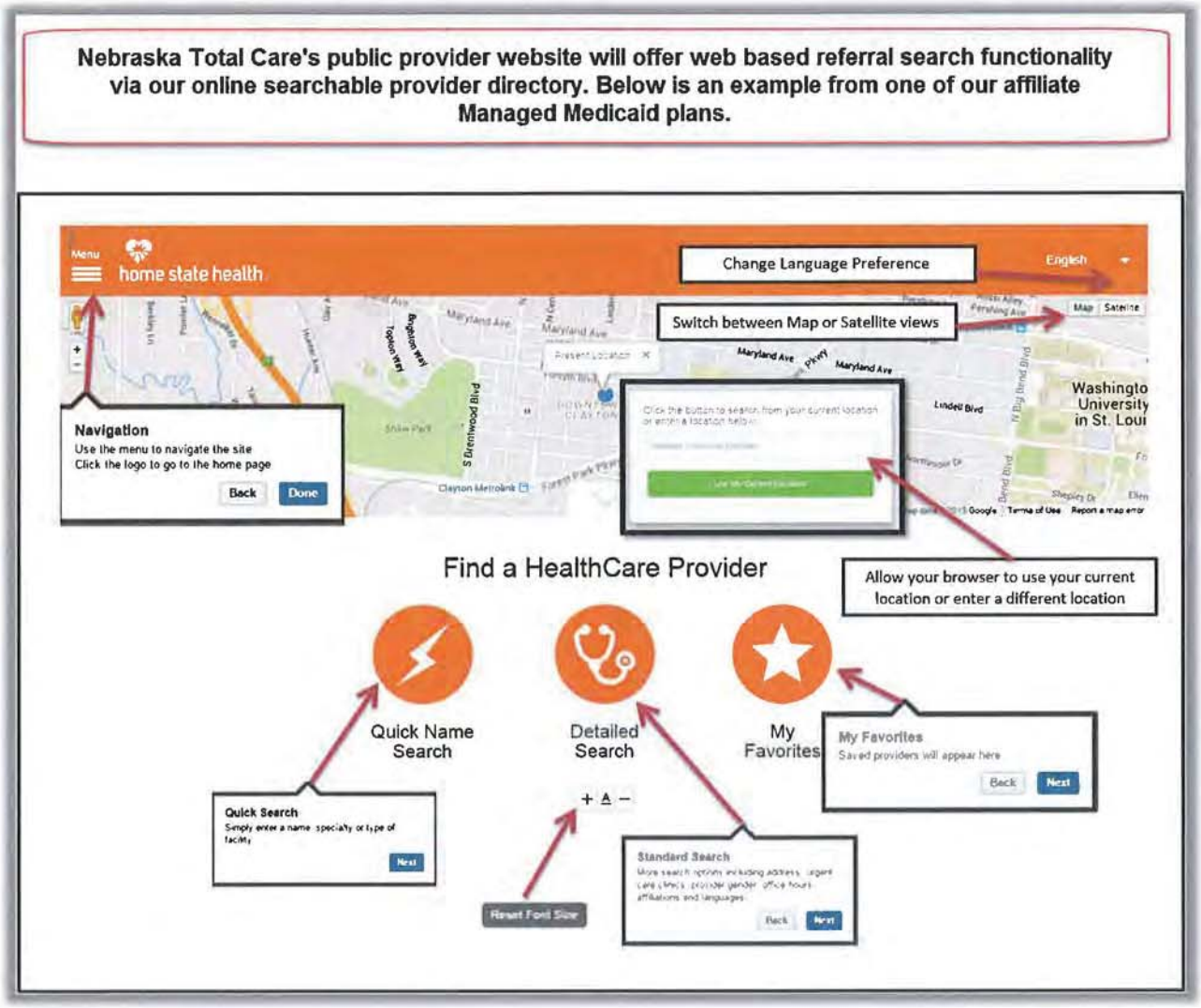
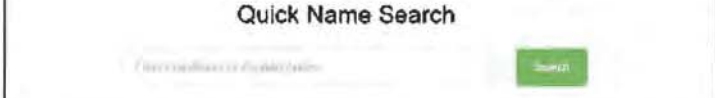
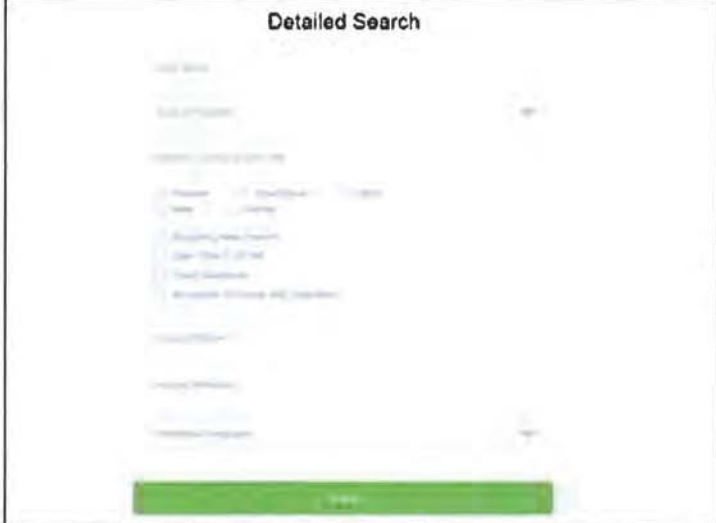
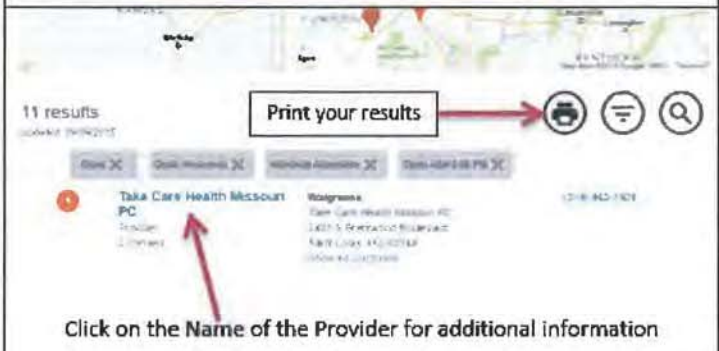
Attachment
Q49-C: Provider Directory

Attachment Q49-C: Provider Directory

Nebraska Total Care's public provider website will offer web based referral search functionality via our online searchable provider directory. Below is an example from one of our affiliate Managed Medicaid plans.



Below is short description of the use and functionality of our online provider directory.

	For a quick search, enter a Provider name, specialty, or a type of facility.
	To get a more detailed search, narrow the search by selecting different criteria options.
	In this screenshot, the criteria selected from the detailed search were: 1. Clinic 2. Open Weekends 3. Handicap Accessible 4. Open After 5:00 PM Click on the X next to any of those options and the search feature will automatically update the results. Use the icons below to: To add new search options to your current search Start a new search
	Practice details for Homestate Health Plan will display: • Office Hours • Open Weekends • Phone and Fax numbers • County • Accessible to People with Disabilities • Patient Types: • Accepting New Patients • Multiple Location Listings • Network • Specialties • Facility Accreditation • Additional Languages

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Attachment
49-D: Claims Processing on the Provider Portal

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Attachment 49-D: Claims Processing on the Provider Portal

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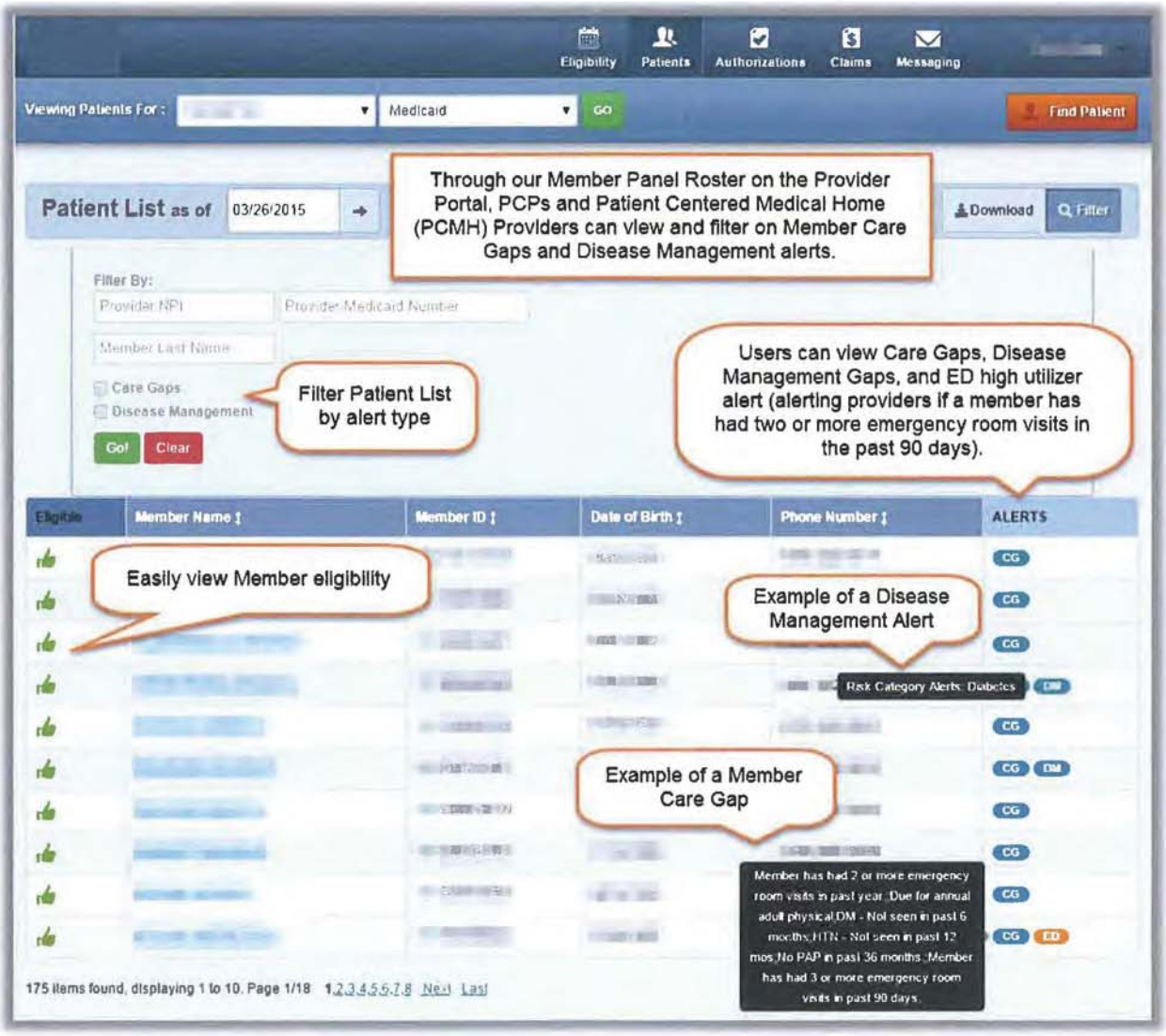
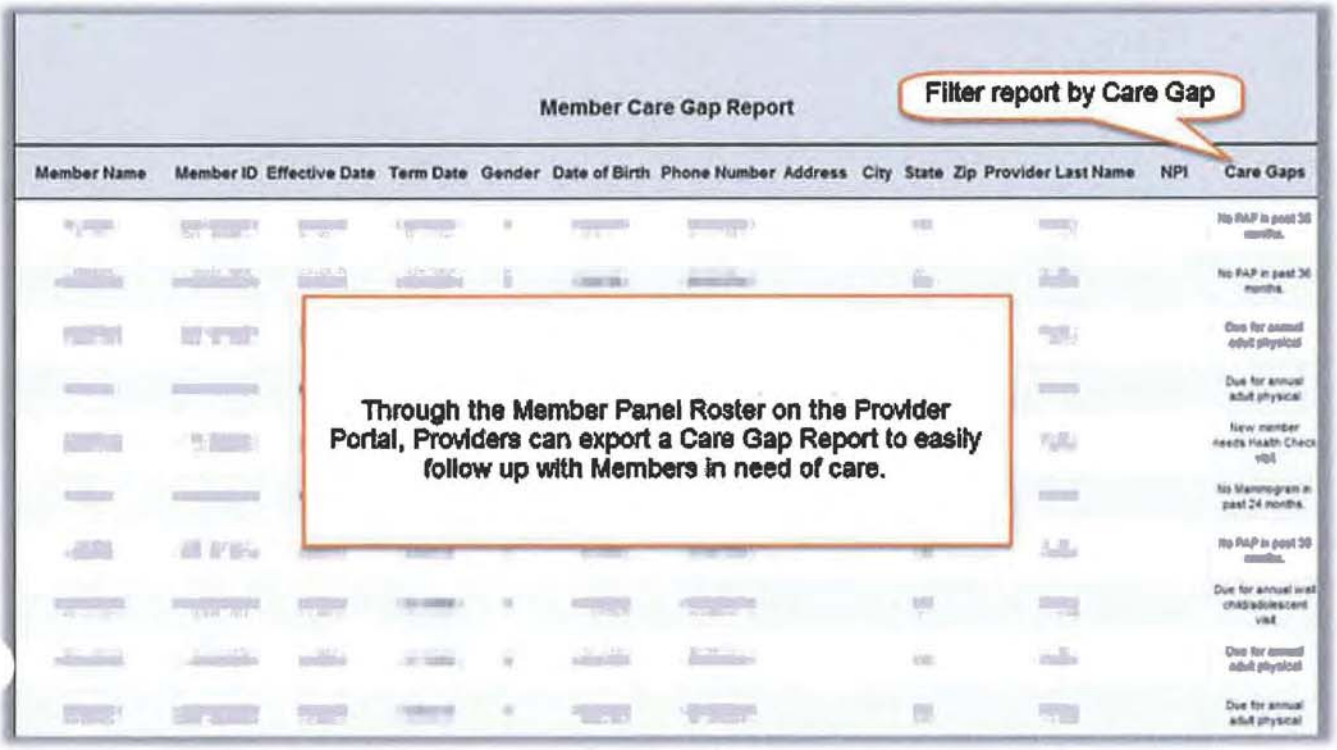
Attachment
Q49-E: Member Panel Roster and Care Gap Report

Attachment Q49-E: Member Panel Roster and Care Gap Report (on following page)




Member Care Gap Report
Filter report by Care Gap
Member Name
Member ID
Effective Date
Term Date
Gender
Date of Birth
Phone Number
Address
City
State
Zip
Provider Last Name
NPI
Care Gaps
Through the Member Panel Roster on the Provider Portal, Providers can export a Care Gap Report to easily follow up with Members in need of care.

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Attachment
Q49-F: Detailed Patient Record on the Provider Portal

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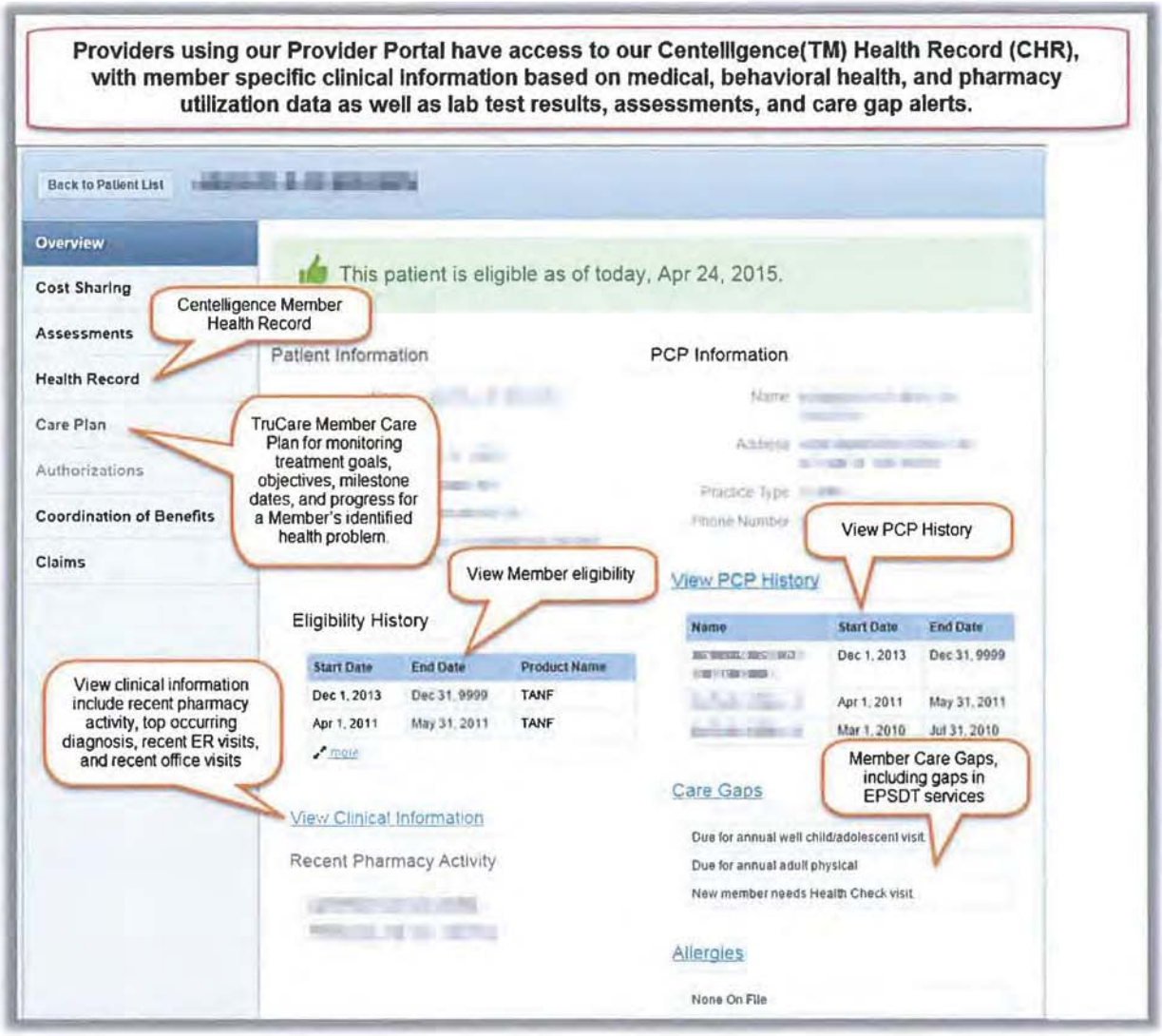
Attachment Q49-F: Detailed Patient Record on the Provider Portal



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Attachment
Q49-G: Care Management Referrals

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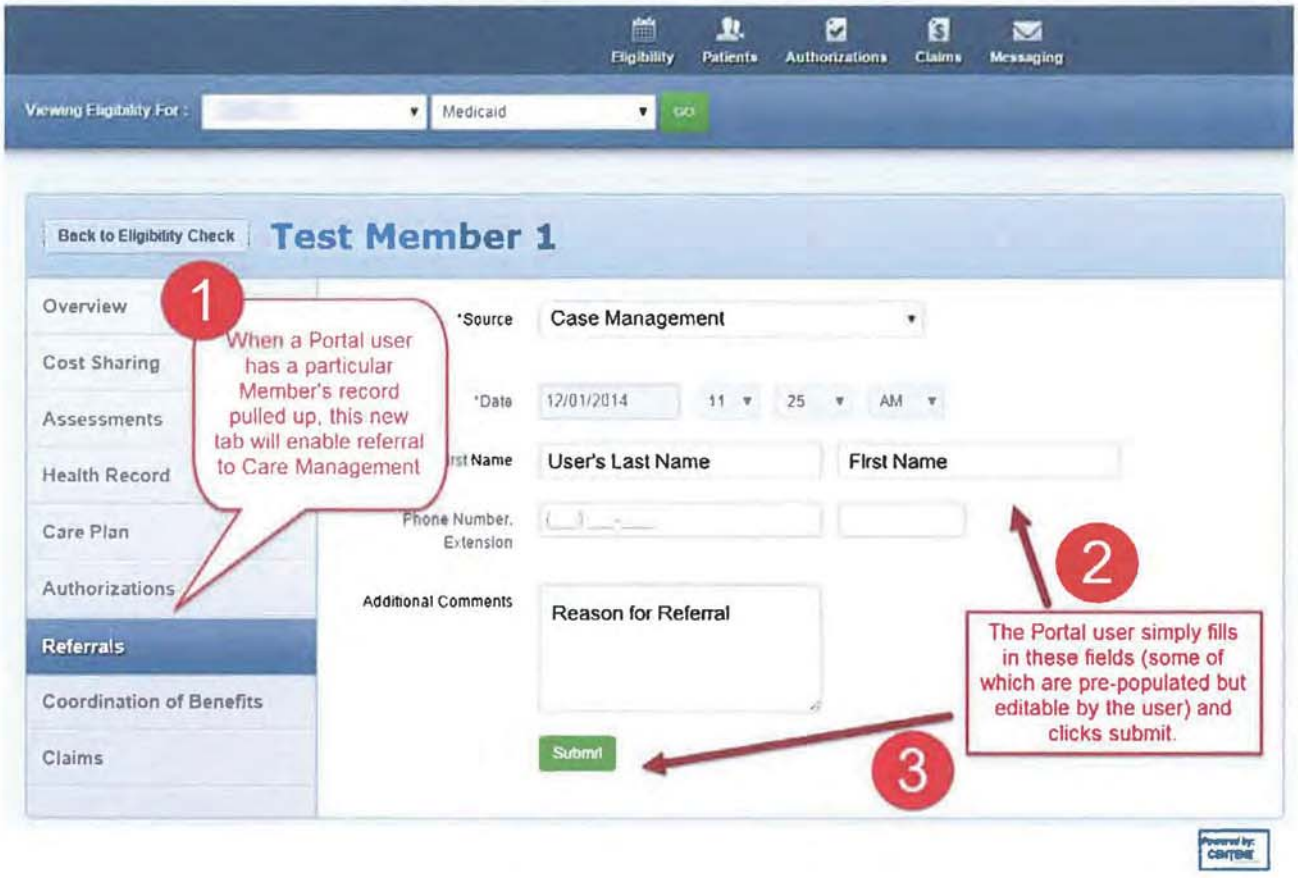
Attachment Q49-G: Care Management Referrals

The *Care Management Referral* function in our Provider Portal allows Portal users to quickly and efficiently refer a patient to Physical or Behavioral Health Care Management



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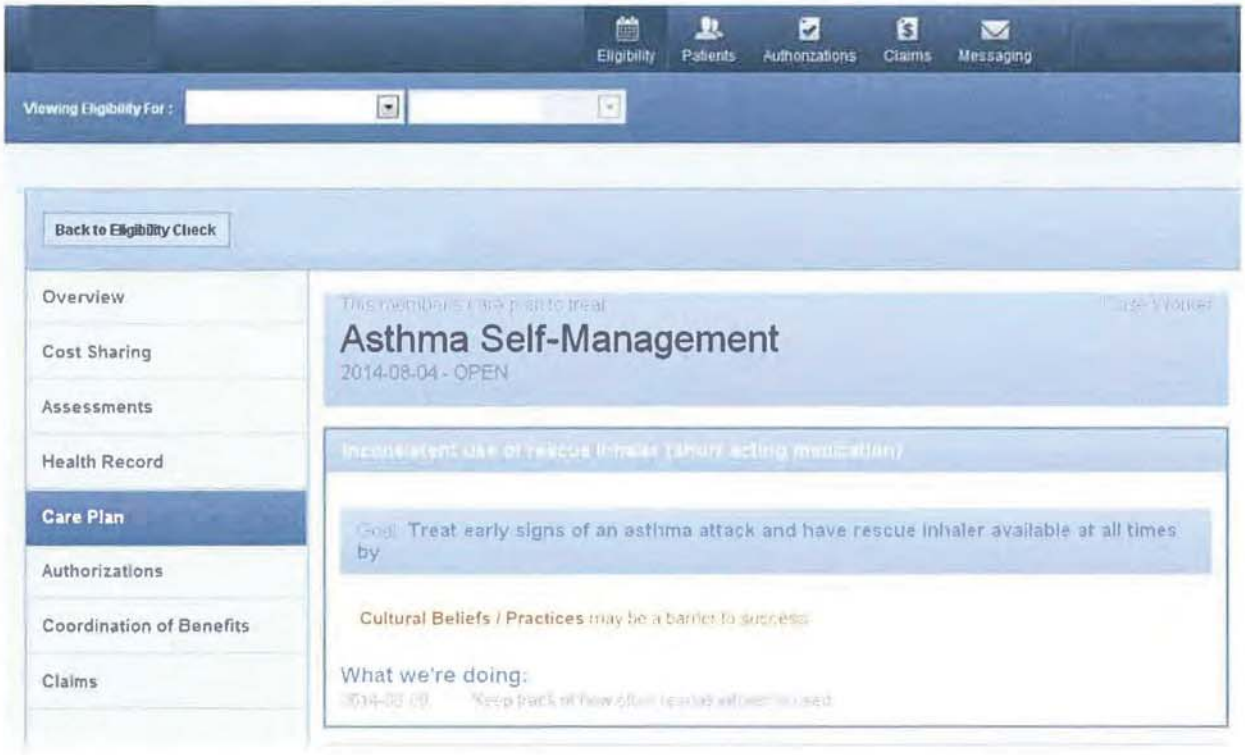
Attachment
Q49-H: TruCare Care Plan on Provider Portal

Attachment Q49-H: TruCare Care Plan on Provider Portal

Providers using our Provider Portal have access to a member's TruCare Care Plan. TruCare is Nebraska Total Care's member-centric collaborative care platform for physical and behavioral health care management.



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Attachment
50.A Provider Orientation

Ambetter [health plan]

Provider Relations Specialist: [Name]

12/16/2015

AGENDA

1. Overview of the Affordable Care Act
2. The Health Insurance Marketplace
3. Verification of Eligibility, Benefits and Cost Shares
4. Specialty Referrals
5. Prior Authorization
6. Claim Submission
7. Claim Payment
8. Complaints/Grievances and Appeals
9. Specialty Companies/Vendors
10. Public Website
11. Provider Took Kit
12. Contact Information

The Affordable Care Act

Key Objectives of the Affordable Care Act (ACA):

- Increase access to quality health insurance
- Improve affordability

Additional Parameters:

- Dependent coverage to age 26
- Pre-existing condition insurance plan (high risk pools)
- No lifetime maximum benefits
- Preventative care covered at 100%
- Insurer minimum loss ratio (80% for individual coverage)

The Affordable Care Act

Reform the commercial insurance market – Marketplace or Exchanges

- No more underwriting – guaranteed issue
- Tax penalties for not purchasing insurance
- Minimum standards for coverage: benefits and cost sharing limits
- Subsidies for lower incomes (100% - 138% FPL)

Health Insurance Marketplace

Online marketplaces for purchasing health insurance

Potential members can:

- Register
- Determine eligibility for all health insurance programs (including Medicaid)
- Shop for plans
- Enroll in a plan
- Exchanges may be State-based or federally facilitated or State Partnership

The Health Insurance Marketplace is the only way to purchase insurance AND receive subsidies.

Health Insurance Marketplace

Subsidies come in the form of:

- Advanced Premium Tax Credits (APTC)
- Cost Share Reductions (CSR)

All Benefit Plans have cost shares in the form of copays, coinsurance and deductibles.

- Some members will qualify for assistance with their cost shares based on their income level.
- This assistance would be paid directly from the Government to the member's health plan.

WHAT YOU NEED TO KNOW…

Verification of Eligibility, Benefits and Cost Share

Member ID Card: [enter graphic of id card below]

**** Possession of an ID Card is not a guarantee eligibility and benefits***

Verification of Eligibility, Benefits and Cost Share

Eligibility, Benefits and Cost Shares can be verified in 3 ways:

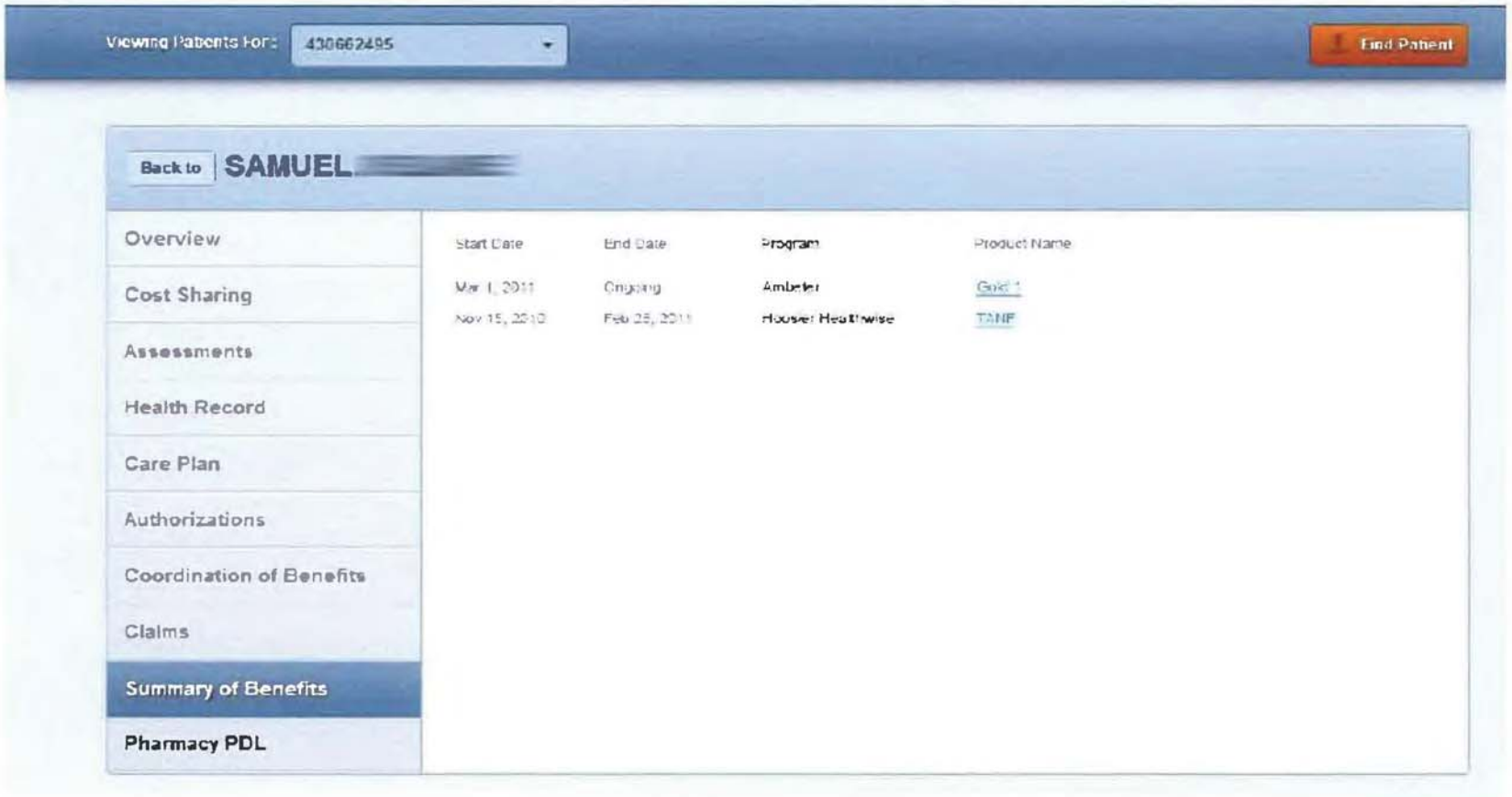
1. **The Ambetter secure portal found at: [website]**
   - If you are already a registered user of the [health plan name] secure portal, you do NOT need a separate registration!

2. **24/7 Interactive Voice Response system**
   - Enter the Member ID Number and the month of service to check eligibility

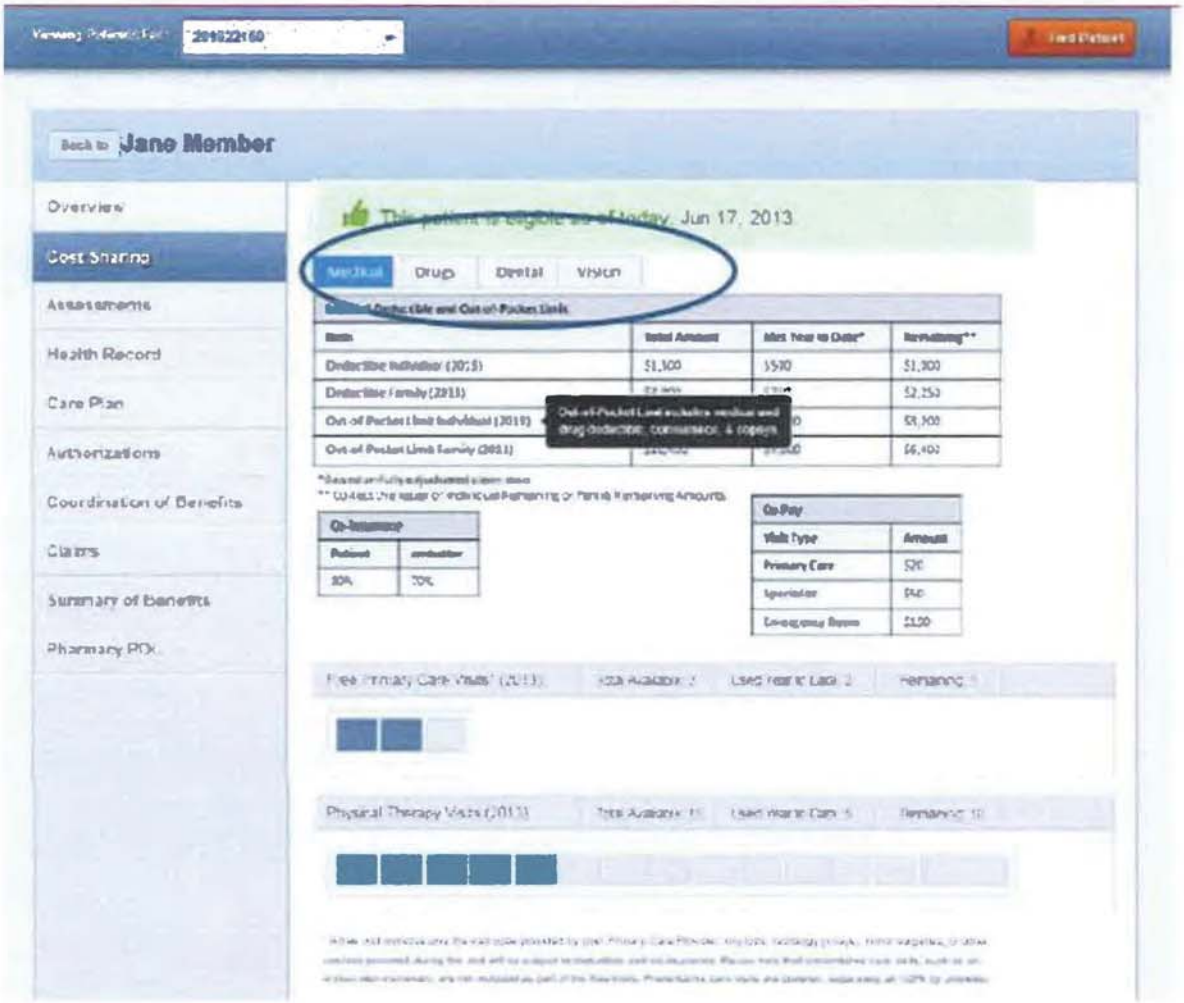
3. **Contact Provider Service at: [phone number]**

Verification of Eligibility

Verification of Benefits



Verification of Cost Shares



Specialty Referrals

- Members are educated to first seek care or consultation with their Primary Care Provider.
- When medically necessary care is needed beyond the scope of what a PCP provides, PCPs should initiate and coordinate the care members receive from specialist providers.
- PAPER REFERRALS ARE NOT REQUIRED FOR MEMBERS TO SEEK CARE WITH IN-NETWORK SPECIALISTS.

** This is not meant as an all-inclusive list*

Prior Authorization

Procedures / Services

[enter pa list here]

** This is not meant as an all-inclusive list*

Prior Authorization

Inpatient Authorization

- **[enter pa list here]**

** This is not meant as an all-inclusive list*

Prior Authorization

Ancillary Services

- **[enter pa list here]**

** This is not meant as an all-inclusive list*

Prior Authorization Request Timeframes

Service Type	Timeframe
Scheduled admissions	Prior Authorization required five business days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required five business days prior to the elective outpatient admission date
Emergent inpatient admissions	Notification within one business day
Observation – 23 hours or less	Notification within one business day for non-participating providers
Observation – greater than 23 hours	Requires inpatient prior authorization within one business day
Emergency room and post stabilization, urgent care and crisis intervention	Notification within one business day
Maternity admissions	Notification within one business day
Newborn admissions	Notification within one business day
Neonatal Intensive Care Unit (NICU) admissions	Notification within one business day
Outpatient Dialysis	Notification within one business day

** This is not meant as an all-inclusive list*

Utilization Determination Timeframes

Type	Timeframe
Prospective/Urgent	One (1) Business day
Prospective/Non-Urgent	Two (2) Business days
Emergency services	60 minutes
Concurrent/Urgent	Twenty-four (24) hours (1 calendar day)
Retrospective	Thirty (30) calendar days

** This is not meant as an all-inclusive list*

Prior Authorization

Pre-Auth Needed Tool:

Are Services being performed in the Emergency Department?

YES ☐ NO ☑

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	○	◉
Is the member having observation services?	○	◉
Are anesthesia services being rendered for pain management or dental surgeries?	○	◉
Is the member receiving hospice services?	○	◉
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	○	◉

Enter the code of the service you would like to check:

69436 Check

N
No

69436 - TYMPANOSTOMY GEN ANES
No authorization required.

Prior Authorization

Prior Authorization can be requested in 3 ways:

1. **The Ambetter secure portal found at [website]**

2. **Fax Requests to: [fax phone number]**
   The fax authorization forms are located on our website at [website]

3. **Call for Prior Authorization at [phone number]**

Prior Authorization

Prior Authorization will be granted at the CPT code level.

1. If a claim is submitted that contains CPT codes that were not authorized, the services be denied.
   - If during the procedure additional procedures are performed, in order to avoid a claim denial, the provider must contact the health plan to update the authorization. It is recommended that this be done within 72 hours of the procedure; however, it must be done prior to claim submission or the claim will deny.

2. Ambetter will update authorizations but will not retro authorize services. The claim will deny for lack of authorization. If there are extenuating circumstances that led to the lack of authorization, the claim may be appealed.

Claim Submission

The timely filing deadline for initial claims is 180 days from the date of service or date of primary payment when Ambetter is secondary.

Claims may be submitted in 3 ways:

1. **The secure web portal located at [website]**

2. **Electronic Clearinghouse**
   - Payor ID 68069
   - Clearinghouses currently utilized by [health plan name] will continue to be utilized
   - For a listing our the Clearinghouses, please visit out website at [website]

3. **Paper claims may be submitted to PO Box 5010 Farmington, MO 64640-5010**

Claim Submission

Claim Reconsiderations

- A written request from a provider about a disagreement in the manner in which a claim was processed. No specific form is required.
- Must be submitted within 180 days of the Explanation of Payment.
- Claim Reconsiderations may be mailed to PO Box 5010 – Farmington, MO 63640-5010

Claim Disputes

- Must be submitted within 180 days of the Explanation of Payment
- A Claim Dispute form can be found on our website at [website]
- The completed Claim Dispute form may be mailed to PO Box 5000 – Farmington, MO 63640-5000

Claim Submission

Member in Suspended Status

- A provision of the ACA allows members who are receiving Advanced Premium Tax Credits (APTCs) a 3 month grace period for paying claims.
- After the first 30 days, the member is placed in a suspended status. The Explanation of Payment will indicate LZ Pend: Non-Payment of Premium.
- While the member is in a suspended status, claims will be pended.
- When the premium is paid by the member, the claims will be released and adjudicated.
- If the member does not pay the premium, the claims will be released and the provider may bill the member directly for services.

Claim Submission

Member in Suspended Status – Example

- **January 1st**
  Member Pays Premium
- **February 1st**
  Premium Due – Member does not pay
- **March 1st**
  Member placed in suspended status
- **April 1st**
  Member remains in suspended status
- **May 1st**
  If premium remains unpaid, member is terminated. Provider may bill member directly for services rendered.

Claims for members in a suspended status are not considered "clean claims".

** Note: When checking Eligibility, the Secure Portal will indicate that the member is in a suspended status.*

Claim Submission

Other helpful information:

Rendering Taxonomy Code

- Claims must be submitted with the rendering provider's taxonomy code.
- The claim will deny if the taxonomy code is not present
- This is necessary in order to accurately adjudicate the claim

CLIA Number

- If the claim contains CLIA certified or CLIA waived services, the CLIA number must be entered in Box 23 of a paper claim form or in the appropriate loop for EDI claims.
- Claims will be rejected if the CLIA number is not on the claim

Claim Submission

Billing the Member:

- Copays, Coinsurance and any unpaid portion of the Deductible may be collected at the time of service.

- The Secure Web Portal will indicate the amount of the deductible that has been met.

- If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the member within 45 days.

Claim Payment

PaySpan

- Ambetter partners with PaySpan for Electronic Remittance Advice (ERA) and Electronic Funds Transfer
- If you currently utilize PaySpan, you will need to register specifically for the Ambetter product
- **To register for PaySpan:**
  Call 1-877-331-7154 or visit www.payspanhealth.com

Complaints/Grievances/Appeals

Claims

- A provider must exhaust the Claims Reconsideration and Claims Dispute process before filing a Complaint/Grievance or Appeal

Complaint/Grievance

- Must be filed within 30 calendar days of the Notice of Action
- Upon receipt of complete information to evaluate the request, Ambetter will provide a written response within 30 calendar days

Complaints/Grievances/Appeals

Appeals

- For Claims, the Claims Reconsideration, Claims Dispute and Complaint/Grievances process must be exhausted prior to filing an appeal

Medical Necessity

- Must be filed within 30 calendar days from the Notice of Action
- Ambetter shall acknowledge receipt within 10 business days of receiving the appeal
- Ambetter shall resolve each appeal and provide written notice as expeditiously as the member's health condition requires but not to exceed 30 calendar days.
- Expedited appeals may be filed if the time expended in a standard appeal could seriously jeopardize the member's life or health. The timeframe for a decision for an expedited appeal will not exceed 72 hours.

Complaints/Grievances/Appeals

- Members may designate Providers to act as their Representative for filing appeals related to Medical Necessity.
    - Ambetter requires that this designation by the Member be made in writing and provided to Ambetter

- No punitive action will be taken against a provider by Ambetter for acting as a Member's Representative.

- Full Details of the Claim Reconsideration, Claim Dispute, Complaints/Grievances and Appeals processes can be found in our Provider Manual at: [website]

Specialty Companies/Vendors

Service	Specialty Company/Vendor	Contact Information
Behavioral Health	Cenpatico Behavioral Health	[phone number] www.cenpatico.com
High Tech Imaging Services	National Imaging Associates	[phone number] www.radmd.com
Vision Services	OptiCare	[phone number] www.opticare.com
Dental Services	DentaQuest	[phone number] www.dentaquest.com
Pharmacy Services	US Script	[phone number] www.usscript.com

Public Website

Accessing the Public Website for Ambetter:

- **Go to [website]**

Public Website

Information contained on our Website:

- The Provider and Billing Manual
- Quick Reference Guides
- Forms (Notification of Pregnancy, Prior Authorization Fax forms, etc.)
- The Pre-Auth Needed Tool
- The Pharmacy Preferred Drug Listing
- And much more…

Provider Tool Kit

Information included in the Tool Kit:

- Welcome Letter
- Ambetter Provider Introductory Brochure
- Secure Portal Setup
- Electronic Funds Transfer Setup
- Prior Authorization Guide
- Quick Reference Guide
- Provider Office Window Decal

Contact Information

[health plan name]

Phone: [phone number]

TTY/TDD: [tty/ttd number]

[website]

Questions

Attachment
50.B Quick Reference Guide

nebraska total care™

Attachment
50.C Prior Authorization

nebraska total care™

IV.K Subcontracting Requirements

IV.K Subcontracting Requirements

IV.K Subcontracting Requirements

(1 page limit per subcontracting organization)

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.***

Nebraska Total Care (NTC) understands that we will be ultimately responsible for all products, services, and obligations agreed to by the health plan and the State of Nebraska, and that we must certify and warrant all subcontractor work. Our subcontracts include appropriate provisions and contractual obligations to ensure the successful fulfillment of all contractual obligations. NTC will be subcontracting for 24/7 nurse advice line, radiology, vision, disease management, pharmacy benefit management, and in-home health services. In addition, we will receive support from our corporate office for information system, claims processing, compliance/fraud and abuse support, provider data management, human resources, and finance services and support through a separate Management Agreement. Below is a listing of the subcontractors we plan to contract with for the purposes of this Agreement (***Tables Q56.A through Q56.I***). All of these subcontractors have performed for us in multiple markets, and we are confident in their ability to provide services for this Contract.

Information includes NTC sub-contractors' organizational role, corporate background and services provided in other states, ownership structure and date formed; and total number of employees and location. For subcontractors' organizational charts, please see ***Attachments 56_ Subcontractor Organizational Charts***.

NTC will submit all subcontracts to MLTC for review at least 90 calendar days before implementation. Further, NTC will comply with all requirements in Section O, 42 CFR 438.6(1), 438.230(a) and 438.230(b)(1), (2), and (3) including:

- Being responsible for oversight of all subcontractors' performance accountable for any function and responsibility that is delegated to a subcontractor, including, but not limited to:
- Evaluation of subcontractor's ability to perform delegated activities
- Certify that subcontractors are financially stable
- Provide a written contract between NTC and its subcontractors specifying the activities and reporting responsibilities delegated to each subcontractor including revoking delegation or imposing other sanctions if a subcontractor's performance is inadequate
- Monitor each subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards.
- Identify any deficiencies or areas for improvement, and take corrective action

Additionally, NTC will guard against executing 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 is otherwise barred from participation in the Medicaid or Medicare programs. The MCO must not enter into any relationship with a subcontractor debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

Figure Q56 is an overview organizational chart that shows the relationship of the subcontractors to both NTC and Centene Management Company:

nebraska total care

Contractual Relationships

Table Q56.A Centene Management Company: information system, claims processing, compliance/fraud and abuse support, provider data management, human resources, and finance services	
Organizational Role	Centene Management Company (CMC) will support NTC by providing information system support, and claims processing and administration; SIU/fraud and abuse; provider data management; human resources support; and finance systems.
Corporate Background and Services Provided in Other States	CMC has provided similar services to Centene-owned Medicaid, CHIP, and Medicare health plans for 30 years and currently serves our full-risk managed care plans 20 states. CMC also serves Centene's Health Insurance Marketplace products in 9 states and provides TPA services for correctional facility healthcare products in 2 states. The strength of CMC's performance is demonstrated by the following: In 2014, Centene's Fraud Waste & Abuse Program saved $142.6 million and is projected to save $184.0 million in 2015; approximately 7% of the growth is due to new programs that were put in place in 2015 • 2014 Prepay Savings: $6,334,851 • 2014 Recoupment Savings: $427,270 • Total 2014: $6,762,121 In 2015 through September: • 2015 Prepay Savings: $4,073,005 • 2015 Recoupment Savings: $67,340 • Total YTD 2015: $4,140,345 CMC's average auto adjudication rate is an industry-leading 85% with 93% claims paid within 15 days and 99.8% within 60 days. CMC currently processes approximately 4.5 million medical and behavioral health claims per month. Centene has won several 2015 awards including: **The Hermes Creative Awards - Platinum** for My Care Planner book series; **Gold** for Darby Boingg Meets Chrys and the Mums book series, and **Gold** for The Gunky Bacteria Brothers book series all for outstanding work outstanding work in the industry while promoting the philanthropic nature of marketing and communication professionals. **The Auburn University Anti-Bullying Corporate Hero Award** for the "No Bullying Zone" Campaign for Being an "upstander" rather than a "bystander from individuals or groups who take the initiative to be "upstanders" **Web Health Awards**—On Target with Your Asthma, Audio (Merit); Listening to Your Heart Matters, Audio (Merit); Living Well with Sickle Cell, Audio (Merit); Off The Chain, Audio (Merit)
Ownership Structure and Date Formed	Centene Management Company, LLC was formed in 1996 and is a wholly-owned subsidiary of Centene Corporation, a publicly-traded corporation.
Total Number of Employees and Location	CMC employs 5,694 full-time staff located in offices in 25 states and the District of Columbia. CMC's headquarters is located in St. Louis, Missouri, and its offices for claims processing services are located in Farmington, Missouri; Great Falls, Montana; and Tyler, Texas.
Organizational Chart	See ***Attachment 56_ Subcontractor Organizational Charts-CMC***

Table Q56.B US Script: pharmacy benefit administration	
Organization's Role	US Script provides pharmacy benefit management (PBM) services to clients through Preferred Drug List (PDL) administration, clinical authorizations, pharmacy network contracting and management, rebate administration, reporting, claims adjudication, account management, pharmacy provider call center and services, pharmacy and therapeutics support, pharmacy auditing, and selected drug utilization review and quality improvement functions, subject to client oversight.
Corporate Background and Services Provided in Other States	US Script operates as a full-service PBM for 16 of our state-sponsored health plans (which includes Medicaid, CHIP, Medicare, and other low-income programs) in 15 states, and serves ***Medicaid Foster Care members in 6 states***. In total, this represents over 4.5 million low-income members and their families who span age and program categories. While Medicaid health plans represent a significant portion of their client base, US Script also provides full-service PBM services to an additional 500,000 lives, including health insurance marketplace clients, workers' compensation programs, behavioral health programs, third party administrators, labor unions and self-funded employers In 2014, US Script processed more than 32 million claims and anticipates processing over 40 million in 2015. US Script owns its own mail order pharmacy and brings more than 10 years of coordinated account management between their mail order pharmacy and PBM operations experience to Nebraska. US Script Account Managers will work directly with mail order pharmacy personnel to offer timely implementation and resolution for NTC mail order pharmacy issues. In 2006, US Script joined Centene Corporation's (Centene) specialty services division, CenCorp Health Solutions (CenCorp). CenCorp is comprised of companies that span the breadth of the health care continuum, from vision to wellness to nurse triage services to pharmacy benefits. In 2008, US Script became one of the first PBMs to receive full PBM accreditation from URAC. Accreditation is achieved by meeting standards and demonstrating industry practices in five areas: organizational quality; customer service, communications and disclosure; pharmacy distribution channels; drug utilization management; and formulary development. In 2014, US Script received full PBM reaccreditation by URAC (valid through March 1, 2017) for Medicaid and Medicare, re-affirming the company's commitment to excellence in pharmacy benefits management.
Ownership Structure and Date Formed	US Script is 100% owned by CenCorp Health Solutions, Inc., which is 100% owned by Centene Corporation, and was founded in 1999.
Total Number of Employees and Location	US Script has 569 full time employees and is located in Orlando, Florida. It has offices in Fresno, California; St. Louis, Missouri; Tempe, Arizona; Ft. Worth, Texas; Texarkana, Texas, and Atlanta, Georgia.
Organizational Chart	See ***Attachment 56_ Subcontractor Organizational Charts-US Script***

Table Q56.C OptiCare: vision services	
Organization's Role	OptiCare Vision Company Inc. is a full service eye care administrator that will provide NTC members with routine and medical surgical eye care benefits. OptiCare will perform 100% of all routine and medical eye care administration services including: • Network contracting and credentialing claims processing and payment • Customer service and provider relations • Full utilization and quality management • Encounter submissions and reporting • HEDIS outreach
Corporate Background and Services Provided in Other States	OptiCare Managed Vision, Inc. (OptiCare) has provided capitated vision administration services for over 25 years, and to the Medicaid population for over 18 years, and currently serves NTC-affilate members in 17 states. OptiCare provides seamless integration with its health plan partners to meet their medical and surgical eye care needs, including participation in disease management programs. OptiCare will work with NTC to ensure that the proper levels of care are provided for both routine and medical eye care, and have deployed programs to target those who may have unique vision care risk factors and needs, including those with diabetes and glaucoma. OptiCare's quality department oversees its HEDIS Outreach **program** targeting diabetes patients at risk for eye problems and vision loss. The program has been successful in increasing diabetic member preventive eye care utilization and awareness. In 2014, OptiCare completed 43,683 calls to members and ensured eye exam appointments for 95% of diabetic patients contacted. OptiCare currently provides benefits to approximately 4.1 million Foster Care, **TANF, ABD, Dual Eligible, Medicare, and CHIP members** in 19 states.
Ownership Structure and Date Formed	OptiCare Managed Vision, Inc. is 100% owned by CenCorp Health Solutions, Inc., which is 100% owned by Centene Corporation and was formed in 1989.
Total Number of Employees and Location	OptiCare has 91 full time employees and is located in Rocky Mount, North Carolina with a satellite office in Dallas, Texas.
Organizational Chart	See ***Attachment 56_Subcontractor Organizational Charts-OptiCare***

Table Q56.D National Imaging Associates: imaging and radiology services	
Organization's Role	National Imaging Associates (NIA) will bring to NTC members strong operational and financial capabilities and provide creative solutions for members with complex issues and challenges in managing a broad spectrum of services including: • Prior Authorization/Utilization Management Prior authorization, clinical protocols, and efficient provider tools for MR, CT, CCTA and PET nuclear cardiology, stress echocardiography, and echocardiography • Provider Quality Assessment/Privileging (Post Go-live) Provider quality assessment and scope-of-service program applied to Plan Free Standing Facilities (FSF) and in-office providers performing advanced imaging services • Provider Training and Education • Customized, Proprietary Claim Edits
Corporate Background and Services Provided in Other States	National Imaging Associates (NIA) is a nationally recognized radiology benefits management company with more than 30 years' experience. NIA leverages the expansive set of resources and incremental competencies provided by Magellan—such as national Call Center Operations, national network development/contracting, and access to more than 1,000 IT resources—to meet diverse customer needs. NIA's program focuses on: • NIA Advanced Imaging Solution • Clinical Appropriateness achieved through prior authorization, peer-to-peer consultation, and clinical validation via records request • Provider Quality Standards achieved through privileging, outcomes analytics, profiling, quality benchmarking and targeted actions • NIA Cardiac Management Solution • Utilization Management achieved through the reduction of unnecessary, duplicative and/or risky Cardiac Imaging tests • Modality Diversion achieved through shifting riskier/more costly studies to the safest, most effective tests • Clinical Review and Provider Clinical Engagement NIA currently serves 55 customers covering 17.7 million lives across 32 states, and currently serves NTC-affiliate members in 17 states. NIA provides RBM solutions for over 30 Medicaid health plans covering 6.2 million Medicaid beneficiaries nationally throughout 25 states and the District of Columbia.
Ownership Structure and Date Formed	NIA is a direct subsidiary of Magellan Behavioral Health, Inc. (intermediate parent organization) and an indirect, wholly-owned subsidiary of Magellan Health Services, Inc, NIA was founded in 1995.
Total Number of Employees and Location	NIA draws on the full resources of Magellan Healthcare, which has a total of 715 employees, including NIA staff. NIA's corporate offices are located in Columbia, Maryland with key operational locations in St. Louis, Missouri, and Phoenix, Arizona.
Organizational Chart	See ***Attachment 56_ Subcontractor Organizational Charts-NIA***

Table Q56.E NurseWise: 24/7 nurse advice line	
Organization's Role	NurseWise (NW) will provide medical/nurse triage phone advice and health education to NTC members after hours and during holidays. During patient interaction, the NW team will: • Accurately identifies patients' needs to ensure they are directed to the appropriate level of care for their situation • Offer around-the-clock access to a highly skilled triage clinical team • Use nationally recognized algorithms to provide the best course of action • Support patients through a Clinical Care Center team comprised of more than 60% bilingual English-Spanish staff, with support of 220 other languages • Provide simple and useful advice about medications, procedures, screenings, health conditions or any other health-related topics • Listen and comfort patients in a culturally and linguistically sensitive manner • Provide a seamless extension of our clients Offer further information through access to a full health information library, in both an audio and online format in multiple languages • Empower patients to make confident and appropriate decisions
Corporate Background and Services Provided in Other States	NW provides quality medical triage phone services for over 77 entities, including publicly funded Medicaid programs, managed care providers, academic institutions, physician groups, hospitals, armed services and employer groups. NW provides telephonic medical and behavioral health care 24 hours a day, 7 days a week. NurseWise maintains six Clinical Care Centers throughout the U. S. and provides staff the ability to telecommute. This enables NW to deliver uninterrupted, continued service to clients, no matter what type of catastrophe occurs by allowing calls to go to the next available professional regardless of the geographic origin of the incoming call. All team members are linked through HIPAA-compliant software systems and have access to all files provided by our clients. NurseWise covers nearly five million Medicaid (including Foster Care, TANF, ABD, and Dual Eligible participants), CHIP, Medicare and other government-funded recipients, in addition to students, employees and private practice patients in 28 states. NW currently serves NTC-affiliate members in 17 states.. The success of NW programs is demonstrated by the following recognitions in 2015: Nurse Call Center: EMS Support Program; finalist in three categories: • Managed Care: Behavioral Health-Providing Whole-Person Support, Transitional Care Coordination and Care-After A Crisis (NW After-Care Recovery Program) • Case Management Specialty: Medicaid Case Management - Achieving Adherence in Hepatitis C Therapies through NW's *Script*Assist® Medication Adherence Program • Managed Care: Disease Management/Population Health - Improving Health Risk Assessment Collaboration-Results in a Medicaid Population • 2014 – Case Management Specialty Programs: Pediatric Case Management; finalist in two categories: • Case Management in Managed Care: Nurse Call Center • Case Management in Managed Care: Utilization Management
Ownership Structure and Date Formed	NW is 100% owned by CenCorp Health Solutions, Inc., which is 100% owned by Centene Corporation and was founded in 2000.
Total Number of Employees and Location	NurseWise has 418 regular employees and 52 contingent workers, and is located in St. Louis, Missouri. Its call centers are located in El Paso, Texas; Ft. Lauderdale, Florida; Atlanta, Georgia; St. Louis, Missouri; and, Tempe and Tucson, Arizona.
Organizational Chart	See ***Attachment 56_ Subcontractor Organizational Charts-NW***

Table Q56.F Nurtur: disease management	
Organization's Role	Nurtur Health, Inc. (Nurtur) will provide health plan disease management programs and will focus on: • Patient-centered care across the care continuum. Nurtur actively partners with Centene's other programs and external programs offering a seamless member experience. • Increased member engagement through telephonic outreach, web portal and mobile resources. Nurtur encourages members to leverage the power of its *MyNurturLife* Web portal and mobile app to drive clinically appropriate engagement in health benefits. On its portal and app, members can view Nurtur program detail, take an interactive NCQA-accredited HRA (if offered), schedule and view biometric screening results when offered, view any plan-related incentives, enroll in health and wellness or DM coaching, take online lessons and Webinars. • Member access to the latest innovative health technologies. Nurtur's accredited DM programs are optional new technologies. For example, through its optional Telecare Monitoring Program (TCM), Nurtur engages with certain high-risk members through TCM. Through TCM, the latest wireless technology enables in-home or at-work biometric readings, such as blood glucose level, blood pressure or weight, to be taken and transmitted electronically to the Health Coach and provider within seconds.
Corporate Background and Services Provided in Other States	Nurtur has implemented disease management (DM) programs in over 90 markets and currently serves over 4.6 million members across state-sponsored health plans, dozens of commercial health plans, and employer groups. Nurtur has significant experience in applying heart disease, asthma, COPD, diabetes, depression management, maternity management, low back pain, wellness management, and other core total population health management programs to improve care and support for the individuals and communities it serves. Nurtur members include CHIP, TANF, ABD, LTC, dual eligible, Foster Care, as well as commercial plan and healthcare marketplace members. Nurtur currently serves clients in 25 states; and currently serves NTC-affiliate members in 17 states. In 2014, Nurtur provided over $62 million in cost savings to its state clients, over $33 million in cost savings combined for its Diabetes DM program, and over $26 million in savings combined for its Asthma DM programs for adults and children. Clinical results included lower event likelihood for respiratory-related emergency room (ER) visits for members with pediatric asthma, COPD ER-related visits for those with COPD, and diabetes-related admissions and diabetes-related ER visits for members with adult diabetes for all active DM participants. The strength of Nurtur's programs is demonstrated by the following recognitions: • 2015 Graphic Design USA Health & Wellness Award for Best Pediatric Obesity Program Logo for "Raising Well" • 2015 Case in Point Platinum Award for Asthma Disease Management Program, especially the Nurtur Health Teen Asthma Program • National Health Information Merit Award for Consumer Decision-Making Information • Medicaid Health Plans of America Center for Best Practice National "Outreach Award" for our diabetes DM program.
Ownership Structure and Date Formed	Nurtur is 100% owned by CenCorp Health Solutions, Inc., which is 100% owned by Centene Corporation and was founded n 1994.
Total Number of Employees and Location	Nurtur employs 426 full time staff and is located in Farmington, Connecticut. Its national operations center is in Dallas, Texas with satellite offices located in Nashville, Tennessee; Tempe, Arizona; Baton Rouge, Louisiana; and Minneapolis, Minnesota.
Organizational Chart	See ***Attachment 56_ Subcontractor Organizational Charts-Nurtur***

Table Q56.G USMM: visiting nurse and physician home care services	
Organization's Role	USMM / Visiting Physicians Association (VPA) will provide in-home health services including primary care. USMM will provide Nebraska Total Care high acuity members with in-home health services such as in-home primary care through nurse and physician visits. Services provided will include health risk assessments, pediatric assessments, gap closure, transitions of care, medical and disease management, health and disease management education, and radiology, ultrasound, and laboratory testing services.
Corporate Background and Services Provided in Other States	USMM / Visiting Physicians Association (VPA) have been providing in-home health services for high acuity populations since 1993. They deliver an in-home, fully integrated continuum of care model, including physician house call, home care, hospice, radiology, diagnostic, laboratory and pharmacy/medical supply services. USMM uses a patient centered, physician-driven EMR with a complete continuum of care, including integrated reporting and scheduling resulting in increased quality of care, efficiency, and patient engagement. Currently, they serve more than 50,000 seniors and homebound patients from more than 90 field locations each year in 12 states. Currently, NIA serves NTC-affiliate members in 9 states. USMM works with more than 1,500 referring hospital and home support agencies and employs over 200 full-time physicians, nurse practitioners, and physician assistants who make more than 450,000 physician house calls, 139,000 home health visits, and 380,000 hospice patient days annually totaling more than 1,000,000 patient interactions. Care provided includes health risk assessments, nursing assessments, pediatric assessments, gap closure, and transitions of care programs to Centene and other managed care entities. CMS recently spoke to the effectiveness of this delivery model and announced that in the first year of the three-year Independence at Home (IAH) Demonstration, USMM and its affiliate VPA were able to achieve significant improvements in quality of care and patient/caregiver satisfaction while reducing overall health care costs for homebound elderly patients with complex, chronic conditions. Year 1 results show a 16.4% reduction in expected costs with a material reduction in all cause 30-day readmissions of 30%, hospital admission reductions of 50%, and emergency department visit reductions for ambulatory care—sensitive conditions of 70%. USMM/VPA represented 87% of the $25M Medicare savings in Year 1 of the Demonstration. USMM/VPA also participated in the three year Pioneer ACO Program with the Michigan Pioneer ACO that was recently announced by CMS as the most successful Pioneer Program out of the original 32 Pioneer Programs across the country. USMM/VPA represented upwards of 39% of Pioneer's total savings with only 10% of Pioneer's total population also achieving a top quintile quality score and top decile satisfaction rating. In November, 2015, Medicaid Health Plans of America (MHPA) and its sister organization, the Institute for Medicaid Innovation awarded US Medical Management and Buckeye Health Plan in Ohio for innovative best practices that have improved the health of Medicaid enrollees. Chosen by an independent advisory panel, these health plans received awards for programs in long-term services and supports, and maternal health. US Medical Management received the Long Term Services and Supports Award for its "Home Based Primary Care" that reduced unnecessary hospitalizations by providing direct primary care to homebound at-risk Medicaid beneficiaries with many chronic health problems.
Ownership Structure and Date Formed	USMM and VPA were incorporated in 1993 is currently owned by Centene Corporation and Mitchell-USMM Holdings, LLC.
Total Number of Employees and Location	USMM employs 426 full time staff and is located in Troy, Michigan. It has satellite offices in in all 12 client states.
Organizational Chart	See ***Attachment 56_Subcontractor Organizational Charts-USMM***

Table Q56.H Cenpatico: behavioral health services	
Organization's Role	Cenpatico Behavioral Health, LLC (Cenpatico) will provide behavioral health care benefits, provider services and training, customer services, and clinical services through a regional administration model, including integrating and analyzing data from diverse data sources in order to provide centralized and efficient management of behavioral health services. Cenpatico will also collaborate with medical healthcare providers to ensure integration of care for members through the Service Management/Service Coordination model. Cenpatico will focus on quality improvement and commitment to quality, innovation, and teamwork. Committees and workgroups are peer-supported and include network providers, which is essential to ensuring that clinical and quality processes and procedures do not unnecessarily burden the provider.
Corporate Background and Services Provided in Other States	Cenpatico has been in business since 1994 and is one of the nation's most experienced behavioral health companies in managing behavioral health benefits for individuals enrolled in Medicaid, CHIP, and other publicly funded programs. Its success stems from a commitment to managing behavioral health care services that can be clinically integrated into health plan programs, while enhancing consumer access to care. In 2012, CBH, LLC received the Dorland Case In Point Award for Complex Case Management in Foster Care. In 2014, Cenpatico's Arizona program received the Dorland Case In Point Award for its Child and Family Team Facilitator certification program. Cenpatico currently provides managed behavioral health services to over 4.6 million primarily Medicaid and similar non-commercial and special populations (including Foster Care, TANF, CHIP, ABD, and Dual Eligible) members in 17 states, including contracts with Medicaid and publicly-funded health plans, and a direct state contract in Arizona. Cenpatico currently serves NTC-affiliate members in 15 states.
Ownership Structure and Date Formed	Cenpatico Behavioral Health, LLC is 100% owned by CenCorp Health Solutions, Inc., which is in turn 100% owned by Centene Corporation. Cenpatico was incorporated in 1996.
Total Number of Employees and Location	Cenpatico has no employees, but it is a wholly-owned subsidiary of Cenpatico Behavioral Health, LLC (CBH, LLC), which has a full-time staff of 1,200. Cenpatico is headquartered in Austin, TX; however, Cenpatico member and provider facing staff (Care Management, Care Coordinators, Utilization Managers, and Network Management) are located across the country in every market Cenpatico serves. For the Nebraska contract, staff will be located in Nebraska Total Care's Lincoln office or active in the field.
Organizational Chart	See ***Attachment 56_Subcontractor Organizational Charts-Cenpatico***

Table Q56.I LifeShare: integrated IDD acute care	
Organization's Role	LifeShare Management Group, LLC (LifeShare) will provide an integrated, person-centered, outcomes-based approach to the long-term care and clinical needs to NTC's members of all abilities. LifeShare provides care coordination within the managed care environment as well as direct provider services. LifeShare will focus on IDD acute case management and a super utilizer solution that will coordinate with NTC case management to address unnecessary overutilization of health care services.
Corporate Background and Services Provided in Other States	LifeShare was founded in 1995 with the mission of creating empowering home and community-based supports for people with developmental disabilities, children in the child welfare system and people of all ages and abilities, particularly those who are often marginalized by society. LifeShare provides: **Adult and Elderly Services—r**esidential and day support, Supported Employment, and vocational rehabilitation **Child and Family Services—f**oster care, independent living, in-home support, home-based therapeutic support, individual and group therapy, adoption services, case management, tracking, and therapeutic services **Educational Services—t**ransition from school to adulthood, school-based support, vocational assessment, career development, after-school outreach program, social and peer networking, and alternative educational placement **Clinical Services—p**sychiatric consultation and behavioral support that includes Rapid Crisis Response System (RCRS), Behavioral Health, and Mental Health. Life Share also offers their Pathways Program that combines their person-first approach with their clinical services to address every facet of a person's life. This program helps support the individual and those involved in every aspect of their life in their shared mission of empowerment and independence. **Training, Recruitment and Licensing including—T**he Mandt System, Core Module Training, American Heart Association Certification, Visions, LifeShare Life Specific Training, Health Information Portability and Accountability Act (HIPAA), Home Visit / Behavior Support, Safety for the Professional Visitor, The Effects of Psychotropic Medications on Children, Inhalant Abuse, Self-Injurious Behavior, and Reporting Abuse and Neglect, among others. LifeShare is nationally accredited by the Council on Accreditation (COA) and offers a range of services including residential, community-based and in-home support programs, competitive employment, as well as mental health services for children and adults. Currently, LifeShare serves individuals in nine states, and has partnered with NTC's parent company, Centene, in three states for more than two years.
Ownership Structure and Date Formed	LifeShare is 100% owned by Centene, and was founded in 1995.
Total Number of Employees and Location	LifeShare employees 300 staff nationwide. LifeShare is headquartered in Manchester, New Hampshire, and will have 19 staff members located in Nebraska Total Care's Lincoln office or active in the field.
Organizational Chart	See ***Attachment 56_Subcontractor Organizational Charts-LifeShare***

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: (8 page limit)

Subcontractor Oversight and Evaluation Overview

Nebraska Total Care (NTC) understands that we will be ultimately responsible for all products, services and obligations agreed to and described in the Scope of Work (SOW) and required by 42 CFR 438.6(1), 438.230(a) and 438.230(b)(1), (2), and (3). NTC will not subcontract with any entity that has been excluded from participation in Medicaid or Medicare, or entities with suspensions/debarments. Our subcontractor agreements will include provisions to ensure the successful fulfillment of all contractual obligations, including performance guarantees and standards for financial stability. NTC will apply the rigorous process for assessing and monitoring subcontractor service performance under our contracts as described herein.

From the member and provider perspective, all services come directly from NTC. Our affiliate subcontractors, including OptiCare, US Script, Nursewise, Nurtur, and Cenpatico, operate on the same communication platforms and share resources on many levels such as reporting applications, and may be co-located in NTC offices to fully and promptly serve members' needs. Our parent company, Centene Corporation (Centene), has maintained long standing contractual arrangements with our proposed affiliated subcontractors. Centene's ownership strategy removes much of the performance risk inherent in subcontracting key functions, removes the necessity to rely on external data, and affords Centene the capability for proactive and rapid response. We apply the same level of scrutiny to our affiliate subcontractors as we would with external vendors through our comprehensive Vendor Oversight Program (VOP) and Subcontractor Assessment Process described below. Our intercompany agreements, which clearly spell out performance metrics, guarantees and reporting requirements will include:

- Responsibilities of the health plan and the subcontractor
- Specific delegated activities, required business and regulatory reporting requirements
- Explicit statement of consequences and the corrective action process if the subcontractor fails to meet the agreement terms, up to, and including revocation of the delegation agreement

NTC will 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 planned implementation. NTC understands that MLTC has the right to approve or disapprove all subcontracts entered into for the provision of services under this RFP.

Pre-delegation Assessment Process

NTC understands how important it is to confirm the readiness of our subcontractors to meet all requirements and ensure the best services for our members. Therefore, we will conduct a pre-delegation audit of all subcontractors with delegated functions. When a subcontractor contracts with two or more of our affiliate health plans we benefit from sharing auditing and oversight responsibilities with Centene Corporation, our parent company. The Centene Corporate Compliance Audit Team collaborates with affiliate health plans to conduct a pre-delegation audit of key potential subcontractors prior to contracting and an annual delegate audit thereafter. These comprehensive audits include an onsite review to evaluate the subcontractor's ability to perform delegated services and to ensure compliance with all contractual requirements. Depending on the functions delegated, this audit includes, but is not limited to reviews of: financial stability, administration and operations (such as Management Information Systems and HIPAA); claims/encounter processing; Member/Provider Complaints, Grievances, and Appeals (referred to herein as Grievance System); provider contracting, network accessibility and availability; (re)credentialing practices; Compliance Program; and quality management, utilization management (UM), and/or disease Management programs.

Vendor Oversight Program

NTC will adopt and adapt Centene's extensive Vendor Oversight Program (VOP) to ensure all subcontractors comply with federal and state laws, regulations and contract requirements. The VOP

encompasses the following key elements: clear accountability, execution of contract terms and agreements, delegation audits, performance monitoring, administration of Corrective Action Plans, enforcement of contractual penalties, quarterly Joint Operating Committee (JOC) Meetings and coordination of day-to-day business operations. NTC's ***Vendor Oversight Manager***, in collaboration with the respective NTC business counterparts, will monitor the day-to-day operations of the delegated subcontractor through interactions with the subcontractors which promotes transparency between NTC, the subcontractors, members and providers. For example, our Pharmacy Director will have joint responsibility for day-to-day oversight and monitoring to assure that US Script pharmacy claims processing meets MLTC specifications. ***The Joint Operating Committee (JOC)*** will include NTC's Sr. Director of Quality Improvement, Vice President of Compliance, leadership from NTC and applicable Centene departments. The purpose of the JOC is to monitor all functions delegated to the subcontractor and to help facilitate meaningful health plan/subcontractor operational efficiencies. If a NTC subcontractor falls outside our monthly performance guidelines, NTC will contact the subcontractor to insure that the subcontractor takes appropriate action. JOC meetings include a review of performance dashboards and member/provider complaints so that any performance or service deficiencies can be addressed and remediated promptly through a Quality Improvement Plan (QIP) or Corrective Action Plan (CAP). We will also use the following tools and resources to monitor our subcontractors to ensure they meet program requirements.

Monitoring Complaints, Grievances, and Appeals (CGA). We will use our Customer Relationship Management (CRM) system component of our MIS to track and manage CGA, including CGA involving our subcontractors. Through CRM, we can determine if a subcontractor is not meeting program requirements due to issues raised in CGA trends occurring with that subcontractor and respond accordingly.

Compliance 360 (C/360). NTC will use our Compliance 360 (C/360) Governance, Risk Management and Compliance (GRC) software system to effectively administer and monitor contract requirements, including those requirements delegated to subcontractors. C/360 enables systematic tracking of compliance activities at specific contract requirement level, and we also use C/360 to manage and track any subcontractor corrective action plans if a subcontractor fails to meet a program requirement.

Vendor Dashboards. We will require our subcontractors to produce vendor dashboards and NTC will monitor each subcontractor's performance in categories that include Provider calls, Enrollment File processing, Utilization Management activity, Network Adequacy, credentialing, encounter data submissions, claims processing and other delegated activities. Vendor Dashboards will be reviewed in depth during the JOC.

Subcontractors Assessment Process. Centene's Corporate Compliance Performance Office will annually perform formal assessments of NTC's subcontractors, using an assessment tool which considers contractual, state, NCQA, and CMS requirements. This tool will be updated to include MLTC requirements. During an assessment, noncompliant findings result in a QIP or CAP. We will also assess the capability and responsibility of any potential subcontracted party through a Pre-Delegation Assessment prior to entering into any agreements.

The annual assessment process reviews the policies and procedures specific to the delegated activities and the delegate's overall performance. Our program incorporates CMS' approach including a Subcontractor risk assessment methodology where the level of risk determines the format of the annual and pre-delegation assessment. For example, a subcontractor who risks

*Today, Centene and NTC affiliate health plans conduct an **annual subcontractor review** process in **20 states nationwide,** modeled on CMS guidelines.*

missing operational targets may warrant a comprehensive on-site assessment, while a more consistently performing subcontractor may complete a questionnaire, a desktop policy review or focused file review to evaluate their performance in identified risk areas. The on-site review could include a policy review, in-depth file reviews of delegated services, and review of operations to ensure that the subcontractor remains fully compliant in the provision of services on behalf of NTC.
Prior to delegating any work performed as part of NTC's contract, we will ensure that the Subcontractor has not been excluded from participation in any Federal or State health care programs including the Department of Health and Human Services (DHS), Officer of the Inspector General (OIG), or by DHS from participating in the Nebraska Medicaid Program for fraud or abuse. Our VOP includes a regular check of these databases every thirty calendar days. In addition, during the annual assessment of the subcontractor, we ensure the subcontractor is performing a similar check on their employees, subcontractors and, if applicable, provider network.

Vendor Training. Subcontractor staff assigned to NTC will be fully trained on all programs, policies and procedures, Heritage Health benefits and services, and related state, federal and MLTC contract requirements. These include all staff trainings on NTC, cultural competency, integration and whole person health, compliance, privacy and security, and other standard health plan training. Respective business areas at the health plan include relevant individuals from each vendor in their department specific training efforts, including onsite training as appropriate, supplemented with webinars and training materials. This includes new hire training, annual training, and upon changes in processes and requirements in their respective business areas.

- ***Ensure receipt of all required data including encounter data.***

Timely and Accurate Data from Subcontractors

NTC will leverage the reporting and encounter data processes and procedures established by Centene and our affiliate health plans across the country to support submissions in accordance with MLTC requirements, including data from our subcontractors. Centene brings over 30 years of experience receiving, processing, reporting, and securely transmitting reporting data (i.e. membership, provider, encounter, and other information) to our state client's MMIS and through Fiscal Agents. This provides us with the experience and capability to meet or exceed state standards and expectations in relation to encounter submission requirements, delivering accurate, timely, and complete encounter data. Centene processes and submits an estimated 8 million encounters per month, and over 96 million encounters a year, from over 237,000 medical and behavioral health providers; Centene supports encounter data submission for over 30 million encounters per year from our pharmacy and vision subcontractors US Script and OptiCare. Behavioral Health claims files will be generated by NTC directly. We will leverage our organizational structure, expertise, technology and lessons learned to ensure the accuracy, integrity, validity, and completeness of all data, including subcontractor encounter data. NTC shares MLTC's emphasis on encounter submissions, not only to remain compliant with state and federal requirements, but to effectively understand managed care operations such as utilization patterns and identification of quality improvement opportunities that will benefit all parties, including MLTC, our vendors, our providers, and in particular, the health of our members. We further support encounter data preparation and submission activities through the following:

Bi-Directional and Secure Data Interfaces. Through our existing HIPAA compliant data exchange interfaces with our subcontractors we will provide all appropriate files and information our subcontractors need to meet applicable RFP requirements. For example, membership daily/monthly files, required reporting, and encounter data.

Subcontractors File Exchange According to Schedule. Our Secure File Transfer subsystem has a configurable schedule, so that our MIS "knows" when we should be receiving data from our

subcontractors. If no file is received, our system issues an alert to our EDI staff to contact the subcontractor to resolve any issues.

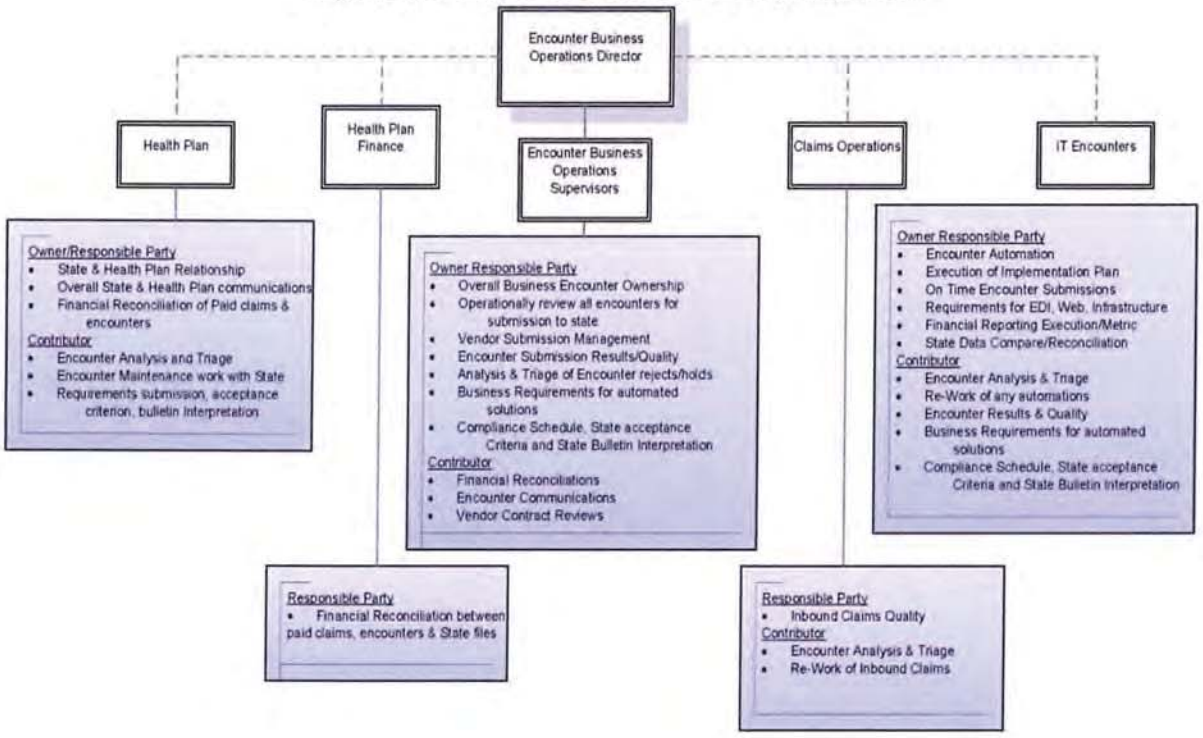
Validation process. Our monthly financial review package will include a report on encounter submissions and completeness of submissions based on a comparison of total claims paid (dollars and volume) and encounters submitted (dollars and volume). These reports will be reviewed at monthly financial calls by our CEO, COO, VP Finance, VP Medical Management, Medical Directors, and Compliance Officer in addition to Centene finance staff. If variances are identified, the Vendor Oversight Manager outreaches directly to the encounter data contact of the designated subcontractor, follows through to resolution and reports back to the VP Finance or designee. Trends in submission errors are tracked by the Vendor Oversight Manager and trainings or other interventions implemented as needed.

Enterprise Support Teams. We recognize that a strong encounter process requires collaboration, adaptation, and change for continuous process improvement. For this reason, Centene created a centralized Encounter Business Operations department (EBO) to define and establish best practices for encounter submission processes in partnership with dedicated encounter IT teams. The EBO and IT Encounter teams are agile organizations that are able to learn and share expertise based on the variations in requirements across our affiliate health plan operations and the states they serve, in addition to supporting NTC's encounter submissions to the MMIS. Our best-in-class MIS technology is configurable to meet all program requirements defined by MLTC. We currently deliver similar requirements outlined in the SOW in all of our affiliate health plans and are equipped to configure our systems and processes to accommodate any changes made by MLTC.

Local NTC Expertise. NTC will hire experienced Encounter Analysts who have in-depth understanding of MLTC-specific claims and encounter processing rules. This team will provide critical feedback to our claim configuration and encounter reporting processes and staff, allowing us to provide MLTC and the MMIS with timely, accurate, and complete encounter submissions. This team will also work with our Provider Relations specialists to support provider communication and education, and resolve issues related provider claim submissions.

A Coordinated Team Approach. The EBO team will coordinate the expertise of the above teams through regular meetings, which includes the NTC Claims Analysts, our dedicated Encounters IT staff members, and others from various teams related to encounter submissions such as Finance, Compliance and representatives from our subcontracted vendors, as appropriate, to ensure encounter processes and performance requirements are consistently met. Agenda items can include (1) overall encounter status including pass rates, paid claims to encounters reconciliation, as well as outstanding and upcoming business concerns; (2) any underlying claims issues; and (3) subcontractor encounter reporting status. See **Figure Q57** for how NTC and Centene teams coordinate encounter-related responsibilities.

Figure Q57 Encounter Roles and Responsibilities



- ***Ensure that utilization of health care services is at an appropriate level.***

Appropriate Utilization of Health Care Services by Subcontractors

NTC will monitor the utilization of healthcare services provided to members by subcontractors through pre-delegation and annual delegation assessments, ongoing compliance monitoring and quarterly JOC meetings. The goal of this process is to provide covered services to our members that are medically necessary, appropriate to the member's condition, rendered in the appropriate setting and meet professionally recognized standards of care. NTC's agreements with subcontractors require a reliable authorization review process employing evidence-based clinical decision support criteria to determine the medical necessity and appropriateness of covered services requiring authorization. The criteria must be developed by or based on recognized national criteria reflecting accepted clinical practice, along with MLTC program requirements. Subcontractors will be required to submit daily, weekly, monthly and quarterly reports that will be reviewed by NTC's Vendor Oversight Manager, in collaboration with the respective NTC business counterparts, to ensure utilization of services is appropriate. For example, NTC will review all denials and mine pharmacy utilization data, in combination with physical health (PH) and behavioral health (BH) claims data, to identify opportunities for medication therapy management and ensure appropriate monitoring and follow up care.

The Quality Improvement Committee (QIC) reviews trends of subcontractors' denials, approves their Utilization Management Program, Work Plan and Annual UM Program Evaluation, and tracks utilization trends to monitor for possible over- or under-utilization of services to take action, as appropriate. Other reporting elements required to be submitted by subcontractors no less than monthly are ***shown in Table Q57 below.***

Table Q57 Vendor Reporting Elements

Network Adequacy	Call Center Metrics	Grievances - Member	Encounters
Urban	*Abandon Rate*	*Acknowledgement timeframe*	Timeliness
PCP	*Answer time*	*Resolution Timeframe*	*Initial Submission*
Specialist	*Block Rate*	Complaints - Provider	*Rejection Resubmission*
Hospital	*Hold Time*	*Acknowledgement timeframe*	Quality
Behavioral Health	Prior Authorization TAT	*Resolution Timeframe*	*Completeness*
Rural	*Standard*	Appeals - Provider Claims	*Accuracy*
PCP	*Expedited*	*Acknowledgement timeframe*	
Specialist	*Notice to Member*	*Resolution Timeframe*	
Hospital	*Notice to Provider*	Claims	
Behavioral Health	*Pharmacy*	*Clean Claim*	
Member/Provider Ratios	*Concurrent*	*Non-Clean*	
Standard- PCP	*Retrospective*	*Interest payment*	
Standard - Other	Appeals - Member	*Claims Financial Accuracy*	
Appointment Wait Times	*Standard*	*Claims Payment Accuracy*	
Non-Urgent	*Urgent*	*Claims Processing Accuracy*	
Urgent	*Notice to Member*	Eligibility File Load	
Emergent	*Notice to Provider*	*% Load within timeframe*	

Ensure delivery of administrative and health care services at an acceptable or higher level of care to meet all standards required by this RFP.

Subcontractor Quality Performance and Adherence to NTC and MLTC Standards

NTC will monitor the quality of administrative and healthcare services provided to members through our VOP described above including pre-delegation and annual delegation assessments, ongoing compliance monitoring and formal JOC meetings. We will require subcontractors to meet both our standards and MLTC requirements for quality assessment, improvement and reporting. In addition to monitoring compliance with operational requirements, the QIC reviews reports of subcontractor performance data including all clinical and non-clinical quality indicators, utilization trends, focus studies and outcomes of improvement initiatives.

On a monthly basis, Quality Management (QM) staff from both NTC and Centene will review required reports to ensure compliance with performance standards and, on a quarterly basis, provide performance reports to the QIC for review and recommendations as needed.

NTC will require subcontractors that maintain NCQA or URAC accreditation, such as Cenpatico (behavioral health), NurseWise (nurse advice line) and Nurtur (disease management); to fulfill all accreditation requirements related to monitoring member satisfaction and provide us relevant reports. For other subcontractors, NTC will monitor service performance measures and grievance trends as well as our member disenrollment surveys. We may also do targeted surveys of member satisfaction for specific services, such as radiology and imaging, and seek input from our Member focus groups and Stakeholder Advisory Board. The QM staff will further assess performance data related to specific enrolled populations. For example, we may analyze utilization or quality indicators by eligibility group, racial group, geographic region, or disease category (e.g. percentage of members with diabetes receiving eye

exams through OptiCare, our vision services subcontractor). Our continuous quality improvement and ongoing dialogue with subcontractors leads to programmatic enhancements and improved performance.

Progressive Approach to Incent Subcontractor Performance. To further improve delivery of administrative and health care services by our subcontractors, NTC will employ a progressive approach which involves early communication of a deficiency related to reporting requirements, performance, or other contract noncompliance or service issues. We strive to ensure positive results and correction at the earliest possible stage using the following elements.

Quality Improvement Plans (QIP). NTC's Vendor Oversight Manager will review the performance issue and will request a QIP, in collaboration with the Corporate Compliance Performance Office, which includes:

- A summary of the performance issue or contract noncompliance that triggered the QIP
- The expected, measurable result indicating acceptable evidence for completion of the QIP
- Detailed action plan, including monitoring timeframes to complete required activities and the responsible party
- Due date for completion of the QIP

Upon acceptance of the subcontractors proposed QIP, it will be loaded into C/360 to monitor and document progress. NTC staff will generate status reports from C/360 for regular review by NTC's VP of Compliance, the NTC and Centene Department Management as applicable and the NTC Board of Directors as needed.

Corrective Action Plans (CAP). If the QIP requirements are not met by the timeframe required, NTC will issue a formal request for a CAP to the subcontractor. The CAP issued will formally define the standards that were violated or the service issue necessitating the creation of the CAP, the expected measurable result, a detailed action plan and due date for completion of the CAP. Details of the CAP are captured within C/360 so that progress can be monitored and shared among all appropriate parties.

Penalties/Termination of Contract. In most instances, performance deficiencies are corrected through our regular communications and detailed plans for performance improvement. Should a deficiency persist with a subcontractor, our agreements include service level language that will allow for the enforcement of penalties if performance is not corrected via a formal CAP. The Vendor Oversight Manager will track and document subcontractor performance results against required standards. The Vendor Oversight Manager will discuss the nonperformance issue with the subcontractor and notify the vendor of any decision to invoke either a financial penalty or at times, a termination of the agreement. All penalties or requests to terminate Subcontractor Agreements will be reported promptly to MLTC.

- ***Ensure adherence to required grievance policies and procedures.***

Grievance Policies and Procedures

NTC will not delegate grievances to our subcontractors. All grievances will be handled at the health plan level. If a member or provider calls a subcontractor to file a grievance, they are trained to warm transfer the member to the health plan to file the grievance. NTC member services will take the grievance, offer assistance in completing or refer a member advocate to assist as needed. It is important to NTC to directly monitor and understand when members or providers have grievances, especially with subcontractors. We include a review of all relative grievances with subcontractors as a standing agenda of the JOC. In addition, the Vendor Oversight Manager will immediately engage subcontractors when a grievance comes in to help resolve as appropriate. All subcontractor staff is trained in our grievance and appeals process, policies and procedures. Contractors are also required to review and be familiar with our provider manual which outlines the member and provider grievance process. All P&Ps are available to our integrated subcontractors through our intranet.

NTC's Board of Directors (BOD) will have final authority and responsibility for the Grievance system process, and will delegate operational oversight and implementation to NTC's QIC. The QIC will review all inquiry, appeal, complaint, and grievance summaries, including any handled by subcontractors under a delegated agreement, on a quarterly basis to identify issues requiring follow up or improvement. NTC's Performance Improvement Team (PIT) will perform a monthly in-depth review of Complaint, Grievance and Appeal data to identify trends. This will include a review of Complaint, Grievance and Appeal data sorted by subcontractor. NTC's Grievance Coordinator (GC) will be responsible for ensuring all aspects of the process are documented, routed, processed, tracked, resolved, and reported per MLTC requirements.

- ***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.***

Provider Reimbursement by Subcontractors

NTC subcontracts will include a provision for payment of providers. The provision will state that "Subcontractor agreements with providers shall not contain terms for reimbursement at rates that are less than the published Medicaid FFS rate in effect on the date of service without prior written approval by MLTC." NTC will monitor this by requiring subcontractors to submit copies of their provider agreements for approval prior to implementation. Following go-live, NTC will monitor adherence through post-delegation audits that include a review of downstream contracts. We will also monitor provider appeals and complaints to ensure compliance with this provision. The claims liaison at NTC will closely review testing data to assure claims payment accuracy before the implementation date and throughout our contract when changes are made to the subcontractor claims processing system.

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IV.K ATTACHMENTS

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Subcontractor Organizational charts have been redacted and are in the envelope of redacted information

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IV.L Care Management

IV.L Care Management

58. Provide a comprehensive discussion of the MCO's care management program, including: (page limit N/A)

Nebraska Total Care (NTC) will build on the more than 30 years of care management experience through our parent company, Centene Corporation (Centene), and its affiliate health plans to implement a best practice program that incorporates a ***person-centered, whole-health*** approach to care management. We will implement proven strategies to connect members to and coordinate across the covered and non-covered services necessary to address their full range of needs (physical health, behavioral health and social needs), and maximize functioning, health, and quality of life. Centene affiliates have implemented similar strategies in other markets, demonstrating success through metrics such as reductions in hospital admissions and ED visits (**Table Q58.A**). For example, an internal analysis of members in care management during 2014 across all Centene health plans (using observational analysis method) found that, on average, our Centene care management program resulted in significant savings in inpatient hospital and ED PMPM costs ($226 and $19 PMPM, respectively). The managed population had better compliance rates in many HEDIS measures and the analysis concluded that our care management efforts resulted in more appropriate and improved quality of care

Table Q58.A – CM Program Outcomes	
Inpatient Admissions and ED Visits: All Centene Affiliates, Q3 2014 to Q3 2015	
METRIC	**REDUCTION**
TANF members Inpatient Admissions	15.8%
SSI members Inpatient Admissions	6.0%
TANF members ED visits	6.4%

NTC's care management (CM) program will incorporate the successful Centene practices that achieved the results described above and the evidence-based Integrated Care Management program promoted by the Case Management Society of America. Founded on continuous quality improvement, NTC's CM program is designed to achieve the Quadruple Aim (as stressed by Bodenheimer and Sinsky in 20146) of improving the experience of care, improving the health of populations, reducing the per capita cost of health care and improving the work life of our network providers and their staff. We will accomplish this by integrating all medical, behavioral health (behavioral health), functional, social and other services the member receives to create a system of care around that individual. Creating this individualized system allows us to effectively address not only the clinical needs of the member, but also social determinants such as transportation, housing, food and employment and other non-clinical needs that have an impact on health outcomes and quality of life. We will facilitate collaboration as appropriate between the member, his/her family, providers, and others providing services to the member, including HCBS service coordinators, to ensure that all stakeholders in this system have timely access to the information needed for evaluation and decision making. This collaborative and integrated approach is intrinsic to our Nebraska development approach and will be incorporated into our value-based agreements with partners such as ENHANCE Health Network, CHI and the state's seven FQHCs. Our CM program will ensure a patient-centered approach that addresses a member's medical and behavioral health care needs in tandem, and provide advocacy, communication, problem-solving, collaboration, and empowerment to support member engagement in care and ensure timely access to needed services in order to achieve positive outcomes for members. Below we discuss:

- Our CM program
- Coordination of services using person-centered strategies
- Interventions focused on the whole person
- Management of co-morbidities
- Incorporation of best practices for behavioral health

[6] Bodenheimer and Sinsky, From Triple to Quadruple Aim: Care of the Patient Requires Care of the provider, Annals of Family Medicine 12:6 Nov Dec 2014 pp 573-576

- Member engagement in self-management strategies
- Social determinants of health, including risk and protective factors for behavioral health concerns
- Identification and tracking of at-risk members
- Case studies and experience from other states illustrating our ability to address community differences

Nebraska Total Care's Care Management Program

NTC will design and implement a CM program to monitor and coordinate care for members identified as having special health care needs such as, but not limited to, high-risk pregnancy, chronic health conditions, lead poisoning, complex or co-morbid conditions, an acute health event, or social determinants of health requiring care coordination. Through our program, we will assist members to achieve optimum health, functional capability, and quality of life through improved management of their disease(s) or condition(s); addressing social determinants of health; and facilitating timely access to benefits and resources. In this section, we describe our:

- CM program goals and oversight
- Integrated, multidisciplinary CM model, which offers a team approach to care management while providing a designated care manager as the primary point of contact for the member
- "Meet The member Where They Are" strategy to provide in person services and engage them in care
- Components of our CM process
- Disease management and targeted care programs we will offer to effectively meet member needs and improve health and quality of life.

A minimum of 60 calendar days prior to the contract start date, NTC will provide our CM program description, policies and procedures, a description of services available at each CM level, member outreach procedures, and flow diagrams to MLTC for review and approval. NTC will 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 will be submitted to MLTC for review and approval a minimum of 60 calendar days prior to intended implementation.

Care Management Program Goals and Oversight

The goal of our CM program is to help members achieve the highest possible levels of wellness, functioning, and quality of life, improving outcomes for all members but particularly for high-risk members with complex needs. Our program will include care coordination, disease management, and care management, collectively referred to as care management. We will encourage and support members to direct and become full participants in planning and managing their care, realizing that improved health and functional outcomes are not just important in and of themselves but also as preconditions for a fulfilling life, particularly for those with complex medical and/or behavioral health needs.

Our Medical Director, who will be a Nebraska licensed physician, will be responsible for oversight of all clinical functions including but not limited to care management programs, the development of clinical care guidelines and utilization management. Our Medical Management Coordinator/Vice President of Medical Management (VPMM), who will be a Nebraska licensed registered nurse, will provide operational oversight for the program, working with the Medical Director to effectively implement clinical policies and procedures and ensure compliance with applicable state and federal regulations, the Contract, and accreditation standards. The VPMM will be supported by a management team of qualified health professionals who will oversee the day to day operations and performance of the program. For example, our CM Administrator will be responsible for overseeing CM Teams (CM Teams) and care plan development and implementation. Our Behavioral Health Clinical Director, a licensed psychiatrist, will provide clinical consultation to our CM Teams (described below) and assist with development and

oversight of comprehensive care management programs for youth and adults with behavioral health concerns, such as ADHD and depression.

Integrated, Multidisciplinary Model

NTC will manage our members across the continuum of care using a needs-based, multidisciplinary, cross-departmental, integrated care management team, recognizing that the populations we serve include individuals with multiple chronic conditions as well as medical, behavioral health, and social needs. CM Teams will work together to assess, plan, facilitate, and advocate options and services to meet members' health and social needs, using communication and available resources to promote quality, cost-effective outcomes.

Integrated Care Teams. NTC members will be assigned a care manager who is charged with leading the CM Team and serving as the primary point of contact for the member and their family/caregivers. Our CM Teams will include registered nurses and behavioral health clinicians, social workers, pharmacy staff, Health Coaches (licensed respiratory therapist, certified diabetes educator, registered dietician, or exercise physiologist), and non-clinical support staff. NTC will staff CM Teams to reflect the needs of each member, and base the team lead assignment on the member's primary need for care manager. Each person on the team will provide input and recommendations based on their expertise and background. For example, our non-clinical community outreach workers (MemberConnections™ Representatives - MCRs) will assist clinical staff by connecting members to services and assisting with outreach and education. Hired from within the communities they serve, MCRs will provide culturally relevant assistance, including in person outreach to high risk members we cannot reach by phone or who require more intensive assistance. Our clinical documentation system, TruCare, accessible by all CM and other clinical staff, will house the member's comprehensive, individualized care plan and all other information needed to manage the member's care. Our CM staff will be co-located to facilitate informal conferences and collaboration on care plans and monitoring.

CM Staff Training. We will cross-train CM staff on physical and behavioral health screening, diagnoses, and symptom identification to ensure a holistic approach regardless of the background of the staff person leading a member's CM Team. CM staff also will receive training on best practices related to interviewing, assessment and coaching strategies such as motivational interviewing, active listening, and the teach-back method. In addition to systems and process training, we will train all care managers, regardless of background, to use best practice and evidence based techniques such as the following (***Table Q58.B***).

Table Q58.B – CM Staff Training Modules to Promote Member Engagement

Training Topic	Content Overview
Health Belief Model	Developed in the early 1950s by the U.S. Public Health Service to address the failure of people to adopt disease prevention strategies or screening tests for the early detection of disease. This engagement model is predicated on the idea that a person's belief in the personal threat of an illness or disease, the effectiveness of the recommended health behavior or action, along with the person's confidence and belief in his or her own ability to take the given action will influence the likelihood that the person adopts the desired behavior.
Poverty Competency	Fosters a deep understanding of the types of poverty; its history and causes; awareness of personal attitudes and beliefs about impoverished people; and understanding oral culture and relational styles of communication.
Engagement Skills	Teaches staff how to effectively establish trust, credibility and rapport with

	each member. This helps open resistant or hesitant members to condition-management objectives and enables staff to recognize members interested in progressing.
Motivational Interviewing	Trains staff to take a partnership approach with members, using open-ended questions, affirmations, various types of reflections and summarizing to assess member attitudes about change and appropriate next steps.
Trauma-Informed Care	Identifying and understanding the effects of trauma on development and particularly on behavior in both children and adults are crucial in assessing each member's needs and in understanding the context of behavior. Centene has the most highly developed trauma-informed training program in the United States among managed care organizations serving this population. The training is not only a component of CM training, but includes expansive curriculum for providers and service organizations. Using this model, our Texas affiliate has provided training on trauma-informed care to over 60,000 people since 2008.

Training also will address biopsychosocial factors that affect member willingness and ability to engage, such as health literacy and the impacts of domestic violence and drug abuse. In addition, we will provide extensive training on cultural competency, including partnering with local organizations to assist in training our staff on cultural considerations specific to Heritage Health members. For example, we will invite Tribes to participate in developing and providing training to CM staff on each Tribe's unique beliefs and preferences related to health care. We will also invite long term service providers, such as League of Human Dignity and Munroe-Meyer Institute, to assist us with CM staff training related to serving individuals with disabilities (such as etiquette and self-direction of services).

Interdisciplinary Case Rounds. For our more complex members, we conduct biweekly and ad hoc interdisciplinary Case Rounds. These reviews allow us to consider and address the full range of each member's needs from the perspective of multiple disciplines and expertise. During the review, CM Team staff evaluate the variety of care, utilization, and chronic care management solutions in each situation as well as comorbid medical and behavioral health and substance abuse issues, including the impact of treatment and care one condition has on the other. For example, our pharmacist may identify a member taking medications that should not be combined or are not appropriate for the member given their medical or behavioral issues. Our nurse and behavioral health care managers can provide input on potential alternatives and coordinate with prescribers to discuss the appropriateness of the medication given its contraindications.

Community Health Collaboratives provide a workable means for better integration of healthcare services and early identification of members that could benefit from care management and coordination by offering providers connection through embedded NTC staff.

Meeting Members Where They Are

NTC, like our affiliate plans, will "meet members where they are" to maximize our ability to identify members that may need care management and to individualize services according to each member's needs. This means meeting members where they are in the community, as well as targeting information and interventions to the member's willingness to engage, level of health literacy, and other factors that affect their participation in their own care.

Initiatives to Facilitate In-person Engagement. A key lesson learned serving Medicaid and other low-income members across the nation is that in-person interaction allows us to establish stronger

relationships with members, which in turn increases member trust and willingness to engage with our staff. Strategies based on this approach, which NTC will implement include:

- CM staff embedded at provider locations
- Concurrent review/discharge planning staff placed onsite at high-volume network hospitals
- MemberConnections staff and community-based events such as Baby Showers for pregnant members and Healthy Lifestyle Events to provide education and activities on topics like healthy eating

NTC will leverage in-person contact to help members understand their own health conditions and needs and identify the services available to meet those needs. We will also provide in-person education and support for accessing recommended care, and identify and address barriers to appropriate access.

Community Health Collaboratives. Community Health Collaboratives (CHCs) are formed as partnerships between key providers in a given area and provide opportunities for onsite CM staff to enhance communication and collaboration, to increase capacity and remove barriers inhibiting access to available resources. Having onsite staff will allow us to identify members seeking care at these locations who may need CM services and immediately provide assistance and comprehensive assessment if warranted. The goal is to remove any barriers that prevent a member from gaining access and benefitting from the resources available from any one of the CHC partners so that members get the right care at the right place in a timely fashion. The CHC model will also promote data-sharing to provide insight into over- and under-utilization of care and other opportunities to provide better care in the appropriate setting. For example, in Norfolk, NTC is forming a CHC with Midtown Health Center, Faith Regional Health Services, Region 4 Behavioral Health and tribal representatives from the region. A care manager embedded at Midtown will coordinate member care between the CHC partners to more efficiently use available resources. Value based payment arrangements will be designed to open appointment slots, increase hours and incent the partners to expand access to providers formerly limiting or not accepting Medicaid patients. In addition to Norfolk, NTC is in discussions with providers in Lincoln, Scottsbluff and the Kearney-Hasting-Grand Island tri-cities region to develop additional CHCs.

Partnering with LTSS Providers. NTC recognizes that members are often more responsive to and engaged with the community organizations and providers they know and trust than with their Medicaid health plan, particularly those with special needs. NTC will outreach to and partner with organizations and providers to leverage their existing relationships with members. NTC will employ an LTSS Liaison to serve as our point of contact with LTSS providers. The LTSS Liaison will work with LTSS providers to develop care coordination strategies for our members receiving these services. For example, NTC has established a partnership with the League of Human Dignity (LHD), a Center for Independent Living, providing long-term services and supports (LTSS) and management, with locations in Lincoln, Norfolk, Omaha, Council Bluffs, Scotts Bluff, Kearney, and North Platte. Our CM Team will coordinate with the LHD case managers for members receiving LTSS to ensure the member is receiving needed covered and non-covered services. NTC will provide education to LHD staff, share utilization data, and provide notification of any gaps in recommended preventive care. The CM Team will invite LHD case managers to participate in our interdisciplinary Case Rounds (such as to develop strategies and service options to address increased ED utilization), and will be available to participate in LHD case conferences for shared members. NTC will also offer pharmacy consults to LHD case management for NTC members.

Partnering With Indian Health Services and Tribal Representatives. NTC is partnering with Indian Health Services, Tribal 638 and Urban Indian providers which provide care coordination services for Tribal members. Our extensive experience working with tribes in other states such as Arizona will inform our approach to Nebraska's Native American population. We respect tribal sovereignty and the need to work with each tribe to develop accessible, integrated and culturally appropriate healthcare services. Our care coordination process for tribal members is detailed in our response to Question 63.

Components of Our CM Process

NTC's CM processes are structured to maximize the impact of Cm program resources for the population as a whole, while providing the most appropriate level of services for individual members. Our CM program will ensure and promote timely access to and delivery of appropriate covered and non-covered services; and coordination and integration of all care the member requires. We will accomplish this through a process that consists of member-centered, goal-oriented, culturally relevant and logical components to assure that a member receives needed services in a supportive, effective, efficient, timely and cost-effective manner (***Figure Q58***). These high-level components include the following:

Figure Q58 – Components of NTC's CM Process

Initial Screening

- Within 90 days of enrollment for new members
- NOP for members who are pregnant

Risk Stratification

- Low, moderate, or high risk
- Risk level reflects physical, behavioral, functional, social and overall need for assistance
- Stratification changes as member's needs change

Comprehensive Assessment

- Claims review, member interview, family/caregiver and provider involvement
- Determines intensity and frequency of follow-up

Care Planning and Montioring

- Individualized and person-centered
- Prioritized and measurable goals, action steps, ongoing communication plan
- Ongoing monitoring to ensure receipt of care

Reassessment

- Regular frequency based on risk level
- Whenever the member has a new or changed condition

Our program will go beyond a purely clinical determination of needs to identify and address functional status and barriers to care such as lack of caregiver supports, impaired cognitive abilities and transportation needs. We will encourage and support members to direct and become full participants in planning and managing their care, realizing that improved health and functional outcomes are not just important in and of themselves but also as preconditions for a fulfilling life, particularly for those with complex health or functional needs.

Remember the Member…
When member Joanne's house burned down while she was hospitalized, our Care Manager (CM) worked with the United Way and the Salvation Army to obtain clothing for Joanne. The CM also obtained a home voucher through the Red Cross and contacted the African American Fellowship Assistance program to obtain sufficient funds for the security deposit on a new rental home for Joanne.

Creating and Supporting a System of Care. We will use the system of care approach to design and develop interventions that are member-centric, holistic, proactive, and integrated. Our assessments are inclusive of all life domains and are administered with each member versus to them. We include identification and assessment of services that the individual is receiving or could benefit from to avoid duplication and gaps. From these assessments, we will develop an individualized care plan that is based on the member's strengths, goals, and preferences, and tailor services to wrap around the member and family. Staff will work to create a system of care around each member, such as:

- Care Management staff will provide telephonic and in-person coordination of all formal and

informal supports. This includes services provided by the school system and other State agencies, as well as social and financial supports provided by non-profit and other public organizations.

- MemberConnections® staff will serve as our community health workers. MemberConnections Representatives (MCRs) are hired from within the communities they serve and receive intensive training on supporting members. MCRs work with members in the community and help them access covered services as well as community resources.
- Utilization Management staff think "outside the box" to identify services that can support members to achieve the highest level of wellness and avoid admission or readmission to the hospital. This may include medically necessary services such as private duty nursing for children with special healthcare needs and infants after an extended stay in the NICU to support their health care needs in the least restrictive environment.
- Customer Service staff will provide information about and connect members to benefits, programs, and processes to assist them in navigating the health care system.

Promoting the Medical Home. NTC will emphasize and support the medical home as the point of direction and coordination for the member's full range of care. We will assist members to identify and select a medical home upon enrollment to ensure that the full array of preventive, primary, and behavioral health care services is available, integrated and coordinated. Care managers will ensure the success of the medical home model by:

- Sharing assessments, care plans, utilization information and monitoring results with PCPs
- Coordinating and facilitating communicating between PCPs and other providers (such as behavioral health providers, other specialists, and providers of non-covered services such as HCBS waiver providers)
- Discussing member needs and care with individual providers or with the full treatment team as needed so that all involved have a clear picture of the issues impacting the member's care
- Supporting provider treatment plans by requesting and incorporating the treatment plan into NTC's care plan and reviewing member progress and adherence through regular monitoring
- Sharing information with both the PCP and other involved providers to obtain input on strategies to address issues or barriers

We will also provide technology support to providers in integrating services for each member. Both participating and non-participating providers can register to access our Provider Portal to view information about a member they are treating, including the care plan, ensuring all treating provider have a holistic view of the member's care and needs. For example, NTC's online Centelligence® Member Health Record provides PCPs with a well-organized view of a member's care gaps as well as summary and detailed clinical data for each member. Information is based on current and available historic medical, behavioral health, and pharmacy claims information, lab test results, health risk screenings, and other information systematically received and processed in Centene's Enterprise Data Warehouse. Our Care Gap Alerts notify providers that a member is due for or missing a service recommended by evidence-based guidelines, including physical health services such as diabetes-related care as well as behavioral health services such as follow up for antidepressant medication. We provide more detail on how we support provider integration efforts below in the section titled Managing Co-Morbidities.

Coordinating with Supports and Stakeholders. Family and informal supports are critical to ensuring members receive needed services and adhere to treatment plans. Care managers will work with members to identify their influencers and other important informal supports, educate the member about the value of including them in assessment and care planning processes, and attempt to obtain member consent to share information with and include them in planning and monitoring care. CM Team staff will outreach to these supports (with appropriate consent) to involve them in assessments and care planning, ensuring adherence

to the care plan and providers' treatment plans. We will also engage them to help monitor the member's condition and care to identify when care plan revisions are needed and involve them in the revisions.

- For members who are minors, we will involve the parent(s)/guardian in all aspects of care management (unless otherwise directed by state or federal law, such as for family planning services). However, particularly for teens, we understand the importance of giving the child a stronger role as the 'driver' of the process, especially as they near the transition to adulthood. care managers will work with parents and guardians to help them understand the need to take the child's preferences into account and help them establish as much independence as possible in managing their own care.
- For child welfare system participants, the CM will coordinate all activities with the DHHS caseworker and, as permitted and appropriate, with the foster parent(s) as well as other stakeholders in the child's life. This may include but is not limited to parole officers, court representatives, CASA volunteers, and others.
- For members who are elderly, particularly those with Alzheimer's or cognitive decline, family and caregivers are a critical part of the care management process as they often have information about the member's condition or care that the member is unaware of or unable to clearly communicate. At the same time, we will help family members/other supports understand the need to support the member's independence and control.
- For members with behavioral health conditions, including substance use disorder, it is particularly critical to identify the member's 'influencers' and other important informal supports such as community case managers or AA sponsors. For example, members with SMI often require additional outreach strategies and support to engage in their care, and control of the behavioral health condition can be a critical factor in the Member's willingness to engage. With appropriate member/authorized representative consent, care managers will work with behavioral health providers and community case managers to monitor service delivery and member compliance, and determine optimal reassessment points.
- For adult members unable to actively participate in their own care or treatment planning due to a condition such as Alzheimer's, psychiatric disability or developmental delay, our CM staff will actively seek and document appropriate guardianship contacts who can represent the member. Should a legal guardian not be established, but the adult member desires to include a parent or other caregiver in care and treatment planning, the care manager will work with the member to obtain an authorization for release of information, both verbally and in writing, which we will maintain in TruCare.

Care managers will share information with authorized family members, caregivers, community caseworkers, and other stakeholders in the member's care, via phone and in person at established points within the CM process. Information shared will include but is not limited to assessment results; member goals and preferences; care manager and other provider recommendations; care plan services; education about the member's condition; self-management strategies; and how the stakeholder can support the member. Points in the CM process at which we will share information with supports and stakeholders and associated goals for sharing the information include, but are not limited to the following (***Table Q58.C***):

Table Q58.C – Sharing Information with Supports and Stakeholders

Coordination Point	Information Sharing Goals for This Point In The CM Process
Care Plan development and revision	• Obtain input on care plan/revisions • Provide education on the member's conditions, self-management, adherence, service options, the role of the care plan, recommended preventive and condition-specific care, and how the stakeholder can support member adherence and self-management
Care Plan monitoring	• Assess member progress on action steps toward goals, self-management,

Table Q58.C – Sharing Information with Supports and Stakeholders

Coordination Point	Information Sharing Goals for This Point In The CM Process
	adherence and alert PCP and treating provider of progress • Identify new or changed needs and barriers • Reinforce self-management and adherence education as needed
Care transition (such as inpatient, ED admissions and discharges)	• Assess transition needs • Provide education about transitional care processes and importance of follow-up care • Obtain input on transition plan

We will make our Centelligence® Member Health Record available to authorized stakeholders via our secure Portals. Because the Member Health Record is completely integrated within our secure, web based, role-specific Portals, authorized Portal users can easily view important contacts related to the member's care and well-being:

- Our Client Portal will provide this information to authorized state users such as child welfare system caseworkers, juvenile justice and court system representatives, and other state agency representatives involved with the child's care.
- Our Caregiver Portal will provide this information to authorized caregivers, such as medical consenters, parents, foster parents, and guardian's ad litem.

Select 2014 Disease Management program success indicators – Percent of Participants Improved or At Goal:

- Total Cholesterol outcomes: 81%
- HbA1c outcomes: 72%
- Diastolic Blood Pressure outcomes: 65%
- Exercise outcomes: 51%

We will also provide information on our public website that supports coordination, regardless of whether a member is in CM or not. For example, our Caregiver Resource Center on our public website will provide an array of resources to support caregivers, such as information about co-morbid physical and behavioral health conditions; physical health side effects of common behavioral health medications; identifying and supporting a person with post-partum depression; warning signs of substance abuse; and community resources such as family support groups.

Targeted Care and Disease Management Programs

NTC will offer targeted disease management and care management programs for members with select chronic conditions or diagnoses, complex or comorbid conditions, or high-risk, high cost conditions. Common elements of these programs will include:

- Program services provided by RNs, behavioral health clinicians and/or licensed Health Coaches, supported by our MCRs (community health workers), using Motivational Interviewing, member-centric assessment and planning, and other strategies to support member engagement, including in-person interaction for certain high risk members
- Condition-specific assessments and targeted interventions, integrated with the member's other health, behavioral health, specialty, and other needs for a whole-person management approach
- Clinical practice guidelines and other tools and support for providers
- Condition-specific education materials geared to specific populations, such as children, non-English speakers, and members with low literacy levels
- High tech solutions such as tele-care monitoring and use of email, text messaging, and mobile applications for information, reminders, and support
- Care gap closure programs aligned with HEDIS metrics
- Medication support, which can include outreach by pharmacy staff to members with asthma and diabetes who are not receiving DM coaching

NTC will leverage our Centene affiliate, Nurtur Inc., NCQA and URAC accredited disease management programs. For Nebraska, NTC will initially implement the DM programs listed in ***Table Q58.D*** below.

We developed this list based on our review of disease prevalence and health disparities within Nebraska. For example, heart disease is the second highest cause of death in the state, and one of the five top health priority areas in the 2013-16 Nebraska State Health Improvement Plan is "Reduce heart disease and stroke morbidity, mortality, and associated risk factors." Thus, we will offer several DM programs that target heart health and the risk factors for heart disease and stroke. We may add to or modify this list based on the unique needs of our membership.

Table Q58.D – NTC Proposed Disease Management Programs

ADHD	***CAD***	***Depression***
Asthma	***CHF***	***Diabetes***
Anxiety	***COPD***	***Hypertension***

Additionally, we will provide lifestyle-coaching programs such as for Tobacco Cessation and Weight Management. While lower risk members may only need coaching, basic care coordination, and monitoring through a traditional DM approach, we will integrate Care and Disease Management services through the CM Team for higher risk members, such as those with multiple co-morbidities, and super-utilizers. The CM Team will assess a member's chronic condition(s) in the context of all their conditions and needs. They will take an integrated approach that recognizes the body and mind as a system that must be addressed holistically, and DM services will be part of the continuum of services that the CM Team provides. The care manager and Health Coach will collaborate to assess the chronic condition along with all other member needs, including depression screening, and develop an integrated care plan and coaching strategies. Based on our experience serving similar populations, NTC will implement CM programs for the targeted conditions in addition to care management for members with complex, comorbid or high-cost, high-risk conditions not otherwise listed in ***Table Q58.E***.

Table Q58.E – CM Programs for Targeted Conditions

Targeted CM programs
Start Smart for Baby® Perinatal/NICU Management program
Our Start Smart for Baby® perinatal and NICU management program emphasizes early identification and stratification of pregnant members, and education and CM interventions to improve birth outcomes for all pregnant members. The program serves as the umbrella for all of our perinatal management efforts. Start Smart staff assist members, in person when necessary, to access prenatal and post-partum care, provide education on their healthcare needs, address social needs and concerns, and connect members to appropriate specialists and non-covered services, such as specialty behavioral health and SUD services and dental services, and community resources. Our Start Smart program is modeled on our parent company Centene's award-winning program that was named a best practice by NCQA is 2009. The program received the 2010 URAC/ Global Knowledge Exchange Network International Health Promotion Award, and a Platinum Award for Consumer Empowerment at the URAC Quality Summit. In 2014, Start Smart received a Case In Point Platinum Award honorable mention.
Perinatal SUD Management program
Our Perinatal SUD program will provide education and resource linkage, and connect pregnant members with SUD to intensive outpatient and partial hospitalization programs along with Subutex and Methadone treatment. When we identify a pregnant member with suspected SUD, a behavioral health clinician care manager will complete, or will coordinate with the existing HROB care manager (who will remain the member's primary contact) to complete, an assessment to confirm the substance use and assess the member's medical, behavioral health, social, and other needs. The program will promote recovery through a care plan developed in collaboration with the member that includes treatment referrals; self-management tools such as workbooks designed to better understand triggers; and use of local support groups and resources. Care plans will also include coordination with the member's providers (including PCPs and OB/GYNs) as well as family and community supports as desired by the member or parent/guardian.
ED Diversion program
The ED Diversion program will provide services to members with frequent or inappropriate ED usage patterns

for physical or behavioral health issues. Care managers will reach out members that had an ED visit to assist with obtaining follow-up care, provide education regarding appropriate use of the ED, importance of getting primary and preventive care, the availability of the 24/7 nurse advice line and the closest urgent care site. The CM also will address barriers to care and assesses health literacy and self-management. In 2012, our Georgia affiliate's similar ED Diversion program received a Case in Point Honorable Mention and Platinum Award.

Transitional Care program

The Transitional Care program will provide transition services to members who are admitted to the hospital in an effort to prevent readmission. We will provide telephonic engagement as well as on-site staff at high volume network hospitals. Transitional care staff will work with the member and hospital staff to identify potential risk factors for readmission and ensure that the member's discharge plan addresses all needs. For members in CM with either physical or behavioral health discharges, we will provide the discharge plan to the PCP. The care manager will follow up with the member 24-48 hours post discharge to confirm that the member has all needed equipment, medications, and in-home services and to reconfirm their understanding of their diagnosis/condition and self-management plan. We will also follow up with members who have had a behavioral health discharge to provide a reminder for the seven and 30 day follow up visits and address any barriers. See our response to Question 64 for more detail.

Lead CM program

The Lead CM program will provide services to children with blood lead levels (BLL) equal to or greater than 10 microgram per deciliter. The care manager will notify the PCP and explain the LCMP program. The care manager will complete a BL assessment on all children to identify health conditions, behaviors, or environmental factors that place the child at higher risk for lead-related health problems; provide focused education and interventions for each child; and guide development of an individualized care plan. We will link members to and collaborate with services such as the Omaha Lead Hotline and home lead screening programs to identify and address lead in the home. The care manager will assist with coordination, linkage to services, and addressing barriers to care to ensure treatment goals are successful.

HIV/AIDS program

Health Educators will provide telephonic and in-person outreach, education, and coordination of services to address the care and treatment for HIV/AIDS and all co-morbid conditions, such as hepatitis B and C, tuberculosis, and behavioral health issues. Because of the important role of antiretroviral (ARV) therapies, members also will receive specialized medication therapy monitoring to assist with ARV drug adherence and other co-morbid condition medication regimens. care managers will partner with community agencies and infectious disease facilities to address the psychosocial barriers that could possibly impede compliancy with medical care. Through community health lifestyle events, health educators ensure health promotion through face-to-face interactions with participating members. Additionally, we will collaborate with existing programs serving these individuals to identify ways our CM program can support their efforts, such as Community Action Partnership of Western Nebraska, which serves over 50 HIV+ individuals in partnership with Chadron Community Hospital and an infectious disease physician.

Sickle Cell CM program

The Sickle Cell CM program will provide services to members with moderate and high risk Sickle Cell disease to improve PCP engagement, increase the use and/or adherence to medications, and support members' pain management skills. The program will provide educational materials and care coordination services, and promote use of, and adherence to, hydroxyurea (a medication used to reduce sickle cell crisis caused by painful events, acute chest syndrome, and anemia). The care manager will work with the member and treating provider to develop a care plan that addresses physical, psychological, social, and environmental needs, goals, and interventions. care managers will provide education on key areas such as hydration and safety. The care plan will also incorporate a pain management plan that outlines how the member can appropriately manage their pain at home and includes pre-defined thresholds for the use of opioids and guidelines for when they should contact their provider.

Palliative Care program

This program will serve members with cancer and other advanced chronic and debilitating illnesses. We plan to hire an RN care manager who is certified through the National Board for Certification of Hospice and Palliative Nurses to provide specialized expertise to members, train CM staff, and consult on complex cases. CM staff will work with the member and treating provider (and family/guardian as appropriate) to develop and monitor a Care Plan that meets the member's health and psychosocial needs, recognizing the critical role of family/caregivers in supporting the member's psychosocial wellness. CM staff will leverage the expertise of our behavioral health

Medical Director in addressing behavioral health issues, such as when the receipt of stressful and difficult information or the need for end-of-life decision making triggers challenging family dynamics. CM staff will make referrals for and incorporate hospice services into the care plan as appropriate. Through our Centene affiliate and national leader in physician house call medicine, US Medical Management, we will provide home-based services when appropriate, such as evaluation and management of the medical condition and pain, and the discussion of treatment goals, including advance care planning or hospice. We also will provide and educate providers about guidelines from the National Hospice and Palliative Care Organization in the Provider Manual and on our Provider Portal. program staff will inform providers of the guidelines when coordinating with the provider in developing and monitoring the member's Care Plan.
LTSS Management program
This program will leverage Centene's national experience coordinating with carved out facility and community-based long-term services and supports (LTSS). Centene affiliates also have experience covering these services, which provides us deep insight into how these services and programs operate, what they offer, and how to effectively coordinate them with the physical, behavioral health and other services covered by Heritage Health. The program will provide specialized expertise and focus to coordinate care for our members receiving LTSS, either through an HCBS waiver program or in a long term care facility. Services we will provide through this team will include Centene's Fall Prevention program, which affiliates have implemented in other states to prevent falls, which frequently result in the need for hospital and/or ED use and long term facility admission. Our LTSS Liaison will provide training and expert consultation to CM staff, and oversee the smooth functioning of our coordination processes with waiver programs and facilities. As part of the program, we will educate members and caregivers as well as LTSS case managers about the importance of preventive and primary care services, which this population tends to underutilize. CM staff will assist with locating PCPs with accessible offices and who have special expertise with this population. We will coordinate with LTSS case managers to problem-solve regarding inappropriate utilization, such as ED use, that indicates underutilization of primary, preventive, LTSS, or other services. We will also offer training to LTSS case managers and providers regarding the importance of preventive and primary care for the members.
IDD Management program
This specialized program for members with intellectual and developmental disabilities (IDD) will leverage Centene's industry-leading expertise in serving this population in managed care. We plan to hire an RN with experience with the IDD population to train and support CM staff and consult on complex cases. CM staff will connect the member to needed covered services, and collaborate with existing medical and service providers who support people with a developmental disability, such as programs, clinicians and staff at University of Nebraska Medical Center Munroe-Meyer Institute and their clinical and other programs, both within metro Omaha/Lincoln and rural/frontier regions of the state. Similar to our LTSS program, we will educate members and caregivers as well as IDD case managers about the importance of preventive and primary care services, which this population also tends to underutilize. CM staff will assist with locating PCPs and other providers such as dentists who have special expertise with this population. We will coordinate with IDD case managers to problem-solve regarding inappropriate utilization, such as ED use, that indicates underutilization of primary, preventive, or other services. We will also offer training to IDD case managers and providers regarding the importance of preventive and primary care for the members.

- ***Coordination of services using person-centered strategies.***

NTC will coordinate services using the following person-centered strategies which will ensure members (and their support networks, such as a parent/guardian for minors and important family/caregivers and others for adults, when appropriate) have meaningful opportunities to be actively engaged in their care:

- Provide member-tailored education and supports
- Support members to assume an active role in the identification of their needs, barriers, preferences, and goals
- Support members to assume an active role in the planning and implementation of an individualized, holistic care plan that is culturally responsive and inclusive of both covered and non-covered services to reflect the full range of the member's health, behavioral health, functional, social, and other needs
- Create a process for continuous care plan review and improvement that ensures the member is at the center of defining quality care and developing solutions that are unique to his or her needs.

Provide Member-Tailored Education and Supports

Education tailored to our members' level of health literacy and individualized supports empower them to assume an active role in their health and wellness and to self-advocate. NTC will provide multiple levels of support and information to assist members be actively engaged and direct their health care services, whenever possible. First, we will educate members about the care coordination process, the importance of their active role, and their right to direct and actively engage in care plan development. Second, we will educate members about their medical conditions and the critical role they play in monitoring and self-managing their conditions. Any meaningful member education and activation model recognizes that members will present with varying levels of interest and abilities associated with this process, thus our CM staff will meet members where they are by evaluating health literacy, willingness to engage, and other factors in order to tailor education and support to facilitate active member engagement in care planning and self-management.

Our member-tailored approach will include multi-dimensional learning strategies so we can respond to the diverse educational needs of our members. While we will provide a variety of written and online materials, our strategies will also focus on ongoing direct member contact. In addition to phone interactions, CM staff will also educate and support members in person, such as at provider locations, and at community events. This will allow staff to immediately determine the extent to which the member understands the information being provided. Our CM staff will ask if the member has questions and will review the information as needed to ensure the member understands his/her roles, rights, and responsibilities related to their care plan. CM staff also will educate members, as appropriate, on disease-specific indicators; important actions specific to their condition(s); important actions to take when there has been a change in condition; strategies to support medication adherence; medication side effects to monitor, including side effects specific to their health condition. Additionally, NTC recognizes the important role technology can play in supporting members to assume an active role in their care. Our mobile application will provide easy to read; culturally appropriate educational resources and members will be able to access their care plan on our secure Member Portal. The CM will link the member/family with community-based educational programs and support groups to support engagement and self-management. Our online Caregiver Resource Center will also facilitate family and caregiver access to needed resources to cope with their own stresses and better support the member.

Support Active Member Role in Identification of Needs, Barriers, Preferences, and Goals

From our first outreach to the member, CM staff will work to establish a trusting relationship and ensure our identification of needs and goal setting processes are person-centered. As part of the initial planning, our CM will ask whom the member (or parent/guardian for minors) would like to include in assessment and care planning processes. The CM will attempt to the identified individuals to invite them to participate in the assessment and care planning process. The member will determine the role of each individual, and at any time, may make modifications to who s/he feels is appropriate to engage.

Person-centered planning was developed for people with disabilities, but it is a useful approach in planning services for all people. Early models varied, but shared several fundamental components:

- *"...seeing people first rather than relating to diagnostic labels;*
- *using ordinary language and images rather than professional jargon;*
- *actively searching for a person's gifts and capacities in the context of community life;*
- *and strengthening the voice of the person and those who know the person best in accounting for their history, evaluating their present conditions in terms of valued experiences, and defining desirable changes in their lives".*

CM staff will complete assessments with the assistance of the member and others as desired by the member. CMs will build rapport with members by being respectful and caring and encouraging the member to express their needs, desires and fears in such a way that the member feels safe and supported. Goals and preferences are more subjective than health status indicators, and may not be fully captured on assessment instruments. NTC will train CM staff on evidence-based engagement techniques, such as Motivational Interviewing, to encourage dialogue and guide members to articulate their goals in ways traditional assessment tools may miss. We will train CMs to recognize their own biases and how to focus on what the member wants and needs while at the same time providing evidence-based context, when appropriate. Upon the completion of the assessment, CMs will assist members to identify goals based on the needs identified through the assessment process. For instance, members will be supported to develop goals related to health, behavioral health, functional status, and overall quality of life (such as daily engagement in meaningful activity, losing weight, or remaining in their home).

Support Active Member Role in Care Planning and Implementation

Once the member determines their goals with assistance from the CM and others engaged, the CM will ensure the member receives any additional education, information, and/or tools to support the member in active implementation of the care plan and to evaluate service options. CM staff will describe the types of activities involved in directing care plan development, such as deciding which available service options the member thinks will best meet their needs and selecting their own providers. The CM will assist the member, to the extent needed, to examine available service options and determine the providers who can to meet the member's needs. Person-centered planning allows our CMs to understand the needs of each member holistically, and in turn, work effectively with the member to develop a care plan that recognizes the impact non-medical factors can have on overall health and quality of life. Our CMs will utilize the person-centered planning process to understand the complex array of social, environmental, educational, and functional factors that will influence the member's success and ensure care plans are responsive to these factors. Our CMs also will use person-centered planning to identify cultural preferences and needs and to work with the member, his/her allies, and community partners to ensure all services are provided in a culturally responsive manner. The CM will work closely with the member, his/her engaged allies, and community partners to identify providers who can meet the language, cultural, and service needs of the member, regardless if the services are a covered benefit. We also will connect members to community resources such as utility assistance, food pantries, domestic violence programs, and support groups, and provide a Community Resource Guide so the member and family can identify and access social services directly. The CM will ensure the member's needs, preferences, goals, and culturally responsive services are outlined in the member's care plan to ensure CM staff and providers are informed and addressing the members' needs and preferences appropriately.

Use Member-Centric Approach to Evaluating and Modifying Services

Person-centered planning is integral to ensuring members assume an active role the continuous review of care plans and overall care plan improvement strategies. For instance, as part of our member education process, CM staff will educate the member about the critical role they play in monitoring their conditions, change in medical status, chosen services, and satisfaction with services. CMs will support members to design an action plan for each goal inclusive of milestones and responsible parties (all of which will be clearly listed on the care plan). By ensuring the member is at the center of these activities, CMs support members to assume an active role in continuously monitoring the effectiveness of their care plan and in identifying any changes required to improve their overall health outcomes. Through initial and ongoing education and written materials, the CM will ensure members understand when to contact the CM (e.g., change in medical status, dissatisfaction with a provider) and their right to request a change in the care plan. In addition, the CM will assess member satisfaction with the care plan and associated services as a part of routine communication and visits with the member. The CM will work directly with the member to make any required changes to the care plan based on his/her needs as well as update all providers on

the changes.

- ***Interventions focused on the whole person.***

NTC's System of Care approach will ensure that all of our interventions are member-driven and respond to the needs of the whole person, addressing co-morbidities and not just the primary condition. We understand our role in facilitating comprehensive and well-integrated care for members, including members with frequent co-morbidities. Our success is dependent on our understanding of the complex factors that influence a member's health and the need for thoughtful strategies driven by person-centered planning to address these complexities. Our care management program includes the following components to ensure interventions are focused on the whole person.

Comprehensive Assessment Strategies

Our comprehensive assessment strategies will ensure a holistic picture of member needs and goals. Our Health Risk Assessment process evaluates the member's medical, behavioral health, dental, functional, and social needs as well as their goals and preferences for services. The HRA is inclusive of all life domains and will be administered with each member (versus to them) through a member-driven process. Our assessment tools also includes the identification and assessment of services that the member is receiving or could benefit from to avoid duplication of services and gaps in care.

Individualized Care Plan and CM Strategies

We will develop individualized, comprehensive, and holistic care plans based on members' individual strengths, goals, and preferences, and tailor services to wrap around the member and family. Care plans will be holistic, incorporating covered services as well as non-covered and community services. Additionally, NTC will partner with medical homes to provide coordination services that effectively address the member's needs in a holistic fashion. For example, we will work directly with the medical home to ensure a holistic review of assessment data, care plans, monitoring practices, recommendations from other treating provider, and other member information to paint a holistic picture of the member for all future provider-member interactions. CM staff will provide telephonic and in-person coordination of supports, regardless if they are formal or informal or covered or uncovered. For instance, our CM staff will engage, when appropriate, in coordinating services provided by the school system and other State agencies as well as social and financial supports provided by non-profit and other public organizations. As outlined in our detail of Creating and Supporting A System Of Care above, MemberConnections Representatives will provide intensive support to facilitate access to covered services as well as community-based and non-covered resources.

Effective member Engagement and Activation

Our whole person care management approach will encourage and support member engagement and activation in all phases of care management. Our CM Teams will use proven methods of health education and coaching and Motivational Interviewing to engage the member in assessment, care planning, self-management, and care plan improvement. Recognizing that each member's clinical condition and psychosocial situation is unique, our education and intervention strategies will vary from one member to another, including those with the same diagnosis, based on the needs of the individual member. We will base all care plans and health coaching strategies on the individual member's strengths, goals, and preferences.

Integrated Care and Disease Management

Our approach to care and disease management (DM) recognizes the body and mind as systems that must be addressed holistically. We will provide an integrated approach to members with co-morbidities and special health care needs by providing DM services as part of the continuum of services that the CM Team provides. The CM and Health Coach will collaborate to assess complex, interrelated factors that influence chronic conditions to develop an integrated care plan and coaching strategies. For instance, the

CM and Health Coach will jointly develop and implement strategies to ensure effective depression monitoring for members with life-altering chronic conditions, as well as ensure effective monitoring of behavioral health medication side effects on physical health (PH) conditions. For example, our Texas affiliate, which has a single-source contract to serve the state's children in foster care, who frequently have multiple co-morbidities, switched from a population-based depression DM model to a whole-person model in which members with depression received DM services as well as all other needed CM services from a CM Team led by a BH clinician. One result of this shift to a whole-person approach was a decrease in the 30-day readmission rates after diabetes-related inpatient stays from 55.7% in 2012 to 14.1% in 2013.

- ***Management of co-morbidities.***

Physical and behavioral health co-morbidities are common within the Medicaid population, particularly among members with special health care needs, adult members, and those in the child welfare system. NTC understands the importance of a whole-person approach that looks at all conditions together, rather than a silo approach that focuses on one condition at a time. We will manage co-morbidities through our integrated approach to CM and our support and tools to ensure providers involved with the member have complete, timely information about the member's needs and services.

Integrated CM Approach

Our predictive modeling approach, described in more detail in our response to Question 59, identifies and conducts focused analysis of members with co-morbid physical and behavioral health issues. The analysis overlays the medical risk score with a behavioral health risk score which takes into account a variety of factors such as a recent ED visit related to a behavioral health issue, age, and gender to show a comprehensive risk picture. Once we identify members with co-morbidities, we assign them to a lead care manager, who may be an RN or a behavioral health clinician depending on the member's assessed primary need for management at that time. The lead care manager serves as the member's primary point of contact and coordinates with the entire CM Team to obtain multidisciplinary input into the full range of the member's needs. As described above in the detail of our *Integrated, Multidisciplinary Model*, CM staff are trained to recognize, screen and coordinate treatment for physical and behavioral health needs. The care manager will work with the member, PCP, treating provider, and others involved in the member's care as appropriate to complete a comprehensive assessment of the member's medical, behavioral health, social and other needs and develop a care plan which addresses each identified need and member goals. Assessment for all members will include behavioral health conditions, substance use history, and depression. Due to the high prevalence of depression in individuals with chronic conditions, members with such conditions will receive additional screening via the PHQ-2. The care plan will identify providers and services for all identified member needs. The care manager will coordinate with the member, PCP, and other treating provider to implement, coordinate, and monitor all services on the care plan. Our interdisciplinary Case Rounds will further facilitate a whole person approach by pulling in the expertise of NTC physicians, pharmacy staff, nurses, behavioral health clinicians, social workers, and Health Coaches to develop interventions that address the full spectrum of the member's needs.

Support and Tools for Providers

The member's PCP and treating provider play a crucial role in managing co-morbidities, including avoiding harmful drug interactions or contraindications, and ensuring treatment or medications for one condition do not undermine treatment for another condition. In addition to educating and encouraging providers to coordinate with other treating provider, our care managers will facilitate the collaboration among all providers in care plan development. This will occur through soliciting care plan recommendations from providers and sharing them with other treating provider along with assessment and other member information. To facilitate an integrated approach to managing co-morbidities, CM staff will regularly share member information and interface with providers upon provider request as well as at established coordination points within the CM process. The key coordination points and activities during

which the CM staff will coordinate with providers will include, but may not be limited to the following (***Table Q58.F***).

Table Q58.F

Coordination Point	Key Coordination Activities
Enrollment of member with existing authorizations and need for ongoing care	• Obtain authorization information, assessment results, treatment plan • Inform about continuity of care policies and procedures • Authorize existing covered services
Care Plan development and revision	• Share assessment results, member goals and preferences, care manager recommendations, other provider recommendations • Obtain input on care plan/revisions • Ensure PCP and all treating provider are involved
Care Plan implementation	• Provide authorizations • Ensure timely initiation of care plan services
Care Plan monitoring	• Ensure PCP and treating provider are aware of member progress, self-management, adherence • Alert providers to gaps in care • Coordinate care and facilitate provider communication
Change in member condition, status, needs, preferences	• Ensure PCP and treating provider are aware of member progress, self-management, adherence • Alert providers to screening and reassessment needs, potential need for treatment plan changes
Care transition (such as inpatient and ED admissions and discharges)	• Alert PCP and providers to transition • Ensure new care setting has care plan, provider treatment plans and other member information • Coordinate care and facilitate provider communication • Ensure PCP and all treating provider are involved in planning for anticipated transitions (such as discharges)
Transition out of plan	• Inform about continuity of care policies and procedures • Ensure transfer of information as required to receiving MCO or entity

Our secure provider Portal supplements care manager interaction to provide tools for the provider to effectively manage a member's co-morbidities. The Portal allows all authorized providers (subject to HIPAA Minimum Necessary Rules) to view a wide variety of data and information about the members they are treating in an engaging well organized online format, including our Centelligence Health Member Health Record described above.

- ***Incorporation of best practices for behavioral health.***

NTC's affiliate health plans have an unmatched level of experience in implementing successful care management programs that incorporate best practices for behavioral health. We offer industry-leading expertise in providing integrated services to Medicaid and other low-income members. This includes but is not limited to serving individuals who meet eligibility requirements for Medicaid's mandatory and optional Aged, Blind, and Disabled coverage categories as well as those eligible for Medicaid due to child welfare system participation. These groups account for the majority of Medicaid spending on behavioral health services, and represent a significant opportunity for improvements in health and cost outcomes through integration efforts and implementation of best practices. We also are a national leader in serving TANF and CHIP members, and understand the opportunity to improve outcomes for this group,

particularly through supporting PCPs to integrate care and implement best practices in behavioral health such as for ADHD treatment. Below we describe some of the best practices for behavioral health that NTC will implement in Nebraska.

Motivational Interviewing

We will develop a Nebraska specific training curriculum that takes into consideration the unique cultural, demographic, social, and health/behavioral health needs of our members. Our engagement techniques for members will use Motivational Interviewing to meet members where they are in regards to their personal levels of motivation, resources and social supports as a best practice in outreaching and engaging members in their own integrated care plan.

Trauma Informed Care Training

Identifying and understanding the effects of trauma on development and particularly on behavior in both children and adults are crucial in assessing each member's needs and in understanding the context of behavior. For example, every child who is, or has been in foster care or out of home placement, experienced an extended stay in an acute medical or behavioral health inpatient facility, or been part of the juvenile justice system, has experienced some degree of trauma, including at least the trauma that results from being removed from his or her home regardless of the necessity for such removal. To address these facts, children engaged in the child welfare system, in residential treatment, or with significant medical or behavioral health inpatient experiences will receive trauma screenings to help identify the degree of trauma experienced and likely effects on behavior. We will offer initial provider training, cross-training for our care management staff, and ongoing training and education for both providers and staff. We will use small group, office-based and e-learning opportunities to ensure that our staff and provider network are aware of best practices and the need for coordination of all care and services. We will also offer trauma care training to all key stakeholders, including foster parents, DCFS caseworkers, HCBS waiver Service Coordinators, and other caregivers.

Recovery and Resiliency Training

As part of our comprehensive training for CM staff, staff education will be grounded in the Substance Abuse and Mental Health Services Administration (SAMHSA)'s Ten Guiding Principles of Recovery and aspects of the agencies Recovery to Practice initiative, which is aimed at broadening awareness, acceptance and adoption of recovery principles and practices amongst behavioral health and primary care providers. From this, we will ensure our CM staff understand how health, home, purpose and community can and do support an individual's journey to improved health and wellness, as well as a rich and fulfilling life. To address the needs of our child & adolescent population, we will cover the well-known Adverse Childhood Experiences (ACE) study that links childhood trauma to adult chronic health and behavioral health problems. It provides an overview of the factors that impact resilience and focuses on steps that adults can take to build resilience in children and youth. The curriculum will cover the three domains previously identified for resiliency development (i.e., supportive relationships with concerned adults, opportunities to solve problems and experience accomplishment, and community participation and sense of social belonging). Through the training, participants will identify ways to incorporate resiliency-related objectives in their work with members. This could be as simple as understanding the importance of having a supportive, trusting, and stable relationship with the member to understanding the types of evidence-based, trauma-informed treatments available to members in order to support individual care planning.

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

To ensure rapid engagement in treatment and integrated care management, NTC will expand awareness of the evidence-based SBIRT model across our medical and behavioral health network. SBIRT is a targeted intervention for EDs and PCPs to quickly identify and engage members when SUD is present or

suspected.

Identification of Co-occurring Mental Health Conditions and Substance Use Disorder (SUD)

We will identify co-occurring mental health and SUD conditions through our Centelligence™ predictive modeling tool looking at diagnoses, claims and trends to identify risk factors for undiagnosed SUD such as high pharmacy utilization or those members that exceed two ED visits within a 90 day rolling period. care managers will reach out to members identified by direct referrals from providers, health risk assessments or predictive modeling due to co-occurring mental health and SUD conditions. The care manager will complete a comprehensive assessment for the member's needs by contacting the member via telephone or through face-to-face interview. care managers will utilize Motivational Interviewing techniques for member engagement and individualized care planning that address goals for mental health and SUD conditions; include social supports, covered and non-covered services; and social determinants of health. Empowering the member to take part in goal development is part of our recovery oriented approach to behavioral health treatment and CM. Our care manager will review the care plan with the member, to ensure that recommended treatments support the member's recovery. The best care for co-occurring mental health and SUD occurs when the treating provider can accommodate the service needs of both diagnoses, so we will continually assess and develop our behavioral health network capacity for addressing both diagnoses in one location.

> ***Remember the Member...***
> CeltiCare, [*our Massachusetts affiliate*], has gone beyond what most other insurance companies are doing, developing one of the most comprehensive plans in the state for preventing and treating addition. [...] "I'm grateful and blessed that I'm still here," [*CeltiCare member Michael Semertgakis*] said. "It's me doing the work, but without asking for that help that I'm getting from CeltiCare and my therapist and my support network, I wouldn't be able to do this on my own."
> ***Insurers tacking opioid crisis with support for addicts***
> **Boston Globe**, 11/11/2015

Harm Reduction

Our CMs will be trained in the principles of harm reduction as a way of maintaining engagement with the member while preventing disease and promoting health. Harm reduction strategies reflect that not everyone is ready or able to engage in recovery and focuses on evidence based strategies for mitigating the risks associated with alcohol and drug use, medication non-compliance, and other high risk behaviors. Our staff will be trained to employ a non-judgmental approach that treats each person with dignity, compassion and respect regardless of the member's circumstance or condition, to accept behavior change as an incremental process, and to recognize the complex social factors that influence behavior, including poverty, lack of social supports and trauma.

Peer Support

Peer support is a powerful tool for providing hope and inspiring individuals to engage in CM and their own care. Peer Support Services, such as working with members pre-discharge to facilitate transition to outpatient, step-down care, or engage in care management, are recognized by CMS and consumer advocacy groups such as Mental Health America as a positive technique for encouraging consumer-choice and empowering members to take accountability for their health care. In addition to developing relationships with existing peer support programs, such as DHHS' Safe Harbor program in Omaha, NTC will provide peer support services as a value-add for members with serious mental illness and help to build capacity in the state. For instance, NTC will provide funding for individuals to take

> Our Arizona affiliate has successfully implemented a ***Peer Support Certification pro***gram, training approximately 400 people since 2005 to become Peer Support Specialists and increasing the number of PSSs in their contracted network from 35 to 250.

the certification exam or provide training directly using the experience of our Arizona affiliate who has successfully implemented a Peer Support Certification program, training approximately 400 people since 2005 to become Peer Support Specialists and increasing the number of PSSs in their contracted network from 35 to 250. We are also exploring expansion of peer support services into the western part of the state via a telehealth model. Our goal is to increase access to Peers in order to provide more member-focused care, improved adherence to treatment goals, and increased member engagement in all aspects of care. Peer Support persons will be an integral part of the member's CM Team as determined by the member but which may include participation in the assessment and care planning processes, connecting the member to services and community resources, and assessing and tailoring outreach and education to the member's willingness to engage and level of activation.

Perinatal Depression Screening

Prenatal depression is associated with increased prenatal risk and, untreated, can lead to increased infant mortality and morbidity. Postpartum maternal depression can also be a danger to the child during the postpartum period, increasing the risk of impaired cognitive development. Evidence indicates that prenatal depression screening is not consistently provided according to guidelines. Our Start Smart for Your Baby® program includes the Edinburgh Depression Screening tool that helps identify members at risk of perinatal depression so our CMs can provide appropriate follow up and educational mailings. Pregnant women will receive a packet including the Edinburgh Depression Scale. Responses will be risk stratified and CM staff will outreach to members with educational material and assistance connecting the member to behavioral health services. We will also provide the screening and appropriate follow up for post-partum members.

Incentive Program to Encourage Post-Discharge Follow-Up

Numerous studies have shown that timely follow-up care reduces behavioral health readmission rates. Our Hope Bear program incentivizes children and their caregivers to pursue appropriate follow-up care as recommended by the discharge plan. Our affiliates started this program in mid-2009 and Centene plans now offer this program in all markets in which they cover behavioral health services, unless prohibited by state requirements. When a child attends his or her first follow-up appointment within seven days after hospital discharge, a care coordinator sends the child a teddy bear, and an illustrated kid-friendly educational book describing emotions and what may trigger them. Caregivers also receive a $10 CentAccount debit card to be used for health care related expenses. The Hope Bear program has helped to increase follow up appointment rates after mental health admissions. For example, in Texas, our largest affiliate health plan participating in the program, follow up after mental health hospitalization increased by 4 percentage points (from 70% in 2014, to 74% in 2015) for participating members.

Post-Discharge Monitoring in Persons with Schizophrenia

The American Psychiatric Association Clinical Practice Guidelines for Schizophrenia, which support a recovery model philosophy, indicate that treatment compliance and community tenure are directly linked to satisfaction with providers and medication compliance in this population. As part of our post-discharge follow up for members with schizophrenia, our CM staff will monitor these two areas closely during each contact with the member.

Health Homes for Members with Serious Mental Illness

NTC is already developing plans to implement Health Homes for members with chronic conditions including SMI. Health Homes are a recommended practice for integrating and coordinating care for these members who frequently have multiple co-morbidities. For example, NTC is developing a written agreement with Enhance Health Network (EHN; formerly the Regional Provider Network), a health care alliance that represents upwards of 40% of the state's providers and includes nine PHOs, over 65 individual hospitals or hospital systems, and more than 3,500 affiliated providers. Our strategic network

alliance with EHN will include co-location of NTC CM staff onsite at various EHN locations for the first year of the contract. NTC staff will help train EHN provider staff and build the provider's capacity to integrate care and provide care management services under a Health Home model. We have also met with representatives from the Behavioral Health Regions, the Nebraska Association of Behavioral Health Organizations (NABHO), and behavioral health providers to discuss opportunities for integrating care (including locating CM staff onsite at behavioral health provider locations as well as other models of care and exchanging data) and increasing use of best practices such as Health Homes.

- ***member engagement in self-management strategies.***

Care managers will engage members in self-management by helping them to make the connection between effective self-management/adherence and reaching their goals, such as feeling better, getting a job, or maintaining important relationships. Using evidence based techniques, such as Motivational Interviewing, our staff will engage, educate, encourage and empower members to actively manage their own care. This will include use of the Patient Activation Measure, a validated tool used by Centene affiliates in Florida and Washington, to determine the member's current level of activation and willingness to engage, and to track changes in the member's PAM in order to tailor outreach and interventions to the member's activation level at a given point in time. Our CMs will outreach to members telephonically or in person to educate them on strategies that support self-management and adherence, providing them with information, tools, and skills needed to improve health and behavioral health outcomes. As described above, we are already working on developing strategies to "meet members where they are" to provide the in-person, customized support needed to effectively engage them in their own care. Additional ways we will engage members in self-management will include the following.

New Member Welcome Tool Box

We know from experience that the best time to engage with and motivate a member toward full member activation is at the beginning of our relationship with the member. In addition to the new member communications and enrollment materials mailed to each new member, we will offer a New member Welcome Tool Box with content organized around the materials, information, and links a new member needs to begin accessing services and taking responsibility for health, including, but not limited to:

- Links to Member Handbooks, Preferred Drug List, Benefits Summary, CentAccount incentive program flyer, Start Smart for Your Baby materials, and link to Start Smart Mobile and MyNTC mobile applications
- A scroll-by window of upcoming community events, member events, and in-person orientations
- Explanation of the secure member Portal's self-service features, benefits, and link to register
- A link to all forms a member needs to complete, including the initial Health Risk Screening
- Information about the care planning such as the steps to care planning, right to have family or other representatives involved in the process, what each component in a care plan means (e.g., problems, goals, barriers, interventions), and an example care plan
- How to obtain all needed assistance, including website navigation, through a call to our Customer Service Representatives.

Member Portal

Our secure web-based Member Portal will offer members online access to their specific NTC information (e.g. eligibility history, benefits) as well as a number of "self-service" functions, such as the ability to view their own clinical service and medication history, change PCPs, update their contact information, take an online Health Risk Screening, view care gap alerts, or their TruCare Self-management Care Plan written at no more than a 6.9 reading level, securely communicate with NTC staff, check the balance of their CentAccount™ incentive program, and access and maintain their own electronic Personal Health Record powered by Microsoft Health Vault.

Member Mobile Application

NTC will deploy Centene's member mobile application (described in more detail in our response to Question 35) designed to be a comprehensive and integrated mobile "one stop shop" for our members. The NTC member mobile application will be available, free of charge for our members and is uniformly branded as a Nebraska Total Care mobile tool so users will know instantly where to turn to for any assistance. Start Smart Mobile, an extension of our award-winning Start Smart for Your Baby® Pregnancy Management program, is an interactive and personalized mobile application for new and expecting mothers. Start Smart Mobile will provide support for NTC's pregnant members from the first positive pregnancy test through the post-partum and early newborn period. The application will help parents stay on track with key prevention milestones, set personalized reminders, proactively identify health issues and take action, and tap into NTC's other programs, such as, telephonic care management and 24/7 nurse advice line. The application will be free for NTC members and content will be personalized based on the expectant mother's due date.

Txt4health Initiative

NTC will offer the Txt4health program. A text message will be sent to members 18 and over who opt-in to the program to encourage healthy behaviors, as well as member use of health plan services and compliance with certain preventive services such as immunizations, check-ups and screenings. These text messages will also contain specific health information a member needs based on their diagnoses and conditions, driven by our Centelligence™ health analytics platform.

ConnectionsPlus®

Centene's experience with the Medicaid and ABD populations has shown that many of these members lack reliable telephone access. This hampers the member's ability to contact their care manager or provider with questions or to report a change in condition. It also impedes the ability of health plan staff and providers to reach the member with education, reminders and other information critical to their care. NTC will partner with certified Nebraska Telecommunications Assistance program (NTAP) carrier(s) to refer qualifying individuals to the program as well as enhance the service by providing unlimited texting and a discount on additional minutes above the 250 minutes per month ordinarily provided to Medicaid-enrolled individuals through NTAP. Additionally, calls between members and NTC staff will not count against the monthly minute allotments. When members do not meet the eligibility criteria for NTAP, such as when another individual at the same address has received an NTAP phone or the member is homeless, NTC may offer our Connections Plus program which provides free restricted-use cell phones to certain high-risk members. These phones will be pre-programmed with numbers for NTC's Member Hotline, care manager, 24/7 nurse advice line, 911, primary care and other treating provider. The care manager will use the phones to contact members for assessment, care planning, education, appointment reminders and ongoing coaching and support for wellness and compliance. With the members consent, we will also send text messages with health information targeted to the member's condition. For example, diabetic members will receive text messages about diet, exercise and stress reduction.

Home Telemonitoring

NTC will provide telemonitoring services to the highest-risk members, for whom intensive monitoring is necessary and the condition is amenable to telemonitoring. This FDA-approved technology is "device-agnostic", interfacing with virtually any medical home monitoring device via wireless or wired modem utilizing landline, cellular (including a ConnectionsPlus phone) or VOIP communications links. Within seconds of a reading being taken in the home, the biometric value, such as a blood glucose level for a diabetic or a blood pressure or weight for a member with congestive heart failure, is transmitted electronically to the member's care manager and evaluated against patient-specific or national guidelines and analyzed for favorable or unfavorable trends. The system can then be set at the member-level to alert the care manager, trigger an Interactive Voice Response phone call to the member, and/or alert other members of the integrated care team or the member's provider. The technology is entirely web-enabled.

We will provide all participating members with a login card that enables them, their family, or their physician to access their biometric information from anywhere in the world at any time, as long as they have access to the Internet, to monitor their own condition.

CentAccount® Member Incentive Program

Our CentAccount program will offer valued financial incentives to members for achieving healthy behaviors such as receipt of EPSDT and prenatal services. We will load CentAccount rewards onto a proprietary health care reimbursement card that can be used only at authorized retailers within our network. The member will be able to use the card to buy health-related items such as groceries, baby and personal care items, and some over-the-counter medicines. More information about out CentAccount program can be found in our response to Question 23, Value Added Services.

Crisis Text Line

NTC is committed to providing various opportunities for creating connections and making outreach to members. In effort to reach members in the most rural areas, NTC members will be able to access crisis support 24/7 through a partnership with Crisis Text Line. NTC's affiliate in Indiana has an agreement in place with Crisis Text Line to provide these services and NTC will be added to the scope. The collaboration with Crisis Text Line is member-focused with our most vulnerable populations in mind including support for teen members in crisis, members who are suffering from depression, or substance use issues. It is imperative we remain vigilant of the various ways in which we can connect with members as well as giving them the opportunity to reach out for help when needed in the manner in which they are most comfortable.

NTC members are able to connect with a Crisis Text trained specialist via text for support. NTC understands that many of our members prefer communication through text as it provides anonymity and when in crisis, accessing this support may also allow the member to engage with the crisis specialist openly and freely.

Social determinants of health, including risk and protective factors for behavioral health concerns.

Member health and wellness are significantly influenced by the social, environmental, cultural, and economic factors such as food, housing and/or economic instability; access to healthcare services and quality education; reliable transportation; personal safety, community connectedness and/or family support. However, all members and their communities also have unique strengths and cultural assets that can help mitigate risk and enhance protective factors that impact physical and behavioral health and wellbeing. NTC will identify barriers to wellness and risk factors and engage members as partners in overcoming them, and leverage and build on individual and community strengths to bolster protective factors. We will use Centelligence™ to analyze member needs and identify prevalent health conditions, barriers to care and disparities to target for quality improvement and care management initiatives. Beyond "hotspotting" to determine level and type of outreach and where to target resources, NTC will differentiate CM initiatives by communities and individuals, using recognized community asset mapping and patient activation practices. In this way, we will address the social determinants that affect each member's health and wellness at the community level, and develop member-centered CM planning that draws on community and personal strengths to support members in successfully managing their own wellness and developing strategies to mitigate risk factors, such as poverty, adverse childhood experiences (ACEs), and employment status.

We will support development of protective factors, such as community connectedness and positive peer relationships, through partnership with local leaders and organizations that are trusted in each community, such as school and places of worship. We will collaborate with local providers, community organizations and other resources such as local Public Health Departments to ensure that a comprehensive array of appropriate covered and non-covered services are available when and where members need them. We will also tailor the intensity of care management services that address social determinants based on individual member needs. For example, our affiliates in Florida and Kansas are providing short-term, intensive,

culturally-relevant interventions that target social determinants of health driving ED use among "super utilizers," many of whom experience barriers such as housing instability and lack of family support which must be addressed before interventions specific to the health/behavioral health condition can be effectively addressed. A Community Resource Specialist (CRS) supplements existing CM Team support, in order to maintain continuity of the existing care manager relationship. The CRS provides intensive assistance to the member and the CM Team to address service gaps and connect the member to community supports related to social determinants affecting the member's health and engagement in care. members can reach the CRS 24/7 via the plan's Rapid Crisis Response System phone line for questions or concerns. The CRS provides assistance until the member's situation is stable, after which the CM Team continues to monitor and assist them. NTC will explore development of a similar approach in Nebraska.

CM Staff Training

CM staff will receive training on how social determinants affect members' health and wellness. Training will 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. Our CM staff will complete training on understanding implicit bias, poverty-related trauma, determinants of health, and other modules tailored to the Heritage Health program. To empower members to actively participate in their health and wellbeing, we will train CM staff to function as advocates within members' communities and to understand the array of services available to address member barriers and needs. This will include training on finding community resources, making referrals to these agencies and other programs that might be helpful. In addition to the initial and ongoing cultural competency and diversity training all NTC staff will receive, we will train CM staff about assisting people who are communication vulnerable (requiring interpreters for any reason, Augmentative or Alternative Communication [AAC] or extra support of any kind), special needs of members, and other issues relevant to each Heritage Health sub-population Understanding the prevalence of trauma within the covered population, we will also provide trauma training to CM staff (as well as providers and stakeholders). Through our affiliates which serve members in the child welfare system in other states, we bring extensive experience in training staff and community stakeholders about the effects of trauma and ACEs on children and families. NTC will leverage this national expertise and develop trauma training for Nebraska members, providers, and others in partnership with Heritage Health stakeholders.

Member Activation and Support

Engaging members as partners requires understanding of their readiness to change and the contextual influences impacting their interaction with the health care system. As discussed above in our detail of *member Engagement in Self-Management Strategies,* our CM staff will engage members using motivational interviewing to determine a member's health confidence based on the Patient Activation Measure (PAM). This will allow CMs to focus interaction with each member to provide education and support at the member's assessed Health Confidence level to **empower** the member to actively work toward improved health outcomes and wellness behaviors. The CM Team will also engage providers and community partners to help boost members' Health Confidence levels, and link members with supportive tools. For example, depression and other mental health issues can impede effective management of chronic health conditions. To support members in managing their mental health and wellbeing, we will provide resources such as MyStrength, which will be available through a link on our website and via our mobile application for smartphones.
MyStrength offers e-learning programs to address depression, anxiety and substance abuse; weekly exercises to promote well-being and motivational support messages.

Community Partnership and Collaboration

Because we will hire and create jobs locally, our employees will be community members, with a *personal stake* in their communities that we serve. Staff in our affiliate health plans volunteer for myriad

organizations in their own communities that benefit our members. NTC will collaborate with community leaders, local advocates, and health and social services providers via community-based advisory committees. We also will collaborate and partner with local organizations to address the determinants of health and maintain a database of community resources, such as organizations that address housing and food instability and domestic violence shelters, for our CM team. Through a variety of community programs and partnerships, we will leverage local resources to help build stronger communities that support health and wellness and connect members with the services they need. For example, we will assist members with disabilities as needed to apply for funding from the League of Human Dignity to modify their homes (including rental and mobile homes) to increase access to accessible housing.

Our CM program will build on strengths in each community to serve members. For example, Thurston County has the highest diabetes rate in the state, and the population there is more than half Native American. We will approach the Omaha and Winnebago Tribes about how NTC can support them to enhance their existing diabetes and behavioral health care management programs, and to learn from them how we can help them to mitigate some of the determinants of health prevalent in the county (eg, high crime rates, poverty) that impact member wellbeing. This year the American Diabetes Association awarded the Winnebago Tribe of Nebraska the American Diabetes Association John Pipe Voices for Change Award for Leadership Excellence for their Whirling Thunder Wellness program that addresses social problems, improves accessibility to services and enhances social well-being through culturally-relevant diabetes treatment and prevention services in Native American and Alaska Native communities. To do so, the program leadership builds partnerships with local and state organizations. NTC will propose to be one of their partners to support our members who access the program.

- ***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.***

NTC will use a no 'no wrong door' approach to ensure that we identify at risk members as early as possible, using multiple methods that include highly sophisticated data analysis techniques with face-to-face, high touch personal efforts. With appropriate management and tracking of at risk members, we may prevent, delay or reduce the disease process and the need for high utilization by ensuring these members access appropriate preventive, primary care, behavioral health, and pharmacy services, as well as non-covered services and community resources.

Identification

As described in more detail in our response to Question 59, our methods for identifying members who may be at risk will include but are not limited to:

- Completing our Health Risk Screening tool with new members
- provider and member completion of our Notification of Pregnancy tool
- Ongoing review of a wide variety of data, such as enrollment data, inpatient and ED utilization, claims and other utilization data
- Referrals from providers, members, family/caregivers, our nurse advice line, and NTC and subcontractor staff interacting with members.

In addition, we will identify potentially at risk members through ongoing biweekly predictive modeling reports generated using Centelligence™, Centene's multi-dimensional, episode-based predictive modeling and CM analytics software to identify members who may need care management. This award winning health informatics platform allows us to integrate, process, analyze, and manage large amounts of data for targeted, actionable information delivery to the right person, at the right time. Centelligence™ stands apart from other predictive modeling systems because it was developed specifically to address the Medicaid population's complex array of needs, including physical and behavioral health comorbidities as well as socioeconomic issues (social determinants of health). Centelligence will also generate Care Gap Alerts when a member has gaps in recommended preventive or chronic care services. Failure to access these services can potentially result in development or exacerbation of health issues.

When we identify a potentially at risk member, CM staff will work with the member, family/caregiver, providers, and others as appropriate to complete a comprehensive assessment to verify the identified potential risks and to identify any other risks. This includes medical and behavioral clinical conditions as well as functional status and social and other factors that could impact the member's overall well-being. Following the assessment, we will revise the member's risk level as needed based on assessment results, and provide appropriate interventions to address and mitigate identified risks.

Tracking

Our CM staff will use TruCare to track at risk members. TruCare is Centene's member-centric health services management platform for collaborative care coordination and care, behavioral health, disease, and utilization management. TruCare provides full care management, care coordination, prior authorization, concurrent review, and transitional care functionality. member care plans, documented in TruCare and available to all Care and Utilization Management staff involved in the member's care, display all identified health, behavioral health, functional, social, and other risk factors, treatment goals and objectives, milestone dates, and progress. TruCare also allows staff to track the member's utilization and service requests and status, and identify the need to re-assess the member such as for a new or changed condition requiring a change in the care plan.

Provide case studies and experience from other states illustrating the MCO's ability to successfully address community differences in its care management approach.

NTC will follow the Centene approach of tailoring programs and services to address the unique differences of the varied communities we will serve. To do this effectively, we will conduct ongoing data collection and analysis of our membership and providers to identify and analyze region-specific characteristics such as age, sex, and race as well as population health factors such as incidence of chronic and complex disease, pregnancy, and preventive health utilization and provider access. This analysis will inform the design and development of targeted programs and approaches to address regional and cultural factors that affect access, utilization, and outcomes. Below we provide case studies and experience from other states which illustrate our ability to address community differences.

Adverse Perinatal Outcomes

Like other states, Nebraska is challenged to address adverse perinatal outcomes. For example, only about half of Nebraska's pregnant American Indian women received first trimester prenatal care in the period from 2006-2010, and the percentage of all Nebraska women receiving first trimester prenatal care decreased across all racial and ethnic groups comparing 2001-2005 and 2006-2010. African American women in the state have higher infant mortality rates than do women nationally.[7] In addition to our Start Smart For Your Baby program, Centene affiliates have developed numerous care management approaches to address adverse perinatal outcomes. This includes approaches to address community differences in perinatal outcomes. For example:

- In 2014, our Missouri affiliate partnered with Uzazi Village, a Center of Excellence for reducing inequities in perinatal outcomes, to promote their Sister Doula program. Through this partnership, the plan contracts with Uzazi Village to provide doula services to members and support their goal to raise awareness of perinatal inequalities in the African-American community, steer women to providers and facilities that practice evidence-based care, and create culturally specific childbirth education with a focus on member and family empowerment and shared decision making.
- In 2010, our Georgia affiliate identified a high rate of adverse pregnancy outcomes, including NICU deliveries, in rural southwest Georgia. To address this, the plan collaborated with an FQHC in Albany to develop a strategy for reducing NICU deliveries and increasing completion

[7] *Nebraska Health Disparities Report: Health Equity for all Nebraskans*. Nebraska Office of Health Disparities and Health Equity, September 2015.

of postpartum services. This strategy centers on plan care managers (Master's level Social Workers) working onsite at the FQHC to provide face-to-face services to pregnant/postpartum members receiving care from the FQHC. Through these interventions, the plan achieved a 56% decrease in NICU rate after the first year of implementation and a 214% increase in postpartum visits comparing 2012 to 2015.

- Our Georgia affiliate also noted a high rate of low birth weight infants and C-sections in a Physician Hospital Organization (PHO) in Dekalb. The plan determined that the PHO, which included two hospitals and their affiliated provider practices, were serving as magnet sites for a large community of Nepali and Burmese refugees. The overall health status of this population, combined with cultural barriers, appeared to contribute to increased risk of maternal-fetal complications. The plan developed a collaborative relationship with the providers and established easily accessible translation services to support communication among the members, plan care managers, and providers. In addition to assisting with medical visits and care management activities, the plan's translators offered insight into South Asian cultures and helped our affiliate to plan initiatives that are both culturally sensitive and likely to succeed. For example, the plan noted that despite assistance with scheduling appointments and transportation, there was a significant 'no-show' rate within this population. To address this, the plan arranged to have the translator offer to meet the member outside of the office and escort them in.

High Prevalence of Specific Chronic Illnesses

Nebraska has geographic pockets with high prevalence of chronic illnesses, such as heart disease in Wheeler County and cancer in Kimball, Richardson, and Thurston counties. NTC will build on approaches successfully used by our affiliates to address community differences in disease prevalence. For example:

- In 2015, our Indiana affiliate partnered with a provider serving individuals with HIV and Hepatitis C to address an increase in new diagnoses of HIV in Scott County. Our affiliate located a nurse care manager onsite two hours per week for six weeks. During the designated time period, the care manager was available to assist our affiliate's members with their health and social needs, as well as being available to meet with any member in Scott County who had questions about their benefits, how to access resources or who needed to complete their Health Needs Screening. The plan outreached to members to alert them of the availability of the care manager and invited them to schedule an in person appointment, or to stop in during the two hour window to receive information. The plan also implemented an intensive education program which included a revision of HIV educational materials using resources such as aids.gov. After the designated sessions ended, the plan continued to host member education sessions at the provider's office with a MemberConnections community health worker and the nurse care manager to answer questions, provide assistance with accessing services, and enroll members in care/complex care management as needed. The field-based care manager also continues to support members in this region including members with HIV.
- To address high prevalence of HIV/AIDS in the Atlanta area, our Georgia affiliate partnered with high volume HIV/AIDS clinics in the area to provide targeted and enhanced CM services. Peach State CM staff coordinate closely with the clinic care managers to ensure integration of care across the entire spectrum of the member's needs. This includes behavioral health needs, which are prevalent within this population. Plan CM staff assist the clinic staff in screening for behavioral health needs and connecting members to appropriate behavioral health providers.
- In 2014, our Louisiana affiliate developed a Community Paramedicine program to address a high prevalence of asthma among members under 21 in the New Orleans area. The program (which we are planning to adapt for Nebraska) provides real time support from a paramedic, including triage, home assessment, and appropriate redirection for this targeted group of members, with a goal of decreasing unnecessary emergency department visits and inpatient stays.

Lack of Nearby Services in Rural Areas

Centene affiliates in many states serve members in rural and frontier areas, and we understand the challenges members in these areas face accessing needed care due to few providers being available. The long distances members must travel to access care, similar to areas such as western Nebraska, is a significant barrier even if the member has reliable transportation. We will tailor our approach in rural areas of Nebraska, such as through the use of telemonitoring, described above. We will also implement other innovative approaches tailored to this community difference. For example, our Indiana and Missouri affiliates deliver home test kits (such as for HgA1c, cholesterol, and nephropathy testing of urine) to members who are non-compliant with their necessary screenings. The member takes samples at their home and mails the kit, postage pre-paid, to a testing facility. This is particularly beneficial for members who live in rural areas. It is also a useful approach for addressing the needs of members with issues such as limited mobility that make office visits difficult to access. First year results for the Indiana plan included an 8.15 percentage point increase in cholesterol testing for cardiovascular disorders; 2.7 percentage point increase in A1c testing; and 4.8 percentage point increase in nephropathy screening.

Remember the Member…

Henry, a 51 y/o male member, designated as medically frail and living in a homeless shelter. Henry was recently discharged following an above the knee amputation due to complications of his diabetes and is now a bilateral amputee. As part of discharge planning, the Care Manager (CM) was able to arrange home health care for Henry at the shelter and coordinated with the shelter to provide a private space where Henry can receive his medical care. The CM also confirmed that Henry has never been to see his assigned PCP and that the PCP will not do home visits. The CM made a referral to our Physician Home Visit program that will be seeing Henry for ongoing care. Additionally, the CM has engaged the program Specialist (Social Worker), who is part of Henry's care team, to coordinate with the shelter to review housing options.

High Rates of Inpatient Utilization

Our Texas affiliate, which holds a sole-source statewide contract to serve the state's children in the foster care system, identified a high rate of inpatient admissions within this population in the Dallas/Fort Worth area in 2010. The plan noted that children with frequent hospitalizations are more likely to experience a change in their placement, which typically leads to changes in treatment providers, making it increasingly difficult for them to succeed. To address this, the plan developed a psychiatric inpatient diversion program for members in the area with three or more inpatient admissions within a six month period. Clinical Service Managers carry small caseloads (50 children/youth per caseload, compared to about 80 for a traditional care management caseload). They use a strength based approach to develop a comprehensive service plan for the child/youth with input from as many people as possible, including but not limited to the youth, caregiver, therapist, psychiatrist, Child Protective Services Case Worker, and staff from the Child Placing Agency. The service plan focuses on both formal and informal supports as a means to achieve short term and long term goals. Cases are monitored very closely through weekly contact and facilitation of clinical case conferences to ensure collaboration across all systems. When new information is obtained, the service plan is changed to better meet the needs of the child/youth. Individuals are discharged from the program when they achieve six consecutive months without an inpatient psychiatric admission. Once the child/youth reaches this level of stability, they are transitioned as necessary to the plan's ongoing CM program. program evaluation in 2012 found that members receiving services from this program experienced significant decreases in the overall number of admissions and average length of stay per admission, as well as fewer admits/1000 and shorter lengths of stay than the control group.

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. (5pgs)***

Nebraska Total Care (NTC) will use a 'no wrong door' approach to proactively identify members with risk factors and those who need Care Management services as early as possible. We will accomplish this through multiple methods, combining review of a wide range of data and referral sources with face-to-face, high touch personal efforts; our Health Risk Screening process; and Centene Corporation's (Centene) highly sophisticated data mining and award-winning predictive modeling technologies. Once we identify a member, we will quickly outreach to assess their needs and provide timely services to achieve positive health outcomes. NTC will continue to monitor members with identified risks on an ongoing basis and update their risk profiles as their circumstances or health needs change.

Approach For Identifying Members In Need of Care Management Services

Our approach builds on the national experience of our parent company, Centene, in identifying, assessing, and addressing the unique health issues of Medicaid and other low-income populations, including the impact of social factors on health, to improve outcomes. As discussed below, we will integrate multiple sources of data along with field intelligence and developed processes to identify members who are at-risk for a negative health outcome. Our approach will also identify members with emerging risk in order to intervene before an event occurs and positively impact the trajectory of those members' overall health. Example sources and processes include but are not limited to those in ***Figure Q59***.

Figure Q59

Once we identify a member who may need Care Management, our highly trained staff will complete a comprehensive assessment that addresses all life domains (including but not limited to medical, behavioral, dental, social, economic, and cultural factors) and evaluates the member's informal and formal supports. Assessment will include a review of a member's risk factors such as over- or under-utilization of services, inappropriate use of services, non-adherence to the established care plan, lack of education or understanding of current condition, financial barriers that impede adherence, compromised safety, cultural or linguistic challenges, and physical, mental, or cognitive disabilities.

In addition to our Health Risk Screening (HRS) process (described below), we will identify members potentially eligible for care management through a wide variety of mechanisms. These mechanisms will include ongoing review of multiple data and referral sources, as well as through in-person strategies.

Data and Referral Sources

NTC staff will proactively identify members potentially eligible for care management by ongoing review of data and referral sources such as the following.

Enrollment Data. We will review the enrollment file for indicators such as pregnancy that indicate potential care management needs. In addition, we will use any other information provided by the State prior to enrollment, such as existing authorizations for specialty services, non-emergency transportation, and certain supplies including oxygen and enteral nutrition to identify members.

Pregnancy Screening/Notification of Pregnancy (NOP). Our NOP process, which assesses more than 20 obstetric history factors, identifies pregnant members at risk for complications so we can establish a relationship among the member, provider, and NTC staff as early as possible. We will require and incentivize providers to notify us of a pregnancy via uploading the NOP to the Provider Portal, fax, mail or telephone as soon as they become aware of a pregnancy. If a new member's HRS indicates pregnancy, and when we identify a pregnant member on the enrollment file, our Start Smart For Your Baby® perinatal management program staff will outreach to complete a NOP screening. Members may also complete the NOP form by mailing in a form, completing the assessment on the web or calling our call center. Any Care Management or Customer Service staff that identifies a pregnant member will help them complete the NOP form.

Inpatient Admissions. On-site and telephonic Utilization Management (UM) and Care Management staff will identify members that have been admitted to an acute setting and assist with discharge planning. During this process, our staff will participate with hospital staff, providers, and when possible the member to identify post-discharge needs, including ongoing care management needs.

Emergency Department (ED) Visits. We will partner with network hospitals to receive daily notification of members with an ED visit in the past 24 hours. We will use these reports to identify members with ED visits for diagnoses that indicate inappropriate or avoidable ED utilization.

Claims Data. Care Management staff will continuously review claims data to identify services which indicate potential need for Care Management, such as behavioral health (BH) and other specialty services. In addition, we will review real time pharmacy data to identify members with medications which indicate presence of a chronic medical or BH issue, polypharmacy, missed prescription fills, multiple prescribers, and multiple pharmacy use. This will include reviews through our Medication Therapy Management Program and our Psychotropic Utilization Review Program *(see response to Question 91).*

Other UM Data. UM staff will use TruCare, our integrated clinical management system, to identify utilization that may indicate a new or changed need which requires assessment and monitoring. UM staff also will review prior authorization requests and other utilization information to identify members in real time who may need Care Management. Additionally, UM staff will assess members for care management needs during concurrent review.

Information Supplied by the Member or Caregiver. We will provide every opportunity for members to self-refer via our Member Portal, call center, and by embedding clinical staff in acute and outpatient settings such as hospitals and FQHCs. We will host quarterly Baby Showers throughout the state and use that opportunity for in-person assessment of pregnant women who attend. We will provide member incentives for completing the HRS and the NOP, which assist us in identifying members who may have physical and BH conditions requiring monitoring, as well as those who are pregnant. We also will provide incentives for accessing EPSDT services and prenatal and postpartum visits, through which the need for care management may be identified.

Provider Referrals. Through initial and ongoing education, we will encourage our Providers to refer members for Care Management. To make the process simple, our Provider Portal offers a one-click option to refer a member to Care Management. Providers may also call us with referrals. We will educate them about the support available through our various Care Management Programs, and how to contact us if they feel a member may need those services. We will incent providers for submitting the NOP to assist us in early identification of pregnancy, as well as for meeting performance measures for EPSDT, prenatal, and postpartum visits through which the need for care management may be identified.

Nurse Advice Line Referrals. Our Care Management staff will review daily reports of after-hours calls to NurseWise, our 24/7 nurse line, to identify members that may need Care Management services.

Referrals from Other NTC or Vendor Staff. We will educate all NTC staff and our vendors about the availability of care management and how to refer members who may need those services. For example, we will educate Customer Service staff to offer to warm transfer to a Care Manager any member who expresses a need for assistance with services or a health or behavioral health issue.

Face-to-Face, High Touch Identification Methods

NTC will "meet members where they are" to maximize the ability to identify members that may need care management and to individualize services according to each member's needs. Strategies we will pursue based on this approach include, embedding Care Management staff at high volume provider locations, placing concurrent review/discharge planning staff onsite at high-volume network hospitals, conducting community-based events such as Baby Showers for pregnant members (attended by our High-Risk OB Care Managers) and our Healthy Lifestyle Events at which our MemberConnections outreach staff provide education and activities on health-related topics such as healthy eating. For example:
We have already made progress to establish multiple ***Community Health Collaboratives*** throughout the state which will provide opportunities for us to place Care Management staff at provider locations to help identify members for Care Management (see our response to Question 58 for more details). One such Collaborative involves Midtown Clinic (an FQHC) and Faith Regional Hospital in Norfolk, BH Region 4 representatives, as well as Tribal representatives and Indian Health Services in the region. As part of our written agreement with these partners, NTC will place Care Management staff onsite at Midtown Clinic and/or a BH clinic, which will allow us to identify members seeking care at these locations that may need Care Management services and immediately provide assistance and comprehensive assessment if warranted. We are working to establish other Collaboratives in Lincoln to serve the Southeast/South Central area, in the Tri-Cities area, and with the BH Regional Administrators which will vary based on the needs of each community and our partners. For each Collaborative, we will locate our staff onsite at one or more locations to provide in-person Care Management services, including but not limited to identification of member Care Management needs. To further expand our capacity to identify members, we will ***leverage our contracts with Indian Health Services and Tribal 638 providers*** which provide care coordination services. We will establish processes to work as a team with the provider-based care coordinator to identify members who may need Care Management. We will also embed Care Managers we will hire from Tribal communities in IHS/Tribal clinics. These staff will assist in identifying members. Additionally, we will work with Tribal Health Directors and IHS clinics to identify newly pregnant members who may need Care Management.

Process for Providing A Health Risk Screening To All Members Upon Enrollment

NTC will provide a health risk screening to all members upon enrollment to identify members potentially in need of Care Management services, including those who currently have or are likely to experience catastrophic or other high-cost or high-risk conditions. Our HRS is a concise tool to identify physical, BH, social, and/or functional needs, and determine potential need for care management or coordination assistance. Our experience with low-income populations has shown that successfully reaching new members for health screening requires repeated attempts using multiple strategies and a strong tracking process. Members may complete the HRS via telephone, electronically through our secure Member Portal, by mail, in person, or via our convenient mobile application, which puts a wide variety of information and tools at their fingertips.
We will mail all new members a Welcome Packet as part of our Member ID card mailing which will include a letter explaining the importance of the HRS tool and instructions for completing it, and notifying the member that they will receive a call from an NTC staff member who will help them complete the HRS, if not already done. New member information will also describe the NTC CentAccount program which rewards members for completing the HRS in a timely manner, and provides instructions and a convenient link for completing it through our secure Member Portal. CentAccount has been effective in encouraging members in our Centene affiliate plans to complete the assessment in a timely manner. NTC will proactively contact new members to complete a Welcome Call and initiate the initial screening process within 15 days of enrollment. In addition, we will use audio- and mail reminder postcards asking the member to call us about their health care. Follow-up reminders regarding member incentives for the completion of an HRS will also be sent to the member at 30 and 90 days after eligibility. If the member submits an incomplete HRS through mail or the Member Portal, our staff will

reach out to the member to assist them in completing it. If we are unable to reach at-risk members, our MemberConnections Representatives will attempt to locate the member.
Our MemberConnections Program offers intensive member education and outreach by MCRs who are from the communities we will serve and are familiar with and know the local businesses and church representatives who in turn are more likely to share with us the potential location of a member. If telephonic and point-of-service outreach attempts are unsuccessful, our MCRs will go to a high-risk member's residence to provide education on benefits, the importance of our ability to reach the member, and to complete an HRS if the member has not yet completed one. The MCR will discuss benefits and our incentive for completion, and attempt to complete the HRS if the member is at home. If not, the MCR will leave a door hanger asking the member to call our toll-free number about their health care.
We will also identify and contact Providers who have submitted a claim for the member, and leverage community organizations such as homeless shelters and churches to locate and contact hard-to-reach members to complete the HRS.

Algorithms and Methodologies to Identify Members

NTC will use Centelligence™, Centene's multi-dimensional, analytics software that includes episode-based predictive modeling to identify members who may need care management. This award winning health informatics platform allows us to integrate, process, analyze, and manage large amounts of data for targeted, actionable information delivery to the right person, at the right time. Centelligence™ stands apart from other predictive modeling systems because it was developed specifically to address the Medicaid population's complex array of needs, including physical and BH comorbidities as well as socioeconomic issues (social determinants of health). NTC will generate bi-weekly predictive modeling reports to identify members that are high-risk or at-risk for an adverse health outcome.
Centelligence utilizes a risk calculation methodology that pre-groups and characterizes unique episodes of care based on individual medical services. Episode-based clusters describe the presence of significant physician-related activity for a member. These episodes describe a member's observed mix of diseases and conditions and underlying co-morbidities and complications, strengthening our predictive risk stratification and identification. Our methodology considers risk factors for each diagnosis and stratifies members into health continuum levels and risk categories: healthy, stable, interventional, chronic high-risk, rare high cost, catastrophic, and end of life. Interventions are then targeted by condition, risk, and comorbidities. Our methodology places a focus on the 'Big Five' prevalent diagnoses that have a high likelihood of being impacted by intervention: asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD), and diabetes. Additional criteria used in our predictive methodology include gaps in care, emergency department or inpatient utilization, and medication adherence.

Conducting Health Risk Assessments for Members Potentially Eligible for Care Management

NTC's comprehensive health risk assessment process, which will be conducted with the member, will include a full review of all available information to fully understand the member and their strengths, needs, and natural supports in order to develop an individualized care plan that is consistent with the member's expressed values, culture and goals. We will encourage the member to include family members, caregivers or other supports in the assessment and care planning process. We will use the assessment process to identify the member's goals and preferences and the types and level of support the member needs. The Care Manager will use age-appropriate questions and open ended questions as well as Motivational Interviewing techniques to engage the member and member's supports in the process.
When we identify a member potentially eligible for Care Management, we will outreach telephonically, or in person for certain high-risk members and those we cannot reach by phone. For low-risk members, a Program Coordinator will contact the member within two weeks of identification to identify and address care coordination needs, such as assistance scheduling appointments and transportation and making linkages to community services. If indicated, the Program Coordinator will connect the member to a

Health Coach to further assess for disease management support or to a Care Manager for comprehensive assessment. A Care Manager will outreach to high-risk members within 24-72 hours of identification, and moderate-risk members within five days of identification, to complete a comprehensive assessment of their physical, BH, functional, social and other needs that evaluates factors such as the following (***Table Q59***):

Table Q59

Ongoing special health care needs and conditions that require a course of treatment or regular care monitoring	Severity of the member's conditions/disease state
Co-morbidities or multiple complex health care conditions	History of prior preterm birth
Recent treatment history and current medications	LTSS the member currently receives
Demographic and social information *(including ethnicity education, living situation/housing, legal status, employment status, food security, etc.)*	ADLs and IADLs
Communication and cognition	Indirect supports
General health and life goals	Safety
Current providers and care plan *(if available)*	BH concerns, including depression, mental illness, suicide risk, and exposure to trauma
Substance use, including alcohol and tobacco	Interest in Care Management services.

The assessment will identify risk factors such as over/under and inappropriate utilization, non-adherence to an established care plan or lack of a care plan, or lack of understanding of their current condition. The assessment will also identify barriers such as a lack of support system, financial barriers, safety issues, cultural or linguistic challenges, and physical, mental, or cognitive disabilities. This includes evaluating the need for social supports and community resources that may improve the health and living circumstances of the member, including but not limited to nutrition, education, housing, legal aid, employment, and issues related to physical or sexual abuse. We will also screen members for the DHHS Division of Behavioral Health Women's Set Aside program. In addition to this comprehensive assessment, the Care Manager will complete condition-specific assessments to identify acuity, co-morbidities, member self-management capability and barriers for each condition. These assessments will include questions about symptom severity and medications, access to support for self-management (such as family, community services), and will assess member readiness for self-management in:

- Daily monitoring and self-triage of health indicators for the member's condition
- Consistent self-management of acute clinical symptoms in the home/community setting
- Correct use of all prescribed medications and medication adherence over time
- Appropriate lifestyle decisions based on member condition and provider recommendations
- Management of depression and other mental health correlates of chronic disease

In addition, our Care Manager will identify and obtain consent from the member to share information with the PCP and treating providers. The Care Manager will also identify whether a member has any other case/care managers, such as a Medicare, HCBS waiver, or community case manager. The Care Manager may contact providers and other case/care managers to gather additional information to obtain a holistic understanding of member needs, such as contacting the provider to inquire about medications and current treatment plan, and other case managers about non-covered services the member is receiving.

Please see the IV.L Care Management Attachments Tab for ***Attachment Q59: Health Risk Assessment Sample.***

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. (5 page limit)

Nebraska Total Care (NTC) will provide Care Management (CM) as a continuum of services that are responsive to the unique, and ever changing needs of each Member. We will deliver CM services through a person-centered, integrated model that promotes access, continuity of care, transition of care support, and discharge planning and follow up, with a goal of improving and maximizing health and wellness. Our interventions will follow evidence-based guidelines and promote the highest standards of care to maximize health and functioning and reduce the risk of exacerbations, deterioration, and complications. As described in more detail in our responses to Questions 58 and 59, our CM program will employ a comprehensive Health Risk Assessment for initial stratification. Our CM staff will assess the member's physical and behavioral health (BH) needs and progress during each contact, while considering the Member's level of engagement, self-management skills, existing formal and informal supports, and geographic location. We will offer the full complement of basic CM services and programs to members at each risk level, as needed, with more intensive and frequent support provided to members with moderate to high-risk needs. As the member's health status and ability to manage their care improve, they will transition to lower intensity of CM services. Should the member's needs increase they may transition to a higher intensity of services.

Types of Care Management Services Members Will Receive At Each Risk Level

We will provide CM services at three levels of intensity based upon the acuity of the member and the level of support needed to effectively self-manage their health. Our CMs at all levels will collaborate with HCBS service coordinators and community support providers to ensure consistency of approach and care plan goals and interventions. ***Table Q60.***A describes anticipated services by risk level.

Table Q60.A: Services Members Will Receive At Each Risk Level

Risk Level	Services
Basic (Low)	Communication via telephone with the member, caregiver, and informal supports/family
	Development of schedules for follow-up and communication
	Development and communication of member self-management plans and, as appropriate for members with BH conditions, crisis prevention plans
	Assistance with scheduling appointments and addressing barriers such as transportation
	Coordination of referrals to appropriate specialists as needed
	Information and assistance with linkage to community resources, for which the member would be eligible, including public assistance programs for health and social services, residential, social, community, and other support services, faith-based organizations, and support groups
	Services through our Smart Start for Your Baby perinatal management program for all pregnant members and assignment to OB CM when risk factors are identified
	Communication via telephone with the member, caregivers, and informal supports/family to monitor the care plan and assess progress against goals
	Monitoring and education regarding gaps in care
Moderate	Communication via telephone with the member, caregiver, and informal supports/family to provide all services listed above for Basic risk level
	Medication education and monitoring of adherence
	Support for the PCP/Patient Centered Medical Home through providing education on evidence-based guidelines, coordination, and information on Member needs and condition(s) including Care Gaps to ensure the Member receives baseline and periodic evaluation
	Interdisciplinary Case Reviews as needed by our Medical Director and staff from across clinical departments including Pharmacy staff, Care Managers, Health Coaches, and UM Nurses.
High	Communication in-person and via phone with the member, caregiver, and informal supports/family to provide all services listed above for Low and Moderate risk levels
	In-person assessment, education, and assistance when needed, such as Care Manager accompaniment to appointments to provide introductions and support for effective communication
	In-person support and coordination during transitions of care, with a focus on members needing

Table Q60.A: Services Members Will Receive At Each Risk Level	
	LTSS services and members with Serious Mental Illness (SMI)
	Facilitation of group visits to encourage self-management of various physical and behavioral health conditions/diagnoses such as pregnancy, diabetes, or tobacco use

Once a member is assigned to a level of CM, we assess the acuity of the member's needs to determine frequency of follow up contact with the member. For example, a member's health risk screening may indicate a need for Basic CM services but the acuity of their needs may be high, particularly during the initial period after enrollment into Care Management. ***Table Q60.B*** outlines the minimum contact frequency for members enrolled in CM according to level of acuity.

Services Provided To Members Regardless of Risk Level

We will provide all members, regardless of level, with support and education about availability of services and how to access them through our Call Center, 24/7 nurse advice line, Member Portal, and mobile applications, as well as written material.

Table Q60.B: CM Contact Frequency by Acuity	
Acuity	Minimum Frequency of Contact
High Risk	Daily until stable then weekly
Moderate	Twice per month to monthly
Basic	Monthly

We will also provide care coordination to any NTC member who requires this service but does not otherwise demonstrate need for CM services. These members will receive education and coordination of care as needed through our Call Center, as well as Program Coordinators, MemberConnections or other members of our integrated CM Team as indicated by the level of support required. Examples of care coordination services include assistance with transportation, scheduling appointments, identifying participating providers and accessing primary care, behavioral health, preventive and specialty care, or coordination that connects members to providers, medical services, or residential, social, community and other support services, as needed.

We provide all members any needed assistance with the following:

- Coordination of all covered services the member receives as well as referrals to and coordination with non-covered services that may affect health or willingness and ability to appropriately access care
- 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
- Identifying participating providers that meet the member's individual needs and preferences, such as providers with particular expertise related to the member's condition or those who speak or whose office staff speak the member's preferred language
- Facilitating access to recommended preventive care and well as other primary care and specialty services to address the member's needs
- 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
- Scheduling appointments and non-emergency transportation
- Education about the member's condition(s), recommended services, care gaps, and effective self-management
- Proactive outreach to members who are difficult to engage, including community outreach and the use of patient engagement tools such as the Member Portal of the website, mobile applications, texts, and other smartphone based support
- Smoking cessation programs
- Medication adherence monitoring programs
- Access to Crisis Text Line services (additional information available in our responses to questions 23 & 58)

Our staff will be trained to understand the health care, social service programs and initiatives offered by MLTC and other State and federal agencies (i.e. HCBS, HIS, DCFS, and tribally based programs) and leverage these programs when appropriate, including but not limited to Moderate and High-Risk members. We will work with any other case or care managers/coordinators and ensure coordination between multiple programs that complements but does not duplicate the member's plan of services and supports. Our staff will coordinate across the system of care, including agencies, State programs, Medicare, other third-party payers, community resources and the member's formal and informal supports to ensure that all care and services are provided and fit together seamlessly without duplication or gaps.

Services Provided To Members at Higher-Risk Levels

We will provide targeted, innovative services for members at higher-risk levels, such as the following:

Face to Face CM Services. NTC will provide in-person CM services to our highest-risk members, such as those with multiple co-morbidities or high-risk pregnancy. This may include in-home visits to complete assessments and develop care plans, or providing in-person outreach, education, assessment and other assistance through CM staff embedded at high-volume provider or other community locations. NTC will leverage in-person contact to help members understand their own health conditions and needs and identify the services available to meet those needs.

Our Georgia affiliate achieved a 56% decrease in the NICU rate for members receiving CM services through a program that involved locating plan CM staff onsite at an FQHC serving a high-volume of high-risk pregnant women. The plan achieved an over 200% increase in the Postpartum Visit rate over the first four years of implementation. This program received the 2014 Dorland Case in Point Platinum Award for innovative strategies to improve pregnancy outcomes in rural areas.

We will also provide in-person education and support for accessing recommended care, and identify and address barriers to appropriate access. Our Care Managers will use our mobile-enabled, secure tablet based software, TruCare On the Go to facilitate interaction with the member, family, and caregivers, by allowing them access in the field to real-time information such as care plans, care gaps, utilization data, and other important information. Examples of strategies we already have begun developing or plan to develop in order to provide face-to-face CM services. We have developed targeted, innovative programs for a variety of high-needs members. These programs include the following:

Community Health Collaboratives. We have already made progress to establish multiple Community Health Collaboratives throughout the state which will provide opportunities for us to place Care Management staff at provider locations. One such Collaborative involves Midtown Clinic (an FQHC) and Faith Regional Hospital in Norfolk, BH Region 4 representatives, as well as Tribal representatives and Indian Health Services in the region. As part of our written agreement with these partners, NTC will place Care Management staff onsite at Midtown Clinic and/or a BH clinic, which will allow us to identify Members seeking care at these locations that may need CM services and immediately provide assistance and comprehensive assessment if warranted.

We are working to establish other Collaboratives in Lincoln (which includes Bryan East/West and St. Elizabeth's/CHI Health) to serve the Southeast/South Central area, in the Tri-Cities area in western Nebraska, and with the BH Regional Administrators which will vary based on the needs of each community and our partners. For each Collaborative, we will locate our staff onsite at one or more locations to provide in-person CM services. We will also develop data sharing protocols to support whole-person care. For example, development of the Lincoln collaborative has included discussions with Lincoln ED Connections at Bryan Health and CHI Health about data sharing to improve support for super-utilizers in obtaining appropriate services. Each hospital will have access to the other's data and will identify and flag members who are frequent ED utilizers, particularly those with non-emergent or narcotics related issues. NTC will provide support which will include but not be limited to providing a Medication Management program, support to develop a narcotics diversion program for members with drug seeking behaviors, and network provider education specific to narcotics abuse, as well as ongoing

Care Management and transitional care services as needed. Our goal is to assist our community partners to address the gaps created in available community services when the county mental health center closed about two years ago. The collaborative will also include working with the local FQHC and Lutheran Family services for Member referrals, in addition to other local providers such as Vest Psychiatric, Dr. Sanat Roy, and Blue Valley Behavioral Health Services.

Partnering With Tribes. To further leverage and expand in-person CM and coordination services within Nebraska, we are contracting with Indian Health Services and Tribal 638 providers which provide care coordination services for Tribal Members. We will establish processes to work as a team with the provider-based care coordinator to engage the member in-person for outreach, education, and other care management assistance. We will also hire Care Managers from Tribal communities to embed in IHS/Tribal clinics.

In-Person Care Management. Our in-person approach to CM will support our highest-risk members with multiple co-morbidities. A Care Manager will make an in-home or, in some cases, telehealth visit to the member to complete a comprehensive Health Risk Assessment and to develop a person-centered care plan. The Care Manager will complete a follow-up in-home/telehealth visit to the member at least monthly for the first 90 days of program enrollment to monitor care plan implementation and identify changes in condition or needs. We will work with high-volume BH providers to embed BH clinician Care Managers onsite to provide face-to-face outreach, education, assessment, and other assistance. Our Care Managers will receive weekly lists of NTC members scheduled for appointments and call to remind the Member of their appointment 72 hours prior. During the member's scheduled appointment, the Care Manager will engage the member in CM services if not already enrolled, and provide education and support for appropriate access to care and effective self-management. We will measure outcomes such as reduced ED and inpatient utilization for BH issues via evaluation of claims data and quality of life indicators such as completion of education, employment status, and ability to live independently via a participant survey.

Post-Discharge Monitoring. Our Care Managers will follow the member's progress throughout the transition period, which may extend beyond 30 days depending on the member's needs and condition. Care Managers and MemberConnections Representatives (MCRs) will remain available to assist any Member needing more intensive, in-person education and support following discharge to ensure they understand the importance of, and are accessing follow-up care appropriately, and adhering to medication regimens.

Telehealth. Telehealth is a means for enhancing health care, public health, and health education and delivery support, decreasing the need for physical health care visits through the use of telecommunication technologies. We will offer live videoconferencing and remote patient monitoring to improve access to primary and specialty care in rural, medically underserved areas, provide our high-risk, fragile members with an alternative to long waits in provider offices and avoidable ER visits, and allow our Care Managers to communicate with and more closely monitor the member's status and needs. **We will use** Telehealth Triage, the clinical content and workflow application supporting our 24/7 nurse advice line, to promote communication within the member's CM Team. Telehealth Triage uses the same member data as TruCare (our integrated health management system), and information, referrals and/or follow-up action can be conveyed to the member's Care Manager via daily electronic reports.

Community Paramedicine Program. NTC will collaborate with local organizations in the development of a Community Paramedicine program that will provide post-discharge support and reduce the risk of admission/readmission for our high-utilizing members, particularly those in remote areas. The program will provide real time support including triage, home assessment, and community based paramedicine protocols designed to help the member receive services at the most appropriate level of care.

In-Home Physician Monitoring. We will implement in-home primary care through our affiliate, US Medical Management for home-based physician visits after discharge for complex, fragile, and special needs members.

Additional Innovative Strategies MLTC May Want To Consider

Based on the experience of our Centene affiliates serving populations similar to the Heritage Health population in other states, NTC would recommend that MLTC consider strategies that improve the ability of all Nebraska MCOs to identify members with risk factors as early as possible so that members receive proactive and timely services to improve health outcomes regardless of which MCO they are in (***Table Q60.C***). Strategies which facilitate coordination and information sharing during the transition into the MCO are particularly critical to achieving that goal. Examples of such strategies include the following:

Table Q60.C

STRATEGY: Health risk screening conducted by Enrollment Broker
The purpose of the screening would be to identify pregnant members and those with special health care needs or other issues (such as scheduled services) at the time of transition into a new MCO. We understand some of this information is already included in the enrollment file, however this screening would facilitate identification of members who may be newly pregnant or experiencing a new or changed need for which they have not previously received services. This in turn would assist the new MCO to prioritize the member for immediate outreach and assessment, and connect the members to needed services as early as possible. MLTC may want to consider developing the tool and a transmission protocol in conjunction with a committee which includes representation from the Enrollment Broker and each Heritage Health MCO.
STRATEGY: Enhance data provided to Heritage Health MCOs
The purpose of this enhancement would be to improve the timely provision of services, reduce duplication, and ensure no gaps in care. • Based on the experience of our affiliate health plans, which receive immunization data from state immunization registries, NTC requests routine data sharing from the *Nebraska State* Immunization Information System (NESIIS). MCOs can use this data to supplement claims and utilization data and identify whether members are due or overdue for immunizations. Our Centelligence™ system is able to accept data from NESIIS, allowing us to import and integrate immunization data directly into our system, and further expand the overall health picture we have for each member. This expanded view would enhance our ability to identify and outreach to members for needed EPSDT and other child health services including immunizations. • We recommend providing MCOs with an electronic file containing two years of claims data as well as any open/approved authorizations for each enrolling member in order to facilitate transition into the plan and integrate the data for the purpose of predictive modeling and risk identification. This enhanced data sharing will also support coordination between MCOs and LTSS programs and BH regions (where some services are covered by block grants) and facilitate continuity of care and coordination of covered and non-covered services.
STRATEGY: Enhance Covered Benefits
We suggest adding to the following as covered benefits to increase the tools available to CM staff to promote positive health outcomes: • ***Birthing and Parenting classes for adults***. These classes positively impact maternal-child health status and outcomes and reinforce education by CM staff. Heritage Health only covers them through the EPSDT benefit. • ***Peer support***. This service can be critical in supporting members to engage in care and improve self-management capabilities. NTC will offer peer support as a value added service. We will also work to expand availability throughout the state, in order to bring the service to more Heritage Health Members regardless of their MCO; coverage of this service would facilitate expansion. • ***Community Paramedicine***. Covering this service will support all MCO CM programs by improving access to this innovative type of post-discharge support to decrease the risk of readmission, particularly for members who are high-utilizers or reside in remote areas. • ***Reimbursement for provider to provider telehealth.*** Coverage of this type of telehealth would increase member and provider access to specialists in remote/underserved areas.

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. (2 page limit)

Nebraska Total Care (NTC) is committed to improving the health and well-being of our members. We strive to address the holistic needs of our members by leveraging available community resources that are not covered under Heritage Health and the Medicaid program. Below is a description of our approach on how we will assist members identify and gain access to community resources.

Integrated Case Management Program. Our Care Management (CM) program is designed to assess and address the holistic needs of an individual including the member's medical, behavioral, functional and social support needs. We coordinate all covered and non-covered services the member receives to create a system of care around each member. This includes social services and other non-Medicaid covered services that have an impact on health outcomes.

Our Care Managers help members access community resources by providing information and guidance, and by arranging for services, as well as recommending or referring members to community organizations that offer support services outside the scope of benefits covered by Medicaid. Care Managers work collaboratively with members to obtain detailed information on their current situation, including an assessment of an individual's social determinants of health such as housing instability, food security, home environment, education, availability of caregiver and family supports and transportation needs. A key component of our care planning process includes helping members identify community resources such as food pantries, homeless shelters and utility assistance programs. Staff also work one-on-one with members who need help overcoming barriers and connecting to community resources, to address socioeconomic issues that affect members' health and ability to access care and comply with treatment. Staff routinely coordinate with a broad range of community resources and community-based organizations to address the wide range of needs a member or family may have beyond Medicaid covered services. We follow-up with members to make sure they were able to access the resource and that their need was met. When a resource can't be found to meet the member's need, our care management staff work in collaboration with community based organizations, faith organizations and other key stakeholders in the community to problem-solve with the member to explore other possible solutions.

Use of Lay Health Workers- MemberConnections Program. In addition to our CM program, we will also implement our Member Connections program to assist members to identify and gain access to community resources. Member Connections Representatives (MCRs) are community health outreach workers, often times previous Medicaid recipients, hired from within the communities we serve to ensure our outreach is culturally competent and conducted by people who know the unique issues, health priorities, needs and available services and resources of each region and area of the state.

Our MCRs live in the communities they serve and are trained on techniques to locate and communicate with members and what questions to ask members in order to facilitate access to the right services. MCRs assist with member outreach, coordinate social services, and attend community functions to provide health education and outreach. In rural and frontier areas where health and social services may be scarce or travel distances are longer, MCRs keep themselves updated on what provider services and community resources are available in each rural community and surrounding communities in order to ensure members can be availed of those services as soon as possible. MCRs are required to keep a listing of community resource organizations such as counseling centers, area agencies on aging, senior centers, transportation assistance agencies, food pantries, low income energy assistance programs and more, arranged by the area the MCR serves.

Linking Members through our Community Resource Database and Screening Tool. Our state of the art Community Resource Database is a critical tool we use to link members to available community resources. Our Customer Service staff, MCRs and CM team will utilize our Community Resource Database and Screening Tool to help identify, refer, and follow up with members in need of community, social, long term care services and supports or behavioral services. Our staff can access the Community Resource Database to help connect members to services that best fit their needs. For example, if a member calls our CSR with an employment need, our CSR can screen the member, use the Community

Resource Database to find upcoming job fairs or job training sites, and can automate text reminders and directions to the member.

The Community Resource Database is a dynamic tool to help our CM staff, MCRs and CSRs identify, refer, and follow-up with members in need of social or behavioral services. Integrated with our Management Information System, our Community Resource Tool is individualized to address each member's unique needs. With the assistance of NTC staff or via the web, members take a baseline questionnaire which dynamically populates different questions based on the respondents answers and then offers resource referrals relevant to that member. This screening tool is written in plain language, and can be translated into any language.

The Community Resource Database functions as a Resource Guide and is also available on our website to empower members to take charge of their social and other non-covered service needs. This resource guide will provide information on resources such as food pantries, clothes closets, support groups, and other social services, by community, to assist members in identifying sources of assistance and support. Our user-friendly, online format is designed to encourage members to seek services on their own, thus promoting personal responsibility and member engagement in their own wellbeing.

Educating Staff on Use of Available Resources. To ensure staff are adept at using these community resources effectively, we will train and educate CM, MCR and CSR staff on the array of community services available, the organizations specializing in each type of service, and how to arrange services for the member. Our training curriculum ensures that health plan staff and our provider partners that interface with members are well positioned to provide assistance and facilitate access to community resources and services. As we add additional community resources to our database, we will conduct refresher training as appropriate.

Member Outreach and Education. Member education is also a key component of our approach and NTC will educate all members about covered benefits as well as available community resources not covered by Medicaid. We will use a variety of strategies and vehicles to educate members on available community services and resources. Our approaches include the use of new member welcome mailings; member handbook, member website; member portal, newsletters and outbound member welcome calls and direct member outreach provided by CM, MCR and CSR staff.

Community Care Centers. In communities that are co-located within existing community hubs (i.e., libraries, fire departments), we will place public computers/internet and phones that are connected to NTC's portal and hotlines within these Community Care Centers so that providers and members living in these communities have a place to access NTC's supports regardless of their ability to access the internet at their own site/home.

Building Community Partnerships. Quality health care is best delivered locally and is enhanced through partnerships with community-based organizations and other support agencies frequented by our members and located in the communities which they live. We will establish collaborative working relationships with the state, providers and local community based organizations to facilitate access to community resources, services and programs not covered by the Medicaid program. We will continue to build upon our efforts to date to build linkages with each community resource and our primary focus will include learning more about community needs, the services provided and how to most effectively use those services to help our members. We will use established relationships with our community partners to provide enhanced family-focused outreach/services that draw from the myriad of services that are available to families in their local communities. To stay abreast of community services and supports available, our NTC staff will look for opportunities to participate in community initiatives such as the Culture of Health Collaborative Summit, local committees and community work groups.

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. (2 page limit)

Strategies for Coordinating Care for Dual Eligible Individuals

Nebraska Total Care (NTC) is committed to work in partnership with the state, providers and stakeholders to ensure a seamless delivery of Medicaid and Medicare benefits and services for dual eligible individuals enrolled in Heritage Health, while retaining responsibility for ensuring members receive appropriate medical services. NTC's parent company, Centene Corporation, has extensive experience coordinating Medicare and Medicaid benefits for dual eligible individuals. Centene currently serves over 134,000 dual eligible members in our Medicaid Managed Long Term Services and Support (MLTSS) and Medicare-Medicaid Programs (MMP) through our affiliated health plans in seven states. In addition, Centene also serves approximately 7,500 dual eligible members in Medicare Advantage Special Needs Plans. We will employ this experience to coordinate care for duals enrolled in Nebraska Heritage Health.

Our experience provides us with a unique perspective into the health care needs and challenges of this population. Dual eligibles represent a small percentage of the Medicaid population but account for a disproportionate share of overall Medicaid expenditures. Duals also have a higher prevalence of serious physical and behavioral health (BH) conditions, including diabetes, congestive heart failure, cardiovascular disease, Alzheimer's/dementia, and depression, as well as significant co-morbidities. We also recognize the health needs of duals over 65 are different than that of younger duals that have a higher degree of physical disability and serious mental illness. Duals also rely on a health system which is fragmented with Medicare paying for primary and acute care services, and Medicaid paying for long term services and supports (LTSS) and BH services. Below are descriptions of our proposed approach and strategies for coordinating care for Nebraska's dual eligible individuals.

Integrated Care Management Model. We will coordinate Medicare and Medicaid benefits and services for dual eligible individuals enrolled in NTC through our integrated care management model. Our person-centered approach integrates all medical, BH, social, LTSS and other services the member receives to create a system of care around that individual. By focusing our care coordination approach on the dual eligible individual, regardless of the primary payer for a particular service, NTC will address the current fragmentation in the system and address the unique needs of each member. NTC's Integrated Care Management model is structured to maximize the impact of resources for the population as a whole, while providing the most appropriate level of services for individual members and appropriate payor source.

Proactive Identification and Documentation of Dual Eligible Members. For dual eligible members, the first step in the care management process is an outbound welcome call and completion of a Health Risk Assessment (HRA) to determine appropriate Level of Care Management to best address the member's unique needs. As part of our assessment process, we routinely assess each member for additional health care coverage. This process includes assessing a member for Medicare coverage and whether the dual eligible member is enrolled in another health plan's Medicare Advantage (MA) plan or in traditional Medicare fee-for-service. This information, including information about other case managers involved with the member, is captured and documented in our health management platform, TruCare, which is utilized for care management, disease management and utilization management. Once identified, a Third Party Liability (TPL) Alert is created in the member's TruCare record automatically alerting the member's Care Manager (CM) and medical management staff that the member has Medicare coverage. In addition, we also identify dual eligible members through the State eligibility and enrollment file and a member's Medicare coverage information is automatically loaded into TruCare if the information is included in state's 834 eligibility file.

Based on identified needs and risk, the member is assigned to an appropriate level of Care Management. The CM in conjunction with an individual's Care Team is a core element of our approach to coordination of care for duals. Our Model focuses on the member by providing that individual and his/her support system, one primary CM with whom to build a relationship of mutual trust and understanding. The CM serves as the member's regular point of contact and is actively involved with the member to ensure the

member's full range of medical, BH, functional and social support needs are addressed, regardless of which program pays for the services or benefit.

Identification and Coordination of Medicare and Medicaid Services. As part of the care planning process a care plan will be developed for dual eligible members, aligning member's needs and preferences to services and supports required to stabilize or improve the member's health and well-being. The member's care plan may include a range of services including but not limited to Medicaid-funded BH and LTSS or Medicare- funded services, such as, physician or hospital services. We include all services the member needs in their care plan and coordinate with out of network and community providers, including Medicare providers, to ensure integration of care. If the member is eligible for LTSS we will coordinate with the member's HCBS service coordinators in a manner that complements and does not duplicate the member's plan of services and supports. All of our CM and utilization management (UM) staff are trained and knowledgeable about Medicare and Medicaid benefits including those that are covered by both Medicare and Medicaid, such as DME and home health.

Another key component of our integrated care management model and approach for serving dual eligible members is our ability to appropriately utilize available Medicaid benefits and community resources to wrap around the member's Medicare covered services and benefits. We will provide medically necessary covered services to dual eligible members if the service is not covered by Medicare. We recognize that a significant percent of Medicaid expenditures for dual eligible beneficiaries in Nebraska are used to support LTSS, including custodial nursing facility and home and community based services for individuals who meet nursing home level of care. As part of our model, we work in collaboration with other entities including Area Agencies on Aging to link dual eligible members to available community resources such as housing and utility assistance, food assistance, public transportation, caregiver support services and other health and social support services to address the entire health needs of the individual.

Coordination with Medicare Payers and Providers. We recognize that the state's dual eligible population receive their Medicare services through Medicare fee- for-service and Medicare Advantage Plans. NTC's goal is to ensure all medically necessary services are in place (irrespective of payer source) for the member. CMs will work in collaboration with and across Medicare payers and providers to ensure the dual eligible member is able to access services included in their care plan in a timely, appropriate, cost-effective setting.

If a member is enrolled in another Medicare Advantage health plan, the CM will identify whether he/she has a care coordination resource and work with appropriate staff to ensure consistency in care planning and access to services, while avoiding duplication. The CM identifies the member's treating providers and other case managers that are involved in the member's care through historical claims data, as made available, and by asking the member during our health risk screening process. Our CM actively works with the member and their case managers, treating physicians (including out of network providers) and other service providers to ensure access to all needed care and prevent duplication of services.

Our CM works with the case manager of other entities to establish protocols for coordinating services, including collaborating on and sharing information about assessment, reassessments, care plans, change in condition and status, transition of care and monitoring. For example, our CM and UM staff will work in collaboration with Medicare providers, case managers and hospital discharge staff during transitions of care to ensure appropriate Medicaid supports and services are provided during transitions from hospital to a home or community-based setting, hospital to nursing home and nursing home to a home or community based setting. In doing so, our goal is to ensure all member's needs are being addressed allowing for an individual to maintain his/her highest level of wellness, safety and independence in the least restrictive setting possible. Our CMs make and document attempts to involve and communicate with the Medicare Provider and/or case manager. When there is no resource at the Medicare Advantage Plan level or if the member is receiving services through Medicare fee-for-service, our CM and Care Team will take the lead in implementing the individual's plan of care and ensure all necessary Medicaid wrap around services are provided to meet the individual member's needs.

63. Describe the process for care coordination for members who are Tribal members or are otherwise eligible for care through Indian Health Services. (1 page limit)

Nebraska Total Care's (NTC's) parent company has worked extensively with tribes in other markets and collaborates with the National Indian Health Board to find ways our solutions can be applied to improve and build upon the healthcare services delivered to American Indians. Our approach to improving the accessibility and delivery of integrated healthcare solutions respects tribal sovereignty. We are cognizant of inter-tribal differences from languages spoken and governance structures to spiritual and ceremonial practices. Further, we are aware that significant health disparities persist in the Native American populations, including greater prevalence of diabetes, suicide, substance abuse and domestic violence.

Coordination with Tribal Organizations. We have met and begun working with the four recognized tribes headquartered in Nebraska (Winnebago Tribe of Nebraska, Omaha Tribe of Nebraska, Ponca Tribe of Nebraska and Santee Sioux Nation) as well as Indian Health Services (IHS) to increase our understanding of their priorities and to explore opportunities to collaborate to improve the health status of American Indians in Nebraska that build upon the strength of the resources within each Native American community. During our outreach, we learned of several barriers to care and unmet needs such as issues determining eligibility for and enrolling in Medicaid, an unnecessarily burdensome and inflexible claims process and difficulties understanding and accessing Medicaid services. To address these issues, we will establish a **dedicated Tribal Liaison position** to develop collaborative relationships with all Indian Health Service, Tribal 638, and Urban Indian Health (I/T/U) programs to ensure access to and the availability of culturally appropriate care and services. In addition, we will also establish a **Tribal Advisory Committee** with representatives from each of the Tribes and tribal communities to promote meaningful communication and input to assist us in providing culturally effective services and care management approaches to the Native American population. We will also collaborate with the Urban Indian Health Coalition to recognize all Native Americans regardless of tribe and location.

Care Coordination Process for Tribal Members. Our Care Management (CM) Program will promote access to and ensure the delivery of physical and behavioral health services and coordination of all required care for Tribal members, both on and off the reservation. A member-centered, culturally relevant process will coordinate all covered and non-covered services, including I/T/U services to create a system of care around each Tribal member.

Care Coordination Team. Our CM Model places the member at the center of an integrated care team comprised of care management staff, the PCP, caregivers and informal supports, and community providers, including I/T/U providers. We will inform Native American members of their right to receive services from both contracted and non-contracted I/T/U providers and we will offer American Indian members unrestricted access to I/T/Us, regardless of their contract status. We will also seek to contract with all I/T/U providers to ensure continuity of care. Continuity with existing patterns of off-reservation care will be maintained via recognition and adoption of existing provider agreements. We will build relationships with off-reservation provider to ensure that, when expansion of off-reservation care is necessary, community involvement and participation in the delivery of healthcare services is preserved.

Identifying Care Coordination Resources. NTC will ensure access to culturally appropriate care coordination services in Tribal communities via an approach that will work collaboratively with rather replace existing resources and programs. First, to preserve the cultural identity of the tribal community, our focus will be to use care coordination resources currently available through the tribes. In cases where there are not available care coordination resources, we will seek to hire Care Managers from the Tribal community and embed them in I/T/Us provider clinics. Second, we will explore the opportunity to contract with individual Tribal communities to train and develop a network of tribal community health workers (CHWs) in each community under our Member Connections Program. A Tribal CHW's role shall include visiting members in their homes, providing member outreach, education and referrals, and care coordination services. We view the Tribal CHWs role as important members of the care team and as the local representatives who can best support Tribal members in a culturally responsive manner.

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. (4 page limit)

Nebraska Total Care (NTC) will coordinate service planning, services delivery, and post-discharge care among discharge planners and home health and other service providers (including State psychiatric hospitals and residential programs for youth) through our evidence based Transitional Care Program. While coordinating, NTC retains responsibility for ensuring the member continues to receive appropriate medical services in the most cost effective manner. The program will build on Centene's evidence-based, best practice model which is based on the Care Transitions Intervention developed by Dr. Eric Coleman, the Transitional Care Model developed at the University of Pennsylvania, and the vision and recommendations of the National Transitions of Care Coalition. This model incorporates proven techniques, policies, procedures, and initiatives, which include:

- Supporting ongoing member engagement with an appropriate medical home
- Addressing the member's individual needs, strengths, preferences and goals
- Educating members on their conditions and promoting self-management skills including understanding signs and symptoms that indicate a need to contact the PCP, when it is appropriate to seek urgent or emergent care, and the importance of medication adherence
- Engaging in member-centric, integrated discharge planning that takes into account social determinants of health
- Ensuring timely initiation of post-discharge services and care
- Linking members to community supports, such as referrals of potentially eligible members to WIC
- Developing targeted strategies for discharge planning that address the unique needs of the seriously mentally ill and those being discharged from state psychiatric facilities.

Our approach will include telephonic and onsite clinical resources, member and provider engagement and education, coordination of care and services, and promotion of self-management skills to achieve a seamless transition for the member and reduce readmission risk. Our Transitional Care Program is not limited to addressing a single illness or condition, but also considers co-occurring conditions and social determinants of health in evaluating risk and identifying services needed to comprehensively address wellbeing and recovery and prevent readmission.

Our Georgia affiliate won a Dorland Case In Point Award in 2014 for best practices in readmission avoidance interventions implemented through its Transitional Care Program, achieving a 73% reduction in the 7 day readmission rates and a 90% reduction in the 14 day readmission rate from 2008 to 2014.

Coordinating Prior To Discharge

Our member centric approach to transitional care focuses on continuity of care, optimizing health outcomes and decreasing fragmentation through communication and collaboration with the member, family, providers, agencies, and social supports. The CM will identify any other case or care managers working with the member and collaborate with the medical home, home health care agency, as well as any existing Care Manager, Care Coordinator or Service Coordinator, or other entity involved, such as other DHHS and state programs, HCBS waivers, tribal health, or Medicare for dually-eligible members to ensure whole-person integrated care and service planning.

Identification of Members Experiencing an Inpatient Event. Our involvement in discharge planning will begin immediately upon notification of admission. In addition to traditional methods of notification (telephone/fax/provider portal), our enterprise MIS incorporates national standard clinical data interfaces which will allow us to connect to Providers directly, or via the Nebraska Health Information Initiative (NeHII), or (where NeHII connectivity is not in place) via our clinical data exchange partner, Availity, LLC. We will use Availity to complement NeHII's existing connections, helping to augment NeHII's existing statewide provider and payer penetration. Availity is a trusted intermediary for secure

information exchange between health plans and providers, connecting more than 900,000 active providers, 2,700 hospitals, and most health plans across the USA, including in Nebraska. Connectivity via NeHII, supplemented with Availity where needed, will allow us to receive real-time Admission, Discharge, and Transfer (ADT) information and thus improve timeliness of discharge planning and transitional care management. This connectivity strategy will also allow us to exchange discharge orders with Providers and accept medical attachments from Providers' electronic medical record systems. Our goal is to increase the information available to our staff and other stakeholders about the member's care and needs throughout discharge, care planning and post discharge monitoring.

In addition to the above, and using a "no wrong door" approach, we will offer participating as well as qualified non-network providers, access to clinical and administrative information on our members via our Provider Portal, as well as both the Availity and NaviNet all-payer portals. Similar to Availity, NaviNet is a major provider connectivity networking company used by health plans in Nebraska today.

Collaborative, Comprehensive, Integrated Assessment and Planning. Our concurrent review nurses and CM staff will collaborate in person or by telephone with the facility discharge planning staff, member/caregiver, PCP, and treating providers. We will also establish communication strategies for collaboration with other entities involved in the member's care, such as social service agencies, DHHS and other federal and state programs, and tribal health in order to comprehensively assess and develop interventions to address physical, behavioral, psychosocial, environmental, financial, cultural, and linguistic needs and barriers. Our CMs will ensure the discharge plan includes referrals to appropriate post-discharge supports such as post-discharge appointments, home care, appropriate waiver programs, DME, transportation, prescriptions, and supplies, as well as community resources needed to support a safe discharge and reduce readmission risk. For example, we may identify and enlist the assistance of community resources such as food pantries, Meals on Wheels, and utility assistance programs, and incorporate them as applicable into the transition plan. Our Care Teams will also coordinate post-discharge access to, or reinstatement of, necessary medical, social, educational, waiver, and other services.

Integrated Care Management Teams

Our integrated CM Teams will include a range of experience and levels of expertise supporting each other by providing discharge plan recommendations for complex members. Teams will develop integrated strategies for self-management, adherence, and reducing avoidable hospital and ED admissions.

Prenatal and NICU Expertise. We will recruit experienced Registered Nurses and Social Workers with expertise in prenatal care and NICU services who will work with our hospital providers with high rates of LBW and VLBW births to ensure appropriate support post discharge. These staff will lighten the burden of the facility staff and reduce unnecessary length of stay by assisting with discharge planning and post-discharge follow up for high risk newborns and their mothers.

Member/Family Engagement. Timely communication of information and assisting the member/family to understand their condition are important factors in reducing readmission risk. Our CMs will attempt to engage the member and family/caregiver in person or via phone while they are inpatient to discuss discharge plans including contact information for the discharging physician, and all instructions and recommended follow-up care. During these contacts, staff will:

- Assess health status, care plan changes, unmet medical, behavioral, educational or social needs, reasons for unplanned admissions and ED visits, and potential risks and barriers in their environment which potentially will, or in the case of readmission, have interfered, with successful wellness and recovery. Assessment will include evaluation of the member's health literacy, self-management skills, social and community supports, and culture and language needs.
- Identify where the member will go post-discharge and determine the need for services such as home health care, telehealth, assistive technology, and home modification to improve safety and support independent living. This may include conducting a home evaluation prior to discharge. For members in waiver programs, child welfare or other DHHS or state sponsored programs,

including those being discharged from state psychiatric and youth residential facilities, we will coordinate with the member's caseworker to identify an appropriate placement and assess caregiver needs for training and other assistance to effectively meet post-discharge needs.

- Assist the member as needed with choosing providers of post-discharge services, including educating the member about waiver programs and referring them, as appropriate.
- Review the final discharge plan and instructions in person with the member (and applicable family/informal supports) whenever possible. Assist the member/family with developing action plans (including crisis prevention plans) to prevent avoidable ER and inpatient utilization.
- Assist with scheduling follow-up appointments and transportation, as needed; verify anticipated start date/time for community based care and services, and arranging to fill any gaps between discharge and initiation of physical, behavioral and community based services.
- Assess caregiver needs and educate the member and involved family/informal supports about our Caregiver Portal, which provides information about supporting individuals in self-management of their conditions and care, and offers resources for caregivers to manage stress.
- Educate the member and their caregivers about available NTC support, such as our 24/7 nurse advice line and how to contact their CM, and help connect members and caregivers to support groups and other community resources.

Discharge Preparation Checklist
- ✓ Condition-specific information
- ✓ Self-management strategies
- ✓ Needed follow-up services
- ✓ Prescribed medications and regimen
  Symptom response plan.

Pre-Discharge Education. Our CMs will attempt to CMs will also provide (or ask hospital staff to provide it, if they are not able to meet in person with the member prior to discharge) the member with our Personal Health Record booklet, which the member can use to track information such as medications prescribed while in the hospital, diagnoses, post-discharge care needed, Provider contact information, and questions or concerns to discuss with the Provider. Staff will use the "teach back" method by having the member/caregiver restate instructions and concepts in their own words. If needed, the CM will obtain provider input on the symptom response plan, share that information with the member, and provide feedback to the PCP and treating providers, as needed.

Communication of Information to the Next Care Setting. This evidence-based practice ensures that all treating providers have full information about the member's care history and current needs as well as the context for planned care. It also ensures that they know whom to contact with questions regarding the member's care history or follow up care. For admissions, we provide information to the facility regarding the member's care plan, authorized services, and providers to support assessment and discharge planning. We will alert the PCP of any transition in care setting, including sending them the final discharge plan, to support oversight of all care by the medical home.

Coordinating Post-Discharge. The Care Manager will conduct a post-discharge follow-up call within 24-48 hours of discharge. Care Managers with neonatal expertise will conduct follow-up calls to caregivers of infants recently discharged from a NICU. During the follow up contact, our staff will:

- Review and reinforce discharge instructions, and provide additional education to ensure the member understands their condition, post-discharge instructions, and the importance of medication adherence and timely follow up.
- Complete a medication reconciliation of newly prescribed medications and all others the member may be taking to identify any potential issues, such as duplication or contraindications; identify any barriers to the member's access to, and compliance with taking the medications, provide education on why the medication is needed and the appropriate way to take the medication, and assist in resolving any issues.
- For BH admissions, the post-discharge call includes a reminder to keep the seven day outpatient visit and assistance with addressing any barriers. CM staff will confirm that the seven day appointment was kept and if not, assist with rescheduling and addressing barriers. Our CM Team will include staff with expertise in managing SMI members and our Peer and Family support

program will be a critical component of the recovery oriented system of care. In addition to our core transitional care strategies, Peers, whenever available, will assist the member in accessing timely post-discharge care and needed community supports. The CM will work collaboratively with the psychiatric facility staff to ensure the member has appropriate clinical, social, and community supports prior to discharge.

Once the Member is stable, we will assess the member for ongoing care management needs and referral for disease management education and health coaching. We will assign members who continue to need monitoring and support to a Care Management Team which will include a nurse, master's level licensed BH clinician, social worker, pharmacist, health coach and non-clinical supports. MemberConnections Representatives (MCRs) will be available to assist any member identified as needing more intensive, in person education and support following discharge to ensure they understand the importance of, and are accessing follow-up care appropriately, and adhering to medication regimens.

Approach to Care Management for Members Discharged from Residential Facilities for Youth

We will bring the experience of our Centene affiliates in developing specific discharge planning and follow up strategies that address the unique needs and circumstances of these members. We will recruit CM staff with knowledge and expertise in managing children with complex needs, and children in unstable households and out of home placements. Our integrated care team will begin discharge planning at the time of admission, employing a holistic, member centered approach that focuses on member and family engagement and participation. We will look at parent education, family therapy services, and community based supports as critical aspects of care planning. Our CMs will work with the member and family to develop crisis prevention plans that identify triggers and interventions that can help safely prevent escalation. We will work with the facility staff, caseworker, and caregiver to ensure an appropriate placement is available and any needed services, caregiver training, or other support are in place prior to discharge. However, we understand that child services are not uniformly available across the state so we will facilitate transportation and attempt to resolve any other barriers to care, including the use of telehealth when other services are not accessible. Finally, our clinical trainers will support evidence based practices for PCPs who are delivering BH services and our CM team will offer consultation to support PCPs in delivering treatment.

Monitoring Post-Discharge Care of Members in Remote Areas

In addition to telephonic outreach, we will automatically authorize a post discharge home health visits to ensure the member has the care, equipment, supplies and services they need. We will also use:

- **Telehealth.** We will offer live videoconferencing and remote patient monitoring to improve access to primary and specialty care in rural, medically underserved areas, provide our high risk, fragile members with an alternative to long waits in provider offices and avoidable ER visits, and allow our Care Managers to communicate with and more closely monitor the member's status and needs post-discharge. **We will use** *Telehealth Triage*, the clinical content and workflow application supporting our 24/7 nurse advice line to promote communication within the Member's CM Team and convey information, referrals and/or follow-up action can to the member's Care Manager via daily electronic reports.
- **Community Paramedicine Program.** NTC will collaborate with local organizations in the development of a Community Paramedicine program that will provide post-discharge support and reduce the risk of admission/readmission for our high utilizing members. The program will provide real time support including triage, home assessment, safety checks, and community based paramedicine protocols designed to help the member receive services at the most appropriate level of care.
- **In-Home Physician Visits.** We will use Centene's in-home primary care subsidiary US Medical Management for home-based physician visits after discharge for our highest-risk members with complex needs at high risk of readmission.

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. (5pgs)

Nebraska Total Care (NTC) understands that collecting data, using evidence-based support tools and getting that data in a timely manner to our providers is essential to maximize care coordination and improve outcomes for our members. Members may require very different levels of care coordination, and we have intentionally designed our integrated tools and data systems to accommodate all members' needs, whether it is well-care visit reminders and health tips, or comprehensive intensive care coordination services for members with more serious episodic,chronic conditions, multiple co-morbidities or special needs. Based on our experience in other states, we have methodically updated, expanded, and continually enhanced our care coordination technology, data support system and management practices. Our data and decision support tools address physical, behavioral health, and social needs, and enable all participating providers to easily share information and collaborate on care decisions and approaches, and identify timely action steps to address our members' health care needs.

Overview of Decision Support Data and Analytic Tools Used for Effective Care Coordination

In our discussions with providers in Nebraska, access to timely information is consistently raised as an issue that impedes their ability to manage their patients' care. Without timely, actionable information, providers are unaware their members are seeking care in emergency rooms or the outcome of those visits; what specialty providers they are seeing or the results of any tests or procedures they receive; or what medications have been prescribed by other providers. Not having this information is not only frustrating for providers, but results in duplicative services and can put the patient's health at risk. Because information is such a crucial element of an effective care coordination program, Centene has invested significant time and resources into developing powerful decision tools and data sets to ensure our providers, members, and Care Managers have the most up-to-date patient information and clinical guidance necessary to coordinate services and ensure members receive the right care at the right time. NTC will use **TruCare**, our fully integrated medical and behavioral health collaborative care management platform to support our care coordination activities. ***TruCare is used both internally and externally by our Care Coordination, Disease Management, and Care Management staff, our providers, and our members to support our person-centered, holistic approach to care coordination.*** TruCare facilitates sharing of physical, behavioral health, LTSS and pharmaceutical information, and provides both administrative and clinical support. Through these electronic support tools and data, we will provide a comprehensive view of our member's record and care history using a web-based, secure electronic administrative and clinical applications for all of our providers. Following is a brief overview of how these data will support care coordination activities.

Provider Care Coordination Support. All contracted health providers will have access to our Provider Portal, which features a full complement of self-service administrative functions and clinical support features necessary for care coordination. Powered by our Centelligence™ data integration, informatics and episode-based predictive modeling system, it includes such features as online care gap notifications and health alerts; summary member health records; member service plans; and practice-level quality reports. The Portal will also house our evidence-based Clinical Practice Guidelines (CPG) in line with a number of NCQA Patient Centered Medical Home recognition elements, which will further assist and encourage any of our providers interested in moving towards PCMH status.

Administrative Functions Designed to Improve Efficiency: To ensure our providers can easily access administrative information needed to coordinate members' care whenever it is necessary and convenient, our Provider Portal includes self-service administrative functionality such as eligibility inquiry; authorization request and response; electronic claim submission, status inquiry, adjustment, and explanation of payment; interactive Preferred Drug List and formulary search; and online authorization requirement search capability that allows providers to quickly determine which procedures and services

require prior authorization. Our public provider website also provides an interactive Provider Directory with multiple search options for all NTC providers, including specialty, institutional, pharmacies, and ancillary providers. The Directory includes the location, type, specialty, gender, language spoken, whether the provider is accepting new patients, and medical and hospital affiliations. The Directory search features make it easy for providers and staff to quickly identify specialty providers and services best suited to their patient's needs based on location, office hours, gender or languages spoken.
Clinical Information and Data to Support Evidence-Based Decisions: In addition to administrative information, our Provider Portal offers clinical information to support providers in their actual practice of medicine and coordination of care. Clinical features include our TruCare Plans, online Centelligence™ Member Health Record (CHR), and practice-level quality reports. Through the TruCare Plan component, providers may access an electronic copy of members' care management service plans displaying the member's identified health problems, treatment goals and objectives, milestone dates and progress, in a well-organized, searchable format. The CHR offers summary and detailed information on the member's most current service utilization activity (based on integrated medical, behavioral and pharmacy claims data) and includes recent inpatient visits, emergency room visits, and provider office visits. The Provider Portal can also be configured to allow us to automatically issue HIPAA compliant e-mail alerts to our Care Management staff when key events occur related to members, such as when there is an Emergency Room (ER) admission in a hospital. For example, if an institutional provider performs an eligibility inquiry on the Portal, the ER staff can indicate that their search is related to ER services, and our system will automatically notify our Care Managers, who can then take appropriate action, (e.g., notify the PCP). Another important function is the Online Care Gap Notifications (OCGN), a web-based alert program that notifies providers of preventive care gaps or health alerts that are systematically identified by our Centelligence™ predictive modeling system and are based on evidence-based clinical rules for services that are appropriate for each individual member. In addition, PCPs and PCMH designated providers may also access the information via the Online Member Panel Roster (see additional discussion below).
Enhanced Support for PCPs and Patient Centered Medical Home (PCMH) Providers: In addition to the above features, our network PCPs and PCMH providers will also have access to the following tools:

- an ***Online Member Panel Roster*** allows providers to view, print, or export to Microsoft Excel all members under their care with summary information on each member. The Roster will include information on whether the member has special healthcare needs and related information based on information provided by the member's NTC Care Manager, PCP, PCMH, or another Designated Provider. Information is also provided on chronic and acute disease conditions the member may have and/or potential health risks and chronic conditions systematically identified by Centelligence™.
- Centelligence™ Member Health Record (CHR) offers a comprehensive view of a member's care gaps; full clinical profiles; and lab test results. The CHR is based on medical, behavioral, pharmacy, claims information, lab test results, health risk assessments, and other information processed in our Centelligence™ Enterprise Data Warehouse (EDW). See Question 49 for additional information on CHR and other online tools available in our Provider Portal.

Member Engagement Tools and Support. Member engagement is also critical to a successful care coordination program and requires a comprehensive, thoughtful strategy that meets members where they are. Our data and tools for supporting member engagement and participation in their care decisions are integrated with our TruCare care management system, which facilitates the sharing of information between members, providers, and our Care Management team to enable continued communication in a way that is least intrusive and user-friendly for our members and their families. During new member orientation, we provide information regarding the benefits of our care coordination activities, and introduce the member to our support tools, such as our Member Handbook, our Online Health Library, and the variety of materials and information available to reinforce wellness, disease prevention and care management. We also introduce members to our secure *Member Portal* with instructions on how to track

their care and services. The Member Portal uses information from our Centelligence™ platform to provide basic plan information, such as eligibility and benefit information; helps members understand what they need to do (care opportunities, care gap alerts, health and wellness reminders, and health information specific to the member) to proactively manage their care; and provides self-service support tools, such as the ability to choose or change their PCP online, exchange bidirectional messages with our staff, and manage their web account information and communication preferences. The Portal includes a consumer-friendly version of the member's TruCare plan and other information to help the member engage in their health care. We also will offer our MyNTC Mobile Application for our Heritage Health members. MyNTC offers the functions of our Member Portal, while taking advantage of the unique capabilities of mobile devices such as "location aware" Provider Directory and "touch to call" technology. Please see question 31 for more information on MyNTC.

One of our innovative tools we will use to encourage member compliance is our CentAccount™ Member incentive program, which promotes personal healthcare responsibility and ownership by offering financial incentives that reward members for healthy behaviors. CentAccount™ has been widely used by Centene in other states and was featured as a best practice in the Medicaid Health Plans of America Best Practice compendium. Enrolled members may earn rewards for completing annual preventive health visits and other health and chronic disease care screening, such as appropriate diabetes testing. Rewards can be used to purchase certain needed health care items, groceries, baby and personal care items. By investing in our member's care, we are able to increase patient compliance and identify conditions that could result in reduced ER visits or potentially avoidable adverse health events. As an example of its effectiveness, in South Carolina, we found one in three members are more likely to complete well-care visits when participating in CentAccount™, and members who had previously earned CentAccount™ rewards were 18 percent less likely to visit the ER than non-participants, resulting in 44 percent lower ER costs. In Missouri, members with CentAccount™ rewards were 23 percent less likely to visit the ER.

NTC Internal Care Coordination Tools and Support. To complement the care coordination services provided within our network, NTC uses Care Teams, a multi-disciplinary team of registered nurses, behavioral health clinicians, social workers, Disease Management Health Coaches, and non-clinical Program Coordinators, supplying them with state of the art tools to enhance their care delivery. Our Care Coordination outreach begins immediately upon a member's enrollment using a variety of data and reports to identify potential candidates for coordination. Our Care Team regularly reviews monthly claims-based reports driven by selected diagnosis, procedure, and pharmacy codes; monthly reports from our Centelligence™ predictive modeling system for members at risk for developing a qualifying condition; monthly ED utilization reports; referrals from concurrent review of members receiving inpatient treatment; information from New Member Welcome Calls and Health Risk Assessments. We also will review pharmacy data to identify members utilizing drug classes that indicate conditions that are appropriate for immediate care coordination. Using these data, the Care Team will coordinate with primary care, behavioral health and other specialty providers to contact members, share information, and coordinate the development of an individual care coordination plan. Throughout every stage of care, the Care Team will support providers by providing authorization information, facilitating sharing of the treatment plan, monitoring information between the PCP and specialist, and alerting them to new or changed needs. All information will be documented in the applicable TruCare applications and accessible through the Provider Portal.

Monitoring to Evaluate Improved Health Outcomes and Cost Effectiveness

As described above, our Centelligence™ technology provides a comprehensive and integrated system of decision support tools, data and information that drives our care coordination system. These same data and tools support our quality management and assessment activities we will use to evaluate provider performance and monitor the ongoing effectiveness of our care coordination activities. While the performance metrics may vary based on the size of a provider's practice, whether the practice is a PCMH,

and other factors that impact the quality and relevance of data (for example, adult metrics will not be used for Pediatric practices), examples of the types of performance metrics we will use in Nebraska to evaluate outcomes and cost effectiveness include:

- Compliance with Clinical Practice Guidelines
- Key HEDIS Measures: Preventive Health Adult Weight Screening and Follow-up; Diabetes Care, Cardiac Conditions; Mental Health Conditions; Maternity Care, Use of Services
- Key Non-HEDIS Measures: Flu Vaccine, Generic Prescription Fill Rates, Medication Possession Ratios, Post-partum Depression Screening, Semi-Annual Chronic Disease Maintenance Visits, Notification of Pregnancy
- Patient Safety and Quality of Care Events
- Access and Appointment Availability
- Emergency Room Utilization and Associated Costs
- Hospital Admissions/Readmissions and Associated Costs
- Overall Health Benefit Ratios.

Provider Reporting to Monitor and Improve Outcomes. NTC will provide an expansive analytics and reporting package, integrated with our Provider Portal, to provide quality, utilization, and cost performance dashboard views for various aspects of the PCMH provider's operations.

Expanded Provider Portal Analytic Capabilities. In 2016, Centene is incorporating two significant functional enhancements with Centelligence™ Patient Analytics and Centelligence™ Analytic Insights. Both of these capabilities support the evolution of provider contracting arrangements towards increasing levels of Value Based Purchasing arrangements, by allowing providers to monitor their performance against pay-for-performance and other innovative payment strategies.

Centelligence™ Patient Analytics (CPA). CPA builds upon our existing Member Panel Roster, evolving the roster into a *patient registry* by allowing providers to instantly view critical information to better identify evidence-based care gaps, understand quality improvement opportunities, and improve their care management functions. CPA offers providers diagnoses, medication, lab, and care team data on an individual member level, while also offering prospective gaps in care to fulfill specific quality measures.

Centelligence™ Analytics Insight (CAI). CAI is a suite of the most important medical cost and utilization, pharmacy, emergency department, clinical, population health, and quality data to help NTC and providers form a cohesive understanding of provider performance and membership trends. Dashboards will allow for, among other uses, provider performance analysis, provider peer group comparisons, cost and utilization trending, quality measure performance, active and non-active member pattern analysis, disease state prevalence, readmission analysis, and population health trend analysis. Users are also offered many of these metrics on a risk and severity adjusted basis.

In addition to quarterly and annual evaluations, to assist providers in assessing and tracking their performance, NTC will generate and distribute PCP performance scorecards monthly, a highly effective tool that compares individual provider practices to benchmark data, so that providers can improve their practice and identify areas where they may need additional assistance from our Care Management team.

Implementing Outcome and Value-Oriented Payment Models

Centene health plans have a wide array of experience creating and implementing integrated, value-based payment arrangements that incentivize and reward providers for behaviors that result in high quality, cost effective care. Our payment models are directly tied to the data and outcome measures generated through the Centelligence™ data system that drives our care coordination support and clinical decision process. As previously discussed, we have learned that payment reform approaches must be responsive to local providers and delivery systems, and should offer a range of alternatives that recognizes the varying levels of readiness and risk that providers are able to accept. Based on our success in other states, we will offer a pay-for-performance program that incorporates measures to improve health care outcomes and reward

cost effectiveness. Examples of measures we will include are HEDIS preventive care measures, appropriate emergency room utilization, extended hours, and focused care coordination activities related to both wellness and chronic care management. The measures will be aligned with goals that demonstrate ongoing improvements in the quality of care and cost effectiveness and will encourage providers to manage their patients' care using the technology and tools described above. Our payment models are sensitive to the challenges small and rural providers face when coordinating patient care, and are easily adaptable to "meet providers where they are." We have already discussed our performance-based payment opportunities with many of the providers in Nebraska and have already reached VBP agreements that include more than 50% of our contracted providers. Over time, the program will provide additional opportunities for providers to share in the cost savings that result from their effective care management. We will continually evaluate provider experience and performance to ensure provider success while achieving the goals of lower costs, improved quality of care, and increased access to care.

Experience and Results in Other Programs Centene currently offers value-based payment programs in 20 states. Over the years, we have continually improved and expanded our programs based on provider suggestions, performance outcomes and evaluations, and increasing interest among our providers to accept additional risk. Company-wide, more than 60 percent of our membership is served by providers participating in VBP models. ***Table Q65*** includes a few examples of the results we have observed.

Table Q65

Value-Based Strategies	Examples	Outcomes
Quality and/or Utilization-Based Pay for Performance		
Activity Based; Real-time claims-based payment with quality targets	Louisiana: All providers eligible; covers 68% of members	Over 12 months, HEDIS Adult Access to Preventive Services exceeded goal by 5%
Quality Target-Based; Retrospective Payment – Quality and Utilization Targets	Ohio Medicaid – All providers Eligible; covers 82% of members	YTD 2015: HEDIS Timeliness of Prenatal Care increased by 24%, Appropriate Treatment of Children with Upper Respiratory Infection increased by 4%. Overall Quality Index 17% higher than plan average.
Gain Sharing (Upside Only)		
Quality Targets and Specified Cost Categories	Indiana Medicaid – Large providers eligible; covers 73% of members	YTD 2015: ER Utilization 18% less, Inpatient Utilization 19% less than plan average
Quality Targets and Total Cost of Care	Georgia Medicaid – Large providers eligible; covers 52% of members	CY 2014: Participating providers higher on all 13 HEDIS incentive measures (1.2-7.9% improvement) compared to non-participants; Overall Quality Index 3% higher than plan average; ER Utilization 8% less, Inpatient Utilization 12% less than plan average
Risk Sharing (Upside and Downside)		
Fund-Based – Quality Targets and Specified Cost Categories	Washington Medicaid – Large providers Eligible; covers 34% of members	YTD 2015: ER utilization 6% less, inpatient utilization 13% less than plan average; Overall Cost Index 8% lower than plan average
Shared Services – Quality Targets and Total Cost of Care	Ohio Medicaid – One Children's health system	YTD 2015: HEDIS: Childhood Immunization Combo 10 rate 50% above and Appropriate Treatment for Children with Upper Respiratory Infections 10% above 2014

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. (3 page limit)

NTC will leverage Centene's national experience coordinating with carved-out waiver services and federal, state and local programs to provide effective service coordination for Heritage Health members involved in multiple State programs. Collaboration will include, but not be limited to, HCBS Waivers and other programs provided by DHHS, including those offered by the Division of Behavioral Health, Division of Children and Family Services, Department of Probation, Department of Education and Early Detection, Division of Developmental Disabilities, and Division of Public Health, as well as those provided by IHS, Tribal 638 and Urban Indian organizations. We will also coordinate, as appropriate, with school based services and targeted case management programs.

Our affiliates have experience directly managing the long term supports and services (LTSS) provided through Nebraska's HCBS waiver programs, giving us the requisite insight and capability to effectively coordinate these services with the physical and behavioral health services provided through NTC. Highly collaborative relationships with state programs, including HCBS waivers, will maximize our ability to help members access existing resources and infrastructure while reducing fragmentation and duplication of effort. Our approach to coordinating any carved-out service will begin with identification of all existing services and ascertaining whether the member has any other case or care managers and/or caregivers that need to be engaged in the overall care planning process. Our approach to collaboration will be holistic and person-centered, recognizing that optimal health outcomes require integration of the full range of services and supports into an individualized system of care around the member, based on HRA risk level, with an emphasis on ADL and current LTSS, as applicable. Care Managers and other member-facing staff receive training on available waiver services and other federal, state and local programs, including education on: eligibility requirements, enrollment and referral protocols, coordination of benefits for dual-eligible members, transition of care coordination, and protocols for collaborating with other community based and facility based service coordinators.

Plan for Coordination for Members Receiving Services from Multiple State Programs. Our plan for coordinating efforts for members involved in multiple State programs, including those enrolled in HCBS waiver programs will incorporate the following components.

Develop Collaborative Relationships. Prior to contract implementation, we will continue to develop collaborative relationships with applicable State programs and develop processes and procedures to coordinate eligibility and service delivery, such as referrals, joint participation in assessments and care conferences, and periodic formal discussions to jointly assess the effectiveness of the coordination. Programs and entities with which we will develop relationships will include, but are not be limited to: HCBS waiver programs, Centers for Independent Living (CILs), Area Agencies on Aging (AAAs), Indian Health Services (IHS), tribally-operated facilities and programs, and Urban Indian clinics authorized to provide services pursuant to PL 93-638, and the Division of Children and Family Services for children in foster care placement. These programs, processes/procedures described above will be submitted to MLTC for approval at least 60 calendar days in advance of intended implementation and as required.

Establish Dedicated Staff Liaisons With Key Programs and Stakeholders. To ensure dedicated focus within our organization to the smooth functioning of our relationships with some of the key stakeholder entities serving our members, we will establish liaison positions to oversee the day-to-day operational effectiveness of our collaborative relationships. Our Child Welfare Liaison will assist with coordination with DCFS as well as other agencies and offices involved in the child welfare system such as juvenile justice and the courts. Our Tribal Liaison will assist with coordination with IHS, Tribes, and Tribal programs and facilities. Our LTSS Liaison will assist with coordination with HCBS programs, AAAs, CILs and other social services programs, long term care facilities, and the Nebraska Health Care Association. NTC's specialized IDD Liaison and Nurse Care Managers, assigned to members with an IDD diagnosis, will collaborate with existing medical and service providers who support people with IDD diagnoses such as vocational rehabilitation providers and the University of Nebraska Medical Center's

Munroe-Meyer Institute. To ensure optimal care coordination, NTC will develop procedures for scheduled follow-up health screenings and identify health needs (via health screenings) that will be monitored and treated as needed. Processes will also be developed for the oversight of appropriate prescription medication usage. Furthermore, procedures will be developed to ensure coordination between providers and the Women, Infants, and Children's program to ensure appropriate coordination.

Identify All State Programs And Other Entities From Which A Member Is Receiving Or Needs Services. NTC will complete a comprehensive Health Risk Assessment of each member to identify all medical, BH, long term care, social service, educational, housing, food, transportation, ADL, and other needs, including inpatient or nursing facility admission risk and the potential need for HCBS or other waiver services in accordance with MLTC requirements. This will allow Care Management (CM) staff to identify all programs and other entities through which the member is receiving or needs services, with which CM staff will need to coordinate in order to integrate care for the member and coordinate appropriate levels of care based on risk stratification.

Collaborate with State Programs and Other Involved Entities to Plan and Monitor Care. We will develop and regularly revise person-centered care plans in partnership with members, caregivers, state staff, HCBS waiver staff, service coordinators, and providers and incorporate all needed services, regardless of payer. We will also coordinate and monitor care plans with health care and social services programs serving our members by sharing assessment, care plan, and monitoring information (with member consent and per state/federal requirements). To coordinate and/or transition care, we will invite these individuals to participate in care conferences and make our CM staff available to participate in their care conferences. Our collaborative relationship with Aging Partners (AP) and League of Human Dignity (LHD) will facilitate direct discharge planning coordination between their service coordinators and NTC case managers \in an effort to reduce readmissions. NTC will operate a pilot program with AP which focuses on nutrition and well-being and identifies consumers who may benefit from innovative strategies, such as alternative meal options, and physical activities through the AP Health and Fitness Program. These efforts will promote improved nutrition, fitness and social well-being. We will also provide important medical and psychosocial information to the member's family or guardian, appropriate waiver and other program staff, Service Coordination staff, and providers as members access waivers and/or transition from one level of service to another.

Invite Providers of Non-Covered Services To Access Member Information. With appropriate consent, providers serving members may register to use our Provider Portal, regardless of network status. This will allow the provider to see the member's care plan and utilization information that will give the provider a holistic view of the member's needs and care and facilitate their ability to assist in integrating care.

Deploying Care Management to Avoid Duplication and Facilitate Information Sharing. Our CM Team will work with the member, family, caregiver, service coordinators and points of contact from other agencies, and other providers to ensure a person centered, collaborative approach that avoids duplication of services and facilitates information sharing to prevent gaps, increase utilization of preventive service and support well-integrated care.

Avoiding Duplication. CM staff will collaborate with HCBS waiver program staff, as well as appropriate staff from other State programs and other entities serving our members, during care plan development, all while working to support the medical home centered around the members PCP. CM staff will share recommendations for care plan services and request feedback not just on appropriateness but also on whether and to what extent the proposed covered services may overlap with the services the member is receiving elsewhere. When we identify overlap, CM staff will work with our Utilization Management staff to determine the appropriate first payer as well as coordinate provision of services, such as home care services for members receiving HCBS waiver services. For example, we will incorporate all member HCBS services into our TruCare care plan to ensure a comprehensive view and prevent duplication of services. We will also coordinate with entities such as the BH Regions to identify any block grant-funded

services the member is receiving, and Medicare providers or Medicare Advantage programs (as applicable) to identify the member's Medicare services.

Facilitating Information Sharing. Regardless of payer, Care Managers communicate reassessment results, member goals, service preferences, and other information to PCP and relevant treating providers to ensure the member's system of care is aware of changes to the member's status and/or Care Plan. The Care Plan will be available via our Provider and Client Portals, and the Care Manager will also share information with the PCP and network/out-of-network treating providers, as well as agency care coordinators, caseworkers or service coordinators and maintains ongoing communication with the member in order to continuously monitor service delivery, continuity of care, member condition and needs. The Care Manager will coordinate among providers and agencies as needed to ensure each has all of the needed information about treatment and services being provided by others, including recommendations for covered and non-covered services. NTC will pay close attention to prescription utilization and partner with AAAs and CILs, as they engage is face to face interactions with consumers, to determine which prescriptions are in the home and being taken, in comparison to the prescriptions which were prescribed and in NTC claims system.

Electronic Facilitation of Information Sharing with State Programs Serving NTC Members. We will make our Centelligence Health Record (CHR) available via our Client Portal to qualified stakeholders involved in the member's care, such as HCBS waiver service coordinators and child welfare system caseworkers. The CHR offers a well-organized, comprehensive view of a member's medical, behavioral, and medication service history, as well as Care Gaps and health alerts for each member for whom we have supporting data. The CHR is based on current and historic medical and pharmacy claims information, lab test results, health risk assessments (including those related to trauma), and other information systematically received and processed via the Centelligence™ Health Information Exchange system (see our response to question 101 for more information). CHR is completely integrated within our secure, web based, role-specific Portals, authorized Portal users, such as LHD and AP, can easily view important contacts related to the member's care and well-being increasing the likelihood of success in our innovative pilots in both rural and urban geographies.

> We will offer qualified stakeholders involved in the member's care - such as State program staff - access to clinical and administrative information on our members via our Client Portal to support coordination and ongoing communication.

Electronic Facilitation of Information Sharing with Providers. Our enterprise MIS incorporates national standard clinical data interfaces which will allow us to connect to Providers directly, via the Nebraska Health Information Initiative (NeHII) or, where NeHII connectivity is not in place, via our clinical data exchange partner, Availity, LLC. This connectivity strategy facilitates information exchange for discharge orders with providers and accepts medical attachments from providers' electronic medical record systems – thus improving the timeliness of information which CM staff can then share with State program partners and other stakeholders. We increase the information available to staff and other stakeholders using a "no wrong door" approach that provides participating, as well as qualified non-network, providers access to clinical and administrative information on our members via our Provider Portal, as well as both the Availity and NaviNet all-payer portals. Similar to Availity, NaviNet is a major provider connectivity networking company used by health plans in Nebraska today.

Immunization Data Sharing. Based on the experience of our affiliate health plans, which receive immunization data from state immunization registries, NTC proposes routine data sharing from *Nebraska State* Immunization Information System (NESIIS) to the Heritage Health MCOs. MCOs can use this data to supplement claims and utilization data and identify whether members are due or overdue for immunizations, as well as avoid duplication of immunizations provided outside the MCO. Our Centelligence™ system is able to accept data from NESIIS, allowing us to import and integrate immunization data directly into our system, and further expand the overall health picture we have for each member. CM staff will be able to share this information with State program staff and other stakeholders in the member's care so that all involved have complete, up-to-date information.

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. (2 page limit)

A key element of encouraging first trimester services will be to partner with providers and organizations that serve childbearing age women to help with our outreaching efforts. We will offer Provider and Member incentives for pregnancy notification and for prenatal visits that occur within seven days of enrollment or pregnancy notification. We will conduct a health risk screening to pregnant Members identified through our Notification of Pregnancy (NOP) form, and ensure appropriate follow-up through a broad network of the PCPs and OB-GYNs who already serve the Heritage Health population. We will support these providers using Centene's award-winning, best practice Start Smart® for Your Baby (Start Smart) perinatal management program.

Outreach Program to Encourage First Trimester Prenatal Services. Our multifaceted outreach program to encourage women to seek first trimester prenatal services will include the following.

Member Education. We will send a Welcome Packet to all new members with information about the importance of accessing prenatal care as soon as possible. Customer Service Representatives (CSR) will offer to schedule a prenatal visit and arrange transportation any time a member indicates during a conversation that they are pregnant. Our website and Member Newsletters will include information about Start Smart and importance of early prenatal care. We will analyze lab and pharmacy claims data weekly to identify potentially pregnant women; we send a pre-recorded message and a mailer asking them to contact us about their health and encouraging first trimester care. CSRs will encourage and assist them to seek first trimester prenatal services when they call us. Outreach and Care Management staff will educate members in-person about accessing prenatal care, such as at community events and provider locations where NTC will embed staff ***(see response to Question 58).***

Provider and Community Partnerships. We will develop our outreach program with providers, community and religious organizations, and other community groups that serve pregnant women. For example, we will inform local health departments, Tribal providers, and child welfare system representatives of the need for pregnant members to access prenatal care in the first trimester and how to refer the member to NTC for assistance such as scheduling and transportation. We have met with all Nebraska Tribes and will work with Tribal Health Directors and IHS to improve our ability to identify newly pregnant members and to assist them with education and tools to encourage Tribal members to access first trimester care. We will provide brochures and periodic articles that emphasize the importance of prenatal care which providers and stakeholders can distribute to members to improve awareness of first trimester care importance and the assistance we can provide. We propose to work with MLTC and other MCOs to develop material for the enrollment broker to distribute to pregnant applicants encouraging them to access a prenatal visit immediately. Similar to our affiliate health plans, we will partner with the March of Dimes to implement their "Go Before You Show" awareness campaign to increase entry into first trimester care.

Incentives. Through our CentAccount Member Rewards program, we will offer Member incentives for NOP submission and accessing HEDIS recommended perinatal visits ***(see response to Question 33).*** Our Provider incentives and value-based purchasing strategies will reward NOP submission and performance on HEDIS perinatal measures ***(see response to Question 97).***

Personal Outreach and Assistance. Start Smart staff will outreach to pregnant members to educate them on the importance of first trimester care, and assist with scheduling and keeping their appointment, such as arranging transportation or locating child care. We will invite pregnant members to Baby Showers which we will hold quarterly in each region. Care Managers (CMs) will attend the events, where we will provide perinatal education and nominal gifts, to identify at-risk members. Our MemberConnections staff will seek hard-to-find members in places such as community centers and homeless shelters.

Technology Solutions for Outreach. We will develop and promote patient engagement tools including mobile applications and smartphone-based support to supplement existing pregnancy services, including tools for outreaching to pregnant members to encourage first trimester care. Our *Member Portal* will offer

a wide range of information such as the importance of first trimester and other prenatal care. Our *Start Smart® Mobile* application will offer interactive tools that inform expectant moms of the importance of first trimester and other recommended care, and allow them to track service milestones and set personalized reminders for prenatal visits as well as other self-service functions. In addition to encouraging all pregnant members to enroll in the national Text4Baby texting program which provides information on recommended prenatal care, we will offer NTC's *SS4B Texting Program* which sends texts with prenatal education including accessing first trimester care. The program has resulted in higher timeliness of prenatal care and frequency of ongoing prenatal care HEDIS rates for participants.

Required Health Risk Screening and Follow Up When Applicable. We will require PCPs, OBGYNs, and our Start Smart staff to attempt to complete our NOP for all pregnant members. Our NOP identifies risk factors such as tobacco, alcohol, and substance use; previous preterm delivery; domestic violence; and existence of chronic or complex conditions such as diabetes or mental illness. We will also screen for the DHHS Division of Behavioral Health (DBH) Women's Set Aside program and make referrals to DBH as appropriate. We will connect pregnant members to community resources, such as WIC and the Baby & Me Tobacco Free Program as well as resources such as CenteringPregnancy providers to facilitate group visits. We will coordinate with these providers such as reporting appropriate medical information. For members with one or more risk factors, a CM will outreach to complete a comprehensive assessment and offer to enroll the member in our OB Care Management Program. We will also promote the use of 17P and use telehealth strategies to improve outcomes for both mom and baby.

Centene achieved a decrease in low birth weight rates (<2500 grams) across all plans from 11.3% in 2007 to 9.81% in 2014.

OB Care Management. For ***moderate risk*** pregnant members such as those with a controlled chronic condition and first time mothers who may have limited knowledge of prenatal care importance, a CM will provide support and education at least once per trimester and more often as indicated. For ***high-risk*** members, including but not limited to postpartum members who had a high risk pregnancy or adverse pregnancy outcomes, including preterm delivery, a CM will work with the member, family, and maternity provider to complete a comprehensive assessment of health and pregnancy risk factors; develop and implement a care plan that addresses the member's full range of physical health, BH, social, and other needs; and follow up every two weeks or more often as indicated. High-risk members may receive in-home monitoring by a nurse. CMs will provide education throughout the pregnancy and the postpartum period, including about depression, substance use disorder issues, and reproductive life planning. We will connect members to safety net services for baby care and breastfeeding support, such as assistance from International Board Certified Lactation Consultants (IBCLC) or, for rural areas, solutions such as Pacify which provides 24/7 access to IBCLCs through a mobile application. For members with substance use disorder (SUD), we will offer our ***Perinatal SUD Program (see response to Question 58)*** to encourage counseling, use of Subutex or methadone, and intensive outpatient or inpatient addiction treatment if needed.

17P Education. For pregnant members with a prior preterm birth, a CM will describe 17P benefits and encourage the member to discuss it with her provider. The CM or our Medical Director will also inform the provider that the member is a 17P candidate. The CM will monitor members receiving 17P, provide education and assistance to access to recommended prenatal care, address barriers, and ensure compliance. The member may receive in home monitoring and, as applicable, 17P by a nurse via our partnership with Alere.

Telehealth. We will implement telemedicine for maternal fetal medicine services through our partnerships with Methodist Hospital, University of Nebraska Medical Center, and Catholic Health Initiatives ***(see our response to Question 25)***. For certain high-risk pregnant members, we will implement telemonitoring of biometric readings such as blood pressure or blood glucose levels to allow real-time monitoring and quick follow up by the CM to advise on behavioral and lifestyle changes or assist with arranging an urgent care or other visit.

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IV.L ATTACHMENTS

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Attachment 59 Health Risk Assessment

Comprehensive Health Risk Assessment

Tab 1- Interval

1-1 Assessment Interval
☐ Initial or ☐ Yearly

Tab 2- Communications

2-1 Do you need assistive (TDD/TTY) equipment to complete this assessment?
☐ Yes ☐ No

2-2 Are there any hearing impairments or hearing loss? ☐ Yes ☐ No

2-3 Are there any visual impairments? ☐ Yes ☐ No

2-4 Please Explain hearing or visual needs or limitations: _____
_____

2-5 What is your primary language? _____

2-6 What is your secondary language? _____

2-7 Do you need a translator to complete this assessment? ☐ Yes ☐ No

Tab 3-Validation

3-1 Are there any additional phone numbers that can be used to reach you?
☐ Yes ☐ No

3-2 Do you anticipate moving from your present address in the next six months?
☐ Yes ☐ No

3-3 Do you know the phone number to get help with you (health plan) coverage?
☐ Yes ☐ No

3-4 Have you [TruCare User] validated this is the correct member?
☐ Yes ☐ No

3-5 Select at least two methods of validation:
☐Name
☐Address (current or previous)
☐Phone (current or previous)
☐DOB
☐Medicaid ID
☐SSN

Tab 4- Life Planning

4-1 Do you or your legal representative give verbal consent to complete this assessment? ☐ Yes ☐ No

4-2 List name and phone number for the legal representative: _____
_____

4-3 Do you have a Medical Power of Attorney, health care proxy, or someone else who makes decisions for you related to healthcare? ☐ Yes ☐ No
If Yes, List name and telephone number and relationship: _____
_____

4-4 Do you, your legal representative or your Medical Power of Attorney give permission to speak with family members or healthcare providers regarding your healthcare?
☐ Yes ☐ No

4-5 List name, relationship, and telephone number for all applicable persons:
_____

4-6 Are you having any issues with the following? Check all that apply:
☐Employment

Comprehensive Health Risk Assessment

☐Transportation
☐Legal issues
☐Childcare
☐Coping
☐Other If yes, please explain: _____

_____

4-7 What are your health care goals? _____

_____

4-8 Do you have any life goals that we can assist you with? ☐ Yes ☐ No
If yes, please explain: _____

_____

4-9 Do you have a will, a trust, a living will or an advance directive?
☐ Yes ☐ No ☐ N/A
If N/A explain why life planning activities were not discussed: _____

_____

4-10 Do you want life planning information? ☐ Yes ☐ No

Tab 5-Health Status

5-1 Do you have a primary care provider? ☐ Yes ☐ No

5-2 How do you describe your health?
☐ Excellent
☐ Very Good
☐ Good
☐ Fair
☐ Poor
If fair or poor, please explain:

_____

_____

5-3 Has a physician told you that you have any of the following diseases? Select all that apply, if checked include date of diagnosis:

☐Anemia, bleeding problems or Hemophilia
☐Arthritis
☐Asthma
☐Cancer/Leukemia
☐Chronic Renal Failure
☐COPD, emphysema
☐Contagious disease
☐Cystic fibrosis
☐Developmental delay or learning problems
☐Diabetes or sugar condition
☐Heart disease
☐Hepatitis
☐HIV/AIDS

Comprehensive Health Risk Assessment

☐High blood pressure
☐Kidney or bladder disease or bladder problems
☐Migraine headaches
☐Multiple Sclerosis
☐Obesity
☐Pregnancy
☐Sickle Cell disease
☐Stroke
☐Skin disorders, serious burns, fungal infections
☐Seizures, epilepsy or paralysis
☐Spinal cord injury

5-4 CHILDREN ONLY: Compared to other children his/her age, does your child have any problems or delays in any of the following? (check all that apply)

☐ Understanding things
☐ Speech or language development
☐ Emotional or behavioral development
☐ Physical development

5-5 Are you taking any medications? ☐ Yes ☐ No
If yes, list medications, dose, frequency and route in the Medication Module.

5-6 Do you have a hard time remembering to take your medicine?
☐ Yes ☐ No

5-7 Have you been diagnosed with any other condition not specified above? ☐ Yes ☐ No
If yes or uncertain, please explain:

_____

5-8 Have any of these reported conditions been diagnosed within the last 6 months?
☐ Yes ☐ No
If yes, Please explain:

_____

5-9 Do you have any medical appointments, medical tests, surgeries, or other health services planned for the next 3 – 6 months? ☐ Yes ☐ No
If yes, please explain.

_____

5-10 Have you been approved for or are you waiting for any type of transplant?
☐ Yes ☐ No
If yes, what type, with whom, when?

_____

5-11 Are you currently receiving any therapy? (Chemotherapy, radiation therapy, physical therapy, occupational therapy, speech therapy) ☐ Yes ☐ No
If yes, which type of therapy, what is your diagnosis and who is your provider?

Comprehensive Health Risk Assessment

5-12 Are you aware of any current abnormal lab or diagnostic test results? ☐ Yes ☐ No
If yes, name of test(s) and result.

5-13 Are you being treated with any kind of alternative/holistic medicine? ☐ Yes ☐ No
If yes, identify type of alternative/holistic medicines, frequency and route.

5-14 Is your physician(s) aware of the alternative/holistic medicine? ☐ Yes ☐ No

5-15 Do you have any allergies? ☐ Yes ☐ No
If yes, please describe and list allergies in Allergy Module.

_____

5-16 Are you receiving home health services such as RN, infusion, aides, PT, OT or ST?
☐ Yes ☐ No

5-17 Do you use any of the following medical equipment? (check all that apply)
If checked, request vendor name and phone number.

☐Breathing devices
☐Feeding tubes
☐Hospital bed
☐Ostomy supplies
☐Diabetic supplies
☐Incontinence devices or supplies
☐Walker, scooter, or cane
☐Wheelchair
☐Prosthesis
☐Toileting device/bedside commode
☐CPAP/BiPAP/Nebulizer/Oxygen
☐Ventilator
☐Other, if yes, please describe:

_____

5-18 Do you need any supplies right now? ☐ Yes ☐ No
If yes, list the supplies that are needed:

5-19 Do you or anyone in your family use any form of tobacco? ☐ Yes ☐ No

5-20 Would you like information on how to quit smoking/using tobacco? ☐ Yes ☐ No

5-21 Are you currently pregnant? ☐ Yes ☐ No

Tab 6- Clinical History

6-1 In the past year, would you say that your overall health has improved, gotten worse or stayed the same?
☐Improved
☐Gotten worse
☐Stayed the same

Please explain:

_____

Comprehensive Health Risk Assessment

6-2 How many times have you been in the hospital in the last 12 months?
☐None
☐One time
☐Two times
☐Three times
☐Four or more times
If yes, what was the reason you were in the hospital?

6-3 Have you been in the hospital in the past 30 days? ☐ Yes ☐ No

6-4 How many times have you been seen in the Emergency Department in the last six months?
☐None
☐One time
☐Two times
☐Three times
☐Four or more times
If yes, what was the reason you went to the emergency department?

6-5 Have you had 3 or more doctor visits in the last 6 months?
☐ Yes ☐ No

Tab 7- Behavioral Health

7-1 Has a health care provider told you that you have a mental health and/or substance abuse diagnosis? ☐ Yes ☐ No
If yes, what was the condition?

7-2 Have you received treatment for mental health, substance abuse or both in the past year?
☐ Yes ☐ No

7-3 Have you been inpatient or outpatient for the care?
☐ Yes ☐ No

7-4 During the past month, have you felt down, depressed or hopeless for longer than a day? ☐ Yes ☐ No
If yes, how many days have you felt this way?

7-5

7-6 During the past month, have you felt little interest or pleasure in doing things?
☐ Yes ☐ No

7-7 Have you reached out to any professional for these feelings? ☐ Yes ☐ No

7-8 Do you drink alcoholic beverages? ☐ Yes ☐ No
If yes, how many alcoholic drinks do you have per week?

7-9 In the past 12 months, have you used drugs other than those prescribed by your provider?
☐ Yes ☐ No
If yes, list names of drugs and frequency of use

Comprehensive Health Risk Assessment

7-10 List names of drugs and frequency of use.

7-11 Would you like to be referred to a behavioral health provider or talk to one of our behavioral health clinicians? ☐ Yes ☐ No

Tab 8- Practitioner

8-1 List the names and phone numbers of the providers managing your illnesses. Which of these providers is your primary treating provider? (indicate with an *)

_____

8-2 Has it been longer than 6 months since you saw a physicians, nurses, physician assistants, dentists? ☐ Yes ☐ No

Tab 9- ADLs

9-1 Do you require assistance with any of the following functions (check all that apply), if yes to any of these activities, please describe who provides assistance for you:

☐Not applicable
☐Bathing
☐Dressing
☐Eating
☐Fixing meals
☐Walking
☐Climbing stairs
☐Using bathroom
☐Managing money
☐Shopping
☐Obtaining food
☐Housing
☐Utilities

Tab 10-Safety Concerns

10-1 Do you feel safe in your home? ☐ Yes ☐ No
If no, please explain any concerns. _____

Tab 11 - Caregiver Resources

11-1 Do you feel that you have help when you need it? ☐ Yes ☐ No

11-2 Are your caregivers adequately involved in your treatment plan and decision-making? ☐ Yes ☐ No

11-3 Caregiver resources (check all that apply)

☐Family
☐Friends
☐Neighbor
☐Church organization
☐Significant other
☐Legal services
☐Other
☐None

Tab 12 - HEDIS / Key Metrics

12-1 Current weight?

Comprehensive Health Risk Assessment

12-2 Height?
12-3 Date of last routine physical
12-4 CHILD ONLY:
Is your child up to date on your EPSDT (Health check exams)? ☐ Yes ☐ No
Are your (the child's) immunizations up-to- date? ☐ Yes ☐ No
Has your child been screened for lead? ☐ Yes ☐ No
12-5 In the last 12 months have you had an eye exam? ☐ Yes ☐ No
If yes, list date of eye exam: _____
12-6 In the last 12 months have you had a hearing screen? ☐ Yes ☐ No
If yes, list date of hearing exam: _____
12-7 FEMALE ONLY:
In the last 12 months have you had a mammogram? ☐ Yes ☐ No
If yes, list date of last mammogram: _____

In the last 12 months have you had a pap smear? ☐ Yes ☐ No
If yes, list date of last pap smear: _____

12-8 MALE ONLY: In the last 12 months have you had a prostate exam? ☐ Yes ☐ No
If yes, list date of last prostate exam: _____
12-9 In the last 12 months have you had a flu shot? ☐ Yes ☐ No
If yes, list date of last flu shot: _____
12-10 In the last 5 years have you had a pneumovax? ☐ Yes ☐ No
If yes, list date of last pneumovax : _____

Tab 13 - Cultural

13-1 Because some race/ethnic groups have a higher risk of certain diseases, will you please tell me your race/ethnicity?

☐African
☐Alaskan Native
☐American
☐American Indian
☐Asian/Pacific Islander
☐Black, Non-Hispanic
☐Canadian
☐Chinese
☐Declined to respond
☐Hispanic
☐Hmong
☐Other
☐Vietnamese
☐White, Non-Hispanic
If other, please list: _____

Comprehensive Health Risk Assessment

13-2 Do you feel anything keeps you from receiving health care or being able to follow your doctor's advice? ☐ Yes ☐ No
This can be related to diet, language, religion, race/ethnicity or other beliefs. If yes, please explain (ensure that the specific diet, language, religion, ethnic background, race or other beliefs noted are listed):

13-3 Do you have any preferences or needs based on the above related to your healthcare?
☐ Yes ☐ No
If yes, please explain: _____

13-4 Have you utilized any non-medical remedies or sought advice from an alternative, folk or spiritual healer? ☐ Yes ☐ No
If yes, please explain: _____

Tab 14 - Benefits/COB

14-1 Do you understand your health care benefits? ☐ Yes ☐ No
If no, what do you not understand about your health care benefits?

14-2 Are your benefits covering your health care needs? ☐ Yes ☐ No
If no, how do your benefits not cover your health care needs. _____

14-3 Are you aware of additional support and community resources available to you?
☐ Yes ☐ No

14-4 Do you need assistance connecting with available community resources?
☐ Yes ☐ No
If yes, describe type of assistance needed: _____

14-5 Are you currently employed? ☐ Yes ☐ No
If yes, what type of work do you do?

14-6 Do you have insurance through your employer, the military, or the Veterans Administration(VA)? ☐ Yes ☐ No
If yes, list name of insurance carrier and group number, policy number etc.

14-7 Have you had injuries that are being covered by a home owners insurance, automobile insurance policy, worker's compensation or other insurance not listed? ☐ Yes ☐ No
If yes, list name of insurance carrier and group number, policy number etc.
_____

14-8 Are you receiving any type of disability? (SSI) ☐ Yes ☐ No

14-9 If yes, what is the main reason you are receiving disability? (check all that apply)
☐Communication
☐Hearing impairment
☐Visual impairment
☐Memory difficulties
☐Mobility
☐Medical condition
☐Mental health condition
☐Other, please explain: _____

nebraska total care

Comprehensive Health Risk Assessment

Tab 15-Internal Case Management

15-1 Does the member display any cognitive impairment such as problems with memory, trouble communicating, etc? ☐ Yes ☐ No
If yes, please explain cognitive impairment: _____

15-2 Does the member understand his/her health conditions? ☐ Yes ☐ No
Please explain member's understanding of condition: _____

15-3 Are there any health literacy issues identified? ☐ Yes ☐ No
If yes, provide detail: _____

15-4 Can the member comprehend and follow instructions regarding their health conditions? ☐ Yes ☐ No
Please explain member's comprehension: _____

15-5 Does the member seem motivated to follow instructions regarding their health conditions? ☐ Yes ☐ No
Please explain how member is motivated to follow instructions.
_____

15-7 Does the member have adequate caregiver resources who are involved in the care plan decision making? ☐ Yes ☐ No
Describe caregiver resources: _____

15-8 Does the member need referrals to providers or community resources? ☐ Yes ☐ No
If yes, explain needed referrals: _____

15-9 Is the member a candidate for Case Management? ☐ Yes ☐ No

15-10 Are there any benefit limitations that could impact the plan of care? ☐ Yes ☐ No
If yes, please explain benefit limitations: _____

15-11 Are there any identified barriers to meeting goals or complying with plan of care? ☐ Yes ☐ No

TECHNICAL PROPOSAL

Response to the Request for Proposal (RFP) No. 5151 Z1 for Medicaid Integrated Managed Care Program for the State of Nebraska

Submitted To:

State Purchasing Bureau

Attn: Michelle Thompson / Teresa Fleming

AS Materiel State Purchasing Bureau

1526 K Street, Suite 130

Lincoln, Nebraska 68508

Opening Date:

January 5, 2016 at 2:00 p.m. Central Time

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IV.M Quality Management

IV.M Quality Management

(10 page limit)

68. Provide a description of the MCO's proposed QAPI program. Include the following in the description:

Nebraska Total Care (NTC) is committed to the provision of quality health care services overseen and monitored through our proposed Quality Assessment and Performance Improvement (QAPI) Program. NTC will design and implement a QAPI Program that meets all contract, State, federal, and National Committee for Quality Assurance (NCQA) requirements. NTC's QAPI Program will support and comply with the Nebraska DHHS, Division of Medicaid and Long-Term Care (MLTC) Quality Strategy, incorporating values consistent with the RFP goals and a modified Centers for Medicare & Medicaid Services (CMS) "Quadruple" Aim (Figure Q68.A).

Figure Q68.A
Values of the "Quadruple" Aim

NTC, through its parent company Centene Corporation (Centene), has over 30 years of managed care experience serving over 4.8 million members nationwide across 23 states. We have successfully implemented QAPI programs that use data collection and monitoring of performance on standardized and state- and plan-specified measures to identify and design appropriate interventions specific to the population being served. Across health plans, Centene has demonstrated success in improving health plan quality indicators for members. NTC will leverage those successes to develop best practices tailored to Heritage Health and the provider community. NTC's Quality Management (QM) program will include our QAPI Program; Performance Improvement Projects (PIPs) and quality performance measurement and evaluation as defined in our QAPI Work Plan; evaluation and monitoring of member and provider satisfaction; MCO operational performance monitoring and accreditation requirements, including a comprehensive provider credentialing and re-credentialing program; and other administrative and clinical oversight and improvement activities.

Quality Assurance and Performance Improvement (QAPI) Program Overview

Our QAPI Program will engage a systematic approach (***Figure Q68.B***) to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care provided to all members, including all demographic groups, geographic regions, and clinical and social needs. This approach provides a rapid and continuous cycle, leveraging robust data systems and technologies to get results. NTC will use the results of its QAPI activities to improve the quality of physical health (PH), behavioral health (BH) and pharmacy services with appropriate input from providers and members. NTC will continuously evaluate the effectiveness of our QAPI Program, building from the methods that our affiliated health plans have developed and enhanced over years of systematic assessments of clinical and non-clinical performance.

Figure Q68.B Quality Improvement Framework

Scope of the QAPI Program. A component of our QM function, the scope of NTC's QAPI Program will be comprehensive, addressing both the quality of clinical care and the quality of our health plan services, as outlined in ***Table Q68.A*** below.

Table Q68.A Areas of Quality Oversight

• Adoption and compliance with preventive health and clinical practice guidelines • Compliance with member confidentiality laws and regulation • Continuity and coordination of care in all settings including home and community based settings and residential and long-term care facilities • Delegated entity oversight • Disparities in care • Employee and provider cultural competency • Health education and promotion • Integrated care management including PH, BH, and LTSS coordination across practitioners • Member experience • Member grievances • Patient safety including appropriateness, quality of health and direct care services, abuse and neglect	• Network accessibility and appointment availability, including specialty practitioners • Performance Improvement Projects (PIPs) (minimum 2 clinical and 1 non-clinical) as approved by MLTC and in compliance with CMS requirements • Pharmacy • Plan/department performance metrics/key performance indicators • Provider experience • Selection and retention of skilled, quality-oriented practitioners and facilities (credentialing and recredentialing) • Service delivery including appropriate referral to and utilization of services • Utilization Management, including under- and over-utilization

Program Goals and Objectives. The program will further address how specific interventions will impact outcomes to achieve the "Quadruple" Aim. QAPI goals include, but are not limited to:

- Members will experience a person-centered approach to care that aims to improve health status, self-management and quality of life and ensures access to quality services in the most appropriate setting
- Network quality of care and service will meet or exceed industry-accepted standards of performance
- Plan services will meet or exceed quality measures included in Attachment 14 Quality Performance Program Measures – Contract Year One and other industry-accepted standards of performance
- Fragmentation and/or duplications of services will be minimized through integration of quality activities across NTC functional areas
- Member and provider satisfaction will meet or exceed the NTC's established performance targets
- Compliance with all applicable state and federal regulatory requirements and NCQA accreditation standards will be maintained

Sample program **objectives** in support of NTC's QAPI goals include:

- Adoption of evidence-based clinical indicators and practice guidelines
- Standardized performance measures such as HEDIS® and CAHPS® that are aligned with the state goals and objectives, clearly defined, objective, measurable, and allow tracking over time
- A Management Information System (MIS) maintained and optimized for data collection, integration, tracking, trending, analysis and reporting, including detection of over- and under-utilization
- Collection, submission, and maintenance of encounter data that accurately captures unique member, provider and services
- A sufficient number of qualified staff and appropriately allocated resources to support and meet the requirements of MLTC and NTC's QAPI Program, including data analysis and reporting
- Education and engagement of members, providers and staff relevant to quality improvement efforts
- Direct input from members, providers and community resources to improve quality of care

- Member and provider incentive programs aligned with QAPI goals and the MLTC Quality Strategy
- NCQA accreditation
- Systematic process for monitoring compliance with contract, regulatory and NCQA requirements

- ***The proposed structure, and policies & procedures that explain the accountability of each organizational unit.***

Proposed QAPI Program Structure, Governance, and Accountability Across the Organization

NTC's QM department will be a separate and distinct operational unit, while QM processes, such as tracking and trending of issues, will integrated across all departments throughout the organization, as overseen by the NTC Board of Directors and the QAPIC.

QAPI Program Accountability. The Board will have ultimate authority and accountability for oversight of the quality of clinical and non-clinical care and services provided to members and will support the QAPI Program by:

- Adopting the initial and annual QAPI Program which requires regular reporting (at least annually) to the Board, and establishes mechanisms for monitoring and evaluating quality, utilization, and risk
- Supporting QAPI Committee (QAPIC) recommendations for quality studies and other QAPI initiatives
- Providing the resources, support and systems necessary for optimum performance of QAPI functions
- Designating a senior physician as NTC's Senior Executive for Quality Management (SEQM)
- Evaluating the QAPI Program and QAPI Work Plan annually to assess whether program objectives were met and recommending adjustments when necessary

Operating authority of the QAPI Program will be delegated by the Board to the QAPIC which will be chaired by NTC's Chief Medical Officer. NTC senior management staff, clinical staff, including the BH Clinical Director, and network providers, who may include primary, specialty, behavioral, and pharmacy providers, will be directly involved in the implementation, monitoring and directing of the relative aspects of the QAPI Program through the QAPIC, with direct accountability to the Board. We have already developed relationships with many providers, advocates and associations and will create a thirteen member Board of Directors, with two internal staff and eleven positions being held by local Nebraska healthcare leaders representing PH, BH, LTSS, and pharmacy.

The QAPI structure reports into the QM Department led by the Chief Medical Officer and Director of Quality Management (described further below). Supported by QM department staff and other clinical and administrative staff from across the organization, the Chief Medical Officer will serve as the SEQM and be responsible for:

- Compliance with state, federal, and NCQA accreditation requirements and regulations
- Chairing the QAPIC, or designating an appropriate alternate chair, and participating as appropriate
- Monitoring and directing QAPI activities among staff and subcommittees reporting to the QAPIC
- Coordinating resolution of outstanding issues with appropriate leadership staff, pertaining to QAPIC recommendations, subcommittee recommendations, and/or other stakeholder recommendations
- Being actively involved in NTC's QAPI Program to include: (1) recommending QAPI study methodology; (2) formulating topics for QAPI studies as they relate to accreditation and regulatory agencies and state and federal law; (3) promoting participating providers' compliance with UM criteria and clinical practice guidelines; (4) assisting in the development of guidelines for on-going patient care monitoring as it relates to preventive health/sponsored wellness programs, pharmacy, diagnostic-specific case reviews and other focused studies; and (5) directing credentialing and recredentialing activities in accordance with NTC's policies and procedures
- Reporting the QAPI Program activities and outcomes to the Board of Directors at least annually

QAPI Committee (QAPIC) Structure. Quality will be fully integrated throughout NTC. To this end, NTC has identified various cross-functional committees, subcommittees, and ad-hoc work groups to monitor and support its QAPI Program. As noted above, the QAPIC will report directly to NTC's Board. The QAPIC will be supported by the Credentialing, Peer Review, Pharmacy & Therapeutics, Utilization Management, Joint Operating, Corporate Compliance, Performance Improvement Team, Member Advisory, Provider Advisory, Clinical Advisory committees and subcommittees including the Behavioral Health, Hospital, and Tribal Healthcare Advisory Committees. Our QAPI Program committee structure is portrayed in Figure 68.3 below. Detailed information about the QAPIC, is included below under Quality Committee Membership and Responsibilities. Descriptions of each subcommittee are included under ***Attachment 68.A_Quality Subcommittee Descriptions.*** In addition, please see ***Attachment 68.B_NTC QAPI Committee Structure.***

QAPI Program Governing Documents. NTC's QAPI Program will be exclusive to Nebraska and incorporate an ongoing documentation cycle that applies a systematic process of quality assessment, identification of opportunities, action implementation, as indicated, and evaluation. Several key QAPI instruments will be used to demonstrate NTC's continuous quality improvement cycle using a pre-determined documentation flow, including:

- QAPI Program Description
- QAPI Work Plan
- QAPI Annual Program Evaluation
- Policies and Procedures

These documents will be reviewed and approved by NTC's QAPIC and Board at least annually.

Program Description. The QAPI Program Description will include the following: specific roles, structure and function of the QAPIC and other committees, including meeting frequency; accountability to the governing body; a description of resources that are devoted to the QAPI Program; and patient safety, all in accordance with the RFP (Section IV.M), ensuing MLTC contract and Quality Strategy. The QAPI Program Description will be reviewed on an annual basis. Changes or amendments made will be noted in the 'Revision Log'. The QAPI Program Description may describe in the form of "Amendments," those QAPI activities or projects to be undertaken for the following fiscal year. NTC will submit the QAPI Program Description to MLTC 60 days prior to contract start date and annually thereafter.

Annual Work Plan. To implement the comprehensive scope of the QAPI Program, NTC's Annual Work Plan will set measurable goals, establish specific objectives, identify specific strategies and activities to be undertaken, monitor results and assess progress towards stated goals. This includes the activities that must be completed by each department and all supporting committees throughout the measurement year. The annual QAPI Work Plan will specify the activities, the driver of the initiative or problem being solved, the person(s) responsible for the activity, the date of expected task completion, and the evaluation and monitoring techniques that will be used to ensure completion within the established timeframe and effectiveness of the intervention. QAPI activities will be consistent with the clinical quality performance measures and targets set by MLTC and the identified needs of the population across the entire state. The Work Plan will be reviewed by the QAPIC on an annual basis and at regular intervals throughout the year, as needed. The Work Plan will be submitted to MLTC for review and approval as part of the QAPI Program 60 days prior to contract start date and annually thereafter. A preliminary work plan is submitted as ***Attachment 68.C NTC Proposed QAPI Work Plan***.

Annual Program Evaluation. The QAPI Program Evaluation will include an executive summary of the QAPI Program, a summary of all QAPI activities, the impact the program has had on members' care and MCO operations, an analysis of the achievement of stated goals and objectives, and the need for program revisions and modifications, and other components as described in Section IV.M.2.h. Program evaluation findings will be used in developing the annual QAPI Program Description and QAPI Work Plan for the subsequent year. The CMD and the QAPIC will evaluate the QAPI Program at least annually. The CMD and QM Director will be responsible for coordinating the evaluation process and a written description of the evaluation and work plan is provided to the BOD for approval annually. NTC will submit the

approved annual QAPI Program Evaluation report to MLTC or the EQRO, as specified by the State. The Annual Program Evaluation and findings and improvement actions from throughout the year will be reported out to key stakeholders, members, families/caregivers, and providers through standing committee reports, an annual report to the community, newsletters, and the NTC Website.

Written Policies and Procedures. Leveraging the robust policies and procedures (P&Ps) implemented across our affiliate health plans, NTC's will tailor our Heritage Health P&Ps to ensure compliance with state, federal, NCQA, and contract requirements, and accountability for quality across all NTC functional units. Our quality P&Ps will clearly define roles, functions, and responsibilities for all QM and QAPI activities, providing for regular quality reporting to NTC's committees, management, and providers, and dissemination of information to members and key stakeholders. NTC P&Ps will promote CQI processes, including systematic data collection, analysis, evaluation, ongoing monitoring, and reporting of performance and results. They will outline procedures for remedial action for deficiencies, timelines for correction, and assign a specific staff person to be responsible for ensuring compliance and follow-up. A sample list of proposed QM P&Ps is included in ***Table Q68.B*** below.

Table Q68.B Sample Quality Management Policies and Procedures

QI Program Description	
Clinician Documentation of HEDIS Data	Members with Special Health Care Needs
Continuity & Coordination between PH and BH	Monitoring Quality of Care
Continuity and Coordination of Care	Oversight of Delegate Vendors
Cultural Competency Plan	Peer Review Committee and Process
Evaluation of Accessibility of Services	Preventive Health and Clinical Practice Guidelines
Evaluation of Practitioner Availability	Provider Experience Analysis
Grievance System	QI Data Integrity of HEDIS Supplemental Database
Health Promotion for BH	QI Documentation Cycle
HEDIS Rates Analysis	QI Program Operations
HEDIS Reporting	QOC Investigations
Medical Record Keeping	Quality Performance Improvement Projects
Member Experience Analysis	Supplemental Data Sources for HEDIS Reporting

Using Compliance 360 (C/360), recognized internationally as the leading Governance, Risk Management and Compliance (GRC) software system across all industry segments, our compliance team will interact with each department, including our QM department, to communicate deadlines and ensure that all written P&Ps for quality assessment and CQI are reviewed annually, evaluated for impact and effectiveness, and updated as necessary. C/360 will allow NTC to effectively administer and monitor our internal governance, as well as our contractual and regulatory oversight capabilities. C/360 provides for workflow enabled policy and procedure formulation (with total history of documentation and sign-offs); distribution of documents to appropriate internal departments and sub-contractors; systematic tracking of compliance activities (also with auditable records of management approval and cited contract and regulatory mandates); and ongoing, proactive assessment of compliance risks.

Accountability Across the Organization. As a quality-driven organization, NTC will adopt CQI as a core business strategy for the entire health plan, not just as part of a separate QAPI Program. Our executive and management teams will use data-driven decision-making methodologies in strategic planning and daily operations. Each operational area will have defined service metrics with accountability to the Senior Leadership team and reported up through the QAPIC. Key leaders will be trained on quality improvement methodologies such as Rapid Cycle Improvement or Plan Do Study Act (PDSA), the IHI Model for Improvement, developed by Associates in Process Improvement and built from the work of W. Edwards Deming, and Lean Six Sigma methodology for process improvement. Senior Leadership and appropriate staff representatives from across functional areas will engage in monthly meetings (more frequently as needed) to review utilization and other quality data (e.g. HEDIS, CAHPS, and provider

satisfaction survey results) for variances and to develop improvement strategies to address any variances. To directly support QAPI activities, each department will be made responsible for monitoring, analyzing and making recommendations regarding identified trends, follow-up, barrier analysis, and interventions to improve the quality of care and service to members. Information will be reported up through the QAPIC and/or the appropriate Senior Executive as defined in policy. All staff will have access to the QAPI Program Description, Work Plan, Annual Evaluation, and P&Ps and will be held responsible for ensuring alignment between quality goals and activities and the work they perform through monthly and quarterly reporting and participation in quality committees and subcommittees.

- ***The program's infrastructure, including coordination with subcontractors and corporate entities***

QAPI Program Infrastructure

The QAPI Program will be supported by the QM department, led by a full time, dedicated Chief Medical Officer (CMO), our corporate infrastructure, and Centene's robust information technology solutions.

Dedicated Quality Management (QM) Department Staff Resources. Accountable to the structure and processes described above, QM will be appropriately staffed to carry out all QM requirements described in Section IV.M of the RFP and responsible for ensuring compliance across the organization. This includes support of external quality review activities and successful implementation of the QAPI Program. NTC's QAPI Program will be infused throughout all operations across the organization; however, key positions will be accountable for leading and supporting these efforts. These positions are described in ***Table Q68.C*** below.

Table Q68.C NTC Quality Management (QM) Staff

Position Title	Responsibilities
Chief Medical Officer	The Chief Medical Officer (CMO) will be the senior physician on our staff with overall accountability for NTC's clinical activities and will have direct responsibility for our Pharmacy, Medical Management and Quality Management departments. The CMO will be a Nebraska-licensed physician in good standing. As Senior Executive for Quality Management, the CMO will be responsible for the successful operation of our QAPI Program. Depending on population size, NTC may also employ an associate Medical Director(s) who will report to the CMO and conduct medical necessity reviews and review potential quality of care concerns. The CMO will also work closely with the BH Clinical Director to ensure integration of services across the system.
Director of Quality Management (QM) (*Quality Management Coordinator*)	The Director of QM is a Nebraska licensed registered nurse in good standing or other appropriately licensed or experienced person with knowledge and expertise in QM, data analysis, barrier analysis, and project management. The QM Director reports to the CMO and is responsible for overseeing the QAPI Program, ensuring compliance with QM requirements and QAPI activities, including PIPs, and directing the activities of NTC's QM staff in monitoring and auditing the health care delivery system. The QM Director assists NTC's senior executive staff in overseeing operational activities to meet program goals, working closely with the BH Clinical Director and Manager, Pharmacy Director, UM Director, and other clinical staff to ensure integration of services. The QM Director coordinates NTC's QAPI proceedings in conjunction with the CMO; supports corporate initiatives through participation on committees and projects as requested; reviews statistical analysis of clinical, service and utilization data; and recommends performance improvement initiatives while incorporating best practices as applicable.
Performance and Quality Improvement Coordinator	The Performance and Quality Improvement Coordinator is a highly trained clinical staff with significant experience in data and outcomes measurement. They will serve as MLTC's contact person for quality performance measures. Primary responsibilities include focusing organizational efforts on the improvement of clinical quality performance measures; utilizing data to develop intervention strategies to improve outcomes; developing and implementing PIPs, both internal and across MCOs; and reporting quality improvement and performance outcomes to MLTC. They are also responsible for ensuring HEDIS data accuracy and timely reporting, tracking compliance with HEDIS measures, maintaining the overall action plan for improving performance on HEDIS measures, and participating in

	related quality improvement initiatives.
Quality Management (QM) Coordinator	QM Coordinators are highly trained clinical staff with significant experience in a health care setting, including experience with data analysis and/or project management. QM Coordinators report to the QM Director and their scope of work may include medical record audits, data collection for various quality improvement studies and activities, data analysis and implementation of improvement activities, and complaint response with follow up review of quality of care/risk management and sentinel/adverse event issues. QM Coordinators are responsible for maintaining departmental documentation to support state contract requirements and NCQA standards. A QM Coordinator may specialize in one area of the quality process or may be cross-trained across several areas. QM Coordinators collaborate with other departments as needed to promote integration and implement corrective action or improvement initiatives as identified through QAPI activities and quality of care reviews.
Maternal Child Health (MCH)/ EPSDT Coordinator	The MCH/EPSDT Coordinator is a current, Nebraska-licensed registered nurse or other qualified clinician or certified individual. The Coordinator will design programs to ensure that all pregnant members receive prenatal and postpartum care and all member children receive necessary EPSDT services; conduct member outreach and education on preventive care and coordinate with physician offices to organize population-based initiatives to improve adherence to recommended preventive health guidelines for examinations, screenings, and immunizations; promote family planning and preventive health services and strategies; identify and coordinate assistance for identified member needs, specific to maternal/child health and EPSDT; and interface with community partners.
Grievance System Manager	The Grievance System Manager (GSM) will report to the QM Director. They will manage/adjudicate member grievances, appeals, and requests for fair hearing and refer those pertaining to potential quality of care issues to a QM Coordinator for investigation and resolution. They will also oversee provider grievances and appeals. The GSM will evaluate complaints and grievances by type, location, and region to identify trends indicating potential areas in need of further analysis and intervention.
Quality Analytics Analyst	The Quality Analyst will interpret & analyze HEDIS and member experience data to accurately assess & demonstrate program performance. They will also provide custom analyses & reporting for internal needs and document them as appropriate, The analyst will assist in the identification of data and intervention opportunities based off of knowledge of the specifications, the market and population, collaborating with the plan to intervene and measure success. They will assist in managing health outcome projects and act as liaison between QI and internal business partners to meet expectations and requirements.

Coordination with Subcontracted Affiliates and Corporate Entity. Quality Management is not a delegated function. NTC will have monthly Joint Operating Committee (JOC) meetings with all of our affiliate subcontractors to ensure quality is permeated throughout the system. NTC will also make available records and other documentation, and ensure subcontractor participation in and cooperation with, any internal or external QM reviews. While NTC will have ultimate responsibility for our quality program, we will be supported by our parent company, Centene. This will include monthly and quarterly meetings with our corporate Quality Department to review policy updates, identify opportunities for improvement, identify and disseminate best practices, and solicit technical assistance and support as needed. NTC will also benefit from Centene's IT infrastructure described below.

Centelligence™ IT Solutions. Centelligence™ is our award-winning proprietary and comprehensive family of integrated decision support and health care informatics solutions. Centelligence™ provides expansive business intelligence support, including flexible desktop reporting and online Key Performance Indicator (KPI) Dashboards with "drill down" capability to help support QAPI activities. For example, Centelligence™ powers our provider practice pattern, provider clinical quality and cost reporting information products. Through Centelligence™, we have the ability to report on all datasets in our platform, including those for HEDIS, EPSDT services, claims timeliness, Performance Improvement

Project informatics, and other critical aspects of our operations. Centelligence™ includes a suite of best-of-breed predictive modeling solutions incorporating evidence-based, proprietary care gap/health risk identification applications that identify and report significant health risks at population, member, and provider levels. Additionally, using Centelligence™, we have the capability to create provider quality and healthcare outcomes reports enabling us to identify care quality and provider training opportunities and interventions, and provide actionable data to our providers to promote member outreach and compare their performance to HEDIS industry standards and peer performance levels.

- ***Proposed QAPIC membership and committee responsibilities.***

Quality Committee Membership and Responsibilities

Designed to monitor and support its QAPI Program, NTC's committee structure will link major quality processes of the QAPI Program across functional areas through established committees, subcommittees and ad-hoc workgroups that will include key stakeholders and members from the community.

QAPI Committee (QAPIC). The purpose of the QAPIC is to promote a system-wide approach to quality assurance, provide oversight and direction in assessing the appropriateness of care and services delivered; continuously enhance and improve the quality of care and services provided to members; and 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. In addition, the QAPIC will be responsible for reviewing, approving and overseeing implementation of the QAPIC Program, Work Plan and Program Evaluation. This will be accomplished through a comprehensive, plan-wide system of:

- Ongoing, objective, and systematic monitoring
- Study and evaluation of issues that MLTC, QAPIC, or staff may identify
- Identification, evaluation, and resolution of process problems
- Identification of opportunities to improve member outcomes
- Analysis and evaluation of QAPIC activities, including annual performance targets
- Recommendations for policy decisions
- Education and engagement of members, providers and staff regarding the QAPI, Utilization Management, and Credentialing programs
- Incorporation of recommendations from all staff and quality committees, the results of PIPs, other studies, improvement goals, and other interventions into the QAPI Program, the QAPI Work Plan, and the QAPI Program Evaluation.

Other QAPIC responsibilities shall include:

- Review the Cultural Competency Plan
- Review and approve all member and provider surveys prior to their submission to MLTC
- Define the role, goals, and guidelines for the QAPIC, set agendas, and produce meeting summaries
- Monitor performance of subcommittees

Committee Composition. NTC has already starting informal recruitment for our Heritage Health QAPIC. The full QAPIC will be formed at least one month prior to contract start date. The QAPIC will be chaired by the Chief Medical Officer (CMO). The QAPIC will include at least four (4) network physicians representing the range of practitioners within the network and across the regions in which it operates (i.e. Family Practice, Internal Medicine, OB/GYN, Pediatrics, Behavioral Health, Vision/Dental care providers, and other high-volume specialists as appropriate). Representation from NTC senior management staff will include respective Vice Presidents (VP) or Directors if a VP position is not staffed (i.e. Medical Director(s), Medical Management, Network Development/Contracting, Member and Provider Services, Compliance, and other QI staff as determined by Plan needs). The Director of Quality Management/QM Coordinator and Performance and Quality Improvement Coordinator will also be standing members of the QAPIC. Delegate entity representatives may also attend the QAPIC as appropriate. To promote stakeholder and community input, the QAPIC will also include family

members/guardians of children or youth who are Medicaid members, Adult Medicaid members, and network providers knowledgeable about disability, mental health, and substance use disorder treatment of children, adolescents, and adults in the state. To encourage member participation, NTC will provide training; participation stipends; and reimbursement for travel, child care, or other reasonable participation costs for members or their family members to attend QAPIC meetings.

Frequency, Reporting and Accountability. QAPIC meeting intervals will be no less than quarterly. The QAPIC acts as an oversight committee receiving regular reports from all quality subcommittees that are accountable to and/or advise the QAPIC. NTC's Committees will keep written minutes of all meetings and a copy of the signed and dated written minutes will be available on-file and available for review by MLTC or its designee. Annually, and as requested, NTC will provide data to MLTC's Quality Committee to support MLTC's Quality Strategy.

Subcommittees. All QAPI committees and subcommittees listed above and described in ***Attachment 68.B***, are responsible for monitoring quality activities and reporting up to the QAPIC with concerns and recommendations. QAPIC reporting, as required by the SOW, will be quarterly or bi-annually. Committees are designed to ensure stakeholder input, including provider and member feedback, is reflected in our programs and improvement activities, and that experts in each field are included in program design and problem resolution. For example, MTC's Tribal Healthcare Advisory Committee will be chaired by our Tribal Liaison to ensure regular coordination with IHS, 638 providers, Urban Indian Centers, and other involved agencies.

- ***How the MCO will comply with and support MLTC's quality strategy.***

Alignment with MLTC Quality Strategy

NTC will comply with and support MLTC's quality strategy through direct alignment and integration with our QAPI Program goals and objectives. Using the current NHC Quality Strategy as a base until MLTC revises and obtains CMS approval of the final Quality Strategy, NTC will develop our programs, policies, procedures, processes, and committee structures to support the needs of MLTC and requirements of the Quality Strategy. For example, we will design programs that effectively integrate PH and BH to improve health outcomes, enhance quality, emphasize person-centered care, reduce costly and avoidable care, and support system sustainability. NTC will comply with all reporting requirements in formats and using data definitions provided by MLTC, including quality of care, access standards, satisfaction surveys, utilization, and encounter data reporting; external quality review; clinical standards/guidelines; onsite operational reviews; performance improvement projects; NCQA requirements; and provider credentialing/re-credentialing. Upon approval from CMS, and receipt of the MLTC Quality Strategy, we will incorporate the content into our quality training, ensuring all QM staff and members of the QAPIC and QAPI subcommittees have access to the Quality Strategy and understand how it is integrated into our QAPI Program and processes. NTC will actively participate in annual meetings of MLTC's QM Committee, including the review of data and information used to develop the Quality Strategy; review of the Quality Strategy; recommendations for improving the Quality Strategy; and recommendations to improve members' quality of care, access, utilization, and satisfaction; and review and recommendations of MLTC's Quality Strategy.

- ***How focus areas will be selected, including how data will be used in the selection process.***

Selection of Quality Focus Areas

NTC will identify opportunities and select focus areas reflective of the needs of our members. QM staff will review qualitative and quantitative data using a variety of analytic tools to identify the most prevalent issues with the greatest potential impact. Recommendations will be made to the QAPIC by the QM team, as well as other departments across the organization, in addition to key stakeholders through established channels of communication (see Question 72). The focus of projects may be clinical, quality of life or operational and address a spectrum of members and services including PH, BH, pharmacy and social determinants.

Process to Select and Prioritize. Based on recommendations from staff and committee, the QAPIC will prioritize potential areas of focus taking into account the degree to which each proposed area:

- Is based on the highest needs of our members
- Supports the vision, mission, core values and goals defined in the Strategic Planning Process
- Is aligned with MLTC priorities and the MLTC Quality Strategy
- Has potential to achieve high impact on the health status of our enrolled population (or a targeted subpopulation), on each member's experience of care, and on the per capita cost of health care
- Has potential to reduce identified treatment disparities.

Upon direction from the QAPIC or QM leadership, QM staff will establish a cross-functional workgroup for each of the highest priority areas of focus to:

- Review the data supporting selection of the area of focus and target population in detail
- Review relevant past NTC, Centene, and/or MLTC initiatives
- Review state and national best practices
- Create a summary document describing the rationale for selecting the area of focus, including how the it aligns with the MLTC Quality Strategy, and how it has the potential to improve member health status, member experience of care, and the per member cost of care.

The QAPIC will make the ultimate decision on which high-priority areas of focus are incorporated into the QAPI Program and Work Plan.

Data Sources Used. QM staff will use Centelligence™ to review and analyze data from a variety of sources, including subcontractors, to identify potential areas of focus. Data elements include, but are not limited to PH, BH, and pharmacy claims; lab test results; health assessments; service authorizations; member information, including current and historical eligibility, demographics (race, ethnicity, etc.), region, and PCP assignment; and provider information, including participation status, specialty, demographics, and languages spoken. Types and sources of data to target focus areas are included in ***Table Q68.D*** below:

Table Q68.D Types and Sources of Data Used to Select Focus Areas

Data Types and Sources	
HEDIS, CHIPRA, CAHPS, and other standardized quality measures	Input from member-facing NTC staff e.g. Care Management, Member Services
Claims/encounters data reflecting utilization and condition prevalence trends	Member and Provider input obtained through advisory committee participation
Medical record audits	Quality of care complaint data
Member Health and Case Management assessments	Member and provider appeals & grievance data
Demographic information and trends	Operational performance data
External data related to conditions or risks for similar populations	Member and Provider satisfaction survey results
Access and availability studies	

Whenever possible, we will identify a target population with treatment disparities for each potential area of focus. To identify such disparities, QM staff will analyze member demographic, predicted future risk, and outcome data using a drill down methodology we refer to as DRAG: Diagnosis, Race/ethnicity, Age, Geography (region, zip code).

- ***The proposed QAPI work plan, including planned initiatives.***

Proposed QAPI Work Plan

NTC's proposed QAPI Work Plan including ***planned initiatives, proposed timelines, and expected outcomes*** is included as ***Attachment 68.C NTC Proposed QAPI Work Plan***. This is a preliminary work plan based on what we know about the Nebraska population through our extensive stakeholder engagement, available population data, and MLTC objectives today; coupled with NCQA standards, best practices, and quality initiatives we have successfully implemented in other Medicaid populations. As we gain our own membership, we will re-evaluate and update based on member specific data and demonstrated needs in communities across the state of Nebraska.

(3 page limit)
69. Describe how the MCO will measure and track the outcome of individual quality improvement interventions over time.

Leveraging the successful quality approaches of our affiliate health plans across the country and industry tested models and frameworks, NTC's continuous quality approach will be applied to each individual quality improvement intervention. This means projects will be measured and re-measured over time. Information will be documented and reported to the appropriate committee, and accountability assigned to determine appropriate follow up. To demonstrate our commitment to this effort, we have included a Quality Analyst within the Quality Management department to help drive and carry out these evaluation and measurement activities. The Quality Analyst is a dedicated position that will interpret and analyze individual quality improvement intervention outcomes, HEDIS, and member experience data over time to accurately assess and demonstrate impact and effectiveness. They will also assist in managing health outcome projects and act as liaison between QM and internal business partners to meet individual expectations and requirements.

Process for Measuring and Tracking Outcomes over Time

Baseline measurement, periodic re-measurement and assessment of success will be basic components of NTC's improvement model. NTC will re-measure each project's established performance measures, compare them to the expected standard benchmarks and goals at the intervals determined at the beginning of the project, and test the comparisons for statistical significance. We will conduct both interim checks and assessments following full measurement periods, using rapid cycle PDSA methodology to examine changes or additions to the intervention if there is no evidence of improvement. With that methodology ***(Figure Q69)*** we:

- **P**lan the change, needed data and the goal
- **D**o a trial of the changed intervention, documenting any barriers
- **S**tudy the results, comparing them to the goal
- **A**ct to further refine the intervention based on the results

Figure Q69

Intervals will be based on the timeframe in which an anticipated improvement in performance is expected to occur, for example, monthly, quarterly, or semi-annually. To ensure comparability, the re-measurement methodology will be the same as that used for baseline measurement. Measures may include both process measures and outcome measures. For example, if an intervention centers on member outreach, how successful was the method of outreach. If by phone, what percentage of the targeted members were reached. For mailings, were mailings returned. If the intervention requires staff action, was the turnaround time for action met. For outcome measures, NTC will focus on standardized measures for comparability across studies and interventions. For example, HEDIS, CAHPS, provider satisfaction surveys, and utilization measures such as a reduction in readmissions and ED visits or an increase in preventive visits or primary care services. Measures may also be broken out and

analyzed by subpopulations or groups such as race or ethnicity, rural or urban, child welfare, super-utilizers and/or members with special health care needs.

Post-Evaluation Activities. If re-measurement does not demonstrate significant improvement and performance does not meet or exceed established goals, the quality improvement cycle begins again. In such cases, the Performance Improvement Team (PIT), in conjunction with the QAPIC, will evaluate each intervention, identify barriers that may be interfering with the achievement of performance goals, and revise the intervention, supplement the existing intervention, or replace it with new interventions to address identified barriers. We will conduct re-measurement at regular intervals, using the PDSA cycle, to test the changed or new interventions quickly and further redesign them as appropriate.
We will consider improvement to be sustained if the level of performance is maintained or further improvement occurs one year after significant improvement has been achieved and the improvement was found to be a result of the project interventions. We will maintain successful interventions, report them to MLTC as possible best practices for other contractors, and communicate them as best practices to other Centene affiliate plans.

Consistency and Accountability. To ensure each individual intervention is subject to this approach, each project, initiative, improvement, or change, will have the following:

- Staff accountability including a project owner and executive sponsor
- Project Charter describing the intervention and the intended outcome
- Baseline measurements and schedule, method, goals, and benchmarks for evaluating, measuring and monitoring
- Committee Reporting Schedule
- Formal transition to operation and appropriate follow up

The following describes technology tools used to support data collection and analytics and sample performance measures.

Technology Tools to Measure and Track Outcomes

Described below, NTC' robust Management Information Systems (MIS) provides key personnel the necessary access and ability to manage the data required to support the measurement aspects of quality improvement activities.

Centelligence™ – Our comprehensive family of integrated decision support and health care informatics solutions. The Centelligence™ platform integrates data from internal and external sources, producing actionable information: from care gap and wellness alerts to key performance indicator (KPI) dashboards, provider clinical profiling analyses, population level health risk stratifications, and over 12,000 unique operational and state compliance reports. For example, our web-based reporting and management Key Performance Indicator Dashboards includes advanced capabilities for provider practice pattern and utilization reporting – supporting both QM staff and providers with summary and detailed views of clinical quality and cost profiling information. This capability gives providers the practice and peer level profiling information needed for continuous clinical quality improvement, supporting both HEDIS and hybrid HEDIS reporting. Our predictive modeling function combines predictive modeling applications with care gap/health risk identification applications to identify and report potentially significant health risks at multiple population, provider, and enrollee levels. This module also powers online care gap notification functionality, allowing providers and enrollees to securely access care gaps and health alerts securely via web based provider and member portals.

Supporting all of this functionality, our Enterprise Data Warehouse (EDW) receives, integrates, and continually analyzes transactional data, such as medical, behavioral, and pharmacy claims, lab test results, health assessments, service authorizations, and enrollee and provider information as required for our QAPI Program. Our EDW is the central hub for service information that allows collection, integration, and reporting of clinical claim/encounter data (medical, behavioral health, laboratory, pharmacy, and

vision); financial information; medical management information (referrals, authorizations, disease management); member information (current and historical eligibility and eligibility group, demographics, PCP assignment, member outreach); and provider information (participation status, specialty, demographics) as required by the QAPI Program. NTC will capture and utilize data from both internal and subcontractor sources for administration, management and other reporting requirements, and can also submit and receive data as well as interface with other systems as necessary.

Specific to quality, Quality Spectrum Insight (QSI) is an Inovalon software system available to monitor, profile and report on the treatment of specific episodes, care quality and care delivery patterns. QSI is a NCQA-certified software; its primary use is for the purpose of building and tabulating HEDIS performance measures and state specific performance metrics. QSI enables NTC to integrate claims, member, provider and supplemental data into a single repository, by applying a series of clinical rules and algorithms that automatically convert raw data into statistically meaningful information. Additionally, the Inovalon product provides us with an integrated clinical and financial view of care delivery, which enables staff to identify cost drivers, help guide best practices, and to manage variances in efforts to improve performance. QSI is updated on a monthly basis by using an interface that extracts claims, member, provider and financial data. The data is mapped into QSI and summarized. Staff are given access to view monthly standard data summaries and drill down into the data or create ad-hoc queries.

Using Program Data to Continuously Monitor Quality of Care and Services

To further support monitoring and evaluation across initiatives Medical Management and QM staff will, on a regular basis, conduct a wide range of activities related to the quality and appropriateness of care furnished to our members. For example:

- Our Performance and Quality Improvement Coordinator and QM Director will review grievance and appeals trends, satisfaction survey results, and other stakeholder input to identify areas for improvement
- Our Quality Management Coordinator and QM Director will generate monthly HEDIS and other health care quality reports to track performance toward goals and identify care gaps for individual members
- The Maternal Child Health (MCH)/EPSDT Coordinator and QM Director will review monthly reports of EPSDT periodicity compliance to identify members for outreach and coordinate with Medical Management to ensure pregnant members are appropriate enrolled into care management or our Start Smart for Your Baby prenatal/postpartum support program
- Medical Management staff will review quarterly reports of measures such as rates of occurrence of certain diagnoses, readmission rates, complications of care (sentinel events), never-events, critical incidents, preterm delivery, NICU admission, inpatient LOS to monitor compliance with evidence based care and patient safety
- The Director of Care Management (CM) will generate weekly reports on readmissions and discharges, and daily reports on our inpatient members, to identify admissions and readmissions that were avoidable or potentially avoidable and monthly reports on top ED diagnoses and members using the ED at least 3 times over a 6 month period
- QM staff will monitor and collect data as needed to determine whether PCPs are conducting assessments for behavioral health and substance abuse issues and referring to specialty providers for evaluation and treatment as required
- QM staff will generate quarterly reports to assess provider compliance with our clinical practice guidelines (CPGs), and several of the indicators on our provider profiling reports will measure compliance with CPGs and identify outliers
- QM staff will monitor reports of member and provider grievances and appeals to identify potential issues with provision of medically necessary or functional support services and satisfaction with NTC operations

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. (5 page limit)

Nebraska Total Care (NTC) will build from its parent company Centene Corporation (Centene)'s ***more than 30 years*** of managed care experience, currently serving over 4.8 million members through government sponsored programs across 23 states, to implement strategies for improving quality indicators for Nebraskans. Practical use of performance measure results is fundamental to the culture of quality that permeates NTC's daily operations. HEDIS and other performance rates are not just produced to meet mandated reporting requirements. Rates are produced monthly and outcomes are validated for data accuracy; compared to national, regional and local thresholds; investigated for opportunities for improvement; and analyzed against interventions and progress toward goals. Our QI staff analyzes and tracks a variety of performance and outcomes data to identify potential areas for improvement in clinical outcomes or service delivery. In the table below, we provide a sample listing of performance measures used to analyze delivery of service and quality of care.

Table 70.1 Sample Listing of Performance Measures

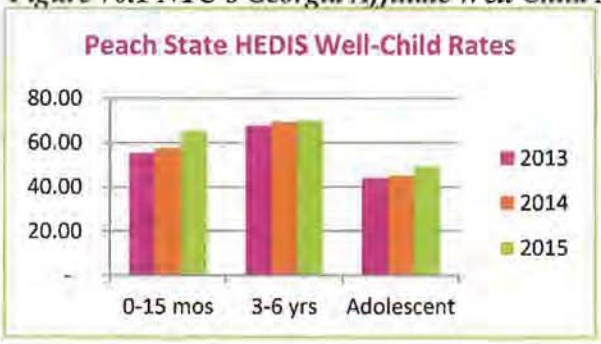
Category	Performance Measures
Over- and Under-Utilization	Emergency room visits/1000; admissions/1000; inpatient average length of stay; NICU days/1000 and NICU average length of stay; narcotic prescriptions, prescribers and pharmacies; child and adult preventive health screenings; immunizations; prenatal and postpartum care
Management of Chronic Conditions	Prescriptions for and compliance with recommended medications for chronic conditions (e.g., asthma, heart disease, sickle cell disease, and diabetes); screening tests and ongoing monitoring such as diabetes screenings
Acute Disease and Conditions	Flu vaccines; appropriate treatment of pharyngitis; upper respiratory infection and acute bronchitis; gestational age and birth weight
Reduction in Health Disparities	Utilization of services by race/ethnicity/language and geographic location; access to care including primary care and specialty providers; use of interpretive and transportation services

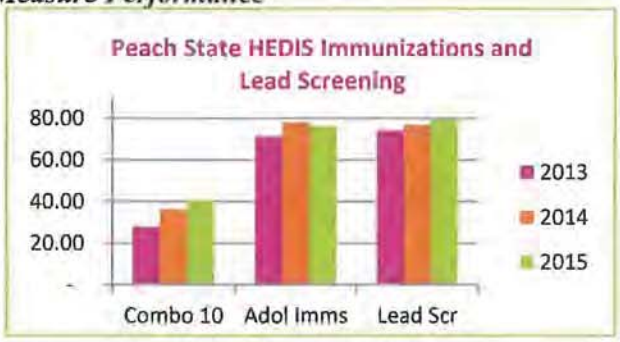
Each Centene plan has an interdepartmental committee that reviews monthly performance measures rates, progress toward goals and effectiveness of interventions, as appropriate. Centene's Corporate Executive Steering Committee also reviews all plans' outcomes routinely and works to identify best practices, sharing that information across all plans. In this way, we ensure that our experience using results of performance measures directly affects the quality of care provided to members.

Experience Using Results of Performance Measures

Centene and its affiliate health plans have been recognized over the years for their commitment to providing clinical and service excellence to the members they serve. We have also been repeatedly recognized nationally. For example, our asthma management program (Environmental Protection Agency) and health risk assessment and diabetes education for patients with serious mental illness have been recognized by Medicaid Health Plans of America Center for Best Practices. We have experience using nationally recognized performance measures to monitor and improve the health outcomes of members. Based on evaluation of HEDIS measures alone, Centene health plans have developed, implemented, and measured more than 300 data driven improvement initiatives over the years. Using these QI models and tools, NTC affiliates have produced statistically significant improvement in member outcomes. Highlights of our affiliate health plan activities are provided here. Well-Child Measures. Ongoing monitoring of CMS416 and HEDIS measures reflects the success of multiple EPSDT/well-child strategies in our Centene affiliate Medicaid plans across the country. For example, NTC's ***Georgia*** affiliate (Peach State) has made significant improvements in CMS 416 Screening Ratios since their inception in 2006. The 2006 Georgia baseline, as reported by CMS was 59%. Peach State has shown statistically significant and sustained improvements over the past 8 years with a 2014 Peach State CMS 416 Screening Ratio of 79%. Congruently, Peach State's performance on EPSDT-related HEDIS measures have also shown year-over-year improvements as displayed in the charts below.

Figure 70.1 NTC's Georgia Affiliate Well Child Measure Performance





NTC's ***Texas*** affiliate (Superior) has achieved statistically significant improvements in all of their well child measures, many exceeding the ***NCQA HEDIS 75th percentile***. Superior has also achieved excellent results for well-child visits for children in foster care; achieving rates in the ***NCQA HEDIS 90th percentile*** for Medicaid Health Plans. NTC's ***Wisconsin*** affiliate, Managed Health Services (MHS-WI), implemented several activities to improve their rate of lead screening in children including outreach campaigns and provider education on the use of point-of-care blood lead testing technology. MHS-WI achieved significant performance improvements on the Lead Screening measure each year from baseline to HEDIS 2014, ***exceeding the NCQA national Medicaid 75th percentile*** with a score of 84.01%.

Diabetes Management. Our ***Indiana*** affiliate, Managed Health Services (MHS-IN), has been reporting HEDIS since 2004, longer than all other Centene health plans. In Q4 2013, MHS-IN began offering mail-in lab testing as an option to members with diabetes and cardiovascular diagnoses who had documented gaps in care. The kit contains the items needed to draw a blood and/or urine sample along with instructions on how to send their samples in for processing. Since initiation of the in-home testing option, the HEDIS HbA1c testing rate has increased from 73.38% (2012) to 79.44% (2015) and the HEDIS nephropathy screening rate has increased from 61.17% (2012) to 67.50% (2015) among Hoosier Healthwise Medicaid program members with diabetes. Similarly, the HEDIS Diabetes Screening rate among Hoosier Healthwise Medicaid program members with schizophrenia or bipolar disorder who use antipsychotic medications has increased from 71.13% (2013) to 75.00% (2015). **Preventive Health Screenings.** NTC's ***Georgia*** affiliate, Peach State, implemented interventions such live calls to members aged 50-74 who had not received their preventive health screening. Peach State also mailed postcards to members who were not reached by telephone and provided an incentive to members who scheduled their appointment and attended the scheduled exam. Data show that 230 of 338 eligible women age 50-74 received breast cancer screening in 2013, for a rate of 72.96%, improvement from 56.46% in 2012. This rate also exceeded the Georgia state Medicaid agency's target of 56.58%.

Experience Using Member Satisfaction Data Results

NTC will build from the lessons learned and emulate the best practices of our affiliate Centene health plans who have used a variety of methods such as satisfaction surveys, direct feedback (both formal through advisory committees and focus groups and informally through member calls), and analysis of grievances and appeals to assess member satisfaction and drive change. The most significant awareness of our member's perspective of our operational processes and programs comes from Centene's Strategic Insights department. In 2014, the department conducted a "member journey mapping" exercise identifying common themes from member feedback –communicate effectively, provide access to needed information, be respectful, and empower through education. From this assessment, the Strategic Insights department implemented its C.A.R.E (communication, access, respect, and education) initiative through which cross-departmental task forces were established and challenged with creating a work plan to address the opportunities identified for improvement in each area. For example, the communication workgroup was tasked with streamlining the initial welcome and health risk screening process based on

feedback and has subsequently redesigned our online version of the health risk screening and established new member incentives. The access workgroup, challenged with providing better/faster access to personalized service, developed business requirements for live chat functionality on our Member Portal. The respect workgroup developed education and training about the journey mapping process and findings and has presented it to senior executives across all health plans. Finally, the education workgroup was tasked with redesigning of member education materials. Starting with our California affiliate, this group redesigned our new member welcome packet to include a benefits booklet that provides key highlights of benefits and programs available from the health plan and further described in the Member Handbook and on the Member Portal, as well as FAQs for how to use our website and Member Portal. Centene will evaluate the effectiveness of these interventions over the next year through the analysis of member satisfaction survey results, feedback from focus groups and review of utilization data.

Experience Using Other Data to Drive Improvements

Birth Outcomes. Centene manages over 100,000 Medicaid deliveries per year in multiple states and uses our Start Smart for Your Baby® program to identify and stratify pregnant women through the use of notification of pregnancy (NOP) assessments and provides members with individualized care plans, education, incentives, support and other tools. Early identification of pregnant women and their risk factors through the NOP process and the monitoring of claims data is a crucial element in improving delivery and birth outcomes. With the help of the program, the percentage of low birth weight (1500 to 2499 grams) deliveries has decreased from 9.23% at baseline to 8.32% in 2014 ($p < .01$), while the percentage of very low birth weight (250 to 1499 grams) deliveries has decreased from 1.75% at baseline to 1.51% in 2014 ($p < .01$). These reductions have resulted in substantial savings. Given the volume of deliveries covered, we estimate that the program ***reduced neonatal costs by over $20 million in 2014*** alone. **Discharge Planning and Transitions of Care.** NTC's affiliate health plans have implemented best practice, evidence based transition of care programs, such as the Coleman Model, to ensure effective transitions and reduce unnecessary readmissions. Our successes in improving transitions across health care settings is supported by an interdisciplinary Care Team approach and includes early discharge planning and direct member outreach post-discharge to ensure effective coordination of care. NTC will implement similar models as those described below. In order to reduce 30 day readmissions for its long term care non-duals population, our ***Arizona*** affiliate, Bridgeway, implemented a Transition of Care program focused on members with multiple admissions or chronic conditions. On a daily basis concurrent care review nurses or care management staff reviewed inpatient census reports to identify members in need of transition of care interventions. Various interventions were implemented based on the particular need identified including referring members to care management and providing assistance in setting PCP appointments within seven days of discharge. Bridgeway's Transition of Care program contributed to a significant decrease in readmissions with only 37 readmits occurring for the year compared to baseline of 104. NTC's ***Georgia*** affiliate, Peach State Health (Peach State), won a Dorland Case In Point Award in 2014 for best practices in readmission avoidance interventions for its Transitional Care Program, which incorporates onsite clinical resources, member and provider engagement and education, coordination of care and services, and promotion of self-management skills to achieve a seamless transition for the member and reduce readmission risk. Peach State's concurrent review nurses and social workers conduct onsite discharge planning at 15 facilities statewide with high volume admissions or longer than average lengths of stay. Our onsite staff provides member education and coordinates with hospital staff, members, and providers to assess member readiness to discharge as well as to determine post-discharge needs. Our onsite staff include a specialized NICU team comprised of highly experienced NICU nurses and a neonatologist. These Care Managers work closely with the treating physician, hospital staff, member and family to develop a discharge plan that meets short-term care needs while supporting long-term improvements in health status to ensure a seamless transition for the member. A Care Manager conducts post-discharge follow up with the member within 24-48 hours of discharge. During the call, the Care Manager verifies that the member has been able to get prescriptions, equipment, and supplies; gains

insight into the member's/family comfort level with the services/equipment in the home; asks questions related to the member's condition and reconfirms the knowledge level and adherence to the discharge care plan. Our staff also educates the member about how to contact the provider when complications arise and how to use our 24/7 Nurse Advise Line. This early outreach allows the Care Manager to identify problem areas early and address those accordingly, and members and their families find these contacts very helpful and reassuring. As a result of implementing the onsite care management with post hospitalization follow-up outreach initiative, the overall seven-day readmission rate has decreased 66% year-over-year and the ***14-day readmission rate decreased by 88%.*** In 2014, NTC's ***Ohio*** affiliate, Buckeye Health Plan (Buckeye), initiated several interventions to improve effective transitions of care. Through the program, Buckeye allowed its prior authorization staff to auto-approve an initial and follow-up home health visit; increased its home health benefit to twice per day and allowed 75 visits per year; and implemented their "Get Well" program, through which a MemberConnections Representative visits the member in the hospital prior to discharge to deliver self-management educational materials. In pilot group 4 alone, they achieved ***more than a 45% decrease in readmissions.***

Emergency Room Diversion. For members with unusually high ER utilization, NTC's affiliate health plans have implemented multi-dimensional programs for monitoring and reducing ER services that rely on identification of frequent ER users, outreach and education by dedicated staff, and an emphasis on primary care. The strategies we have used for our ER Diversion Program have a proven track record of reducing inappropriate ER utilization. For example, our ***Indiana*** affiliate's ER visit rate for these members dropped 48% from 2009 to 2010. NTC's ***Missouri*** affiliate, Home State Health, saw ***ER utilization reduced by 14%***. In addition, 60% of members who received outreach through this program discontinued inappropriate use of the ER 90 days after outreach. In a related quality improvement project, oral health initiatives implemented by our Missouri affiliate in 2013 resulted in a decrease of 88.8% in ER visits for dental issues. Our ***Florida*** affiliate has started using a daily electronic data file from participating hospitals, which was created from the hospitals' Admission, Discharge and Transfer (ADT) registration data. A Care Manager reaches out to each member or applicable caregivers to educate the member on the importance of following up with his/her PCP; discuss and address any possible barriers; assist the member in making any appointments for needed follow-up care; and explain key benefits such as the 24/7 Nurse Advice Line, care management and disease management services. Florida saw a ***46% decrease in ER utilization*** between 2012 and 2013.

Nebraska Total Care's Florida affiliate has started using daily Admission, Discharge and Transfer (ADT) registration data – they have seen a ***46% decrease in ER utilization.***

Sickle Cell Disease Management. In a similar program, Centene's Clinical Programs team developed a comprehensive program that includes proactive education and care coordination specifically aimed at improving adherence to treatment with hydroxyurea for members with sickle cell disease (SCD). Data on emergency room (ER) and inpatient (IP) visits, acute chest episodes, co-morbidities such as asthma and depression and hydroxyurea candidacy are used to effectively prioritize and manage our members with SCD to provide them with timely outreach and the best quality of care. Our results show that, as the number of members in care management increases, we see a decrease in ER visits, IP visits, and pain crisis visits. The program has shown a 21.3% decrease in ER visits PMPM ($p<0.01$), a 25.5% decrease in ER crisis visits PMPM ($p<0.01$), a 19.8% decrease in IP visits PMPM ($p<0.01$) and a 20.3% decrease in IP crisis visits PMPM ($p<0.01$). This resulted in savings of over $860,000 in 2014.

Pychotropic Medication Utilization Review. Seven of our affiliates have implemented psychotropic medication utilization review (PMUR) to evaluate use of these drugs, particularly in members under five years of age and in instances of polypharmacy utilization. PMUR is one tool used as part of a broader medication monitoring process. The PMUR process includes pharmacy claims review, medical record review, and peer-to-peer consultation and education. PMUR is generally well received, partly due to being a retrospective review process that does not interrupt service while changes are made. It is very much a collaborative process, particularly for providers that are PCP/Pediatricians and do not have a behavioral health (BH) background. Since implementing the PMUR process in Texas, there has been a dramatic decrease in polypharmacy due to physician awareness of and improved compliance with quality and clinical practice guidelines. Between 2008 and 2013, the program has achieved a 22 % decrease in overall psychotropic drug use, a class polypharmacy utilization decrease of 36 %, and a 42 %decrease of using five or more medications for Texas foster care program members.

*Between 2008 and 2013, our Texas affiliate's PMUR program has achieved a **22% decrease in overall psychotropic drug use**; for children in foster care.*

Substance Use in Pregnancy. This best practice program identifies pregnant members with addiction problems and provides integrated care management through our obstetric nurse Care Manager and behavioral health clinician. Care Managers assess the member's readiness to change and focus on moving her through the stages of change related to addiction treatment. Medication-assisted treatment with Subutex or methadone can replace the need for dangerous prescription or street drugs and prevents the pregnant member from going into withdrawal, which can be dangerous for the fetus. Subutex is particularly encouraged, as it has been shown to reduce the rates of infants with neonatal abstinence syndrome (NAS) and also NICU length-of-stay[8,9]. This program was initially piloted by our Ohio affiliate health plan, Buckeye Health, and received the 2014 Ohio Association of Health Plan's (OAHP) Pinnacle Award for Best Practice Healthcare Programs. Early data shows that our Buckeye's neonatal inpatient length-of-stay was reduced to an average of 13 days among infants delivered to mothers enrolled in the Substance Abuse in Pregnancy Program. Comparatively, the average inpatient length of stay for NAS infants in Ohio ranged from 20.1 in 2008 to 15.9 days in 2011. Most recently Buckeye's Addiction [Substance Use] in Pregnancy Program was honored with the Medicaid Health Plans of America Best Practices Compendium - Maternal Health Award.

Overall Effectiveness of Care Management Programs. Centene's Outcomes Efficacy Analytics team conducted a retrospective case-control observation study evaluating medical costs and HEDIS compliance rates for members in care management. The study analyzed claims data for members under the age of 64 who were enrolled in care management across Centene health plans during 2014. Our results show statistically significant savings in inpatient (-$226 PMPM) and emergency (-$19 PMPM) costs for managed members compared to the control group. Additionally, the study concluded that case-managed members had significantly higher compliance rates for several HEDIS measures compared to the control group.

Table 70.2: Effectiveness of Care Management

HEDIS Measure	Improvement
Breast Cancer Screening (BCS)	18.43%
Cervical Cancer Screening (CCS)	12.16%
Colorectal Cancer Screening (COL)	6.94%
Comp Diabetes Eye Exam	13.15%
Comp Diabetes HbA1C Testing	4.94%

[8] Kakko J, Heilig M, Sarman I. Buprenorphine and methadone treatment of opiate dependence during pregnancy: Comparison of fetal growth and neonatal outcomes in two consecutive case series. *Drug Alcohol Depend*. 2008.96(1-2):69-78. doi: 10.1016/j.drugalcdep.2008.01.025.
[9] Nocon, JJ. Opioid Dependence in Pregnancy- an Evidence-Based Toolkit. Indiana Perinatal Network. http://www.indianaperinatal.org/news/news.asp?id=105526. October 15, 2012.

71. 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 page limit)

Nebraska Total Care (NTC) will assess the quality and appropriateness of care furnished to members with special health care needs (SCHN), members with co-occurring physical health and behavioral health concerns, and dual-eligible members through both our quality improvement program and through our integrated care coordination/care management program.

Examples of Specific Quality Assessment and Monitoring Strategies for Special Populations.

SHCN Fall Prevention. Members taking immune globulin therapies are usually older adults with neurological disorders and at risk for falls because of numbness, tingling, and sensation loss in the lower limbs. Fall injuries can impede Members' ability to self-care and live in the least restrictive environment. Injuries also add to health costs. NTC's internal specialty pharmacy affiliate, AcariaHealth, has developed a clinical IVIg program that includes Fall Risk interventions for Members who are at greatest risk for falls. A clinician or pharmacist counsels high risk Members on preventing falls on a monthly basis, and informs the Member's Provider of the Member's risk level. They counsel moderate risk Members on a quarterly basis. From March to October 2015, AcariaHealth **counseled 29 Members, and estimates the interventions avoided about $1,763,867 in emergency room and hospital stay costs.**

Co-occurring Physical and Behavioral Health Conditions and PMUR. To ensure appropriate psychotropic drug utilization, particularly for individuals with complex BH conditions or co-occurring PH and BH conditions with a complex medication regimen, NTC will implement our **Psychotropic Medication Utilization Review (PMUR)** Program. PMUR is based on our Texas affiliate's successful program originally implemented for children in substitute care. NTC's PMUR program, which reviews all filled psychotropic medications, will support PH and BH prescribers with Member oversight and treatment, reduce polypharmacy, reduce adverse drug effects (including obesity), reduce unnecessary drug costs, and identify where psychosocial interventions may be more effective or needed to complement drug therapy. The program also identifies Members that may be appropriate for Integrated Care Management. Since implemented in TX in 2008, **PMUR process have reduced overall psychotropic medication use in foster children by almost 23%; class polypharmacy utilization by 36%; and use of 5 or more medications by 42%.** NTC's PMUR will include a Metabolic Screening Review to help prescribers address avoidable weight gain and risks for associated metabolic issues that are common side-effects of psychotropic medications. ***Co-occurring PH and BH Conditions and Drug Seeking Behaviors.*** NTC will develop ongoing or ad-hoc DURs when we identify opportunities for drug utilization improvements through sources such as medical and pharmacy claims, utilization management reviews of medical services, feedback from Providers and Members, and recommendations from Nebraska's or NTC's P&T Committee. We will continually evaluate opportunities for DUR improvements, such as in response to sudden drug cost increases and evolving industry standards. One example of a ***specialized, ad-hoc DUR*** recently occurred with our Georgia affiliate in response to national trends regarding individuals seeking narcotics at emergency rooms (ERs). Our affiliate used pharmacy and medical claim data to identify hospital ERs with high narcotic prescribing and contacted at least 10 hospital ER directors to educate them about the findings, and encourage them to change prescribing policies and participate in tracking frequent users. ***Dual-Eligible Care Gap Review.*** The Medical Management Coordinator and QM Coordinator will review monthly utilization reports to identify dual-eligible members for whom over- or under- utilization indicates outreach is needed to prevent or address gaps in care. When potential gaps are identified, Quality Assurance and Performance Improvement (QAPI) staff will work with Medical Management staff to conduct case studies and determine whether medically necessary services are being provided. For example, staff will track claims data back to a particular case to see where we can improve our interventions and services to both the member and providers. The QM Coordinator will submit quarterly and annual reports on findings to the QAPI Committee for improvement recommendations as needed.

Monitoring for Appropriateness of Care through Quality Improvement

NTC staff will conduct a wide range of monitoring activities related to the quality and appropriateness of care provided to our members. Key examples of these activities are described below.

Adherence to Evidence-Based Guidelines. The QAPI Department will generate and analyze monthly reports to assess provider compliance with distributed clinical practice guidelines (CPGs), and several of the indicators on our annual provider profiling Overview Reports will measure compliance with CPGs. Our Medical Director will review these reports quarterly and educate providers who are not providing care according to guidelines. For example, if a PCP has diabetic members who are not receiving annual foot exams, the Medical Director will discuss evidence-based CPGs relating to diabetes with the provider and encourage them to refer for podiatry services. The Medical Director will report results quarterly to the QAPI Committee for improvement recommendations. ***HEDIS.*** The QM Coordinator will generate monthly HEDIS-like reports, using administrative data, to track performance toward goals and identify care gaps for individual members. Medical Management staff will review these reports monthly and the QAPI Committee quarterly to identify and address trends and monitor improvement initiatives. Our Arizona affiliate, Bridgeway Health Solutions, implemented a Case Management Monitoring Tool that increased ability to capture data for HEDIS-like measures, particularly for dual members. As a result, Bridgeway achieved a 94% rate for LDL screening, increasing its rate from the previous year by 50%.

Data Integration. NTC's IT modular system is designed for total data integration that supports both our QAPI program, as well as our utilization management and care management functions. That integration is operationalized in key ways that support our ability to assess the quality and appropriateness of care furnished to members with special health care needs, members with co-occurring PH/BH concerns, and dual- eligible members. For example:

- Using 3M's Potentially Preventable Event (PPE) software, an integrated component of our Centelligence analytics platform, we will systematically **analyze claims data to identify PPEs** (including Potentially Preventable ER Visits, Admissions, Readmissions) and work with Providers to ensure care is delivered in appropriate settings.
- We support medical and behavioral health administration on one IT platform;
- Our customer service software (CRM) is integrated with all core IT components;
- We integrate a comprehensive range of clinical and administrative data systematically via a high performance Enterprise Data Warehouse (EDW), itself an integral component of our Centelligence™ data integration and analytics platform;
- All NTC departments and internal affiliates use and communicate via one common office data, voice, and video system.

Over/Under-Utilization Analysis. To fully understand the utilization trends of our members and providers, as well as the underlying causes, NTC will analyze a variety of utilization data "snapshots." The UM Committee will analyze data at aggregate and detail levels including by member, individual provider or facility, provider specialty, type of service, diagnosis, place of service, and by comparing services authorized to services received. Routine monthly trend reports will allow staff to monitor key utilization measures such as inpatient admissions and days, ER visits, and specific preventive care services. The UM Committee will establish benchmarks using industry standards, national Medicaid HEDIS averages, or MLTC thresholds. We will also develop internal benchmarks based on historical data that reflect variances in population demographics, seasonal variations, cultural disparities and regional characteristics of our members. Each report will include a drill-down capability to more specific areas of interest. For example, when analyzing ER visit or inpatient utilization, staff will look not only at total number of visits or days, but also at the utilization in relationship to readmissions, frequent ER utilization, or presence or absence of physician office visits. We can look for patterns of under- or over-utilization by provider, by member, and by county. They will use these reports to target member and provider outreach, engagement and education, and to identify members for inclusion in our ER Diversion Program. ***Provider Profiling for lack of adherence to CPGs.*** We profile provider prescribing patterns, including patterns that deviate from clinical practice guidelines in the use of controlled narcotics and psychotropic medication.

Centelligence™ integrates data from internal *and* external sources, producing actionable information, everything from care gap alerts to online dashboards, Provider profiling analyses, population level health risk stratifications, and NTC quality management, utilization management and operational reports, as well as MLTC required standard and ad hoc reports. ***Enrollee and Provider Feedback.*** The QAPI Department will analyze monthly reports of member grievances, provider complaints, and appeals, as well as annual member and provider satisfaction surveys and input from our Member Advisory Council, and Clinical and Provider Advisory Committees to identify potential issues with provision of medically necessary services. The Department will forward identified trends to the QAPI Committee quarterly for recommended corrective action.

Monitoring Appropriateness of Care Through Care Coordination

NTC's care coordination program will include a system to monitor member receipt of recommended care. As part of the care planning process, our Care Managers (CM) will schedule follow up discussions with members and will review the member's care plan at each interaction, **confirming receipt of services** and that the services continue to meet the member's needs. NTC's member care plans are documented in TruCare, including member responsibilities. This information is available to the CM during each member interaction. During conversations with members, CMs are able to review the information and ask members if they are complying with expected receipt of services, such as provider visits or medications, and with agreed upon behavior modifications, such as dietary changes or stopping smoking. The CM may also contact a member's provider directly to confirm that they are attending scheduled visits or to inquire about vital signs such as blood pressure or weight as a means to assess care plan compliance.

NTC will also use Centelligence reporting to monitor receipt of services. NTC will use medical, behavioral health, LTSS and pharmacy claims to generate these reports. These reports will allow our CMs to ensure that members are attending scheduled appointments and refilling prescribed medications. NTC will also use available lab data to determine if members are adhering to care plan requirements such as dietary modifications, which should result in improved HgA1c values for members with diabetes or lower cholesterol levels for members with previously reported high cholesterol levels. ***Care Gaps***. The Care Team staff will review quarterly reports of measures such as rates of occurrence for certain diagnoses, pre-term delivery, NICU admission, re-admission, complications of care (sentinel events), never events, inpatient length of stay, and relevant HEDIS measures to identify potential gaps in needed services. When potential gaps are identified, QI staff will work with Medical Management staff to conduct case studies and determine whether medically necessary services are being provided. Staff will track claims data back to the case to identify how to improve services to the member and providers. ***Member Panel Roster and Special Needs Registry.*** PCPs also have access to a comprehensive Online Member Panel Roster (Roster) and Special Needs Registry (Registry) of assigned members. Care gaps are displayed when the provider views their Rosters. The Registry provides information on the member's Special Health Care Needs status and major conditions and allows the PCP to view, print, or export to Microsoft Excel all members under their care, with summary and detail information on each member. ***Interdisciplinary Case Reviews.*** For our more complex members, including SHCN, PH/BH co-occurring and the dually-eligible, NTC will conduct biweekly and ad hoc Interdisciplinary Case Reviews. We have five Interdisciplinary Case Review teams: adult complex medical, pediatric complex, high risk OB, NICU, and Behavioral Health. Each team is comprised of staff from Care, Disease, Utilization, and Pharmacy Management and led by a Medical Director with relevant experience. The Case Review teams evaluate the appropriateness, variety of care, utilization, and chronic care management solutions in each situation as well as comorbid medical and behavioral health and substance abuse issues, including the impact of treatment and care for one condition has on the other. ***Avoidable Admissions/Readmissions.*** The Care Management leadership will generate and analyze weekly reports on readmissions and discharges, and daily reports on our inpatient members to identify admissions and readmissions that were avoidable or potentially avoidable. The Medical Management Coordinator will review this analysis monthly to identify potential areas for improvement in interventions and services.

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. (2 page limit)

Community engagement is a key cornerstone in NTC and our parent company Centene's approach to serving Medicaid populations. This includes members, families, caregivers, providers, state agencies, community agencies, schools, churches, associations, and other key stakeholders. This engagement starts with our initial introduction to the market. To customize and ensure barriers to care are understood and addressed adequately, we incorporate community level input from all constituents. Soliciting feedback and recommendations from a range of advisors in the communities ensures our service and programs are tailored for the needs of the unique populations being served. A range of input from different providers (e.g. PH, BH, LTSS, Pharmacy) and members with different needs (e.g. cultural needs, clinical needs, social needs) also promotes integrated approaches and caring for the whole person. Individual perception of care and services can also affect service utilization and member wellness and can indicate not-yet-evident trends that need to be addressed before they become pervasive.

Processes for Soliciting Feedback and Recommendations

NTC will actively seek and document member, family, caregiver, provider, and other key stakeholder input on our programs and performance. Methods and frequency are described in ***Table Q72.A*** below.

Table Q72.A Sources and Mechanisms to Encourage Feedback

Methods and Frequency			
Stakeholder (member, family/caregiver, provider, community representatives, etc) participation in quality committees and advisory groups	Meetings held Quarterly	Sources: QAPIC, Member Advisory, Clinical Advisory, Provider Advisory, P&T, Behavioral Health and Tribal Healthcare Advisory Committees	Stakeholders are asked to review programs and documents (e.g. member materials, satisfaction surveys, QM program) and report on perceptions, concerns, recommendations, and general plan feedback. Information collected is documented in meeting minutes and assigned to appropriate staff to follow up. Information on how the feedback was used is then brought back to the committee and measured and monitored as appropriate.
Member and provider satisfaction surveys	No less than Annually	Sources: CAHPS, Annual Provider Satisfaction Survey, Care Management Survey	Surveys are a direct source for identifying and designing interventions. Information is reviewed at the committee level and then a workgroup assigned to develop improvement initiatives and communications to address opportunities for improvement and maintain strengths.
Trends in member and provider grievances and complaints	Reviewed Monthly	Sources: Trend reports on member appeals, grievances and complaints and provider grievances and complaints.	Trend reports are reviewed with the QAPIC and other appropriate committees for additional feedback and appropriate intervention. Reports are sorted by different member demographics, providers, subcontractors, and other identifying variables.
Operational contact points	Ongoing	Sources: Provider visits, trainings and calls; incoming and outgoing member calls; CM outreach; community trainings and forums; and staff participation in community events	NTC will use every point of stakeholder contact as an opportunity to solicit and document feedback as appropriate. Information collected through these interactions will be maintained in the appropriate system (e.g. CRM, TruCare) and then consolidated and analyzed through our Centelligence™ data platform. Immediate issues and concerns are addressed in real time, with appropriate documentation to ensure follow up and inclusion in future analytics as indicated.
Targeted channels	As needed	Sources: Focus groups, targeted outreach	NTC will solicit specific feedback on new programs, proposed interventions, and as a method for evaluation. Targeted outreach may focus on subpopulations such as child welfare, Tribal, IDD, and homelessness.

Using Feedback to Improve Quality of Care

NTC will use the input and recommendations received through all of these channels to improve programs and plan performance. Issues and trends identified are reported up to the QAPIC where the QM team or impacted business unit makes recommendations for improvement initiatives which are monitored and tracked through the QAPI process. Examples of how our affiliate plans have implemented change as a direct result of stakeholder feedback are included in ***Table Q72.B*** below.

Table Q72.B Examples of Using Stakeholder Input to Improve Quality of Care

Using Stakeholder Input	
Stakeholder (member, family/caregiver, provider, community representatives, etc) participation in quality committees and advisory groups	In our Indiana health plan affiliate, Managed Health Services (MHS), the Member Advisory Committee (MAC) reviewed member materials printed on postcards and identified font size as an issue. The plan revised the content to incorporate a larger font that would encourage members to read the information contained on the postcard. In our Mississippi affiliate plan, they learned of mold issues on the coast and lack of new housing and type of housing in the delta. In response, the plan paid for mold removal and pest removal and facilitated moving members out of certain apartments, helping pay deposits to get them into healthy homes and apartments.
Member and provider satisfaction surveys	As a result of Provider Surveys, MHS improved their on hold messaging prompts so that providers were directed to the appropriate staff to address their inquiry, which has improved provider satisfaction and decreased call handle time metrics. Additional member satisfaction survey examples are described in Question 74 below. In our Massachusetts affiliate, CeltiCare, if membership files come over from the state without a PCP assigned, CeltiCare is required to assign them. Member feedback indicated dissatisfaction with being assigned a PCP that the member had not had an opportunity to choose. As a result, they changed the process so that, before a PCP is assigned, every member without a PCP assigned in the file is called to promote active PCP choice. Only after multiple attempts to reach a member by phone do they now assign a PCP without the member's input.
Trends in member and provider grievances and complaints	In our Missouri affiliate plan, Home State, the health plan received complaints from providers that after appropriate collaboration and due diligence resulted in the removal of a prior authorization requirement for obstetrical ultrasounds. CeltiCare saw appeals related to Pharmacy spike to 48 (64% of all appeals). Nine (19% of pharmacy appeals) were related to Suboxone treatment. The appeal trends indicated that CeltiCare's Suboxone policy was potentially too stringent and also there was difficulty obtaining clinical info needed to support medical necessity. CeltiCare updated the policy by removing a 6- month time limit on the medication to meet the needs of the population and ensure that all provider notifications clearly articulated what was needed to obtain approval. Following the intervention, Pharmacy related appeals declined to only 18 and have remained low based on continuous monitoring.
Operational contact points	In Arizona, our behavioral health affiliate responded to the needs of Native Americans by implementing a Tribal Warm Line, which employs tribal members who live in tribal communities, understand the culture, and offer non-crisis support line with respect to the member's culture. To address high claim denial rates for select providers at our Washington plan affiliate, Coordinated Care, the Medical Director conducted targeted outreach and education for an identified list of providers with the highest denials on claims. Similarly, our Texas affiliate, Superior, created Quick Reference Guide for UM procedures to help reduce denials based on lack of information.
Targeted channels	Home State learned in a member focus group conducted with pregnant women and mothers with young children that many participants believed it was dangerous to receive a flu shot while pregnant. This information led the health plan to develop outreach material that would explain the benefits and risks of flu shots and that it was in fact quite important for a pregnant woman to be immunized against the flu not only for her own health but for that of her baby.

3 page limit)

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.

Continuous Quality Improvement (CQI) is Nebraska Total Care (NTC)'s core business strategy. Building from the best practices of our affiliate health plans' more than 30 years of experience, NTC will use core CQI methodologies to identify, design, implement, and evaluate the effectiveness of interventions or process changes both in Performance Improvement Projects (PIPs) and in daily management throughout the organization. As part of our QAPI program, NTC will conduct a minimum of two clinical and one non-clinical PIP annually. At least of one PIPs will address a clinical issue of concern to the covered population, which is expected to have a favorable effect on health outcomes and Member satisfaction and a second clinical PIP will address a behavioral health concern. Additionally, NTC will participate in at least one (1) joint PIP with the other MCOs in the state. NTC acknowledges that topics for joint PIPs will be identified by MLTC. Our PIPs will be included in NTC's written QAPI program description, annual work plan, and annual program evaluation. Our PIPs will meet all relevant CMS requirements as outlined in Section M.7 of this RFP and be approved by MLTC prior to implementation. NTC will report the status and results of each project to MLTC as outlined in the Quality Strategy.

Proposed Performance Improvement Methodology

Using our QM Framework as noted in Figure 68.2, NTC will conduct a strategic analysis that an exhaustive review of demographic and epidemiologic data for our Members, as well as historical data about the Nebraska Medicaid population including HEDIS, CAHPS (adult and child), and other Nebraska Performance Measure data. We will use this analysis along with evidence-based improvement methodologies such as the Six Sigma DMAIC (Define, Measure, Analyze, Improve, Control) methodology to select, design, implement, and evaluate the effectiveness of interventions or process changes both in PIPs and in other quality improvement activities.

Identify Opportunities and Select Improvement Projects. NTC will identify opportunities and select improvement projects specific to the needs of our Members. QM staff will review qualitative and quantitative data using a variety of analytic tools to identify the most prevalent issues and those impacting multiple departments. Facilitated by Centelligence™, our award winning proprietary and comprehensive family of integrated decision support and health care informatics solutions, we will consider data such as:

- Demographic information relevant to health risks or disparities
- Related to conditions or risks for similar populations
- Utilization and condition prevalence trends
- Performance on clinical and operational performance measures
- Access and availability studies
- Quality of care complaint data
- Results of EQRO reviews, MLTC audits, and contract monitoring
- Member and provider grievance and complaint trends and satisfaction survey results

We also may implement additional PIPs based on quality improvement needs. We will engage in collaborative improvement activities with participating high-volume clinics and hospital systems as appropriate. NTC has identified Enhanced Health Network (formerly Regional Provider Network), CHI

Health, and the Munroe-Meyer Institute (MMI) as provider partners in our efforts to improve the health and quality of care our Members receive. For example, NTC's contracting team has met with Galen Bernadt from Lincoln ED Connections at Bryan Health to discuss opportunities for partnering on their emergency department (ED) super-utilizer program. Through this collaborative effort, Bryan East/West and St. Elizabeth's have joined together to track patients who frequently visit the ED and to offer those Member's care management services. They have identified many of these patients as 'drug seekers'. NTC discussed opportunities to share utilization data so that the ED has a broader perspective of the Member's utilization of services and filled prescriptions, identify and conduct outreach to Members who use the ED for non-emergent reasons who have not yet meet the superutilizer criteria, and refer Members to NTC's pharmacy lock-in program.

Design Objective and Well-Defined Performance Measures. The focus of projects may be clinical, quality of life or operational and address a spectrum of Members and services including physical health, behavioral health and LTSS. When possible, we will analyze preventive health and other care and service measures to compare differences by race/ethnicity and region (rural compared to urban). We will use evidence of disparities to help select the most appropriate target populations for our projects and to support collaborative preventive care projects with peer MCOs. NTC will emphasize preventive care services as the most efficient route to improved health outcomes, and will actively outreach to Members, using culturally appropriate educational materials, to encourage compliance with our evidence-based preventive care guidelines. We will measure our success in these efforts and use these data to guide project selection and to support our participation in collaborative projects with our network providers. Each PIP will include:

- Measurement of performance using objective quality indicators
- Implementation of interventions to improve quality
- Objective measurement of intervention effectiveness
- Activities planned to sustain or increase improvement
- Status reports and results to DHS and EQRO
- Timely completion to complement an annual reporting cycle.

NTC's QAPI Committee will evaluate and approve objective, well-defined, measurable indicators for each project such as HEDIS, CHIPRA or Agency for Healthcare Research and Quality indicators, or other MLTC-specified measures. We will use industry-standard operational indicators for projects involving, for example, call center, service authorization, or claims adjudication processes. We will determine a baseline and establish goals for each indicator that reflect the desired level of performance. Goals may be established as "perfection," an industry benchmark, MLTC requirement, or a projected percentage change from baseline measurement reflective of a demonstrable improvement.

Implement Improvement Activities. NTC's Performance Improvement Team (PIT) will solicit input from health plan and external subject matter experts, Members, providers, and community resources when considering interventions. With this input, QM and other staff will identify barriers to performance and develop interventions that specifically address the identified barriers and that are most likely to succeed. The PIT will establish implementation plans that include clearly defined, specific tasks to be accomplished by specific departments, accountability for each task, timelines for intervention, and a plan for how and when the effectiveness of the intervention will be measured. Most interventions implemented by our affiliates have been cross-departmental. For example, our Centelligence care gap alerts are visible to our care management and Member Services staff so that we can take advantage of every Member contact to educate and remind Members of preventive health services for which they are due. Care gaps are also visible to providers on our Provider Portal so that they can engage Members as well. Though clinical interventions may be coordinated by care or utilization management staff, QM staff will coordinate most interventions, monitor for effectiveness, and provide progress reports to the PIT. The PIT will track all interventions and report to the QAPI Committee.

Evaluate Progress. Regular, periodic re-measurement and assessment of success are basic components of NTC's improvement model. We will conduct both interim checks and assessments following full measurement periods, using rapid cycle PDSA methodology to test changes or additions to the intervention if there is no evidence of improvement. With that methodology we:

- **P**lan the change, needed data and the goal
- **D**o a trial of the changed intervention, documenting any barriers
- **S**tudy the results, comparing them to the goal
- **A**ct to further refine the intervention based on the results.

We then repeat the cycle with incremental changes to the interventions until improvement is achieved and sustained. NTC will re-measure each project's established performance measures, compare them to the established benchmarks and goals at the intervals determined at the beginning of the project, and test the comparisons for statistical significance. Intervals will be based on the timeframe in which an anticipated improvement in performance is expected to occur. To ensure comparability, the re-measurement methodology will be the same as that used for baseline measurement. We also may track additional measures related to the project, such as intermediate process indicators or Member or provider satisfaction, including monitoring the quality and appropriateness of care delivered to Members with special health care needs. If re-measurement does not demonstrate significant improvement and performance does not exceed established goals, the quality improvement cycle begins again. In such cases, the PIT, in conjunction with the QAPI Committee, will evaluate each intervention, identify barriers that may be interfering with the achievement of performance goals, and revise the intervention, or replace or supplement it with new interventions to address identified barriers. We will conduct re-measurement at periodic intervals, using the PDSA cycle, to test the changed or new interventions quickly and further redesign them as appropriate. We will consider improvement to be sustained if the level of performance is maintained or further improvement occurs one year after significant improvement has been achieved and if the improvement likely was a result of the project interventions. We will maintain successful interventions, report them to MLTC as possible best practices for other contractors, and communicate them as best practices to other Centene plans.

Examples of Successful Performance Improvement Projects

NTC's affiliates have implemented physical health PIPs and other quality improvement activities addressing issues related to: management of asthma and diabetes; children with special health care needs; preventive health screens for women; appropriate antibiotic use; emergency room and readmission rates; cancer screenings; EPSDT screenings; prenatal and postpartum care; breastfeeding; lead poisoning screenings; and immunizations. For example, in Georgia, two sequential multi-year PIPs yielded statistically significant improvements in several important childhood HEDIS measures – BMI Assessment: 22.69% to 47.69%, Counseling for Nutrition: 40.74% to 56.02%, and Counseling for Physical Activity: 29.40% to 47.69% (all from CY 2011 to CY 2012 with $p<0.0001$) and Childhood Immunization (Combo 10): 27.91% to 36.24% from CY 2013 to CY 2014 with $p<0.0003$. NTC's affiliate health plans also have conducted PIPs addressing behavioral health issues such as depression screening for adults and children, perinatal and postpartum depression, treatment of depression in primary care settings, community tenure for Members with schizophrenia, psychotropic polypharmacy and coordination of medical and behavioral health care. Non-clinical PIPs have included Member satisfaction, provider satisfaction, access to health plan Member services call center, primary care and specialty provider availability.

Collaborating with MLTC and Other MCOs to Conduct Statewide PIPs

NTC's affiliate health plans have extensive experience parting with state Medicaid agencies and other MCOs to conduct statewide PIPs. For example, several of our affiliates have statewide PIPs related to improving well-child preventive health screenings, prenatal/postpartum care, oral health and increasing HPV vaccination rates.

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. (1 page limit)

Approach to Annual Member Satisfaction Surveys

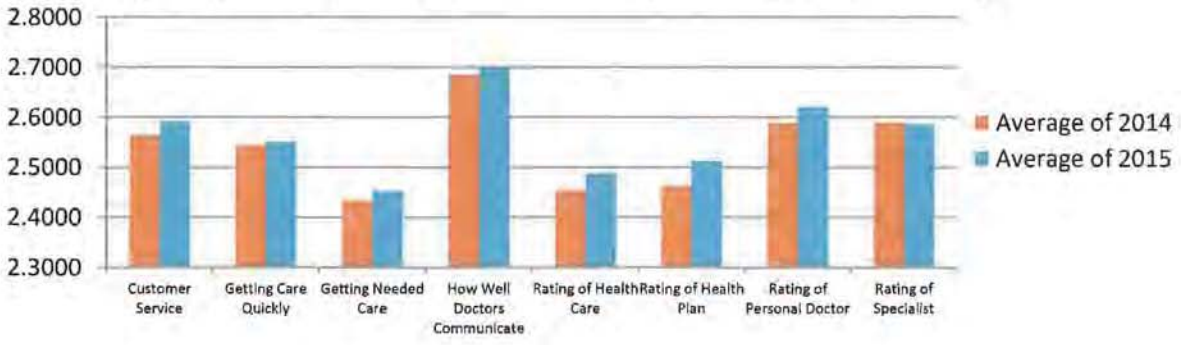
NTC will emulate the best practices of our affiliate Centene health plans and use a variety of methods such as satisfaction surveys, program satisfaction assessments, direct feedback (both formal through committees and focus groups and informal through member calls), disenrollment activity, turnover, and analysis of grievances and appeals to assess member satisfaction, and drive change. NTC will conduct annual CAHPS® surveys to assess the quality and appropriateness of services from our members' perspective. We will contract with , an NCQA-certified CAHPS vendor, to conduct the most current CAHPS Medicaid Adult and Child Surveys with a random sample of our population. In addition, NTC will conduct program-specific satisfaction assessments, for example, after participation in MemberConnections events, education activities, and Care and Disease Management Programs. Survey results will be reviewed by our Performance Improvement Team and Member Advisory Committee, with reports and specific recommendations for interventions or actions presented to the QAPIC.

Utilizing Results to Improve Quality

NTC will use all survey results to measure how well we are meeting member expectations and goals, identify opportunities to improve quality, and design QAPI initiatives to address gaps in performance. Some of the best practice interventions we have implemented across health plans include:

- ***Rating of Health Plan***. Outbound calls implemented for members with multiple inbound Member Service (MS) calls. Members that call multiple times may have unresolved issues and dissatisfaction with the information that was provided during the contacts with MS. A return call from a Supervisor/Manager provides members with a reliable source, improving member experience.
- ***Getting Needed Care***. While our Indiana affiliate, MHS's appointment access survey results indicated 100% compliance with State Medicaid appointment standards, the plan could see from CAHPS data that members were not entirely satisfied with access, so they changed their PCP auto-assignment logic from the State-required 30-mile radius to a 15-mile radius at the beginning of 2014. As a result, the Getting Needed Care improved from 86% in 2013 to 87.4% in 2014 and 90.7% in 2015.
- ***Customer Service.*** In response to scoring below the 75th percentile on providing necessary information/help, our Massachusetts affiliate, CeltiCare, redesigned their Quality Assurance program to focus on the content of the call rather than the framework and logistics. Customer Service Representatives were trained to take ownership of the call with an emphasis on first call resolution to ensure that issues are fully resolved as best as possible on the caller's first inquiry. The Quality Audit Tool and questions were redesigned to include 14 questions under the categories of Human, Business, and Process skills and questions weighted. The plan scores now exceed the 75th percentile.
- As a result of these and other improvement activities, we have seen the following results in CAHPS survey measures from 2014 to 2015 across all NTC affiliated health plans (***Figure Q72***).

Figure Q72: CAHPS Results Overall Average Rate Vs. Percent Change



(1 page limit)
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.

Submitting HEDIS Measures

Nebraska Total Care's (NTC) affiliate health plans have over a decade of experience submitting annual HEDIS measures to their respective state agencies and NCQA. NTC will use the best practices of our Centene affiliates and use Inovalon's Quality Spectrum Insight (QSI®) product, an NCQA certified HEDIS software, to calculate HEDIS rates and produce the HEDIS report. NTC affiliates have experience incorporating supplemental data sources such as state immunization registry and lab values and contracts with medical record vendors, such as Altegra Health to conduct medical record reviews for select hybrid measures as required by HEDIS technical specifications. Our NCQA certified HEDIS auditor, Attest Health Care Advisors perform the required audit of the HEDIS process.

In addition, we have experience with reporting Prevention Quality Indicators (PQI), CMS core measures and state specific measures in order to facilitate analytical review to assess the quality of care and service provided to members, and to identify opportunities for improvement.

NTC will supply claims and encounter data to the EQRO and will work collaboratively with MLTC and the EQRO to assess and implement interventions for improvement.

Submission by Product Line

Our Indiana affiliate, MHS has been administering an active, effective quality management and improvement program since their inception in 1995 and has been submitting HEDIS results since 2002. The program has demonstrated sustained improvements over time in objective measures such as HEDIS indicators and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys. Last year we submitted HEDIS measures for the following product lines enterprise wide:

Type	Count
Commercial	**7**
Medicaid	**35**
Medicare	**6**
SNP	**6**

NTC is prepared to generate and submit performance measures within the timeframe as outlined in Attachment 6. We will use Centene's reporting and data analytics team to customize any MLTC specific reporting requirements.

(2 page limit)
76. Provide the MCO's vision for the MCO's Clinical Advisory Committee. Discuss how the requirements of the RFP will be met.

Vision for NTC's Clinical Advisory Committee

NTC's parent company, Centene, has demonstrated strong and active provider engagement as a foundation to developing and sustaining its medical model throughout its 20 managed care states leading to excellence and best practices that will be utilized in Nebraska. NTC will recruit network providers, including primary, specialty, behavioral, pharmacists, and home and community based service providers, to participate at various levels throughout our QAPI Committee structure. We will invite practitioners who represent a range of specialties to serve on Committees such as the QAPI Committee, Clinical Advisory Committee, Credentialing Committee, Pharmacy & Therapeutics Committee, and Provider Advisory Committee. By including practitioners on our Committees, NTC ensures providers are involved in the implementation, monitoring and directing of the relative aspects of our quality improvement program.

NTC's Clinical Advisory Committee will report to the QAPI Committee and engage with other Committees to provide consultation or other assistance as needed. NTC envisions that our Clinical Advisory Committee will serve as consultative experts representing a range of specialties common in the Medicaid population. Our Clinical Advisory Committee will review and provide input into all care management and utilization management processes including clinical guidelines and UM criteria. Additionally, we will task our Clinical Advisory Committee in reviewing and providing feedback on proposed provider quality improvement activities as well as member and provider materials to be sent as part of these initiatives.

It is intended and will be incumbent upon the Clinical Advisory Committee to be prepared to work and collaborate with state agencies and divisions in ongoing studies, working meetings and the evolution and implementation of new policies and strategies across the provider communities to further the integration of all populations, benefits and services and to assure a meaningful transition into a fully integrated and whole person care coordination model. This will require the Clinical Advisory Committee and NTC support staff to prepare and sponsor continued learning and education throughout the provider community in the NTC network. This Committee will be required to work in collaboration with other NTC Committees to make certain the underlying Committee structure is working in concert and the body of work will be effective in delivering consistent outcomes.

The Clinical Advisory Committee will be required to consider ways in which the challenges such as geographical gaps of service, lack of PCP's, support services and co-existing conditions, as well as cultural obstacles existing in the Native American and refugee communities can be addressed and solved. This will include new approaches that include identifying alternative methods of Primary Care such as the innovative utilization of nurse practitioners and, ways in which PCP's can affect cultural differences, as well as mentor and support and community based providers to support and extend primary care services.

Meeting RFP Requirements for the Clinical Advisory Committee

NTC will establish a Clinical Advisory Committee that meets the requirements of the RFP as outlined in Section M.12 of the Scope of Work. NTC's Chief Medical Director will oversee the Clinical Advisory Committee to ensure that it meets RFP requirements and will serve as a Co-Chair along with an elected network practitioner. NTC's Clinical Advisory Committee participants will represent a variety of specialties and have experience caring for children, adolescents and adults across a variety of races and ethnicities. We will recruit participants from across the state to ensure that there is an awareness of differences between rural and urban populations. We will include physical and behavioral health providers as well as pharmacists. NTC has already begun outreach efforts to identify participants for this

Committee. NTC's partners, including ENHANCE Health Network (formerly Regional Provider Network), CHI Health, and the Munroe-Meyer Institute (MMI), a federally designated University Center of Excellence for Developmental Disabilities Education, Research and Service, have agreed to designate representatives for participation on this Committee. NTC's Clinical Advisory Committee will target quarterly meetings, but at a minimum will meet twice per year.

NTC will assemble its *initial Committee meeting at least 30 days prior to the contract implementation date* to approve the Committee Charter and review and approve our initial clinical practice guidelines and criteria. NTC's Clinical Advisory Committee will also assist with identifying new technologies or new use of existing technologies, particularly those that do not yet have InterQual criteria, and recommend criteria to guide medical necessity determination of the treatment. These recommendations will then be sent to Centene's Clinical Policy Committee for review and approval and distribution across all Centene health plans. NTC's Clinical Advisory Committee will also review existing and proposed CM programs and interventions including review of Member and provider educational materials. The Chief Medical Director, or designee, will maintain meeting minutes including approvals and recommendations. A summary report of the Committee's actions will be submitted to NTC's QAPI Committee quarterly.

In addition to the technical compliance and support of the RFP requirements, this Clinical Advisory Committee will be focused on participating in other deliverables required in the spirit of the RFP such as: participating in the framework and execution of Primary Care Providers engagement, education and training to effectuate their role in the provision of behavioral health (BH) services and the coordination of co-existing conditions; participation in Telehealth and traveling specialist programs; PCP adherence to Quality and Incentive measures; monitor and devise ways in which to engage PCP satisfaction and improvement of communication, feedback and solutions. The Network Provider Coordinator staff member will be integrally engaged in this Committee's activities and will pattern day to day PCP engagement and policies upon the work of this Committee.

The Clinical Advisory Committee will also be engaged with the several other like sister Committees that are engaged across the nation working to support PCP's in NTC's sister organizations. This will provide opportunities to continuously check on introduction of best practices, new strategies and to network the Nebraska PCP community outside of the state.

Much of the RFP's requirements either directly or indirectly include technology, data, claims and other IT related systems. The Clinical Advisory Committee will be in a unique position to include in its activities and discussions oversight of these systems and be a body that the PCP community can depend upon to advocate necessary changes or adjustments, education, training and other activities to improve upon the provider experience while at the same time support NTC's efforts to operate a stable system and improve and update pursuant to experience in Nebraska.

(3 page limit, excluding sample quality reports)
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.***

Profiling the Quality of Care Delivered by Providers

Provider profiling is a highly effective tool that compares individual provider practices to normative data, so that providers can improve their practice patterns, processes, and healthcare outcomes in alignment with evidence-based clinical practice guidelines.

Following the successful approach adopted by our affiliate health plans, NTC's practice of provider profiling is statistically valid and based on five key elements:

- Data will be normalized for variations (e.g. geography, panel size, population demographics, acuity and clinical conditions)
- Performance measure sets will be customized for each provider based on services provided
- Reporting will allow for easy identification of the problem
- Reporting will include drill down functionality so that providers can filter to specific tax ID numbers (TIN), national provider identifier (NPI), measures and/or members
- Frequency of reporting will be quarterly to provide sufficient data samples and allow adequate time for claims submission and processing

NTC's Profiling Program is based on five key elements:
- Normalized for variation
- Customized by provider type
- Easy identification of problem
- Drill down functionality
- Quarterly profile reports

Provider profiling increases provider awareness of performance, identifies opportunities for improvement, and facilitates plan-provider collaboration in the development of clinical improvement initiatives.

NTC will jointly develop our approach with participating providers to ensure the process has value for providers and members. Our Chief Medical Director (CMD) has final authority and responsibility for our provider profiling program, which encompasses a variety of provider types in addition to PCPs and OB/GYNs, such as behavioral health providers and facilities. Through the Quality Assessment Performance Improvement (QAPI), Clinical Advisory and Provider Advisory committees, we will work closely with providers to select profile indicators and help providers understand and use feedback to improve care. This collaborative effort fosters provider acceptance of profiling and helps NTC motivate providers to continuously improve performance in targeted areas. Our Provider Performance Specialists will work with assigned providers to educate them about the drivers behind performance and identify opportunities for improvement. We will conduct discussions directly with providers and work with them to develop action plans to improve their performance. Our Provider Performance Specialists are highly trained and have the necessary skill set to assist providers in accessing the tools available on our provider portal to understand and analyze data that can be used to improve their performance and the care provided to members.

NTC will use profiling reports internally to develop clinical programs, quality improvement initiatives and network contracting strategies. Our Provider Relations staff will share reports with providers and assist them to develop action plans to improve compliance with clinical practice guidelines and reduce the occurrence of provider preventable conditions. Profile reports will be available through our Provider Portal making them accessible to providers whenever they want to take action. Our Profiling Program incorporates the latest advances in this evolving area.

Sophisticated Analysis and Reporting Capabilities. To ensure the best possible results, we use both health plan and Centene analysis capabilities as the foundation for profiling, since effective improvement

requires complex analysis and feedback at several levels of the care process. Our provider profiles are produced from Centelligence™, our robust, integrated business intelligence platform, supported by Centene's TerraData-powered Enterprise Data Warehouse. Centelligence™ components can generate all required performance indicators, and have the additional capabilities of producing refined peer-to-peer comparison groups within specialties, regions, and programs, and risk-adjusting performance scores based on member acuity. Our profile reports for different provider types will include unique sets of indicators that are relevant to the services rendered by those providers and that promote compliance with evidence-based CPGs.

Determining How Many Providers Will Be Profiled

NTC will review program participation criteria annually to ensure that we include as many providers as possible in our profiling program, but will target providers with sufficient panel size to allow statistically valid comparisons. To this end, we initially profile all PCPs with a total panel size for an individual or group practice of 250 or more members. However, all PCPs will have access to personalized profile reports on our Provider Portal regardless of panel size. The QAPI Committee re-evaluates this panel size criterion and specialty types after each profiling cycle to ensure that we achieve our goal of maximum participation.

Determining Which Providers Will Be Profiled

Prior to the start of each profiling year, the QAPI Committee, which includes network primary care (including OB/GYN) and other specialist providers, reviews and approves the types of providers to be profiled; the participation criteria for individual providers or group practices; and the performance indicators to be used in the profiling reports. The QAPI Committee considers the average number of members served and the specific needs of enrolled members when determining the types of providers to include, such as cardiology and pulmonologist, as well as acute care hospitals. All primary care providers and select specialty providers meeting the minimum panel size requirements will be included in our profiling program.

Sample Quality Profile Reports

Please see attachments Att_77.a –Att_77.c for sample quality profile reports including primary care provider, behavioral health facility and cardiologist.

Rationale for Selected Measures

Each year, the QAPI Committee will approve profile indicators that provide a multi-dimensional assessment of performance, using clinical, administrative, and member satisfaction-related data aligned with the dimensions of the Triple Aim, MLTC's Quality Strategy, NTC's unique quality goals and the needs for the entire Heritage Health population being served. The indicators will be measurable, reliable, and valid; have available, reliable benchmark data; and be relevant to our members, providers, and our QM program. These categories address preventive health visits, screening for disease, management of chronic health conditions such as diabetes and heart disease, prescribing patterns and utilization of services. Reports for different provider types will have unique sets of indicators that are relevant to the services rendered by those providers and that promote compliance with evidence-based clinical practice guidelines. For example, internal medicine providers will have measures related to adult preventive care services while pediatricians will have measures related to well-child screenings. OB/GYNs will have measure related to prenatal and postpartum care. A family practice physician may have a combination of these measures depending on member age, diagnoses, and services provided.

To establish trends and to permit assessment of improvement efforts over time, we measure the same indicators for multiple years. NTC will continue to refine and develop key performance indicators that align with improving outcomes, Member experience of care, and reducing per capita costs.

Proposed Frequency of Profile Reporting

Each quarter, individual PCPs will receive a performance profile scorecard (along with scorecards at the group level for group practices) that includes specific quality indicators. The profiles increase provider awareness of performance, help identify opportunities for improvement, and facilitate plan-provider collaboration in the development of clinical improvement initiatives. The quarterly scorecards will use claims data and provide national Medicaid NCQA data or NTC goals, as appropriate, as benchmarks for each indicator.

Sharing of Provider Profile Reports with Providers

NTC will make provider profile reports available to providers on our Provider Portal. Profile reports will be updated on a quarterly basis to allow time for change to occur. After the reports are generated, the Chief Medical Director or Provider Performance Managers will meet face-to-face with each provider whose combined score on all indicators falls below two standard deviations to develop an action plan for improving identified measures to a target level of performance. QI staff will re-evaluate the provider's performance every three to six months, until an acceptable level of performance is achieved. They also will meet with select high-performing providers to identify best practices that can be shared with other participating providers.

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. (5 page limit)

Member Advisory Committee Overview

Nebraska Total Care (NTC) understands that our ability to effectively engage stakeholders, including members, family members, caregivers, advocates, and community organizations, in our QAPI program is a crucial component of our collaborative efforts to enhance a patient-centered service delivery system, optimize clinical outcomes, and positively affect our program operations. NTC's Member Advisory Committee (MAC) will be accountable to NTC's Board of Directors. NTC will incorporate the best practices of its affiliate health plans to ensure an effective MAC that includes participation from members, members' representatives, providers and advocates that reflect NTC's covered population and communities served. For example, our Georgia affiliate addressed the challenge of engaging members in its MAC by encouraging its advocacy group participants to invite a member to accompany them to the MAC. NTC's MAC will represent the geographic, cultural and racial diversity of our membership across Nebraska. It will meet at least quarterly and will provide input and advice on our program and policies, including planning and delivery of services, quality improvement activities, program monitoring and evaluation, and member, family, and provider education. NTC will develop a Member Advisory Committee Charter (Plan) that describes the meeting schedule and the draft goals of the MAC that includes, at a minimum, members' perspectives about improving quality of care. Our MAC Charter and work plan will be submitted to MLTC for approval within 60 calendar days before the contract start date and annually thereafter. At our first meeting, our Director of Member & Provider Services will provide an orientation to MAC participants so that they have sufficient information and understanding of the managed care program, including our Medicaid 101 training, an overview of NTC's organizational structure and our quality improvement process, and the Heritage Health contract requirements. We will involve members in the design of our educational materials and quality improvement initiatives, empowering them to be actively engaged in their health care. The Director of Member & Provider Services, or designee, will maintain written minutes of the meeting and any materials distributed during the meeting, and these materials will be copied to MLTC. We will ensure the location of our meeting is accessible to all attendees and provide face-to-face interpretive services as needed. NTC will pay for travel costs for committee members who are NTC enrollees or their representative. NTC will create a semi-annual report on the activities of the MAC that will include the membership of the committee, a description of the orientation and ongoing training activities for the committee, and logistical information about the committee meetings such as date, time, location, meeting attendees, and minutes from each meeting. The MAC semi-annual report will be submitted to MLTC according to the schedule in Attachment 6 – Reporting Requirements.

Using the Member Advisory Committee to Improve Quality and Direct Change

Focused on a primary goal to improve the health and well-being of members, NTC has built its advisory approach on lessons learned from our affiliate health plans. NTC will engage members and other stakeholders in dialogue regarding a number of program and operational topics, such as member satisfaction with their healthcare services and member education and materials, and allow for open discussions that address concerns and/or generate questions. These open dialogues generate input that helps identify improvement opportunities across a wide range of program and operational areas. For example, our Louisiana affiliate's MAC feedback and recommendations have resulted in the following program and operational changes:

- Additional value-added benefits, specifically related to dental, vision, circumcision, hearing aids, and portable oxygen
- Improvements to the CentAccount Member Incentive Program educational materials that better explain the program and how the incentives can be earned and redeemed

- Changes to the health plan's Interactive Voice Response System, such as press options and messaging

NTC will rely on our MAC to help us continue to build a culturally accessible community outreach approach and to enhance our awareness of how, and which, specific cultural issues must be factored into the design of any approach. NTC will use feedback obtained from and through the MAC to develop and implement our process improvement strategies, as well as to inform policy and procedure development and modification. Issues raised by stakeholders will be incorporated into NTC's QAPI program as appropriate. We will also incorporate the MAC's feedback into operational planning and management activities as appropriate. NTC will implement mechanisms for contact between meetings to keep members of the MAC engaged and communicate progress of activities discussed at each meeting. Our MAC model will help us continually align our goals with locally defined needs, develop our base of member and community champions due to earned credibility and trust among MAC participants, and gather contextual information about how members interact with the healthcare system. Thus, as the MAC participant model evolves and expands, NTC is poised to develop a foundation for true culturally competent member and community engagement. We will continually provide feedback to the MAC participants regarding the results of their improvement ideas and suggestions so that they know their voices are heard and acted upon.

Member Advisory Committee Participants

Our MAC will serve as a consultative committee with local representation from members, family members, caregivers, advocates and community stakeholders. NTC will establish its MAC with a broad representation of members, families, significant others and advocacy groups that reflect the population and community served. The Director of Member & Provider Services will chair NTC's Committee. NTC staff participants will include our Supervisor of MemberConnections, our community health outreach program, Tribal Liaison, LTSS Community Liaison, and as indicated by agenda topics, representatives from our Quality Improvement, Grievance, Marketing & Communications, Care Management, and Provider Relations departments.

As a lesson learned from affiliate health plans' models, NTC knows that the community voice sometimes overshadows our members' voice during meetings. As a result of this observation, we will take steps to promote member voice and engagement. We will hold quarterly MAC meetings in each region, and members and community agencies/partners will both be invited to attend. We will establish two parallel and distinct agendas to assure we allocate focused time to hearing the insights of our members, as well as those of our community partners. We believe that continuing to host these two stakeholder groups at the same time, but with separate parallel agendas, will strengthen our members' voice while supporting the role our community partners have traditionally played in engaging and mentoring our members through the Advisory Committee process.

Nebraska Total Care Members. NTC will work diligently to engage with our members to actively participate on our advisory boards. As we continue to build relationships with key providers and stakeholders within the community, our goal will be for members to represent 51% or more of MAC participants. NTC will regularly conduct region-specific demographic analyses to help assure that our MAC is reflective of the members we serve. We will include members who represent a wide range of ethnicities and chronic conditions prevalent within the population. For instance, U.S. Census data shows that the number of people who were classified as racial or ethnic minorities in Nebraska increased by 50.7% in 2010. Specifically, data shows that 9.2% of Nebraskans in the southeast region, particularly the Omaha area, identified themselves as Hispanic; 4.4% identified as African American; 1.8% identified as Asian American; and 0.8% identified as American Indians (mostly Knox and Thurston counties). We recognize that Nebraska has a high population of migrants and refugees representing over 25 different languages across the state. Nebraska also has one of the largest population of the Sudanese Nuer, most of whom live in high poverty and high crime areas of Omaha. NTC will also strive to include members that represent the range of eligibility categories across the Heritage Health program. For example, we will

invite members or their representatives of adults and children, members in Child Welfare, and members receiving home- and community-based services so that we gain perspective of the unique challenges each group may face. NTC may also convene subgroups of the MAC for specialized populations or conduct focus groups to provide another forum for direct member input in the development and continuous improvement of our policies and programs. Our focus group results will be reported to the MAC. These subgroups are not created to separate members from each other, but to allow topics and discussions to focus on the unique needs of each. Any member, regardless of diagnosis, program type, or ability is invited to participate on our MAC. For example, as MLTC proceeds with its vision to incorporate LTSS into the Heritage Health Program, NTC will organize MAC subgroups to allow NTC members affected by this change to be actively engaged in the design of our programs and processes.

Community Stakeholders. One of the many strengths of our MAC model is the rich diversity of regional community representation. NTC has already begun to identify community partners in each region to participate on our MAC, choosing those known as influential leaders with a history of advocating for the well-being of their communities. We include representatives from community centers, housing authorities, outreach services, schools, and places of worship, as well as mission-driven, health-focused nonprofit organizations. For example, we have invited and received commitments from the stakeholder representatives listed in ***Table Q78***.

Table Q78: Member Advisory Committee - Stakeholder Representatives

Name	Position/Agency
Adi M. Pour, Ph.D	Director, Douglas County Health Department
Carol Wang	Executive Director, Metro Omaha Medical Society
Judith Halstead	Director, Lancaster County Health Department
Pat Lopez	Public Health Advocate
Sandy Lutz, MA	Aged & Disabled, Medicaid Waiver and Senior Care Options Supervisor
Sandy Roes	Director, Western Community Health Resources
Susan Bockrath, MPH	Executive Director, Nebraska Association of Local Health Directors

Geographic Areas. Based on the geography of the state (urban, rural, and frontier), NTC will include representation from across the state to ensure input from a wide range of members who, based on geography alone, have different perspectives and face different health disparities. We will host each quarterly MAC meeting in a different region of the state, allowing all Committee participants the opportunity to attend at least one meeting per year face to face. Attendees in other areas of the state will participate by teleconference or video conferencing technology. NTC will host meetings in centrally located, accessible locations, and remote attendees may participate from their home, NTC Community Engagement Center, or another preferred location. NTC will pay for and arrange transportation as needed, as well as face-to-face interpretive services such as sign language.

Identifying Participants of the Member Advisory Committee

NTC will employ a variety of outreach tactics to identify members from our plan and community to participate in our MAC, as described below. Our goal is to identify members who will actively engage with us. In turn, we will provide a supportive and positive environment to encourage sharing ideas and concerns on an ongoing basis.

Member Participants. NTC will conduct outreach to identify potential member participants through multiple means. We will provide information on the MAC's purpose, benefits of engagement, and how to get involved on our website (both our public-facing and secure Member Portal), as well as in our Member Handbook. We also will train member-facing staff on the MAC's purpose and the benefits of engagement so they can help educate and recruit members for the MAC. Our MemberConnections Representatives (MCRs) also assume a key role in identifying and reaching out to potential MAC members. With each outreach, we will communicate the MAC's purpose and the many ways in which it influences NTC's

quality strategies, operations, and service delivery. We also will educate members on the support services, accommodations, and member incentives available to those who wish to participate on our MAC. NTC will implement a best practice from our Georgia affiliate health plan that was able to significantly increase the number of health plan member participants on their MAC. Our Georgia affiliate, Peach State Health Plan, challenged each of their community champions/stakeholders to invite a health plan member to participate in the MAC with them.

Community Partners. As noted above, NTC has already begun identifying key community partner participants for our MAC who have a focus that aligns with MAC's purpose. We select community partners based on their demonstrated interest in the well-being of their community and assure they represent entities that are responsive to, and reflective of, our members and the communities in which they live. NTC will continue to examine MAC representation so that we include community partners that are important to the health and well-being of our members and that appropriately reflect their demographics, service utilization, and ongoing needs.

Affiliate Experience Collaborating with Members to Drive Program Improvements

The goal of each MAC meeting is to assure that member and community stakeholders have a forum to provide feedback and recommendations on improvements to the Heritage Health Program, quality improvement processes, and operational practices. This includes how we respond to member satisfaction survey findings, issues related to utilization of services, access to care, and the development of new programs and initiatives to improve health outcomes. MAC participants play a meaningful role in identifying unique community conditions, assets, and needs. Since their inception, our affiliate health plans' Member Advisory Committees have been instrumental in providing input and support. Examples include:

- Identifying additional community resources;
- Assisting in developing programs targeting specific populations such as Latino, African American, and Burmese;
- Providing feedback and recommendations on member educational materials and approaches to engage members; and
- Providing feedback on existing programs and recommendations on the design and implementation of new programs.

Below are examples of how our affiliate health plans' MACs have contributed to program and clinical improvement, as well as operational enhancements.

Peach State Health Plan (Peach State)– Georgia. Peach State, NTC's affiliate in Georgia, conducted a barrier analysis on members' response rates to our outbound mail campaigns encouraging wellness visits and prevention screens. Based on feedback from members, the MAC, and providers, they tested a postcard resembling a traditional appointment reminder from a provider's office instead of using a full-color postcard. In the first test with the simpler postcard, 50 out of 101 members responded to schedule an appointment, exceeding initial expectations. Peach State has also used feedback from stakeholders and the MAC to test materials and distribution. Peach State's MAC felt strongly that anti-bullying efforts should begin with very young children. As a result, for Peach State's 2014 "Bully-Free Zone" events targeted toward 4th-5th graders, they used additional materials and props ("Petey the Peach State Pup") to deliver messages targeted to preschoolers. Based on the positive feedback Peach State received from professional educators and parents, as well as the children, they are launching a permanent health education series and anti-bullying prevention program for preschoolers that will be used in schools throughout Georgia.

Managed Health Services (MHS) – Indiana. NTC's Indiana affiliate's Member Advisory Committee reviewed member materials printed on postcards and identified font size as an issue. MHS revised the content to incorporate a larger font that would encourage members to read the information contained on the postcard.

Home State Health Plan (Home State) – Missouri. This affiliate health plan was established in 2012 and already has demonstrated success implementing a wide range of stakeholder engagement strategies to

address unmet member, provider, and community needs. Since its inception, Home State has routinely hosted focus groups to evaluate the effectiveness of member materials, services, and benefits. They also host one-on-one meetings and large group listening sessions with physician groups to gain insights on how the health plan can better serve minority communities. Through these sessions, Home State learned about transportation barriers and immediately renegotiated its vendor contract to allow members to make transportation plans with less than 24-hour notice of a scheduled appointment with their PCP or obstetrician. In a member focus group conducted with pregnant women and mothers with young children, Home State learned that many participants believed it was dangerous to receive a flu shot while pregnant. This information led the health plan to develop outreach material that would explain the benefits and risks of flu shots and the importance of a pregnant woman being immunized against the flu not only for her own health but for that of her baby. Through Home State's member and community engagement meetings, leadership from the Betty Jean Kerr People's Health Center shared their concern about the rising number of children and adolescents with mental health needs in underserved communities. As a result, Centene's Charitable Foundation contributed $500,000 in 2015 to support the "Building Hope" project, which will build a facility designed by local expert psychiatrists and other mental health professionals to expand children's and families' access to mental health services provided within a dignified and respectful environment.

Superior HealthPlan (Superior) – Texas. Superior, our affiliate health plan in Texas, created its first Member Advisory Group (MAG) in 2005. Superior conducts regional MAG meetings quarterly to engage members in dialogue regarding a number of program and operational topics, such as member satisfaction with their healthcare services and member education and materials, and to allow for open discussions that address concerns and/or generate questions. Recent input from Superior's MAGs resulted in the following:

- Development of improved member education regarding appointment availability, in-office wait time standards, and plan assistance available to members for scheduling appointments
- Improved member education on programs offered by Superior, such as the MemberConnections Program, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program, health education classes, and features offered on their Member Portal
- Revised MAG agenda formats to include an education and orientation portion for each meeting

As noted above, NTC has already taken steps toward implementation of its Member Advisory Committee for the Heritage Health Program and will implement lessons learned and best practices from its affiliate health plans to ensure our MAC has an active role in our QAPI Program.

(2 page limit)

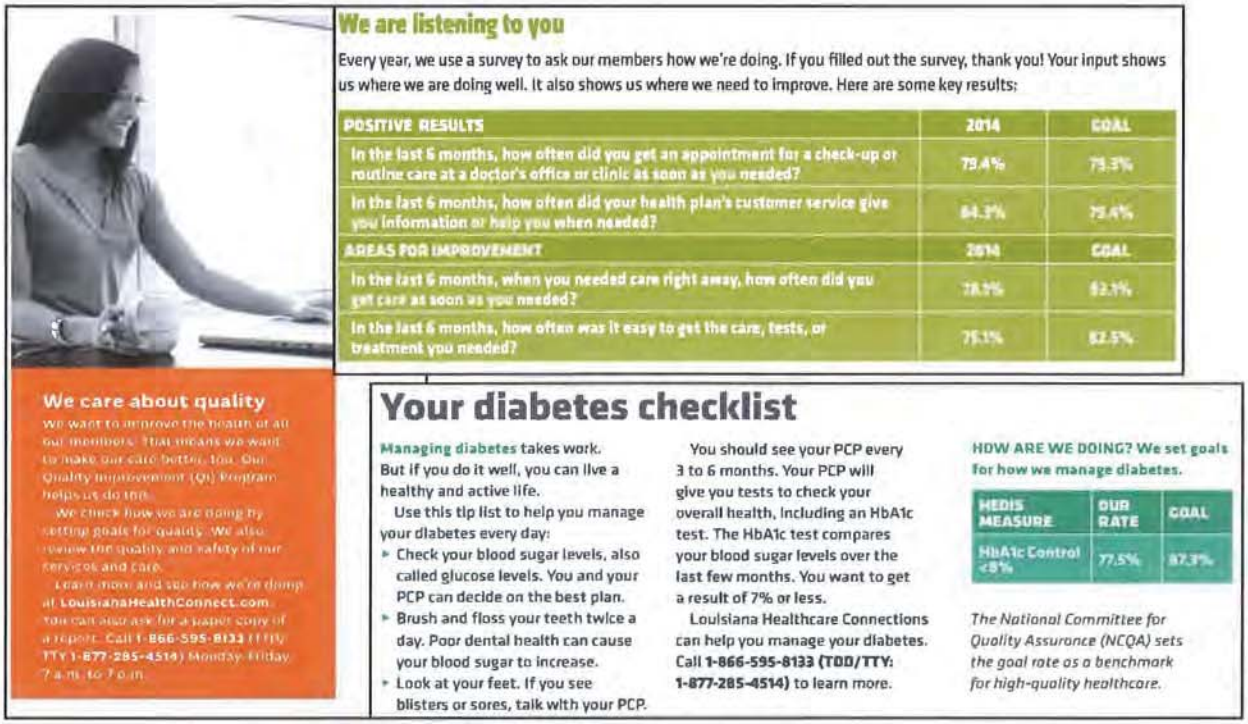
79. Describe the information the MCO will provide to members and providers about the QAPI program.

Distributing QAPI Program Information to Members and Providers

At least annually, Nebraska Total Care (NTC) will provide information to members and providers, including a description of the QAPI program and a report on NTC's progress in meeting QAPI program goals. Our communication will include information about QI program goals, processes and outcomes as they relate to member care and service such as specific HEDIS and member and provider satisfaction survey results. Similar to our affiliate health plans, NTC will make our QAPI Program Description and quarterly Health Plan Report Card available to members and providers on our Member and Provider public website along with information about how to obtain a hard copy description of the program. Specific results and areas for improvement are primarily distributed through the Member/Provider Newsletters. In addition, NTC will engage our member, provider and community stakeholder advisory committees to communicate program results and obtain feedback on proposed interventions.

Communication to Members. NTC's first communication to members about our QAPI program begins with our Member Handbook. NTC's Member Handbook includes a brief introduction to our QAPI program including some of program's key elements. Our Member Handbook also provides information about our Member Advisory Committee and invites members to contact our Member Services line if they are interested in attending. Our Member Handbook and member website include information about our Grievance Process, which is a component of our QAPI program. As part of our ongoing communication to members regarding our QAPI program, NTC will include a summary of our QAPI program, member satisfaction (CAHPS) survey results and results of select HEDIS measures and actions taken to improve them in our Member Newsletter (distributed at least twice a year). Information provided to members is written in easily understood language at or below a 6.9 grade level. All materials provide information to members about obtaining alternate formats including translated materials, Braille, large print, audio or face-to-face interpretation such as sign language. All member materials will be approved by MTLC prior to distribution. ***Figure Q79.A*** provides example Member Newsletter articles.

Figure Q79.A: Excerpts from NTC's Louisiana affiliate health plan's Member Newsletter



We are listening to you

Every year, we use a survey to ask our members how we're doing. If you filled out the survey, thank you! Your input shows us where we are doing well. It also shows us where we need to improve. Here are some key results:

POSITIVE RESULTS	2014	GOAL
In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?	79.4%	79.3%
In the last 6 months, how often did your health plan's customer service give you information or help you when needed?	84.3%	79.4%
AREAS FOR IMPROVEMENT	**2014**	**GOAL**
In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?	78.9%	82.1%
In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?	75.1%	82.5%

We care about quality

We want to improve the health of all our members. That means we want to make our care better, too. Our Quality Improvement (QI) Program helps us do this.

We check how we are doing by setting goals for quality. We also review the quality and safety of our services and care.

Learn more and see how we're doing at LouisianaHealthConnect.com. You can also ask for a paper copy of a report. Call 1-866-595-8133 (TDD/TTY: TTY 1-877-285-4514) Monday–Friday, 7 a.m. to 7 p.m.

Your diabetes checklist

Managing diabetes takes work. But if you do it well, you can live a healthy and active life.

Use this tip list to help you manage your diabetes every day:

- Check your blood sugar levels, also called glucose levels. You and your PCP can decide on the best plan.
- Brush and floss your teeth twice a day. Poor dental health can cause your blood sugar to increase.
- Look at your feet. If you see blisters or sores, talk with your PCP.

You should see your PCP every 3 to 6 months. Your PCP will give you tests to check your overall health, including an HbA1c test. The HbA1c test compares your blood sugar levels over the last few months. You want to get a result of 7% or less.

Louisiana Healthcare Connections can help you manage your diabetes. Call **1-866-595-8133 (TDD/TTY: 1-877-285-4514)** to learn more.

HOW ARE WE DOING? We set goals for how we manage diabetes.

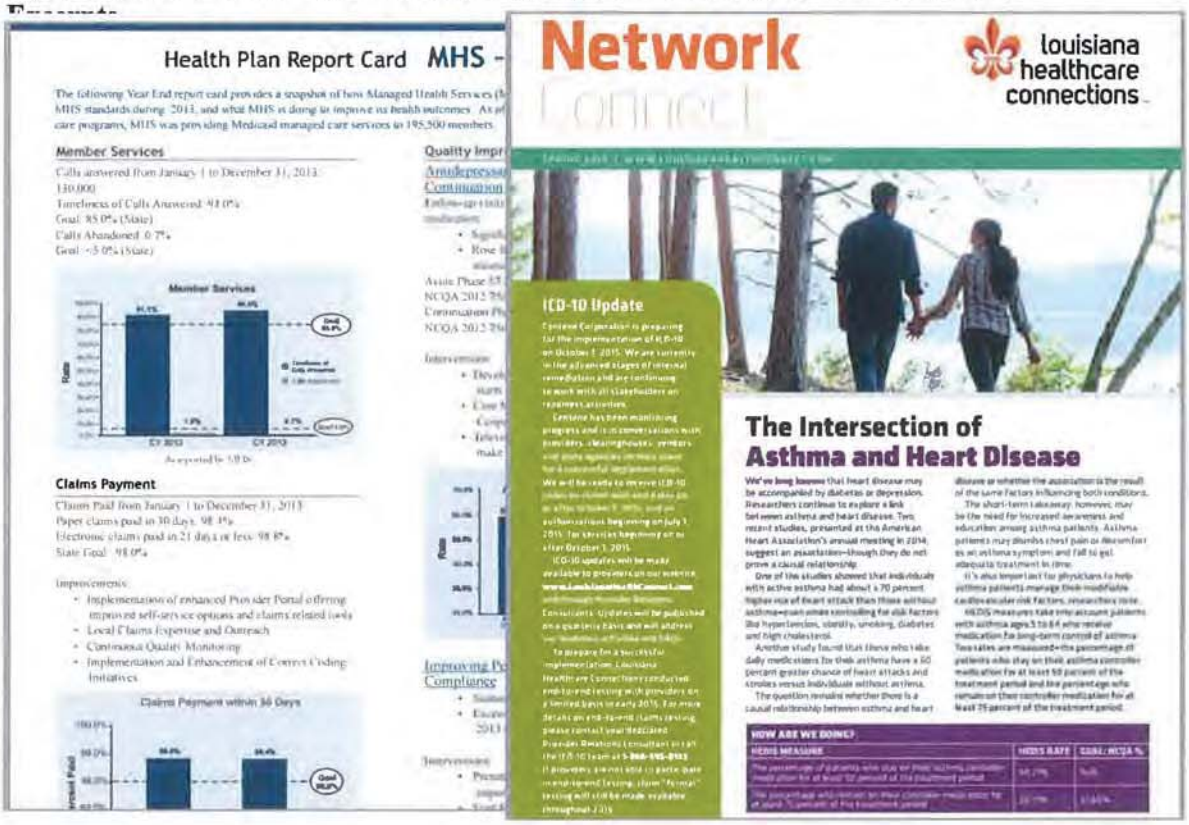
HEDIS MEASURE	OUR RATE	GOAL
HbA1c Control <8%	77.5%	87.3%

The National Committee for Quality Assurance (NCQA) sets the goal rate as a benchmark for high-quality healthcare.

Communication to Providers. NTC's communications to providers about our QAPI program begins as early as our initial contracting discussions. Our Network Contracting staff talks to providers about our quality programs, including our provider profiling and value-based contracting models. We also begin to identify and invite providers to participate on our various QAPI committees during these initial discussions. NTC's Provider Handbook and new provider orientation materials contain a brief introduction to our QAPI program including HEDIS measures and their use in the QAPI program. Our Provider Handbook also provides information about our QAPI Committees, Grievance and Appeal processes, and provider profiling activities as well as our approach to value-based contracting. NTC will also include a HEDIS Reference Guide, used by our affiliate health plans, in our new provider orientation packet. As part of our ongoing communication to providers regarding our QAPI program, NTC will include a summary of our QAPI program, provider satisfaction survey results and results of select HEDIS measures and actions taken to improve them in our Provider Newsletter. We also provide information about clinical practice guidelines, medical record documentation standards, and the processes NTC will use to monitor compliance with each in the Provider Handbook and Provider website. NTC will implement a best practice initiated by our Indiana affiliate health plan to post our quarterly Health Plan Report Card on the provider website. In addition to the above communications, NTC's Provider Relations staff discusses, as part of our QAPI program, results of provider profiling and value-based contracting reports with providers on an ongoing basis to help them identify and implement programs for improvement.

Affiliate Experience Communicating Program Results. Our Indiana health plan affiliate publishes a Health Plan Report Card (Figure 79.2) accessible to providers on the provider website. Also shown in ***Figure Q79.B*** below, our Louisiana affiliate communicates key HEDIS measure results in the Provider Newsletter along with reference to associated clinical practice guidelines and tips on how providers can improve compliance with the guidelines.

Figure Q79.B NTC Affiliate's Health Plan Report Card and Provider Newsletter Excerpts



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IV.M ATTACHMENTS

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Attachment
68.A Subcommittee Responsibilities and Composition

Credentialing Committee (CC). The CC will be a standing subcommittee of the QAPIC, and will oversee and have operating authority of the Credentialing Program. The QAPIC is the vehicle through which credentialing activities will be communicated to the BOD. The CC will be responsible for development and annual review of the Credentialing Program Description and associated policies and procedures. The CC will have final authority for review and appropriate approval of licensed physicians, other licensed healthcare professionals, and certain facilities that will have an independent relationship with NTC. Credentialing activities are performed in compliance with NCQA standards as well as State and federal guidelines, as applicable. The Credentialing Committee is chaired by the CMO and includes representation from a range of practitioners across the contracting area to include the specialty and types of practitioners it reviews. The Director of Credentialing maintains detailed records and minutes of all Credentialing Committee meetings, activities, program statistics and recommendations made by the Committee. The Credentialing Committee routinely submits meeting minutes as well as written reports regarding analysis of the above tracking and monitoring processes and status of corrective action plans (as applicable) to the QAPIC.

Pharmacy and Therapeutics Committee (PTC). The PTC will be a standing subcommittee of the QAPIC, with oversight of and operating authority over NTC's Pharmacy Program. The P&T Committee will be multidisciplinary and include representation from a range of network physicians and pharmacist(s), clinical pharmacist(s), and a psychiatrist. NTC executive leadership and Pharmacy/QM staff will also participate as appropriate. The PTC will be responsible for the development and annual review of the Pharmacy Program Description and associated policies, as well as activities such as reviewing pharmacy utilization; specific drug utilization review studies, particularly on the polypharmacy risks of SSI Members; and drug interaction reports. The PTC will also be responsible for making recommendations regarding drug utilization review activities such as targeted prescriber and/or member education initiatives and activities that affect access and patient safety. The PTC may also assist with the review of complaints and grievances regarding pharmacy issues, and have oversight of US Script, our Pharmacy Benefit Manager. The Plan Pharmacist/Director of Pharmacy maintains detailed records and minutes of all P&T Committee meetings, activities, program statistics and recommendations made by the Committee. The PTC routinely submits meeting minutes as well as written reports regarding analysis of the above tracking and monitoring processes and status of corrective action plans (as applicable) to the QAPIC.

Utilization Management Committee (UMC). The UMC, also a standing subcommittee of the QAPIC, will have oversight of and operating authority over the Utilization Management (UM) Program, including second opinions, referrals and other prior authorization, pre-certification, concurrent review, ambulatory review, retrospective review, discharge planning and care coordination. The UMC is chaired by the Chief Medical Director, who is responsible for the review and approval of medical necessity criteria; utilization management policies and procedures; after-hours nurse advice line protocols; and monitoring and analyzing relevant data to detect and correct patterns of potential or actual inappropriate under- or over-utilization of that a significant or severe adverse outcome has potentially occurred, or other cases as deemed appropriate by a Medical Director.

Peer Review Committee (PRC). Each PRC will include three or more network physicians who represent a range of specialties including at least one physician with the same or similar specialty as the provider or issue under review. PRC members will use their clinical judgment to assess the appropriateness of clinical care and to recommend follow-up actions that may include a Corrective Action Plan (CAP) that will best address each particular situation. Network physician members are not standing members of the committee and their attendance may change based on type of case being reviewed. If the PRC assessment results in a recommendation to terminate the provider, the recommendation is presented to the Credentialing Committee for final determination. Reviews resulting in the reduction, suspension, or termination of a provider's participation due to the quality of care or services rendered will be reported to the National Provider Data Bank (NPDB) and the appropriate State licensure board in accordance with the Health Care

Quality Improvement Act. Complete documentation will be maintained in the QI Department files and will be reviewed at least quarterly for trends and repeat occurrences. This information is incorporated into the recredentialing and other quality improvement processes. Aggregate reporting of Peer Review activities is conveyed to the QAPIC at least quarterly.

Joint Operating Committee (JOC). The Joint Operating Committee (JOC) is an active subcommittee of the QAPIC, whose primary function is to provide guidance to, and oversight of the operations affecting the scope of functions of delegated vendors, review periodic activity reports from delegated vendors, ensure compliance with all NCQA standards and regulations related to the delegation relationship, and recommend actions to address any identified opportunities for improvement in delegated services. The purpose of the committees is to provide oversight and assess the appropriateness and quality of services provided on behalf of the health plan to NTC members. The JOC will include representation from applicable functional area as well as the delegates. .

Performance Improvement Team (PIT). NTC's PIT is a Centene best practice, and is a management-level, cross-functional quality improvement team that facilitates the ongoing integration of quality improvement throughout the organization. The PIT will include representation from each functional area (e.g., Care Management, Compliance, MemberConnections™, Member Services, Utilization Management, Contracting, Provider Relations/Services, Quality Management or others as determined by the topic under discussion), as well as employees who conduct or directly supervise the day-to-day activities of a department. The PIT will gather and analyze performance measures, perform barrier and root cause analysis for indicators falling below desired performance levels, and make recommendations regarding corrective actions or interventions to produce improvement. The PIT will oversee NTC's performance measures, CAHPS® results and HEDIS® processes and is responsible for reviewing performance measure trending and identifying areas in need of improvement. The committee will review, approve and implement Centene-led initiatives as well as direct NTC initiatives to improve selected performance measures, directing both clinical and non-clinical, and member and provider initiatives to improve performance measure scores. The PIT will also review or establish benchmarks or performance goals for measures and HEDIS and oversee delegated vendor roles in improving HEDIS scores. Finally, the PIT will oversee the implementation of recommended corrective actions and interventions from the QAPIC and/or its supporting subcommittees, and will monitor the outcomes and report back to the designated committee.

Corporate Compliance Committee. The purpose of the Corporate Compliance Committee is provide monitoring and oversight for NTC's compliance program, policies and procedures. This includes reporting on regulatory and compliance functions to ensure that NTC meets all applicable statutory, regulatory and contractual requirements; internal and external compliance and auditing activities; ensuring compliance with privacy/HIPAA rules; and fraud, waste, and abuse (FWA) activities. The Corporate Compliance Committee will review and approve the Compliance Plan at least annually. Members of the committee will include the Chief Executive Officer, Chief Operating Officer, Chief Medical Officer, VP Finance, VP Medical Management, Medical Director, and Compliance Officer. The Corporate Compliance Committee will report to the QAPIC at least quarterly.

Clinical Advisory Committee. The purpose of the Clinical Advisory Committee is to facilitate regular consultation with community experts familiar with standards and practices of treatment for a Medical population and to solicit input into all policies, procedures, and practices associated with Care Management 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. The Committee will review and approve initial practice guidelines, as well as any significant changes, prior to adoption by NTC. The Committee will include representatives serving children, adolescents, and adults across the state in both rural and urban areas, and representing a variety of races and ethnicities reflective of the population, including pharmacists, physical health and behavioral health providers. The Clinical Advisory Committee will report to the QAPIC at least quarterly and forward copies of minutes to MLTC.

NTC will submit final committee members and documents to MLTC for approval at least 60 calendar days in advance of its establishment. The MCO must also provide copies of the committee's minutes to MLTC.

Member Advisory Committee (MAC). NTC's MAC will include members, parents/foster parents/guardians of children who are plan members, and staff, as appropriate. The Director Member & Provider Services will chair the Committee. Members and their family members may volunteer for the committee or be suggested by staff. Plan informs members about the MAC through member materials such as the Member Handbook and member newsletters, and through member contacts at community events. The MAC shall recommend program enhancements; review satisfaction survey results; and provide feedback on plan performance levels. The MAC will meet at least four (4) times per year. The Director of Member & Provider Services maintains detailed records of all MAC meetings, activities and recommendations for improvement activities, and submits reports to the QAPIC quarterly.

Provider Advisory Committee (PAC). NTC will also establish a PAC. The PAC will be comprised of the CMO, network providers from across the contracting area, the Director of Contracting and Network, and Provider Relations staff as appropriate. The CMO will chair the PAC. The committee will provide input on NTC's provider profile, incentive programs and other administrative practices, and support development of value based purchasing, the physician scorecard indicators, useful analyses of the data, and effective means of helping providers improve their performance. In addition, NTC will establish a Hospital Advisory Committee, Behavioral Health Advisory Committee and a Tribal Healthcare Advisory Committee to provide input to the Provider Advisory Committee. For example, the Tribal Healthcare Advisory Committee will be chaired by our Tribal Liaison to ensure regular coordination with IHS, 638 providers, Urban Indian Centers, and other involved agencies. The PAC will report to the QAPIC at least quarterly.

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Attachment
68-B QAPI Commitee Strucutre

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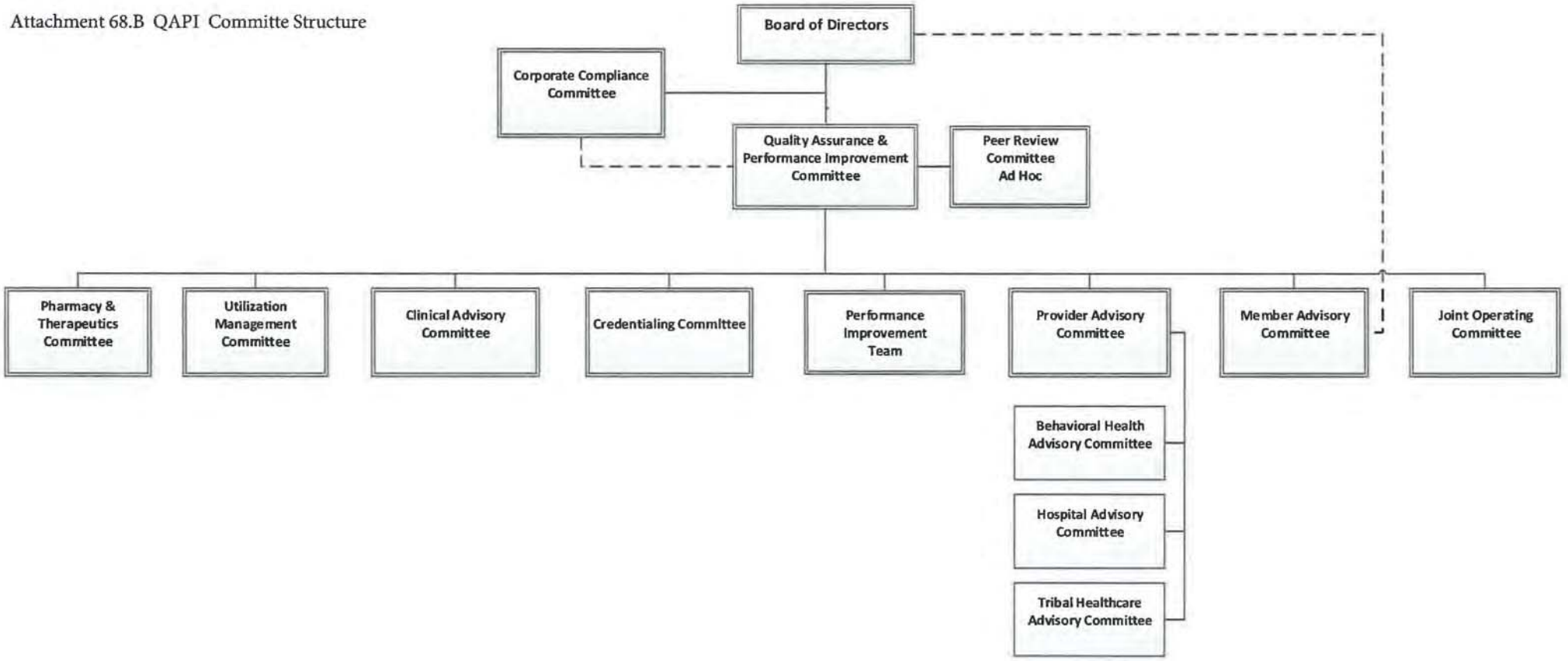
Attachment 68.B QAPI Committe Structure

Committee Chart



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Attachment
68.C NTC Proposed QAPI Work Plan

NEBRASKA TOTAL CARE (NTC)
QUALITY IMPROVEMENT WORK PLAN 2017
Attachment 68.C NTC Proposed QAPI Work Plan

STANDARD/SCOPE	OBJECTIVE	DESCRIPTION	ACCOUNTABLE	TIMELINE	MONITORING STATUS
QUALITY IMPROVEMENT					
QM- 1 Program Structure	**NCQA Standard**	**Action Plan**	**Primary Lead**	**Reporting Schedule**	**Monitoring Status**
QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT COMMITTEE (QAPIC) STRUCTURE	Quality Improvement Program to meet 100% of NCQA requirements.	Infrastructure designed to improve the quality & safety of care and services provided to members. Standing subcommittees include: -Utilization Management Committee -Credentialing Committee -Pharmacy & Therapeutics Committee -Joint Operating Committee -Performance Improvement Team -Clinical Advisory Committee -Member Advisory Committee -Provider Advisory Committee -Corporate Compliance Committee	Director, Quality Management (QM)/Chief Medical Officer	Ongoing. Quality Improvement Committee (QAPIC) – Quarterly Standing committees – meet at a minimum of quarterly (or more frequently as necessary).	Quarterly
BOARD OF DIRECTORS (BOD)	Annual Board approval of Quality Assessment Performance Improvement (QAPI) Program Description and the QM Work Plan for NTC.	Board of Directors (BOD) meetings scheduled quarterly	President/Chief Executive Officer	BOD meets a minimum of 4 times per year.	
BEHAVIORAL HEALTH (BH)	Monitor and improve BH aspects of the QM Program	BH described in the QM Program BH participation at the QAPIC	BH Clinical Director/ Director, QM/Chief Medical Officer	On-going. QAPIC- quarterly	Quarterly
CULTURAL COMPETENCY / CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES	Cultural Competency Program to meet 100% of NCQA requirements	Analyze Consumer Assessment Healthcare Providers and Systems (CAHPS®) survey for demographic information and for identification of any indicators of heath care disparities that need to be addressed Compile data on member ethnicity,	Director, QM Marketing Manager	Cultural Competency Program Description to QAPIC for approval annually Cultural Competency Program Evaluation to	Annually

STANDARD/SCOPE	OBJECTIVE	DESCRIPTION	ACCOUNTABLE	TIMELINE	MONITORING STATUS
		language and other demographics for inclusion in the Cultural Competency Program utilizing member enrollment data and/or census data which can be generalized to the population. Examples for consideration to include are gender, age, race/ethnicity, languages, eligibility income group, disease prevalence, etc. Examples of data to review for potential disparities are CAHPS, HEDIS & non-HEDIS data such as inpatient, ER, OP facility and OP professional utilization. • Cultural Competency Program Description – annual approval by QAPIC • Cultural Competency Program Evaluation - annual approval by QAPIC		QAPIC for approval annually and as an update semiannually	
QUALITY AND SAFETY OF CLINICAL CARE/ PATIENT SAFETY	Patient Safety Plan to include: 1) Communication/ Education for members and providers. 2) Monitoring of Quality of Care grievances 3) Review of medical management adverse event referrals 4) Pharmacy initiatives: a) Narcotic shopping 5) Improve clinical outcomes	Patient safety described in the QAPI Program Description. • Safety information in the Providers and Members newsletters • Trend adverse and/or sentinel events, implement follow-up action as required. • Trend members exceeding a threshold of narcotic prescriptions • Patient Safety Report annually to QAPIC • Evaluate clinical effectiveness through HEDIS measures and identify opportunities for improvement (see HEDIS work	Director, QM & Director, UM Corporate and Health Plan Clinical Pharmacy Services	Annual Patient Safety Plan to QAPIC for approval On-going collection of data Annual Patient Safety Reports to QAPIC annually	Annually

STANDARD/SCOPE	OBJECTIVE	DESCRIPTION	ACCOUNTABLE	TIMELINE	MONITORING STATUS
		plan); • Concurrent and retrospective drug utilization review (DUR) • Analysis of utilization data • Provide feedback to providers who demonstrate inappropriate prescribing patterns that deviate from recognized practice standards and guidelines			
ANNUAL EVALUATION	To annually evaluate performance on the QM activities described in the QAPI Program Description and QM Work Plan	The QAPI Program Evaluation will include: • Description of completed and ongoing activities for the previous year • Monitoring previously identified issues • A quantitative analysis and trending of measures • A barrier analysis to identify reasons when goals are not met • A description of the Program's overall effectiveness	Director, QM	Annual evaluation due to QAPIC end of Q1 2018	Annual
Mid-year Evaluation:					
Revised Plan:					
QM-2 Program Operations	**NCQA Standard**	**Action Plan**	**Primary Lead**	**Reporting Schedule**	**Monitoring Status**
QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT COMMITTEE (QAPIC)	Meets quarterly. Complete 100% of required activities by year-end	• Committee minutes completed, signed and dated by the recorder within thirty (30) calendar days and signed and dated by the Chair within five (5) business days following approval of the minutes	Medical Director /Director, QM	Ongoing. CY 2017 meetings – February, May, August, and November	Quarterly

STANDARD/SCOPE	OBJECTIVE	DESCRIPTION	ACCOUNTABLE	TIMELINE	MONITORING STATUS
		at the next meeting • Approve the Quality Assessment Performance Improvement (QAPI) Program Description and the QM Work Plan • Active participation of providers in QM Program • Makes information about the QM program available to members and providers • Ensure monitoring of previously identified issues		2017 QAPI Program Description – Q1 2017 2017 QM Work Plan – Q1 2017	
Mid-year Evaluation:					
Revised Plan:					
QM-3 Contracts	**NCQA Standard**	**Action Plan**	**Primary Lead**	**Reporting Schedule**	**Monitoring Status**
HEALTH SERVICES CONTRACTS	Practitioner and providers' contracts include all required components.	• Ensure contracts are compliant and include language to address: quality improvement, access to medical records, confidentiality, notification of termination and open communication of treatments	Vice President, Provider Network	Ongoing assessment of active contracts	Bi-Monthly
Mid-year Evaluation:					
Revised Plan:					
QM- 4	**NCQA Standard**	**Action Plan**	**Primary Lead**	**Reporting Schedule**	**Monitoring Status**
QUALITY OF SERVICE / AVAILABILITY OF PROVIDERS	1) The Plan will insure adequate providers to meet the needs of the members via geo access and ratio reports	Geo-access evaluation of the distribution of providers in various groups against Plan standards • Primary Care Providers • Identify high volume specialists and Behavioral Health providers by claims volume	Vice President, Network and Provider Relations Vice President QM, Cenpatico	Reporting at a minimum of semi-annually to QAPIC	Annually

STANDARD/SCOPE	OBJECTIVE	DESCRIPTION	ACCOUNTABLE	TIMELINE	MONITORING STATUS
	2) Assess cultural needs and preferences	• Approve PCP/member and SCP/member ratio goals • Access closed/open panels Compile and analyze data from vendor language line. Identify member's secondary language and geographic location and assess for provider coverage to meet member's needs. Review CAHPS survey results and analyze member grievances related to availability of providers	Vice President of Member Services & Director, QM	Annually	
Mid-year Evaluation:					
Revised Plan:					
Quality of Service; QM- 5	**NCQA Standard**	**Action Plan**	**Primary Lead**	**Reporting Schedule**	**Monitoring Status**
QUALITY OF SERVICE / ACCESSIBILITY OF SERVICES	• Members have timely appointment access to PCPs, specialists & BH in accordance with established standards. • Members are able to access The Plan via telephone in a timely manner.	• Providers are evaluated monthly via telephone survey for compliance with standards for routine, sick and urgent care appointments. • Cenpatico evaluates compliance for routine, urgent and life-threatening appointments. • Monitoring telephone wait times and abandonment rates. • Review CAHPS survey results and analyze member grievances related	Vice President, Network and Provider Relations Vice President QM, Cenpatico Vice President, Member Services Director, QM	Results of telephone surveys conducted by PR staff reported annually to QAPIC. Monthly monitoring via system data. Reported quarterly to QAPIC Annually	Monthly/Annually

STANDARD/SCOPE	OBJECTIVE	DESCRIPTION	ACCOUNTABLE	TIMELINE	MONITORING STATUS
		to appointment access			
Mid-year Evaluation:					
Revised Plan:					
QM- 6	**NCQA Standard**	**Action Plan**	**Primary Lead**	**Reporting Schedule**	**Monitoring Status**
MEMBER SATISFACTION	The Plan Health Plan evaluates member satisfaction with its services and identifies potential areas of improvement. The assessment of member satisfaction includes monitoring of member grievances and appeals and CAHPS results.	Adult and Child CAHPS surveys when membership reaches threshold. Multi-disciplinary work group to analyze CAHPS survey results, conduct barrier analysis, identify opportunities for improvement and make recommendations of interventions to the QAPIC. Monitor grievances tracked in QM Dept.	Director, QM Vice President, Member Services and Director, QM Director, QM	CAHPS Survey fielded annually. Report results and recommendations to QAPIC Reported quarterly to Grievance and Appeal Committee	Annually
Mid-year Evaluation:					
Revised Plan:					
QM-1 7	**NCQA Standard**	**Action Plan**	**Primary Lead**	**Reporting Schedule**	**Monitoring Status**
COMPLEX CASE MANAGEMENT	The Plan coordinates services for members with chronic conditions and assists them to access needed resources. This activity is administered by the Medical Management Department.	The Case Management Program documents the process and reports evidence of the process of identifying members for complex case management using the identified data sources. The Case Management Program is conducted in compliance to NCQA standards. The Case Management Program description,	Director, Utilization Management	Annual UMC approval of CM Program Description and CM Program Evaluation. Ongoing monitoring in UMC. To QAPIC annually via	Monthly/Annually

STANDARD/SCOPE	OBJECTIVE	DESCRIPTION	ACCOUNTABLE	TIMELINE	MONITORING STATUS
		work plan and annual evaluation are monitored by the Case Management Department and evaluated by the UMC. The findings from the UMC are reported to the QAPIC.		Utilization Management Committee (UMC) minutes/reports.	
Mid-year Evaluation:					
Revised Plan:					
QM-8	**NCQA Standard**	**Action Plan**	**Primary Lead**	**Reporting Schedule**	**Monitoring Status**
DISEASE MANAGEMENT	The Plan Health Plan actively intervenes to assist members and practitioners to manage chronic conditions.	The Disease Management Program actively works to improve the health status of its member's with chronic conditions. The Disease Management Program is conducted in compliance with NCQA standards. The Disease Management Program, work plan and annual evaluation are monitored through the Disease Management Department and the UMC. The findings from the UMC are report to QAPIC.	Director, Utilization Management	Annual UMC approval of DM Program Description and DM Program Evaluation Ongoing monitoring via UMC. To QAPIC annually via UMC minutes/reports.	Monthly/Annually
Mid-year Evaluation:					
Revised Plan:					
QM 9	**NCQA Standard**	**Action Plan**	**Primary Lead**	**Reporting Schedule**	**Monitoring Status**
CLINICAL PRACTICE GUIDELINES	The Plan Health Plan is accountable to adopt and disseminate Clinical Practice Guidelines (CPGs) relevant to its population for medical and behavioral health services.	• Adopt CPGs for at least two medical conditions and two behavioral health conditions. Guidelines must be evidenced-based and relate to at least two conditions included in the Disease Management Program as described in NCQA standard QM 9. • Distribute the guidelines to the	Medical Director/Director, QM & Vice President QM, Cenpatico	Approved by QAPIC annually or when changes are needed	Annually

STANDARD/SCOPE	OBJECTIVE	DESCRIPTION	ACCOUNTABLE	TIMELINE	MONITORING STATUS
PREVENTIVE HEALTH GUIDELINES	The Plan utilizes preventive guidelines to encourage early detection of illness.	appropriate provider groups via printed and /or web communication. • The Plan measures performance against two aspects of selected CPGs for medical conditions. (NCQA Auto-credit is received for the DM-based and BH guidelines since delegating to accredited entities) • Measure practitioner compliance with CPGs in compliance with NCQA requirements. • Adult and pediatric preventive guidelines are reviewed and updated annually. • Annual review of CPGs and PHGs by applicable department directors to ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines		Approved by QAPIC annually or when changes are needed Results to QAPIC annually	
Mid-year Evaluation:					
Revised Plan:					
QM 10	**NCQA Standard**	**Action Plan**	**Primary Lead**	**Reporting Schedule**	**Monitoring Status**

STANDARD/SCOPE	OBJECTIVE	DESCRIPTION	ACCOUNTABLE	TIMELINE	MONITORING STATUS
CONTINUITY AND COORDINATION OF MEDICAL CARE	The Plan monitors and takes action to improve the continuity of care and services across its delivery network.	• Plan collects and analyzes data to ensure coordination of care and services in compliance with NCQA Standards. Metrics and data analyzed and approved by QAPIC annually • The Plan notifies members affected by any changes in their practitioner's status and terminations of PCP providers (Internists, Family Practitioners, and Pediatricians). • The Plan must demonstrate that in defined situations members have continuous access to practitioners whose contract is terminated. • The Plan demonstrates efforts to assist members transitioning care. • Number of ER discharges that were seen in 30 days. • Number of inpatients that were seen in 30 days. • Smart Start program-number of pregnant women who had a post-partum visit. • Provider satisfaction of the coordination between spec & PCP.	Director, QM Corporate Senior Director, Pharmacy Services Director, Utilization Management Director, Provider Relations	QAPIC annually	Ongoing
Mid-year Evaluation:					
Revised Plan:					
QM 11	**NCQA Standard**	**Action Plan**	**Primary Lead**	**Reporting Schedule**	**Monitoring Status**

NEBRASKA TOTAL CARE (NTC)
QUALITY IMPROVEMENT WORK PLAN 2017
Attachment 68.C NTC Proposed QAPI Work Plan

STANDARD/SCOPE	OBJECTIVE	DESCRIPTION	ACCOUNTABLE	TIMELINE	MONITORING STATUS
CONTINUITY AND COORDINATION OF BEHAVIORAL HEALTH CARE	The Plan will collaborate with Cenpatico to monitor and improve the coordination of care between medical and behavioral health services.	1) Annually, Cenpatico will collect data relevant to: • The exchange of information • Referral and treatment of BH conditions seen in medical practice • Treatment access and F/U of coexisting conditions • Use of psychopharmacological agents 2) Analyze data to identify opportunities for improvement and institute action to address one area of improvement.	Sr. Director QM, Cenpatico Director, QM/Utilization Management	QAPIC annually	Annually
Mid-year Evaluation:					
Revised Plan:					
All Department Operations	**NCQA Standards**	**Action Plan**	**Primary Lead**	**Reporting Schedule**	**Monitoring Status**
POLICIES AND PROCEDURES	Policies and procedures serve as a guide to organizational operations and a key resource for personnel to reference. All organization Policies and Procedures are reviewed and revised in a timely manner.	• Staff trained in the utilization of the Compliance 360 system to revise existing P&Ps timely • Develop and approve new policies in Compliance 360 • Quality Improvement policies and procedures will be brought to the QAPIC for approval	The Plan Department Representatives Director, QM & Director of Compliance	All policies approved on Compliance 360 by due date Annual reporting of Plan compliance to QAPIC	Annually
Mid-year Evaluation:					
Revised Plan:					
DELEGATION	The Plan will maintain oversight of all functions performance by delegated entities.	The following vendors perform delegated services (except for QM/QM, which is not delegated) for The Plan Health Plan members:	Director, QM/UM	Annual reporting of Plan and vendor compliance to the QAPIC	Monthly/Quarterly

STANDARD/SCOPE	OBJECTIVE	DESCRIPTION	ACCOUNTABLE	TIMELINE	MONITORING STATUS
		• Cenpatico – behavioral health • OptiCare – vision services • Nurse Response – 24 hour nurse advice line • U.S. Scripts – pharmacy services • Nurtur – disease management • NIA – radiology services			
Mid-year Evaluation:					
Revised Plan:					
REGULATORY INITIATIVES / CLINICAL PERFORMANCE METRICS					
QUALITY OF CLINICAL CARE / PERFORMANCE IMPROVEMENT PROJECTS	Upon approval by MLTC, the Plan will conduct at least three (2 Clinical, 1 non clinical) Performance Improvement Projects (PIPs). PIPs will be forwarded to the QAPIC to review previously identified issues, perform data analysis, identify opportunities for improvement and make recommendations for interventions.	The Plan will conduct a minimum of two clinical and one non-clinical PIPs. A minimum of one (1) clinical issue will address an issue of concern to the MCO's population (such as reducing health disparities), which will have a favorable effect on health outcomes and member satisfaction. A second clinical PIP will address a behavioral health concern (such as appropriate use of psychotropic drugs). PIPs will meet all relevant CMS requirements and will be approved by MLTC prior to implementation. The Plan will participate in a minimum of one (1) joint PIP with the other MCOs; the topic will be identified by MLTC	Director, QM	To QAPIC for approval annually	Annually

NEBRASKA TO..AL CARE (NTC)
QUALITY IMPROVEMENT WORK PLAN 2017
Attachment 68.C NTC Proposed QAPI Work Plan

STANDARD/SCOPE	OBJECTIVE	DESCRIPTION	ACCOUNTABLE	TIMELINE	MONITORING STATUS
HIPAA COMPLIANCE AND CONFIDENTIALITY	The Plan Health Plan is required to establish policies that address privacy and confidentiality of member information. Specific policies detail the Plan's collection, use and disclosure of protected health information (PHI), and are shared with the members.	• Perform quarterly internal compliance audits • Complete annual compliance training for all personnel. • Monitor member complaints regarding management of health information. • All member information will be maintained in a secure system and location / hard copies in locked files.	Director, Compliance	On-going QAPIC - Annual report December of each year	Quarterly
QUALITY OF CLINICAL CARE / HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)	The Healthcare Effectiveness Data and Information Set (HEDIS) is a collection of performance measures developed and maintained by NCQA. Participation in the program enables organizations to collect and submit verified data in a standardized format. The Plan submits HEDIS data annually in accordance with HEDIS specifications. The Plan will design and implement key interventions to increase the Plan's HEDIS rates.	• Submit the HEDIS Roadmap to Centene Corporate • Ongoing monitoring of HEDIS rates • Conduct monthly HEDIS Steering Committee meetings • Specific Teams to monitor and improve HEDIS indicator rates associated with NCQA accreditation. • NCQA measures will be key performance areas • Conduct off-season HEDIS outreach efforts • Enter information into database for administrative HEDIS • Explore collaborative efforts with vendors • Consider Provider Incentives based upon HBR and HEDIS scores • Consider additional incentives • Continue interventions to increase	Director, QM	Monthly reviews by the HEDIS Steering Committee, annual reporting to QAPIC	Monthly/Annually

STANDARD/SCOPE	OBJECTIVE	DESCRIPTION	ACCOUNTABLE	TIMELINE	MONITORING STATUS
		rates			
NCQA ACCREDITATION	Ensure The Plan's compliance with the NCQA 2013 Health Plan Accreditation standards	• Coordinate efforts across departments and with corporate Centene to bring all areas into full compliance with applicable NCQA standards • Compile required documents and information for review. • Conduct mock survey(s) to assess compliance and readiness for survey	Director, QM	Interim Health Plan Survey May 2014	Monthly
QUALITY OF CARE/PREVENTIVE HEALTH REMINDERS	Improve awareness of and adherence to recommended preventive health guidelines for examinations, screening tests and immunizations promoting the prevention and early diagnosis of disease	Identify measures in need of improvement and which would benefit from the preventive health reminder program Schedule for mailing various reminder cards and coordinate with national awareness months as appropriate http://www.healthfinder.gov/nho/default.aspx)	Director, QM	Annual Review of Reminder content and identification of measures	Monthly

STANDARD/SCOPE	OBJECTIVE	DESCRIPTION	ACCOUNTABLE	TIMELINE	MONITORING STATUS
QUALITY OF CARE/ADULT CORE MEASURES	The Plan will monitor performance and design/implement key interventions to increase the Plan's Adult Core Measure rates.	• Regular monitoring of rates • Monitor performance at monthly HEDIS Steering Committee/Performance Improvement Team meetings • Explore collaborative efforts with vendors • Consider Provider Incentives based upon HBR and Core Measure/HEDIS scores • Consider additional incentives (including member incentives) • Utilize established preventive Health Outreach and education interventions to increase rates	Director, QM	Monthly Review at HEDIS Steering or Performance Improvement Team meetings, annually to QAPIC	Monthly/Annually
QUALITY OF CARE/ADULT CORE MEASURES/CARE FOR CHRONIC ILLNESS	To monitor and improve quality of care for members with chronic illness Comprehensive Diabetes Care – HbA1c Testing Poor HbA1c Control (>9 %)	• Consider Member Incentive Program (CentAccount) • Member and Provider educational and reminder Mailers. • Provide Member disease specific resources on member website. • Conduct or participate in Community Health Fairs • Referral to Disease Management Program • Consider Provider Incentives based upon HBR and Core Measure/HEDIS scores	Director, QM	Monthly Review at HEDIS Steering or Performance Improvement Team meetings, annually to QAPIC	Monthly/Annually

NEBRASKA TO..AL CARE (NTC)
QUALITY IMPROVEMENT WORK PLAN 2017
Attachment 68.C NTC Proposed QAPI Work Plan

STANDARD/SCOPE	OBJECTIVE	DESCRIPTION	ACCOUNTABLE	TIMELINE	MONITORING STATUS
QUALITY OF CARE/ADULT CORE MEASURES/PREVENTIVE HEALTH	To monitor and improve quality of care for members through preventive health screenings Breast Cancer Screening	• Consider Member Incentive Program • Educational Mailers and POM calls. • Outbound calls for women due for a mammogram. • Breast cancer Awareness Mailer in October for noncompliant women. • Targeted CM outreach at identified clinics • Consider Provider Incentives based upon HBR and Core Measure/HEDIS scores	Director, QM	Monthly Review at HEDIS Steering or Performance Improvement Team meetings, annually to QAPIC	Monthly/Annually
QUALITY OF CARE/ADULT CORE MEASURES/BEHAVIORAL HEALTH	To monitor and improve quality of care for members with behavioral health concerns Follow-Up After Hospitalization for Mental Illness	• Outreach to members to assist with appointment scheduling and offering member incentives. • Provider education on follow up needed, coding and billing practices.	Director, QM	Monthly Review at HEDIS Steering or Performance Improvement Team meetings, annually to QAPIC	Monthly/Annually

Approved by QAPIC _____

NEBRASKA TO..AL CARE (NTC)
QUALITY IMPROVEMENT WORK PLAN 2017
Attachment 68.C NTC Proposed QAPI Work Plan

STANDARD/SCOPE	OBJECTIVE	DESCRIPTION	ACCOUNTABLE	TIMELINE	MONITORING STATUS
QUALITY OF CARE/CHILD CORE MEASURES	The Plan will monitor performance and design/implement key interventions to increase the Plan's Child Core Measure rates.	• Regular monitoring of rates • Monitor performance at monthly HEDIS Steering Committee/Performance Improvement Team meetings • Explore collaborative efforts with vendors • Consider Provider Incentives based upon HBR and Core Measure/HEDIS scores • Consider additional incentives (including member incentives) • Utilize established preventive Health Outreach and education interventions to increase rates	Director, QM	Monthly Review at HEDIS Steering or Performance Improvement Team meetings, annually to QAPIC	Monthly/Annually
QUALITY OF CARE/CHILD CORE MEASURES/PREVENTIVE HEALTH	To monitor and improve quality of care for members through preventive health screenings and well child check-ups Well Child 15 month (W15)	• Newborn letters (personalized letter with CDC inserts for scheduled immnuzations from birth to 6 years of age) • Monthly birthday reminder postcards to infants • Member incentive for well-child 6 or more visits before 15 months), • Targeted well-child reminder calls by Member service call campaigns.		Monthly Review at HEDIS Steering or Performance Improvement Team meetings, annually to QAPIC	Monthly/Annually

STANDARD/SCOPE	OBJECTIVE	DESCRIPTION	ACCOUNTABLE	TIMELINE	MONITORING STATUS
QUALITY OF CARE/CHILD CORE MEASURES/PREVENTIVE HEALTH	To monitor and improve quality of care for members through preventive health services Maternal Health Prenatal & Newborn Care Initial Prenatal Exam	• Start Smart For Baby and Notice Of Pregnancy mailings. • OB medical home • Outreach calls to pregnant provider education • Consider year-round chart reviews.	Director, QM	Monthly Review at HEDIS Steering or Performance Improvement Team meetings, annually to QAPIC	Monthly/Annually
QUALITY OF CARE/CHILD CORE MEASURES/PREVENTIVE HEALTH	To monitor and improve quality of care for members through preventive health screenings and immunization schedule Follow State Pediatric Preventive Health visits and immunization schedules (Birth - 21)	• Member outreach through Pfizer/Televox phone calls to Members • Healthy Reminder mailing • Monthly outbound calls to parents of non-compliant children • Monthly • Consider offer member/guardian incentive • Annually educate parents regarding pediatric preventive health and immunization schedule • Consider Provider Incentives based upon HBR and Core Measure/HEDIS scores	Director, QM	Monthly Review at HEDIS Steering or Performance Improvement Team meetings, annually to QAPIC	Monthly/Annually
Mid-year Evaluation:					
Revised Plan:					
PROVIDER SERVICES /CREDENTIALING					
CR 3, CR 7	**NCQA Standard**	**Action Plan**	**Primary Lead(s)**	**Reporting Schedule**	**Monitoring Status**
PROVIDER SERVICES	The Plan health Plan will ensure that the network of physicians and healthcare entities is adequate in order	• The Plan Health Plan conducts the annual Provider Satisfaction survey to ascertain how well the Plan is	Vice President, Network and Provider Relations	Field survey in Q3 2017	Annually

STANDARD/SCOPE	OBJECTIVE	DESCRIPTION	ACCOUNTABLE	TIMELINE	MONITORING STATUS
	to provide members with access to all covered services.	meeting the providers' expectations and needs. • Create multi-disciplinary work group to analyze Provider Satisfaction survey results, conduct barrier analysis, identify opportunities for improvement and make recommendations of interventions to the QAPIC. • Distribution of the provider newsletter (Provider Watch) as needed and other clinical services related materials. • Track, trend and monitor provider complaints data	Manager, Marketing & Communications Director, Compliance	To QAPIC annually QAPIC semi-annually	
Mid-year Evaluation:					
Revised Plan:					
PROVIDER PROFILING	To improve quality and control costs	• Evaluate Provider network for distribution of PCP provider profiles semiannually • Evaluate Provider network for distribution of Specialist provider profiles annually	Vice President, Provider Relations	PCPs semiannually Specialists annually To QAPIC annually	Annually
Mid-year Evaluation:					
Revised Plan:					
Practitioner Office Site Quality/ CR 5	**NCQA Standard**	**Action Plan**	**Primary Lead(s)**	**Reporting Schedule**	**Monitoring Status**
OFFICE SITE QUALITY	To detect and act on potential concerns about office sites	Ensure monitoring of member grievances about practitioner office sites every six months according to NCQA standard	VP of Provider Relations Director, QM	Concurrent monthly reports to Credentialing Committee	Monthly

STANDARD/SCOPE	OBJECTIVE	DESCRIPTION	ACCOUNTABLE	TIMELINE	MONITORING STATUS
				Credentialing Summary report to Credentialing Committee every six months	
Revised Plan:					
Ongoing Monitoring/ CR 6	**NCQA Standard**	**Action Plan**	**Primary Lead(s)**	**Reporting Schedule**	**Monitoring Status**
ONGOING MONITORING OF PRACTITIONERS VIA GRIEVANCES AND ADVERSE EVENTS	To detect and act on potential patterns of concern involving individual practitioners performance.	Ensure monitoring of member grievances and adverse events between re-credentialing cycles at least twice per year	Director, QM	Credentialing Committee biannually	Biannual
Mid-year Evaluation:					
Revised Plan:					
PROVIDER CREDENTIALING	The Plan has a rigorous process to select and evaluate licensed practitioners who provide care and services to its members.	Provider credentialing activities are performed on an ongoing basis.	Director, Provider Relations	Credentialing Committee meets Quarterly and reports to the QAPIC.	Quarterly
Mid-year Evaluation:					
Revised Plan:					

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Attachment
77.a_Sample PCP Provider Profile

IlliniCare Health Plan

A Physician Profile
Presented by Centene Corporation

PCP Patterns of Care

Reporting Period:
07/01/2014 - 06/30/2015

Physician

Name:	VANDNA A SHAH
Secondary ID:	UnKnown
Primary ID:	1124003462
Specialty:	General Practice
Number of Members:	2,006
Member Months:	12,281

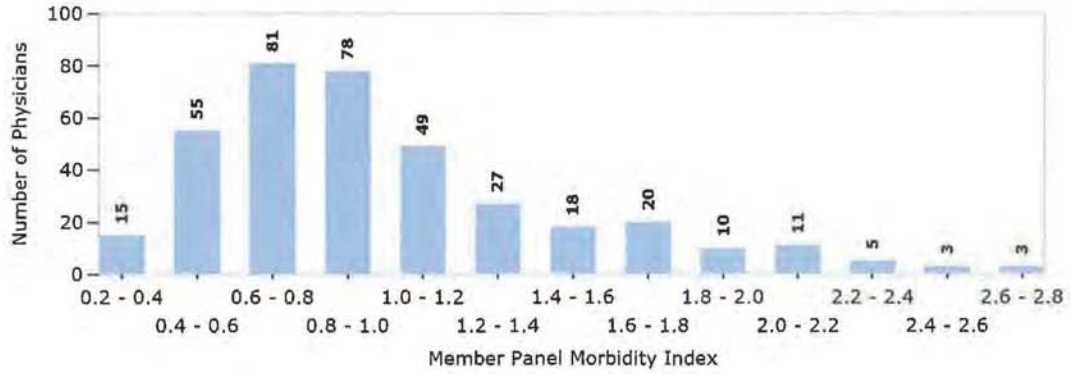
Member Panel Morbidity Index:	0.53
Peer Group	
Peer Group Member Months:	556,313
Peer Group Name:	Centene PCP (Family)
Key Statistics	
Overall Quality Index:	1.02
Overall Cost Index, Population:	0.99

Member Panel Analysis

	Female			Male			Total		
Age Group	**PCP #**	**PCP %**	**Peers %**	**PCP #**	**PCP %**	**Peers %**	**PCP #**	**PCP %**	**Peers %**
00-17	3,888	31.7%	16.3%	3,661	29.8%	16.3%	7,549	61.5%	32.6%
18-30	1,174	9.6%	11.1%	462	3.8%	6.9%	1,636	13.3%	18.0%
31-44	1,428	11.6%	11.2%	457	3.7%	6.5%	1,885	15.3%	17.8%
45-64	629	5.1%	14.0%	483	3.9%	11.0%	1,112	9.1%	25.1%
65-74	48	0.4%	2.7%	20	0.2%	1.2%	68	0.6%	3.9%
75+	19	0.2%	1.8%	12	0.1%	0.9%	31	0.3%	2.7%
Total	**7,186**	**58.5%**	**57.1%**	**5,095**	**41.5%**	**42.9%**	**12,281**	**100.0%**	**100.0%**

Relative Morbidity Histogram

Distribution of Morbidity Across Peer Group Providers

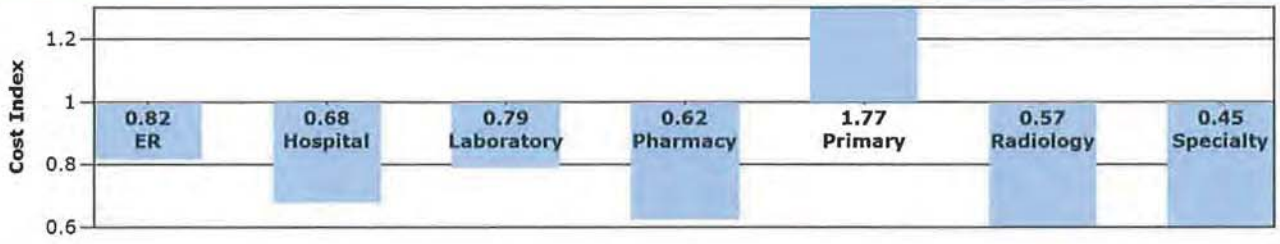


Quality Measures

Analysis Period (07/01/2013 - 06/30/2015)

NO DATA AVAILABLE

Cost Index Summary, by Service Category



Cost and Utilization Summary Measures

Profiled Costs

	PMPM			Total
	PCP Actual	PCP Peers	PCP Index	PCP Actual
Hospital Services	$46.29	$68.18	0.68	$568,541
Pharmacy	$41.46	$66.37	0.62	$509,188
Primary Care Core	$17.92	$10.13	1.77	$220,058
ER	$7.20	$8.81	0.82	$88,374
Specialty Care	$20.93	$46.08	0.45	$257,059
Radiology	$4.27	$7.56	0.57	$52,487
Laboratory	$5.49	$6.94	0.79	$67,480
Total	$143.57	$214.07	0.67	$1,763,188

Overall Cost Index: 0.99

Utilization Rates Per 1,000 Members

Number of Encounters (Annualized per 1,000 Members)

	Actual	Peers	Index
Primary Care Visit Rate	3,835	2,551	1.50
Specialty Care Referral Rate	846	1,320	0.64
Visits per Specialist Referral	1,166	1,906	0.61
Radiology Procedure Rate	486	758	0.64
MRI Procedure Rate	18	31	0.57
Laboratory Procedure Rate	1,731	2,058	0.84
Overall Prescribing Rate	14,840	17,808	0.83
Generic Prescribing %	86%	85%	1.01
ER Visit Rate	558	648	0.86
Admits per 1000 Members	56	93	0.60
Days per 1000 Members	795	1,493	0.53
Average Length of Stay	14.28	16.02	0.89

Episode Detail and Analysis

) DATA AVAILABLE

Report Introduction and Interpretation

Patterns of Care

Member Panel

Panel Morbidity - Peer Distribution

Quality

Cost and Use

Episode Detail

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Attachment
77.b_Sample BH Facility Profile

IlliniCare Health Plan

Affiliation Group Profile
Presented by Centene Corporation

Specialty Patterns of Care

Reporting Period:
07/01/2014 - 06/30/2015

Affiliation Group

Affiliation ID:	366006553-LV1
Affiliation Description:	DUPAGE CITY HEALTH DEPT-LV1
Number of Providers:	44
Number of Episodes:	74
Case Mix Episodes:	0.49

Peer Group

Peer Group Number of Episodes:	460
Peer Group Name:	Centene Allied Behavioral Health (Non-MD)

Key Statistics

Overall Quality Index:	1.23
Overall Cost Index, Episode:	0.45

Episode Case Mix Summary

Top 10 ETGs, by Total Cost (Completed Episodes of Care)

ETG Family Description	Episodes			Encounters (Per 1000 Episodes)	
	Episodes	Actual Cost / Episode	Peers Cost / Episode	Actual Encounters / 1000 Episodes	Peers Encounters / 1000 Episodes
Mood disorder, bipolar	24	$3,326.89	$3,289.71	68,893	62,478
Mood disorder, depressed	40	$1,951.93	$1,394.14	53,301	32,791
Psychotic & schizophrenic disorders	10	$6,752.64	$11,792.26	67,808	108,435
All Others	0	--	--	--	--
All Episodes	**74**	**$3,041.54**	**$3,396.71**	**60,371**	**52,609**

Relative Morbidity Histogram

NO DATA AVAILABLE

Quality Measures

Analysis Period (07/01/2013 - 06/30/2015)

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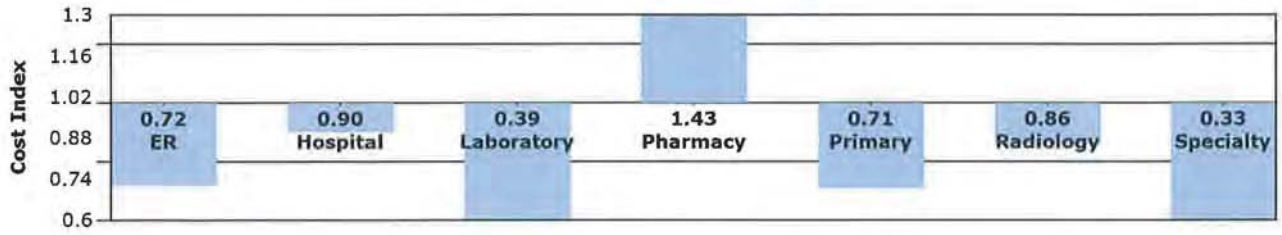
Cost Index Summary, by Service Category



Cost and Utilization Summary Measures

Profiled Costs

	Actual Encounters	Peers Encounters	Actual Cost / Episode	Peers Cost / Episode	Cost / Episode Index	Actual Total Cost
ER	11	13	$25.80	$35.98	0.72	$1,912
Hospital Services	1,432	558	$1,155.82	$1,282.16	0.90	$85,647
Laboratory	28	66	$17.96	$45.84	0.39	$1,331
Pharmacy	1,462	1,728	$1,491.55	$1,043.55	1.43	$110,524
Primary Care Core	39	66	$32.69	$46.13	0.71	$2,422
Radiology	2	2	$7.65	$8.91	0.86	$567
Specialty Care	1,499	1,465	$310.07	$934.15	0.33	$22,976
Total	4,473	3,898	$3,041.54	$3,396.71	0.90	$225,378

Overall Cost Index: 0.45

Utilization Rates Per 1,000 Episodes

	Actual	Peers	Index
Specialist Visit Rate	0	229	0.00
Other Specialty Care Rate	3,846	4,040	0.95
Radiology Procedure Rate	31	20	1.54
MRI Procedure Rate	7	5	1.32
Laboratory Procedure Rate	374	896	0.42
Overall Prescribing Rate	19,730	23,317	0.85
Generic Prescribing %	92%	94%	0.98
ER Visit Rate	135	118	1.15
Admits per 1000 Episodes	0	144	0.00
Days per 1000 Episodes	0	5,980	0.00
Average Length of Stay	0.00	41.65	0.00

Episode Detail and Analysis

) DATA AVAILABLE

Report Introduction and Interpretation

Patterns of Care

Episode Case Mix Summary

Panel Morbidity - Peer Distribution

Quality

Cost and Use

Episode Detail

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Attachment
77.c_Sample Specialist Profile_Cardiology

IlliniCare Health Plan

A Physician Profile
Presented by Centene Corporation

Specialty Patterns of Care

Reporting Period:
07/01/2014 - 06/30/2015

Physician

Name:	SUNG SUP KIM
Primary ID:	1700822541
Specialty:	Cardiology
Number of Episodes:	33
Case Mix, Episodes:	0.97

Peer Group

Peer Group Number of Episodes:	2,308
Peer Group Name:	Centene Cardiology

Key Statistics

Overall Quality Index:	1.00
Overall Cost Index, Episodes:	1.46

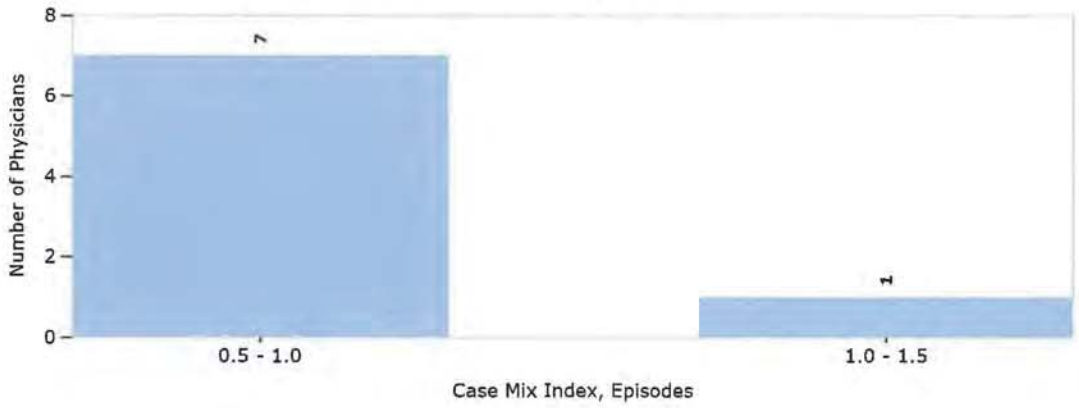
Episode Case Mix Summary

Top 10 ETGs, by Total Cost (Completed Episodes of Care)

ETG Family Description	Episodes	Episodes: Specialist's Cost / Episode	Episodes: Peers Cost / Episode	Encounters (Per 1000 Episodes): Specialist's Encounters / 1000 Episode	Encounters (Per 1000 Episodes): Peers Encounters / 1000 Episode
Ischemic heart disease	15	$5,917.49	$3,918.48	39,541	33,288
Hypertension	14	$1,441.06	$1,004.90	29,868	27,453
Heart failure, diastolic	2	$10,401.82	$4,579.98	14,781	15,645
Cardiomyopathy	2	$893.39	$1,665.96	9,405	21,265
Congestive heart failure	0	$4,829.38	$2,063.50	174,875	27,625
Hyperlipidemia, other	0	$111.93	$314.00	12,244	12,707
All Others	0	--	--	--	--
All Episodes	**33**	**$3,896.56**	**$2,539.61**	**32,274**	**28,865**

Relative Morbidity Histogram

Distribution of Case Mix Across Peer Group Providers



Quality Measures

Analysis Period (07/01/2013 - 06/30/2015)

	Number of Quality Opportunities		Rates		Index
	With Compliance	Total	Provider Rate	Peer Rate	Quality Index
Cardiology					
CHF					
Patient(s) currently taking a beta-blocker.	1	1	1.00	0.88	1.14
CHF					
Patient(s) currently taking an ACE inhibitor or acceptable alternative.	1	1	1.00	0.83	1.20
CHF					
Patient(s) taking ACE inhibitor, angiotensin II receptor antagonist, selective aldosterone receptor antagonist, or digoxin that had serum potassium test in last 12 reported months.	1	1	1.00	0.96	1.04
CHF					
Patient(s) taking contraindicated Class I antiarrhythmic medication (excludes patients with diastolic heart failure).	1	1	1.00	0.99	1.01
CHF					
Patient(s) that had an annual physician visit.	2	2	1.00	0.78	1.27
Total	**6**	**6**	**1.00**	**0.87**	**1.15**

Cost Index Summary, by Service Category

Cost and Utilization Summary Measures

Profiled Costs

	Actual Encounters	Peers Encounters	Actual Cost / Episode	Peers Cost / Episode	Cost / Episode Index	Actual Total Cost
ER	8	7	$38.22	$40.29	0.95	$1,274
Hospital Services	80	64	$2,711.57	$1,563.79	1.73	$90,349
Laboratory	68	57	$72.25	$46.64	1.55	$2,407
Pharmacy	663	569	$271.80	$287.74	0.94	$9,056
Primary Care Core	31	22	$56.70	$33.32	1.70	$1,889
Radiology	29	24	$320.85	$106.73	3.01	$10,691
Specialty Care	197	219	$425.17	$461.11	0.92	$14,167
Total	1,075	962	$3,896.56	$2,539.61	1.53	$129,833

Overall Cost Index: 1.46

Utilization Rates Per 1,000 Episodes

	Actual	Peers	Index
Specialist Visit Rate	2,371	2,756	0.86
Other Specialty Care Rate	1,741	1,775	0.98
Radiology Procedure Rate	860	709	1.21
MRI Procedure Rate	60	6	10.00
Laboratory Procedure Rate	2,048	1,718	1.19
Overall Prescribing Rate	19,898	17,084	1.16
Generic Prescribing %	95%	96%	0.99
ER Visit Rate	60	94	0.64
Admits per 1000 Episodes	210	163	1.29
Days per 1000 Episodes	960	979	0.98
Average Length of Stay	4.57	5.99	0.76

Episode Detail and Analysis

Congestive heart failure

Total Specialty Episode Costs: $386

Cost per Episode	# of Episodes	Total	Primary Care Core	Specialty Care	Laboratory	Radiology	Hospital	Pharmacy	ER
Actual	0	$4,829.38	$0.00	$4,366.00	$0.00	$200.38	$0.00	$263.00	$0.00
Peers		$2,063.50	$24.00	$360.38	$39.13	$51.63	$1,325.75	$235.00	$27.63
Index									
Encounters per 1000 Episodes									
Actual			0	99,875	0	25,000	0	50,000	0
Peers			500	6,125	2,125	750	1,250	16,625	125
Index									

Hypertension

Total Specialty Episode Costs: $20,290

Cost per Episode	# of Episodes	Total	Primary Care Core	Specialty Care	Laboratory	Radiology	Hospital	Pharmacy	ER
Actual	14	$1,441.06	$71.50	$141.78	$23.01	$342.72	$419.62	$437.51	$4.92
Peers		$1,004.90	$50.54	$276.21	$34.16	$88.12	$277.48	$267.38	$11.01
Index			1.41	0.51	0.67	3.89	1.51	1.64	0.45
Encounters per 1000 Episodes									
Actual			1,172	3,658	553	657	994	22,798	36
Peers			994	5,131	1,024	511	1,346	18,391	57
ndex			1.18	0.71	0.54	1.28	0.74	1.24	0.63

Ischemic heart disease

Total Specialty Episode Costs: $88,289

Cost per Episode	# of Episodes	Total	Primary Care Core	Specialty Care	Laboratory	Radiology	Hospital	Pharmacy	ER
Actual	15	$5,917.49	$59.15	$741.71	$115.36	$358.28	$4,401.56	$178.90	$62.53
Peers		$3,918.48	$25.15	$630.10	$58.91	$144.40	$2,639.15	$356.35	$64.41
Index			2.35	1.18	1.96	2.48	1.67	0.50	0.97
Encounters per 1000 Episodes									
Actual			938	8,530	3,136	966	3,952	21,716	302
Peers			490	8,608	2,349	956	2,690	17,875	318
Index			1.92	0.99	1.33	1.01	1.47	1.21	0.95

Report Introduction and Interpretation

Patterns of Care

Episode Case Mix Summary

Panel Morbidity - Peer Distribution

Quality

Cost and Use

Episode Detail

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IV.N Utilization Management

IV.N Utilization Management

80. Describe the MCO's approach to utilization management, including: (5 page limit)

Approach to Utilization Management. Nebraska Total Care (NTC) will leverage our parent company, Centene Corporation (Centene)'s, experience managing and overseeing utilization for more than 4.8 million Members in government sponsored healthcare programs in 23 states, combined with our local health plan approach and the requirements of the Scope of Work (SOW) to develop and implement a Utilization Management (UM) program for Heritage Health. The scope of our UM Program applies to all eligible Members across all product types, age categories and range of diagnoses as well as all services and care settings across the continuum of care. The goals of the UM program are to optimize Members' health status, sense of well-being, productivity, and access to quality health care, while at the same time actively managing cost trends. Our UM program will focus on both individual and system processes and outliers to assess whether individuals are meeting their health care goals and that the system as a whole is meeting the goals for delivery of community based services. Using established criteria and guidelines tailored to the community, NTC's UM program will ensure the right services, at the right time, in the right setting. The functions of the program will include referrals, second opinions, prior authorization, concurrent review, discharge planning and utilization oversight for physical and behavioral health, and pharmacy services. Our UM policies and procedures, as well as those of our subcontracted vendors, will comply with all elements of the SOW, the most current NCQA Health Plan Standards and Guidelines, and other applicable State and Federal guidelines. Our integrated UM, Care Management, and Quality Management programs will work together to promote a lifetime of healthy behaviors and outcomes. NTC's written UM Program, including all elements described in SOW Section IV.N.2, will be fully articulated in a comprehensive UM Program Description to be reviewed at least annually by the UM Committee (UMC) and QAPI Committee (QAPIC). We will submit the description to the State for written approval within 30 days of execution of a contract, annually thereafter, and prior to any material revisions. The program structure, procedures, and criteria; evaluation, oversight and accountability; and integration of physical, behavioral, and pharmacy services, are all designed to promote medically necessary, fair, impartial, and consistent decisions. Under the direction of our Chief Medical Director (CMD), our UM staff will be highly trained to facilitate the provision of medically necessary care by authorizing covered services that are appropriate for the member's condition in amount, duration, and scope; provided in the appropriate setting; and meet evidence-based care standards. Key staff include the Vice President of Medical Management (VPMM), nurses, behavioral health clinicians, referral specialists, and pharmacy staff. We will hire local, appropriately licensed personnel to ensure our review process considers the regional and cultural characteristics of our members, the local delivery system, and practice patterns of our providers.

- ***Innovations and automation the MCO will use for its' UM program.***

UM Innovations and Automations. Leveraging Centene's robust technology platform and best practices from our affiliate plans across the country, NTC proposes to bring a combination of innovations and automations to members and providers of Heritage Health that support medically necessary care, consistent application of guidelines and monitoring and intervention for under- and over-utilization.

Centelligence™ Data Analytics. NTC's UM Program is supported by Centelligence™, Centene's proprietary family of integrated decision support and healthcare informatics solutions. Centelligence facilitates robust data collection, indicator measurement, analysis, and improvement activities. Centelligence uses a Teradata-powered Enterprise Data Warehouse (EDW) as the central hub for service information that allows collection, integration, and reporting of both internal and external data including medical, behavioral health and pharmacy claim/encounter data. NTC will monitor claims and other data to identify instances of over- and under-utilization of health care services, identify aberrant provider practice patterns (especially related to emergency room, inpatient services and drug utilization), evaluate efficiency and appropriateness of service delivery, identify quality of care issues and facilitate program management. **Predictive Modeling.** Centelligence predictive modeling utilizes a risk calculation

methodology that pre-groups and characterizes unique episodes of care that describe a member's observed mix of diseases and conditions and underlying co-morbidities and complications. Our methodology considers risk factors for each diagnosis being managed and stratifies members into health continuum levels and risk categories. Additional criteria used in our predictive methodology include gaps in care, emergency room or inpatient utilization, and medication adherence. **Embedded Clinical Criteria to Ensure Consistent Application of Medial Necessity Criteria.** NTC will use TruCare, our fully integrated medical management documentation and authorization system to support our utilization review, discharge coordination and care management processes. Both physical and behavioral health staff will use TruCare, ensuring a truly integrated approach to coordination of care. TruCare incorporates InterQual® Criteria (described below) in a fully automated, interactive workflow that supports real-time physical and behavioral health appropriateness reviews and determinations, consistent application of criteria and clear documentation of the review process and rationale for each decision. All entries are electronically date and time stamped indicating user name. Supporting medical records, letters and associated communications are linked to the auto-generated authorization number. TruCare also includes a fully integrated appeals workflow management for timely appeals process support, management, and reporting. **Continuity of Care for New Members.** NTC proposes to implement an automated process to support continuity of care for new members. Using historical claims data and open/approved authorization files provided by the state agency, NTC affiliates auto-generate authorizations for physical health, behavioral health and pharmacy services for new members during the designated continuity of care period. This automation significantly reduces member and provider administrative burden of obtaining authorizations for services in process at the time of enrollment and prevents claims from being denied due to lack of authorization.

Innovative Provider Tools and Automations

Robust and Interactive Provider Portal. Our secure Provider Portal reduces our provider's administrative burden by enabling all authorized network and out of network (OON) providers to view a wide variety of data and information about the members they are treating to monitor their utilization and ensure they are accessing care appropriately. NTC's Secure Provider Portal offers the following functionality to support accurate and timely processing of prior authorization requests:

- Web-based prior authorization module that allows submission of supporting information; the online form speeds PA decisions and reduces denials by not allowing the submission of requests that are incomplete or for members no longer enrolled
- Access to InterQual® SmartSheets™ that provide guidance on clinical information necessary to complete the review; shown to reduce or eliminate the need to request additional information
- Centelligence Member Health Record which provides a well-organized view of a member's use of services, including a summary "face sheet" and detailed claims information; providers can also view the member's health risk screening results and care plan
- Online Care Gap Alerts indicating when a member is due for or missing a service recommended by evidence-based guidelines as well as an emergency department (ED) alert for members with three or more ED visits in a six month period
- Emergency Department Flag function that enables ED staff checking the member's eligibility to indicate when a member is being admitted to an ED, allowing our staff to take appropriate action at a 'teachable moment'

Value-Based Reimbursement. While the traditional fee for service model creates incentives for providers for the quantity of services provided, our shared savings model and other incentive programs will reward providers for behaviors that drive high quality, cost effective care. Creative structuring enables us to engage providers in both cost containment and quality improvement initiatives through various payment reform options geared toward incentivizing the right care, in the right place, at the right time. In Nebraska, as in other states where Centene has successfully implemented innovative payment models, we will work closely with our providers to build a program that "meets providers where they are

and takes them to where they want to be." Our payment initiatives include both value-based and incentive-based pay-for-performance components, such as shared savings and episode based payments that focus on impacting quality and reducing costs. We also offer several non-financial incentives, such as our Gold Card Program which rewards strong clinical management by providers who consistently comply with clinical practice guidelines and exempts them from certain PA requirements. In addition, we will actively partner with high volume hospitals to implement value-based purchasing programs that encourage providers to support the concurrent review clinicians in effective discharge planning.

Innovative Member Programs, Tools and Automations

Member Portal. NTC's Member Portal enables members to be active participants in their healthcare, equipping them with information to make appropriate utilization decisions, such as getting timely preventive care and appropriate use of services. NTC's Member Portal gives our members a holistic online experience – allowing them to seamlessly access administrative (e.g. authorization status and requirements, PCP changes) and health related functionality. NTC's Member Portal offers members consumer friendly information specific to their particular health and care situation including access to their medical, behavioral, and pharmacy service level information such as personalized care gaps alerts presented in an actionable manner useful to lay persons. Members can also exchange secure messages in an e-mail format with NTC clinical care staff. Additionally, NTC's health data exchange capabilities supports a secure data interface with the health industry's leading Personal Health Record (PHR) platform: Microsoft HealthVault. Upon member request and formal "opt-in" authorization, NTC securely sends claims data to the member's HealthVault account. The member (or anyone the member authorizes within HealthVault) has easy access to their health history. In the event of a dislocating emergency, members with a PHR are able to share health history with providers wherever they may find themselves. The member's HealthVault PHR stays with the member regardless of their enrollment status in NTC, an important consideration should members transition between MCOs or to other health insurance.

NTC Member Mobile Application. We are deploying an NTC Member Mobile Application (MyNTC) designed to be a comprehensive and integrated mobile "one stop shop" for our members and support member self-management. We continue to evolve our mobile strategy keeping in mind the needs of our members and will have mobile functions available to help support appropriate utilization of services. For example, our Find-a-Provider tool uses the native Global Positioning System (GPS) technology included in mobile devices to help members not only find network providers near them, but also automatically get directions to those providers, and instantly call a selected provider. MyNTC also includes health and wellness resources, including interactive resources such as personal health challenges and fitness and nutrition tracking to keep members engaged in their health on an ongoing basis. CentAccount® Member Incentive Program. CentAccount promotes personal responsibility by offering members financial incentives that reward them for healthy behaviors, such as timely preventive services. Recognized as a best practice by the Medicaid Health Plans of America, CentAccount rewards can be used to purchase health care items, groceries, baby and personal care items, and some over-the-counter medications.

- ***Accountability for developing, implementing, and monitoring compliance with utilization policies and procedures, and consistent application of criteria by individual clinical reviewers.***

Accountability for UM P&Ps and Consistent Application of Criteria. Oversight and operating authority for the UM Program is delegated to the UMC, which is accountable to the QAPIC and ultimately to the NTC Board of Directors. The UMC focuses on oversight of clinical service delivery trends; coordinates annual review and revision of the UM Program Description, Work Plan and the Annual UM Program Evaluation; monitors compliance with UM P&Ps; and reviews results of oversight activities including inter-rater reliability (IRR), operational performance metrics, and clinical quality activities. The CMD and VPMM are the senior executives accountable for implementing the UM Program including cost containment; medical necessity review activities related to UM; monitoring and analyzing UM data reports; medical quality improvement;; complex, controversial, or experimental services; provider practice compliance auditing and successful operation of the UMC. Additionally, NTC's Clinical Advisory Committee (CAC) reviews and provides input into all P&Ps, including clinical

and practice guidelines and criteria. UM Policies and Procedures. UM P&Ps are adopted in consultation with contracting health professionals and ensure covered services are medically necessary and not arbitrarily or inappropriately approved, denied, or reduced in amount, duration, or scope. We begin with evidence based, nationally recognized clinical guidelines, contractual requirements, applicable corporate policies, and accreditation standards, and develop policies and procedures that support high quality, compliant processes. The policies are presented to the CAC and UMC, which review in consideration of the unique needs of our population related to health disparities and regional variances in the Nebraska health delivery system, and makes recommendations that support clinically sound, efficient, and cost effective processes. Approved guidelines are then submitted to the state for final approval. Monitoring. The UMC is accountable for monitoring and analyzing relevant UM data to determine compliance with and effectiveness of the UM Program. The UMC reviews data to detect and correct patterns of potential or actual under- or over-utilization. The UMC also monitors performance metrics, including phone access, adverse determinations, appeals volume, outcomes of IRR and medical record audits, and timeliness of decision making. Accountability for Consistent Application of Criteria. The CMD is accountable for oversight of UM staff training and measuring performance against standards such as timeliness of decision-making and notice, consistent application of CPG's, and quality initiatives. NTC will provide training to all UM staff on approved UM criteria, P&Ps, use of our clinical system, NCQA standards, and documentation. Our Clinical Trainers, dedicated to training our UM staff, maintain and implement a robust and comprehensive role-based training program. We will use classroom training, an established training curricula, online courses, and case studies to train new employees on job-related skills and situations. All UM staff are required to engage in mandatory quarterly training to ensure up-to-date knowledge regarding CPG's, and to support ongoing skills development. UM staff responsible for medical necessity decision making receive in-depth training and testing on application of our adopted medical necessity review criteria. Inter-Rater Reliability. UM staff and clinical reviewers, complete IRR testing within 30 days for new hires and annually thereafter to evaluate the consistency with which staff apply UM criteria. We use the McKesson IRR test that is applicable for InterQual criteria. The test evaluates the consistent application of medical necessity criteria by comparing decision making among clinical reviewers against the standards provided by InterQual. Staff who do not achieve a score of >90% on any subset must attend retraining and successfully retest within 30 days of retraining. The VPMM implements a departmental CAP when there is a cumulative score of <80 on any one question. The UMC and QAPIC review these reports at least annually to identify potential trends or patterns that require corrective action or additional training as needed.

- ***Mechanisms to detect and document over- and under-utilization of medical services.***

Mechanisms to Detect and Document Over- and -Under Utilization

NTC will identify patterns of under- and over-utilization by continually monitoring and analyzing UM data (i.e., claims, encounters) from clinical processes, activities, and programs including prospective, concurrent and retrospective review; adverse determinations; preventive care; transition planning; and drug utilization review. These analyses allow us to identify opportunities for improvement, assess plan- and provider-level compliance with our UM guidelines, and monitor program integrity and authorization accuracy. NTC's UM staff will review and analyze a variety of utilization data reports on a regular basis (i.e., daily, weekly, monthly, quarterly, and ad hoc). We will monitor and analyze data at aggregate and detail levels by Member, individual provider or facility, provider specialty, type of service, diagnosis, place of service, region, and comparing services authorized to services received. Each report will include a drill-down capability to more specific areas of interest. For example, when analyzing ER visits or inpatient utilization, we look not only at total number of visits or days, but also at the utilization in relationship to readmissions, frequent ER utilization, or presence or absence of physician office visits. UM reports are presented to the UMC and QAPIC at least quarterly.

- ***Processes and resources used to develop and regularly review utilization review criteria.***

Development and Review of Utilization Review (UR) Criteria. Our UMC will develop, review, and maintain UR criteria which are clinically sound and meet federal, State, and professional standards.

Nationally Recognized Criteria. NTC will use InterQual® to determine medical necessity of service and level of care for physical and behavioral health services. InterQual guidelines are nationally recognized and developed by physicians and other health professionals who review medical research and incorporate the expertise of a national panel of clinicians and medical experts. These experts represent community and academic practice settings, as well as managed care, throughout the United States. The clinical content of these criteria is a synthesis of evidence-based standards of care, current practices, and consensus from licensed specialists and PCPs. We will also use American Society of Addiction Medicine (ASAM) criteria for inpatient and outpatient chemical dependency care. For pharmacy services, NTC will follow the Nebraska Medicaid PDL. Preferred drugs will be adjudicated as payable without prior authorization, unless they are subject to clinical or utilization edits, as defined by MLTC. **Internally Developed Criteria.** For services which InterQual and ASAM have no criteria, NTC will use internally developed guidelines as approved by the our CAC and UMC, including a voting majority of physicians who are not employees of NTC. To support this process, we will leverage our parent company, Centene's, Clinical Policy Committee (CPC), which includes Medical Directors and nurses from each Centene health plan and develops criteria in the form of Clinical Policies. The CPC reviews sources including, but not limited to, scientific literature, government agencies such as Centers for Medicare and Medicaid Services (Coverage Determinations and other policies), specialty societies, and input from relevant specialists with expertise in the technology or procedure. NTC's Chief Medical Director will participate in the CPC, and submit guideline development requests to Centene's Chief Medical Officer. The CPC develops guidelines based on such requests and on new technologies, procedures, and certain durable medical equipment and specialty pharmaceuticals identified during its quarterly reviews. NTC's Medical Director will work with the CPC and MLTC to ensure guidelines address Nebraska requirements and the needs of our Members. **Continuous Improvement and Review.** NTC will actively solicit network provider input into UM criteria through multiple channels including input from providers participating on our CAC and UMC. We will also incorporate other provider feedback into decision making that reflect provider satisfaction or concerns with our criteria, including feedback obtained during peer-to-peer conversations, office visits by Provider Relations staff, responses on questions related to UM on our provider satisfaction surveys and feedback from providers who have been involved in appeals of UM decisions. UM criteria will be reviewed no less than annually.

- ***How the MCO will use its' UM Committee to support UM activities.***

How NTC will use its UMC to support UM activities. The NTC Board of Directors oversees the development, implementation, and evaluation of the UM Program and approves the Annual UM Program Description, Annual Evaluation, and Work Plan. The Board delegates oversight and operating authority through the QAPIC to the UMC. The CMD has oversight of the UMC and the UMC oversees an integrated management system that is responsible for the assessment, planning, implementation, and evaluation of all UM activities, including, but not limited to review and approval of UM policies, procedures, protocols, criteria, and clinical guidelines. UM policies and procedures describe the process by which UM conducts prospective, concurrent, and retrospective review for medical necessity, referral management, second opinions, and coordination of care through collaboration with other clinical functions. All UM data is reported to the UMC quarterly unless significant variances are identified requiring immediate interventions. In such cases, the CMD and VPMM assess the variance, and recommend appropriate action. Routine reports provide a comprehensive analysis of data, including identification of variance or trends, review of outcomes, and recommended interventions based on the findings. The UMC makes recommendations that may include additional data analysis, continued monitoring of a process or provider, and/or corrective action. Recommended actions may be multi-departmental; revisions to prior authorization requirements; new or revised CPG's or criteria; network development activities; improvements in UM data collection and monitoring; staff and/or provider training; or addressing the practice patterns of a particular provider or the UM patterns of an individual Member.

(2 page limit)

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.

Process to Determine Appropriate Practice Guidelines

Clinical Practice Guidelines (CPGs) assist providers, members, and caregivers in making decisions regarding health care for specific diagnoses and symptoms. Nebraska Total Care (NTC) will base our guidelines on valid and reliable clinical evidence, consensus of health care professionals practicing in the relevant field, and the needs of our members including children with serious emotional disorders and adults with serious and persistent mental illness. NTC's affiliate health plans in 23 states across the country have implemented CPGs that are valid and reliable, evidence-based, consistent with national standards and in accordance with 42 CFR 438.236. As our affiliates have done, we will adopt CPGs for prevention and management, that reflect specific recommendations published in peer-reviewed literature and by nationally recognized or governmental organizations (such as the American Academy of Family Physicians, the Centers for Disease Control and Prevention, and American Academy of Child and Adolescent Psychiatry).

NTC will coordinate CPG development with other Heritage Health MCOs and adopt CPGs based on the identified needs of our enrolled population, variations in network practice patterns, feedback from staff and providers, and opportunities for improvement identified as part of our Quality Assessment and Performance Improvement (QAPI) Program. To do so, we will review relevant research findings, clinical trials, published best practices, and CMS, NCQA, DHHS and MLTC requirements; analyze claims data to identify member needs or variations in provider practice patterns; and assess trends in member complaint and quality of care data related to specific clinical conditions. CPGs will be reviewed by the Clinical Advisory Committee and submitted to NTC's Quality Assurance and Performance Improvement Committee (QAPIC), which includes network providers, for suggestions, review, and approval at least annually and as needed based on updated guidelines. NTC will obtain prior approval from MLTC for practice guidelines and UM guidelines adopted by NTC and any modifications made to the guidelines. NTC will ensure that all decisions related to utilization management, course of treatment decisions, and member education are consistent with the established CPGs. NTC will submit CPGs recommended for adoption to MLTC 30 days prior to the contract start date.

Proposed Practice Guidelines. Evidence-based health care supports the triple aim of improving population health, improving the care of individuals, and reducing the cost of care. These guidelines and measures assist in providing a common understanding between providers and members, and facilitate improved care coordination and member outcomes. They can also be used to support value-based reimbursement. NTC's proposed CPG's for physical and behavioral health may include, but are not limited to:

- ADHD Treatment Guidelines
- Bipolar Disorder
- Coronary Artery Disease (CAD)
- Diabetes
- Heart Failure
- Chronic Respiratory Disease incl. Chronic Obstructive Pulmonary Disease (COPD)
- Hypertension
- Major Depressive Disorder (MDD)
- Prenatal Care
- Schizophrenia

Preventive Health Guidelines. NTC's health plan affiliates across Centene have also implemented Preventive Health Guidelines (PHG) for perinatal care, care for children up to 24 months old, care for children 2-19 years old, care for adults 20-64 years old, and care for adults 65 years and older. NTC proposes to implement PHGs in Nebraska as well to expand opportunities for education, engagement and support of integrated, high quality health care. PHG's may include, but are not limited to:

- Adult Preventive Health Guidelines
- Asthma Guidelines
- Routine Perinatal Care Guidelines
- Practice Guidelines for the Prevention of
- Diabetes Care Guidelines
- Lead Toxicity Screening Guidelines
- Immunizations
- Preventative Health and Maintenance of Sickle

Childhood Obesity
- Pediatric Preventive Health Guidelines

Cell Patients
- Diagnosis and Management of Pharyngitis

Notification to Providers of New Practice Guidelines. NTC will notify providers of all new or revised CPGs, and will monitor their implementation. NTC will distribute CPGs to the practitioners who are likely to use them and other providers upon request. NTC will disseminate new or updated guidelines to providers via NTC's website in a timely manner consistent with MLTC requirements. Our **Provider Handbook** will include reference to all adopted CPGs and PHGs and links to the full guidelines available on NTC's website, as well as directions for requesting a hard copy. Additional mechanisms to notify and distribute guidelines include, but are not limited to:

- New provider orientation materials
- Provider and member newsletters
- Member Handbook
- Special mailings, for example distribution of CPGs and PHGs will be tracked in the QAPI Work Plan and summarized in the QAPI Annual Program Evaluation.

Monitoring Implementation of Guidelines. Provider compliance with CPG recommendations indicates successful guideline implementation. At least annually, NTC will measure provider performance against at least two of our adopted clinical practice guidelines, and provide the QAPIC and the MLTC with the results and a summary of any corrective actions taken to ensure compliance. Whenever possible, NTC will use HEDIS metrics derived from nationally recognized CPGs to measure provider and practitioner adherence to the guidelines. We will analyze these CPG adherence metric results in conjunction with other data points, such as complaints, adverse incidents and results of focused quality reviews. If the performance measurement rates fall below set goals, NTC will implement interventions for improvement as applicable.

Motivating and Facilitating Compliance. Our strategies for effective CPG implementation focus on motivating providers and facilitating their use of guidelines. By involving providers in the selection and adoption of CPGs and distributing performance data to providers, NTC obtains valuable input on guideline structure and improvement activities to maximize acceptance by the provider community. We will monitor indicators that measure guideline performance and include this data and comparative benchmarks in our Provider Profile Reports. Our Provider Portal offers access to practice-level clinical quality reports so providers can self-monitor CPG compliance. The Provider Portal displays member-level care gaps (with practice-level summaries) that identify panel members in need of specific guideline-recommended preventive care and chronic condition related services. Our Care Management (CM), Utilization Management (UM) and Disease Management (DM) programs are consistent with, and support compliance of, approved CPGs. Our CM, UM and DM staff will provide education and guidance on CPGs when interacting with providers serving members who have conditions relevant to our CPGs. By using *Centelligence*™, our integrated suite of decision support and health care informatics solutions, they keep providers updated on member-level utilization, risk, service, and DM data.

When we identify providers with persistent CPG noncompliance, an NTC clinician will provide targeted education to support use and compliance with the CPGs. In conjunction with the clinical technical assistance, our provider relations staff will provide training related to proper coding and claim submission. All corrective actions are developed in concert with the provider/practitioner and are monitored by our QI department.

Financial and Non-Financial Incentives. NTC will motivate CPG compliance through financial and non-financial incentives. In part, our incentives are linked to performance on CPG-related Provider Profile indicators. See our response to question 97 Provider Reimbursement, for details on our provider incentive programs. In addition, CPG compliance measurements will be included in the Value Based Purchasing agreements that we are executing with our provider partners as part of our Quality program.

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). (4 page limit)

Nebraska Total Care (NTC) is very sensitive to State finances. By incorporating the strategies and experience of our parent company, Centene Corporation (Centene), and our affiliate health plans who have more than 30 years of experience in managing costs of populations similar to those in the Heritage Health Program, NTC will be a conscientious steward of Nebraska Medicaid dollars. Our policies, practices and programs will be strategically targeted to reduce or at least control the cost of care while improving the health of the communities we serve. NTC will work to maximize health outcomes by ensuring our members receive consistent, unduplicated care that is of the best quality and in line with **evidence-based** clinical practice guidelines. Our goal is not simply to reduce inappropriate utilization and cost, but to ensure member access to the **right care, at the right time, at the right place**, in order to establish a lifetime of healthy behaviors and outcomes. Recognizing that members will often have complex needs and require a level of ongoing engagement and care, our clinical programs will focus heavily on coordination of care, including physical, behavioral health, and pharmacy as well as services from other state programs such as home and community based services. NTC's programs will be closely integrated across functional units including finance, utilization management, care management, quality management and provider network to effectively monitor allocation of funds while promoting the right service, at the right time, in the right setting, with every department responsible for monitoring and controlling costs and promoting efficiency across functions.

Initiatives to Address Waste, Improve Quality, and Enhance Cost Containment

As a data driven organization with a focus on continuous quality improvement, our efforts will be supported by Centelligence's sophisticated data management and predictive modelling capabilities for data collection, indicator measurement, and analysis. As potential areas of waste are identified, we will have a formal process for reporting, developing and implementing interventions, and evaluating and continuously monitoring results, making necessary improvements along the way. Information will initially be brought to the appropriate subcommittee, and ultimately to the QAPIC Committee. For example, an issue of waste tied to a specific provider will be brought to the Utilization Management and Credentialing Committees.

Leveraging best practice programs from our affiliate health plans, coupled with local community feedback we have collected through our face-to-face stakeholder engagement across Nebraska, NTC will tailor programs aimed at reducing waste and maximizing cost effective service delivery model. Some of these programs build on standard managed care processes built on evidence based practice and designed to ensure appropriate service delivery, such as our Utilization Management and Prior Authorization process and our Fraud, Waste and Abuse program, while others are more targeted at specific areas of identified waste or potential inefficiency. Centene affiliates have implemented comprehensive strategies demonstrating success through metrics such as reductions in hospital admissions and ED visits. For example, an internal analysis of members in care management during 2014 across all Centene health plans (using observational analysis method) found that, on average, our Centene care management program resulted in significant savings in inpatient hospital and ED PMPM costs ($226 and $19 PMPM, respectively). The managed population also had better compliance rates in many HEDIS measures concluding that our care management efforts resulted in more appropriate and improved quality of care. Below we describe specific programs aimed at reducing or maintaining utilization of services.

Inappropriate Utilization of Emergency Department (ED). Emergency room services for non-emergent conditions are one of the most commonly 'wasted' services in health care, especially in low-income populations who are affected by barriers to meeting their basic care needs. NTC will build from the best practice programs established by its affiliate health plans to implement a comprehensive ED diversion program through member education, early identification of super-utilizers and intensive care

coordination to help members address barriers including social determinants of health (e.g. healthy foods, stable housing, health literacy). As further described in our response to Question 88, NTC's ED Diversion program will provide services to members with frequent or inappropriate ED usage patterns for physical or behavioral health issues. Care managers will reach out members that had an ED visit to assist with obtaining follow-up care, provide education regarding appropriate use of the ED, importance of getting primary and preventive care, the availability of the 24/7 nurse advice line and the closest urgent care site. The CM also will address barriers to care and assesses health literacy and self-management. In 2012, our Georgia affiliate's similar ED Diversion program received a Case in Point Honorable Mention and Platinum Award. Our Florida affiliate, Sunshine Health, saw a 46% decrease in ER utilization between 2012 and 2013. In 2015, as part of its ER Diversion and avoidable readmissions care management programs, Sunshine Health started using a daily electronic data file from participating hospitals, which is created from the hospitals' Admission, Discharge and Transfer (ADT) registration data. Our Indiana affiliated health plan's (MHS) Emergency Room (ER) Diversion Program achieved a reduction of over 12 percentage points between measurement year 2009 and 2013. For members in their Lock-in Program, MHS saw a decrease in costs by 30.7% for emergency room utilization and 37.7% for inpatient services in 2013. Our Missouri affiliate, Home State Health, saw ER utilization reduced by 14%. In addition, 60% of members that received outreach through this program discontinued inappropriate use of the ER 90 days after outreach. In a related quality improvement project, oral health initiatives implemented by our Missouri affiliate in 2013 resulted in a decrease of 88.8% in ER visits for dental issues. Home State was honored with a 2015 Case In Point award for its ER Diversion Program. **Stakeholders, Timelines, and Outcomes.** NTC will partner with local network providers such as Catholic Health Initiatives (CHI) and ENHANCE Health Network (formerly RPN) to implement programs to support reduction of inappropriate ED services. For example, NTC's contracting team has already met with Galen Bernadt from Lincoln ED Connections at Bryan Health to discuss opportunities for partnering on their emergency department (ED) super-utilizer program. Through this collaborative effort, Bryan East/West and St. Elizabeth's have joined together to track patients who frequently visit the ED and to offer those Member's care management services. They have identified many of these patients as 'drug seekers'. Upon contract award, NTC will formalize our partnership and processes to share utilization data so that the ED has a broader perspective of the member's utilization of services including prescriptions and to identify and conduct outreach to members whose use of the ED for non-emergent reasons has not yet met the super-utilizer criteria. We will ask the participating facilities to refer members to NTC's care management programs as appropriate including our pharmacy lock-in program for members identified as having frequent ED use or multiple prescriptions and/or prescribers of narcotic medications. Additionally, NTC staff have been in discussions with FQHCs in Norfolk regarding an ED diversion pilot and have also spoken to Lutheran Family Services and Health 360 regarding similar opportunities. Expected outcomes include decreased ED use for non-emergent services, increase use of primary care services, and increase compliance with preventive health services such as cancer screenings and diabetic monitoring. **Reducing Unnecessary Readmissions.** NTC's affiliate health plans have implemented best practice, evidence based transition of care programs, such as the Coleman Model, to ensure effective transitions and reduce unnecessary readmissions. Successes in improving transitions across health care settings is supported by an interdisciplinary Care Team approach and includes early discharge planning and direct member outreach post-discharge to ensure effective coordination of care. NTC's strategy to reduce unnecessary readmissions, built from the best practices of our affiliate health plans, ***is described in our response to Question 88***. NTC's Louisiana affiliate's hospital onsite care management initiative combined with the member outreach within 24-48 hours after discharge demonstrated a 66% decrease in 7-day readmission rate and an 88% decrease in 14-day readmissions rate in 2014. NTC's Ohio affiliate, Buckeye Health Plan (Buckeye) initiated several interventions in 2014 to improve effective transitions of care. Through the program, Buckeye allowed its prior authorization staff to auto-approve an initial and follow-up home health visit, increased its home health benefit to twice per day for up to 75 visits per year, and

implemented their "Get Well" program through which a MemberConnections Representative visits the member in the hospital prior to discharge to deliver self-management educational materials. In pilot group 4 alone, they achieved *over a 45% decrease in readmissions*. Our Missouri affiliate has seen a significant reduction in readmission rates since implementing their post discharge outreach call process in late 2013. The overall readmission rate has decreased from nearly 13% in 2013 to less than 10% through the first half of 2014. A total *cost savings in excess of $ 1.2 million* is expected. Home State also achieved a 24% decrease in the readmission rate from 2012 to 2013. Additionally, their Follow-Up after Mental Health Admissions rate has increased to 46.88% exceeding the NCQA Medicaid 50th Percentile score.

Stakeholders, Timelines, and Outcomes. NTC is developing a written agreement with ENHANCE Health Network (EHN - formerly the Regional Provider Network), a health care alliance that represents upwards of 40% of the state's providers and includes nine PHOs, over 65 individual hospitals or hospital systems, and more than 3,500 affiliated providers. Our strategic network alliance with EHN will include co-location of NTC CM staff onsite at various EHN locations including onsite concurrent review clinicians at the time of contract implementation. NTC is working on a collaborative telemedicine solution to improve access to specialist providers in rural and underserved parts of the state. This program will allow us to ensure closer monitoring of members with post-discharge needs. NTC is in active discussions with the University of Nebraska Medical Center Network (UNMCN) and their Munroe-Meyer Institute, which together have the single largest network of telehealth service providers in Nebraska. For our proposed telemedicine program, NTC will implement targeted telemedicine pilots within the first six months of the contract to expand telehealth, including point-to-point live video, through experienced telehealth providers like Avera Health, and working with the Great Plains Telehealth Resource Center that services Nebraska. In discussions with provider groups in all six Behavioral Health Regions we have heard that a primary challenge is the communication between hospitals and outpatient BH providers. We believe there is an opportunity to reduce inpatient readmissions by improving the transition to outpatient care, including 7-day follow-up care, increasing medication adherence, and partnering with community resources to ensure our members have the needed support in the community, such as access to substance use treatment. Upon contract award, will promote the use of peer supports and ensure lower levels of care are available in the network and members are appropriately placed. For example, the Keya House is for adults with mental health and substance abuse issues who live in the Region V Systems service area. Staffed with trained peer specialists, the Keya House offers self-help and proactive recovery tools in a safe environment. As part of our BH Advisory Committee, NTC will collaborate with all six regions to identify where additional mobile crisis capacity may be needed and as part of our Quality Management work plan, develop strategies to expand availability of services. Expected outcomes include decreased readmissions within 30 days of discharge, increase use of primary care services, increase use of alternate levels of care such as intensive outpatient treatment, and increase compliance with seven day follow up after mental health admissions. **High Risk Pregnancy, Preterm Deliveries and NICU Admissions.** Preterm delivery, defined as a delivery before 37 weeks, and the resulting NICU admissions that follow these early births are a large portion of health care expenses across the United States. Centene's award winning Start Smart for Your Baby (Start Smart) program was developed in an attempt to reduce preterm deliveries and low birth weight babies and improve the health outcomes of moms and babies. The Start Smart program is comprised of multiple components which includes enhanced member outreach and incentives, wellness materials, intensive one-on-one care management, provider incentives, and supports the appropriate use of medical resources to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease. An essential component of the Start Smart program is the Notification of Pregnancy (NOP) process. The NOP form is a well-organized approach that aims to identify pregnant members at risk for pregnancy complications early in pregnancy and establish relationships between the member, provider, and health plan staff. Early identification of pregnant women and their risk factors through the NOP process and the monitoring of claims data is a crucial element in improving delivery and birth outcomes.

As part of our Start Smart model, we will identify women who qualify for 17 hydroxyprogesterone (17P) early in their pregnancy and coordinate with the OB Provider to enroll the member in the 17P program. Promoting the benefit and use of 17P has been a major initiative of Centene health plans over the past several years. With the help of the program, the percentage of low birth weight (1500 to 2499 grams) deliveries has decreased from 9.23% at baseline to 8.32% in 2014 ($p < .01$), while the percentage of very low birth weight (250 to 1499 grams) deliveries has decreased from 1.75% at baseline to 1.51% in 2014 ($p < .01$). These reductions have resulted in substantial savings. Given the volume of deliveries covered, we estimate that the program reduced neonatal costs by over $20 million in 2014 alone. **Stakeholders, Timelines, and Outcomes.** Stakeholders for our Start Smart program include OB providers, members, State and community based organizations such as the WIC program, Nebraska Health and Human Services - Healthy Mothers, Healthy Babies Helpline. With MLTC approval, NTC will implement its Start Smart program at contract go live. We will partner with local agencies such as Public Health Departments and providers such as FQHCs, EHN and CHI, to promote our Start Smart program. NTC expects similar outcomes as those noted by our affiliate health plans including decrease in low birth weight babies, decreased length of stay in NICU and decrease in preterm births. **Controlling Pharmacy Costs.** Specialty medications including high-cost medications to treat Crohn's disease, hemophilia, hepatitis, HIV, psoriasis, rheumatoid arthritis, and sickle cell disease, are another area of waste reduction and cost savings. For individuals requiring specialty medications, NTC's specialty pharmacy affiliate, AcariaHealth and CVS/Caremark are able to provide this distinct set of drugs to members as part of our specialty pharmacy program. Both have clinicians experienced in specialty conditions available to facilitate appropriate administration of the medication, monitor compliance and participate as an integral part of a member's Care Team. For example, clinical pharmacists and nurses monitor and support patient compliance to therapy. They also conduct monthly refill reminder/compliance calls to members and schedule injection training appointments for self-injectable devices. By utilizing these Specialty Pharmacy Providers, NTC is able to ensure appropriate administration and monitoring of these high cost medications, including member adherence to the drug regimen most appropriate for treatment of their condition. Another opportunity related to pharmacy is the use of psychotropic medications in children, particularly those five years old and younger. NTC proposes to implement Centene's Psychotropic Medication Utilization Review (PMUR) program that was developed by our affiliate in Texas out of concern that children in foster care are medicated in larger percentages than other child and adolescent populations and is a 2013-2014 Best Practices Compendium Award winner. As further described in our response to Question 91, the goal is to ensure that pharmacological treatment is benefitting the member and that all parts of the treatment team are working together to accomplish this outcome. When psychotropic medications are used in the treatment of children, their use should represent acceptable practice, promote safety, and enhance the stability and functioning of the child. Since implementing this review process in 2008, our Texas affiliate plan has reduced overall psychotropic medication use in foster children by almost 23%; class polypharmacy utilization by 36%; and use of 5 or more medications by 42%. **Stakeholders, Timelines, and Outcomes.** Stakeholders for our pharmacy programs include primary care providers, specialists, mental health and substance use providers, pharmacist and the Nebraska Pharmacy Association. With MLTC approval, NTC will implement our specialty pharmacy programs through AcariaHealth as well as our PMUR processes at contract implementation. We will educate and train providers on availability of these programs and associated evidence based practices to ensure appropriate treatment. Outcomes of our pharmacy programs are to improve the health of our members, improve treatment adherence with subsequent outcomes related to decrease in ED use and unnecessary inpatient admissions/readmissions.

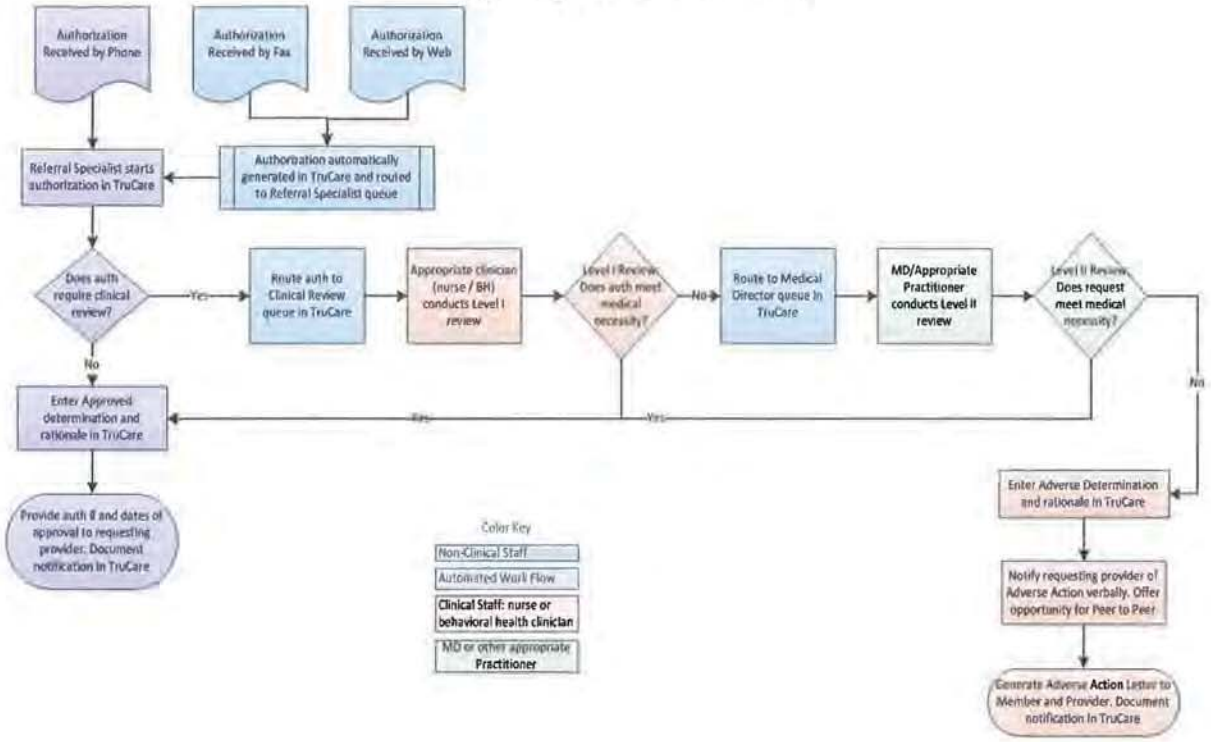
(4 page limit)
83. Describe the MCO's proposed approach to prior authorization, including:

NTC's Proposed Approach to Prior Authorization

Nebraska Total Care (NTC) will leverage the best practices of our health plan affiliates across the nation to support our goal to provide members with the right services at the right time by the right provider. Additionally our approach to prior authorization (PA) physical, behavioral health and pharmacy services will rely on evidence-based practices and clinical care guidelines, while promoting the provider experience through collaboration, data-driven decision-making and administrative simplicity. For example, our web-based authorizations, available through our Provider Portal, walk providers through each step of the authorization and offers real-time determinations on select procedures. Our InterQual Smart Sheets guide providers on what clinical documentation is required with the submission thus eliminating callbacks and speeding up the decision timeframe. In addition, we will monitor local provider practices to help inform PA policy. All NTC written PA policies and procedures (P&Ps) will comply with all applicable regulatory, accreditation, RFP and contract requirements. We will submit all PA criteria and related P&Ps to the state for approval a minimum of 60 calendar days prior to implementation. NTC will hire and train qualified staff to conduct the PA process and will implement inter-rater reliability testing and auditing to ensure consistent application of criteria for all authorization decisions.

As illustrated in ***Figure Q83***, NTC will accept PA requests by phone, fax or via our Provider Portal. Authorizations that require clinical review will be routed to a nurse or behavioral health clinician trained in the application of our adopted clinical criteria as appropriate to conduct a first level review against our adopted medical necessity criteria. For requests that do not meet criteria, the clinical reviewer will route the authorization to NTC's Medical Director (physician, behavioral health practitioner or other appropriate specialty practitioner) for second level review. Only the Medical Director/specialty practitioner is authorized to make an adverse determination to deny or reduce services in an amount, duration or scope less that what was requested.

Figure Q83 PA Process Flow



NTC will process all requests for authorization as expeditiously as the member's health condition requires and within State-established timeframes as required in Section IV.H.3 Service Authorizations and Notices of Action of this RFP. Standard authorization requests will be processed and notification made to the requesting provider (and member for adverse determinations) within 14 calendar days following receipt of the request. Expedited service requests will be processed and notification made within 72 hours of receipt of the request for service. In the case of an adverse determination, NTC's PA staff will offer the provider the opportunity for a peer to peer consult with the Medical Director An untimely service authorization constitutes a denial and therefore constitutes an adverse action. Members or providers acting on behalf of the member and with the member's written consent may appeal an adverse determination in accordance with the processes and timeframes outlined in Section IV.H.4 Appeal Processes of this RFP and as described in our response to Questions 36 & 37.

Pharmacy PA Process. In general, NTC's process for prior authorization of pharmacy services will follow the same steps as noted above except as otherwise noted here. Within 24 hours of receiving a PA request and all necessary and requested information, we will review the request against the preferred drug list and formulary requirements. If the request meets criteria, we will notify the prescriber's office of the approval. Any requests that do not meet criteria will be referred to a practitioner with the necessary credentials and experience in treating the member's condition (e.g. physician or behavioral health practitioner) for final determination based on established criteria. A licensed child or adolescent psychiatrist will review prior authorization requests for psychotropic medication use in youth as described in ***Section IV.D Staffing Requirements of this RFP***. Determination and notification for request for prior authorization for outpatient prescription drug or device will be made within one calendar day of the request. As noted above, members or providers acting on behalf of the member and with the member's written consent may appeal an adverse determination. NTC will 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.

- ***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.***

NTC will only require prior authorization (PA) for those procedures/services for which the quality of care can be favorably influenced by medical necessity or appropriateness review, such as out-of-network services, inpatient admissions (excluding routine deliveries), certain outpatient services and procedures (such as plastic surgery), ancillary services, and some medications. We will begin with Centene's recommended PA list, developed using data and experience gathered from affiliate plans across the country, and then customize our requirements based on local utilization trends, practice patterns, population disparities, and federal, state, and contract requirements. NTC will not require PA for preventive, emergency, urgent, or post-stabilization services. Centene's Corporate Medical Management Department reviews the prior authorization list at least annually, in conjunction with NTC's Medical Director, Vice President Medical management, and other NTC departments to determine if there should be any revisions to the prior authorization list. Such decisions are based on NTC program requirements, or to meet federal or state statutory or regulatory requirements. The review will evaluate data including, but not limited to, current utilization patterns, denial rates for specific PA types, provider complaints and appeals, member satisfaction, and issues identified via inter-rater reliability testing to determine:

- If a PA requirement should be implemented to manage over utilization or inappropriate utilization
- If the PA adverse determination rate is so low as to deem it unnecessary
- If a PA requirement needs to be revised to improve clarity and consistency of application
- Other changes to streamline the process while ensuring quality and appropriateness of care approved

We will remove PA requirements when we determine that review does not favorably influence quality of care. For example, in 2014, our Georgia affiliate's (Peach State Health) utilization reports indicated a very low rate of adverse determination for OB ultrasounds. Their Medical Director met with some of the Georgia network providers to solicit their input, finding a concern that the PA requirement was delaying necessary testing and intervention. Further discussion with their Maternal Fetal Medicine specialists indicated that it would be helpful if ultrasounds could be done during telemedicine consultations without the necessity of obtaining a PA. Peach State's VPMM presented the data to their UMC, which decided to remove the PA requirement for prenatal ultrasounds. Ongoing monitoring has shown no appreciable increase in the volume of ultrasounds being performed except for two provider groups, which were placed back on PA review and re-trained on policy requirements and appropriate utilization.

- ***The proposed prior authorization processes for members requiring services from non-participating providers and expedited prior authorization.***

PA Process for Services from Non-Participating Providers. NTC will require prior authorization for services from non-participating providers except in the case of emergency services, post stabilization services and family planning services. NTC will accept requests for out-of-network (OON) services by phone, fax or web. If the service being requested is not otherwise listed on our PA list as requiring medical necessity review, NTC PA staff will make a decision to authorize use of an OON practitioner based on continuity of care, availability and location of an in-network practitioner of the same specialty, expertise, and the complexity of the case. If a member requires services that are not available from a qualified network practitioner, NTC will adequately and timely authorize medically necessary covered services by out-of-network (OON) providers. For new members, NTC will authorize the service with the OON for up to 90 calendar days in compliance with our continuity of care policy. For prior authorizations that require medical necessity review of the particular services being requested, NTC PA staff will process the request in accordance with the same clinical criteria and within the same timeframes as requests made from our network providers as described above.

PA Process for Expedited Authorization Requests. If a provider indicates or NTC determines that following a standard PA timeframe could seriously jeopardize the member's life or health or ability attain, maintain or regain maximum function, NCT will make an expedited authorization decision and notify the requesting provider as expeditiously as the member's health requires, and no later than 72 hours of receiving the request for service. As noted above, a clinical reviewer (nurse or behavioral health clinician) will review the request against our adopted medical necessity review criteria. If the request does not meet the criteria, it will be referred to our Medical Director or other appropriate practitioner for second level review. Only the Medical Director/appropriate practitioner can make an adverse determination. We will notify the provider (and member in the case of an adverse determination) immediately upon making a decision by telephone and mail the written authorization within one business day of the decision, not to exceed the 72-hour timeframe for determination. NTC's 24/7 nurse advice line will have access to on-call staff to ensure timely authorization of expedited requests after normal business hours.

- ***The role of the Clinical Advisory Committee in developing service authorization procedures.***

As further described in our response to Q.76, Clinical Advisory Committee, NTC will develop, establish, and maintain a Clinical Advisory Committee to facilitate regular consultation with experts who are familiar with standards and practices of treatment for adults, children, and adolescents in Nebraska. NTC envisions that our Clinical Advisory Committee will serve as consultative experts representing a range of specialties common in the Medicaid population. Our Clinical Advisory Committee will review and provide input into all care management and utilization management processes including clinical guidelines and UM criteria as well as making recommendations regarding our prior authorization list. Additionally, NTC's Clinical Advisory Committee will assist with identifying new technologies or new use of existing technologies, particularly those that do not yet have InterQual criteria, and recommend

criteria to guide medical necessity determination of the treatment. These recommendations will be sent to Centene's Clinical Policy Committee for review and approval and distribution to all Centene health plans.

- ***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.***

Notification Process. An adverse determination is defined as a reduction, suspension, denial or termination of any service based on medical necessity or benefit limitations. In the case of adverse determination for medical, behavioral health or pharmacy services made by the NTC Medical Director, NTC PA staff will give verbal notification to the requesting provider followed by a written notification to the member and requesting provider in accordance with all RFP, State contract and regulatory requirements. The written notification will be mailed within the timeframes noted above, be easily understandable and will include the member-specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process and timeframes for appeal of the decision. Practitioners are provided with the opportunity to discuss any adverse determination with a NTC Medical Director. The NTC Medical Director serves as the point of contact for the peer to peer discussion. This is communicated to the practitioner at the time of verbal notification of the adverse determination, as applicable, and is included in the adverse determination notice to the member and requesting practitioner.

(2 page limit, excluding the listing of services)
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.

Prior authorization is required for only those procedures and services for which the quality of care can be favorably influenced by medical necessity or appropriateness of care review, such as non-emergent inpatient admissions (other than normal newborn deliveries), all out-of-network services and certain outpatient services, ancillary services and specialty injectables as described on the prior authorization list. Prior authorization is not required for medical, behavioral or substance use emergency services, urgent care services, stabilization of emergency care or in-network primary care and specialist visits.

Listing of Services Requiring Prior Authorization

The Centene recommended prior authorization list is provided below (***Table Q84***). Nebraska Total Care (NTC) will use this as a foundation in determining what services will require prior authorization:

Table Q84

Ancillary Services	
• Cochlear Implant • DME-Some - include enteral and parenteral pumps, wound vacs, bone growth stimulator, customized equipment • Fixed wing non-emergency air transport • Hearing aid devices • Home health care (includes infusions, home health aide, private duty nursing) • Hospice services (other than inpatient facility)	• Hyperbaric oxygen treatment (outpatient) • Implantable devices (infusion pumps, intraocular implant/shunt, neuromuscular stimulator, spinal stimulator for pain management, testicular/penile prosthesis, vagus nerve stimulator) • Orthotics & prosthetics • Rehabilitative therapies including occupational, physical and speech therapies
Behavioral Health	
• Autism spectrum disorders diagnosis and treatment and habilitative services • Intensive outpatient program (IOP) • Neuropsych testing • Outpatient electroconvulsive therapy (ECT) • Partial hospital program (PHP)	
Facility Services: *(includes medical, behavioral health and substance use)*	
• Elective/planned hospitalizations must be prior-authorized • Emergency admissions and/or observation requires notification within 1 business day of admission • Observation services (outpatient)	
Pharmaceuticals	
• Enteral/parenteral formulas • Selected injectable therapy/biopharmaceuticals (i.e. Synagis, growth hormone, Sovaldi, interferon) • Specialty pharmaceuticals	
Physician Office Services/Procedures	
• Chiropractic services • Infertility treatment • Pain management services • Plastic surgery/potentially cosmetic • Transplant related services (evaluation, testing, etc.)	
Radiology & Laboratory Services	
• CT, MRI, MRA, nuclear cardiology, nuclear radiology, PET scans • Genetic/molecular diagnostic testing • MR-guided focused ultrasound (MRgFUS) to treat uterine fibroid • OB ultrasounds (>2, except when rendered by a perinatologist) • Quantitative drug screening	

Surgery & Procedures	
• Ablative techniques for treating Barrett's Esophagus and for treating primary and metastatic liver malignancies • ALCAT Allergy Testing • Bariatric surgery • Capsule endoscopy • Cardiomyoplasty • General Anesthesia for dental procedures • Hyperhydrosis treatment • Joint replacement • Lung volume reduction surgery • Maze procedure (for treatment of atrial fibrillation) • Muscle flap procedure • Orthognathic surgery (treatment of maxillofacial (jaw) functional impairment)	• Pain management services Potentially cosmetic or plastic surgery (e.g. blepharoplasty, blepharoptosis repair, cranial/facial/jaw procedures, nasal/sinus surgery, and vein procedures) • Potentially experimental treatment/clinical trials • Sleep apnea procedures and surgeries • Sleep studies • Spinal surgery • Surgeries/procedures performed in outpatient facilities or ambulatory surgery centers • Tonsillectomies in children • Transplant surgery • Ventriculectomy • Wearable cardioverter-defribillators
Out of Network Providers & Services	
Out of network providers & services – excluding emergency care and post-stabilization services	

How We Communicate Information

The NTC Provider Relations staff will provide training in provider offices, through webinars, and telephonically when we update UM processes; identify issues with the provider, and upon provider request, we will provide a Quick Reference Guide that includes a summary of PA information. We will also provide information in the Provider Manual, and will provide all of the information listed above and more on our Provider Portal including the "Pre-Auth Needed?" tool, where Providers can quickly determine if PA is needed by entering a CPT code. We also offer providers an opportunity to request an informal reconsideration/peer-to-peer discussion with our CMO/CMD or other appropriate specialty clinical reviewer who makes the adverse determination. We will communicate this option to the provider at the time of verbal notification of the denial, and include it in the standard Notice of Action letter template.

Communicating the Results of Authorization Decisions

If the request for authorization is approved, the case manager or designee notifies the requesting provider of the approval by telephone, fax, or email within one (1) business day after the decision is made, not to exceed the original 14-calendar day determination period and:

- When notifying by telephone, the medical director and/or case manager documents the date and time of the notification as well as who was notified of the decision, in the clinical documentation system
- When verbally notifying a provider of an approval, staff will give the authorization number, authorization dates, and number of units

Whenever making a decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, we will communicate a Notice of Action (NOA) to the member and provider. All notifications will be written in language easily understood by the member and include the member-specific reason/clinical rationale for the determination; specific criteria used and availability of the criteria; and the availability, process, and timeframes for appeal of the decision. The UM staff will issue in a timely manner the written authorization notice including the authorization number; the approved provider; approved service; date approved; and amount, duration, and scope of the service. When extending the timeframe, our written notifications include the reason for the extension, and provide information about the member's right to file grievance if they disagree with the extension. NTC will notify Providers of a denial in the same manner in which they request PA, such as fax or web portal.

(1 page limit)
85. Describe how the MCO will ensure members receive written and timely notice of action relating to adverse actions taken by the MCO.

Timely Notice of Adverse Action

Nebraska Total Care (NTC) will provide written and verbal notifications, which comply with the timeframes outlined in the contract and below:

- A minimum of 10 days before the date of action when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services
- The period of advanced notice may be reduced to five days if probable member fraud has been verified

Receipt, review, and resolution of PA including notification of approval or adverse determination is included in TruCare. We attach a copy of the adverse notice of action to the authorization in TruCare noting the mailing date. Management staff monitor daily reports to ensure timely processing of requests. Additionally, our Clinical Trainers conduct random audits of UM files and confirm we make appropriate notifications in a timely manner.

NTC's written notifications will be easily understandable, not exceed a 6th grade reading level, and will include the member- specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision, as well as the availability, process and timeframes for appeal of the decision. NTC agrees to give notice as expeditiously as the member's health condition requires, and within State-established timeframes, not to exceed 14 calendar days following receipt of the request for service. NTC will only allow extensions to the processing time when a member or practitioner makes the request or NTC justifies a need for additional information and the extension is in the member's interest. NTC's Utilization Management team will utilize daily reports to ensure that authorization requests are processed timely and that the appropriate notifications of determinations are issued timely. Managers will also provide oversight to the notification process to review written notifications before they are issued to ensure accuracy. Additionally, NTC incorporates regular audits to identify opportunities for retraining and quality improvement.

Prior to mailing the NOA, NTC will use an address scrubbing program (SmartyStreets, a leading USPS approved validation service), as well as LexisNexis (a leading provider of authentication and verification solutions) to eliminate unnecessary returns. We will augment the member record in our Customer Relationship Management system (CRM) but not delete the original state enrollment file data; we can supply updated contact information back to the state. For returned packets, NTC Customer Service will use all available resources, such as pharmacy telephone records, PCP on file, claims information, personal, and SafeLink cell phone numbers, and email outreach to obtain updated contact information. We will deploy Google Analytics as a last resort to search for a valid member phone number or address, and to capture accurate member contact information for a single member. We then validate the address with the member and re-send the packet.

86. Describe the MCO's process for conducting concurrent reviews for inpatient services. (2 page limit)

Nebraska Total Care (NTC) will implement a system of concurrent review for inpatient services as described in the ***Scope of Work Section IV.N.6*** to monitor the medical necessity of and need for a continued stay. NTC will evaluate the medical necessity of continued stay, based on nationally recognized, commercially available criteria approved by our Clinical Advisory Committee (e.g. InterQual® for medical and behavioral health inpatient services and American Society of Addiction Medicine - ASAM for substance abuse services). InterQual® and ASAM criteria guide the clinical staff in determining the most appropriate level of care based on severity of illness, comorbidities and complications, and intensity of services being delivered while considering individual member condition and needs as well as the local delivery system. As further described below, our processes will provide for multiple day approvals in cases where care is reasonably expected to last more than one day.

Concurrent Review Staff. Working under the direction of NTC's Medical Director, our concurrent review staff will consist of Nebraska-licensed nurses with recent experience in an acute care setting. For behavioral health services, concurrent review staff will consist of Nebraska-licensed behavioral health clinicians (LCSW, LPC, Licensed PhD/PsyD or Psych RN) with recent experience in a behavioral health or substance abuse service acute care setting. We will train concurrent review clinician (CRC) staff in the application of medical necessity criteria to ensure that services provided are a covered benefit, medically necessary, appropriate to the member's condition, and rendered in the most appropriate setting.

Notification of Admission. NTC contracted facilities will be required to notify our UM department of urgent/emergent admissions within one business day of such admission so that we may conduct our concurrent review process in a timely manner. We will accept notification of inpatient admissions telephonically, by fax or through our Provider Portal. Additionally, network facilities, such as but not limited to those associated with ENHANCE Health Network (formerly Regional Provider Network) and CHI Health, can send electronic, HIPAA-compliant ADT (Admit, Discharge and Transfer) files. Building from a best practice in our Florida affiliate, NTC will use these ADT files to serve as notification of the admission, reducing perceived provider burden related to the notification requirement. Upon notification of an admission, our CRCs will conduct concurrent review telephonically, by fax or when mutually agreeable, onsite at large volume hospitals. Our affiliates' experience has shown that onsite concurrent review not only reduces the need for phone calls and faxes between the health plan and hospital staff, but also improves our discharge planning process. Another best practice that NTC is prepared to support, comes from our California affiliate where two major network facilities granted CRCs the ability to remotely and securely access electronic medical records to identify admits and discharges and conduct concurrent review. This efficient use of technology reduces perceived complexities in the process.

NTC proposes industry best practices including onsite concurrent review staff and use of ADT files to facilitate timely concurrent review.

Conducting Concurrent Reviews. Our CRCs use our daily Inpatient Census Report populated by authorizations created in our clinical documentation system, TruCare, to manage their daily reviews. The Inpatient Census Report includes the member's admission date, next review date and anticipated discharge date allowing our staff to ensure timely concurrent reviews. Our CRCs obtain clinical information from the facility and apply both clinical inpatient criteria and level of care criteria to determine ongoing medical necessity for the admission. Clinical reviews will be completed with every initial admission review and with every concurrent review. During the concurrent review process, CRCs will assess the clinical status of the member, determine the appropriateness of treatment rendered, verify the need for continued hospitalization or transition to lower level of care, and monitor the quality of care to verify professional standards of care are met. Information assessed during the review will include:

- Clinical information to support the appropriateness and level of service proposed
- Whether the diagnosis is the same as provided on admission or if it has changed
- Additional days/services/procedures proposed

- Reasons for extension of the treatment or service
- Assessment of member status to determine special requirements to facilitate a safe discharge to another level of care

CRCs monitor for sentinel events and potential quality of care concerns as part of the concurrent review process by gathering initial data, addressing immediate concerns with the Medical Director, and referring to the QI department as appropriate.

Frequency of Review. Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. The frequency of concurrent review is based on the severity/complexity of the member's condition and/or necessary treatment and discharge planning activity. For members expected to have a long length of stay, such as a NICU stay, the CRC will provide multiple day approvals with the Medical Director's approval. All inpatient cases with a length of stay longer than five days will be discussed in our weekly Inpatient Case Rounds.

Determination and Notification of Authorization. The CRC will review clinical information and make a determination within one calendar day of notification or within one calendar day of the next review date for ongoing reviews. For inpatient authorization requests that meet InterQual®/ASAM criteria, the CRC will notify the hospital staff verbally of the approval and document the rationale and notification in TruCare. When the medical necessity for care does not meet inpatient criteria, discharge criteria are met and/or alternative care options exist, the CRC will communicate this information to the facility staff. If the provider does not feel the member can be discharged or moved to a lower level of care, the case is referred to the Medical Director for review and final determination. Only the Medical Director can make an adverse determination including denial or reduction in amount or scope of service requested. If the Medical Director makes an adverse determination, the CRC will contact the provider verbally to notify them of the decision and offer the provider an opportunity to request a peer-to-peer discussion with our Medical Director or other appropriate specialty clinical reviewer. The CRC documents the verbal notification in TruCare and generates the written notice of adverse determination to the member and provider as further described in our response to Question 85.

Discharge Planning and Transition of Care. Our CRCs begin discharge planning as early in the admission as possible to identify referrals or services that need to be arranged to support the member's safe discharge. As part of the discharge planning process, our staff will:

- Participate in interdisciplinary rounds if conducting onsite concurrent review
- Identify and attempt to resolve barriers to care
- Coordinate home health and durable medical equipment needs
- Encourage medication adherence and assist with scheduling follow-up appointments
- Complete referrals to appropriate community agencies
- Discuss when to contact PCP, ED and urgent care use and what is considered a true emergency

As part of discharge planning, our CRCs will use information from the facility, treating providers, and the member to identify members at increased risk for readmission. This includes but is not limited to members with complex medical and social needs, co-existing medical and BH conditions, fragile infants (NICU), and members with a history of non-compliance or poor community supports. For members identified as moderate or high risk for post-discharge complications, NTC's CRC engages the member's assigned Care Manager (CM) or makes a referral to care management if the member is not already engaged. Based on assessment findings, the CM collaborates with the member and hospital staff to develop a transition plan that addresses identified barriers. This may include recommending that the attending physician order home-care services or durable medical equipment, setting up homemaker services, involving community agencies to help obtain support for paying utilities or with home modifications, educating the member's family or friends on post-discharge care, arranging for in-home delivery of medications, and coordinating transportation for appointments. The CM authorizes services, assists with arranging or coordinating the services, and communicates with the member's providers.

(2 page limit)

87. Describe the MCO's process for conducting retrospective reviews to examine trends, issues, and problems in utilization.

Retrospective Review Process

NTC's primary utilization management (UM) goal is to facilitate the provision of medically necessary covered services that are appropriate for the member's condition, provided in the most appropriate setting, and meet professionally-recognized, evidence-based standards of care. As part of the UM Program, NTC will develop and implement P&Ps that govern the retrospective review process and identify and address utilization trends, issues, and problems. Using our award winning Centelligence data analytics platform, NTC will monitor, review, and analyze utilization data including PH, BH and pharmacy services. For example, length of stay (LOS) data, inpatient acute care days or discharges, readmissions, ER visits by member and provider, PCP visits, pharmaceutical and poly-pharmacy use, referral to ancillary providers, EPSDT services and preventive service rates, provider practice patterns, and super-utilizers. Standard (e.g. monthly, quarterly, annual) and ad hoc reports will be reviewed by designated UM staff and presented to the UMC and QAPIC at least quarterly. To fully understand the utilization trends of our members and providers, as well as the underlying causes, NTC will analyze a variety of utilization data "snapshots" at aggregate and detail levels including by member, individual provider or facility, provider specialty, type of service, diagnosis, place of service, and by comparing services authorized to services received. NTC will establish benchmarks using industry standards, national Medicaid HEDIS averages, or State specific thresholds. We will also develop internal benchmarks based on historical data that reflect variances in population demographics, seasonal variations, cultural disparities and regional characteristics of our members. Below are two examples of our efforts to examine trends, issues, and problems that resulted in the detection, prevention, and reporting of inappropriate utilization at one of our affiliate markets.

- A provider in our affiliate Georgia market was consistently sending incomplete records with PA requests, triggering an on-site audit for potential FWA. The audit revealed incomplete medical records, including missing documentation and test reports. The provider was also subleasing office space to other therapists although no therapy services were actually being provided and no proof of visits for the amount of therapy requested. We reported the provider to the appropriate regulatory agency and he was subsequently convicted of fraud with criminal charges and civil penalties.
- Our Indiana affiliate identified a practitioner who was ordering significantly more laboratory tests than others within the same specialty. Provider Relations, QI and UM reviewed reports and shared the results with the practitioner. The practitioner was placed on PA for certain laboratory tests until we were confident that he was performing within expected standards.

Inappropriate Utilization. Under-, over- and inappropriate utilization are reviewed at the system and individual level. For example; when analyzing ED utilization, the clinical leadership team will review monthly reports on top ED diagnoses and members with high ED utilization, staff will look not only at total number of visits, but also at the utilization in relationship to admissions and readmissions, pharmacy use, and/or presence or absence of physician office visits. We will look for patterns of under-or over-utilization by provider, by member, and by county. We will use these reports to target members and provider outreach, engagement and education, and to identify members for inclusion in our ED Diversion Program. As trends are identified, further qualitative analysis is conducted, including analysis by product and provider or practice site, to determine potential reasons for the results and to formulate effective interventions. As an example of under-utilization, we will look at preventive care services including EPSDT and routine screenings for chronic conditions. We may also identify members who are under-utilizing treatment services such as low use of controller medications in members with asthma. Also, members identified with a pattern of over-utilization of acute care services may be under-utilizing lower levels of care, preventive services or behavioral health services.

Avoidable Admissions/Readmissions. UM will create and review regular reports on admissions and readmissions that were avoidable or potentially avoidable in accordance and see if an improvement in interventions and services can be developed. For example, lack of medication adherence, specifically discontinuing medication, has been strongly linked to a risk of ED utilization and inpatient admissions especially for people with co-morbidities including BH. Our clinical team will work with providers and facilities to identify and educate potential members at risk for non-adherence by using pharmacy claims data, combined with PH and BH claims data.

Quality of Care Issues. Our UM staff will review standard and ad hoc reports to identify events over which providers could have exercised control and which were associated in whole or in part with medical intervention, rather than with the condition for which the intervention occurred. These reports include information from claims, NTC staff referrals, member grievances, and external sources. We will investigate the events and factors surrounding them, in order to make a determination of severity and need for corrective action. The QAPIC reviews quality of care and service issue data quarterly, and may recommend corrective action for specific providers or improvement activities, that could include training. The UM Department will review quarterly reports of measures such as rates of occurrence for certain diagnoses, pre-term delivery, NICU admission, re-admission, complications of care (sentinel events), never events, inpatient length of stay, and relevant HEDIS measures to identify potential gaps in needed services. When potential gaps are identified, QI staff will work with UM and CM staff to conduct case studies and determine whether medically necessary services are being provided. Staff will track claims data back to the case to identify how to improve services to the member and providers.

Provider Practice Patterns. NTC will assess and identify aberrant provider practice patterns in a number of ways. We plan to utilize the proven approaches from the collective experience of our affiliated health plans and apply them to the NTC program. We will regularly examine aggregate and provider-level compliance with preventive health and clinical practice guidelines (CPG's), utilization trends for inpatient, emergency, pharmacy and outpatient PH and BH services, as well as factors such as appointment access and after hour's availability, authorization and billing practices, and appropriateness of services. Review processes will include using our Centelligence clinical decision support, claims and outcome data, and medical record audits. We will also track member complaints regarding providers and potential quality of care and service events. Many of the provider-level indicators we will track will also be shared with providers in our multi-dimensional provider scorecard along with national benchmarks and state goals. Information will be assessed at all levels of care, and can be broken down by providers' utilization of services by race, ethnicity, gender, and age. Aberrant practice patterns may also be detected by suspicious billing trends identified by specialized FWA software that will be used in NTC's claims adjudication process. If an aberrant provider practice pattern is confirmed, UM staff will refer the provider to Provider Relations staff, with the participation of the Medical Director as required, for discussion of the identified pattern, comparison to peer performance and any evidence-based relevant guidelines. If analysis identifies an issue which requires intervention, a corrective action plan (CAP) is developed within thirty (30) days, for approval at the next scheduled UMC. The CAP is collaboratively developed with the provider and implemented within 30 days of creation. Six months after implementation of the CAP, data is analyzed to determine the impact. If the issue is unresolved, the CAP is reassessed and revised and a date for re-evaluation is established. Dependent on the issue and the need for meaningful improvement, the UMC may decide that the CAP should be extended. If at the end of an extension the issue remains unresolved, the Medical Director will prepare a written summary for review by the Peer Review or Credentialing Committee to consider the issue and make its recommendation within fifteen (15) days of receipt of the Medical Director's summary if there is evidence of under-or over utilization that could seriously affect care received by members.

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. (6pgs)

Initiatives to Control Unnecessary and Avoidable Use of Services

NTC will tailor the proven techniques, policies, procedures, and initiatives of our Centene affiliate plans from across the country to control unnecessary hospital and emergency department (ED) utilization. NTC will promote care in the most appropriate and cost-effective setting and reduce inappropriate and duplicative use of health care services through a multi-dimensional plan that incorporates:

- Early identification of physical and behavioral health conditions as well as psychosocial issues through initial and ongoing member screening and assessment, data mining, review of monthly reports, and predictive modeling through Centelligence™, our award-winning family of integrated decision support and health care informatics solutions
- Risk stratification and targeted interventions to maximize the impact of care coordination resources
- Best-in-class care and disease management programs that improve health outcomes through individualized treatment plans, timely referrals and assistance to providers, and identifying and overcoming barriers to primary and preventive care
- Resources and support for members/caregivers including but not limited to in-person assistance through our MemberConnections™ community outreach program and linkage to community resources to address social determinants of health such as stable housing
- Care coordination and referrals, telephonically or in-person depending on member acuity, to facilitate access to all needed services and supports. This includes, but is not limited to scheduling assistance, monitoring, and follow-up. It also includes appropriate methods of assessment, referral, and coordination with other State programs such as home and community based waiver services
- Effective care transition planning and post-discharge follow-up to reduce readmission to inpatient facilities and avoidable ED visits

Through the proven programs and interventions, rates in inappropriate hospital admissions and ED visits across Centene health plans for TANF and SSI members have experienced significant reductions from Q3 2014 to Q3 2015, as presented in ***Table Q88*** below.

Table Q88 Reductions in Inappropriate Utilization

METRIC	REDUCTION Q3 2014 to Q3 2015
TANF members Inpatient Admissions	15.8%
SSI members Inpatient Admissions	6.0%
TANF members ED visits	6.4%

Non-Emergent Use of the Emergency Department (ED). NTC will build from the best practices of its affiliate health plans to prevent and reduce non-emergent ED use through multiple strategies, such as promoting primary care through the medical home, ensuring availability of appropriate urgent care settings, interventions targeted to super-utilizers, and other strategies described in the relevant sections below. In addition, we will educate members and providers regarding appropriate utilization of ED services, including behavioral health emergencies, and monitor emergency services utilization by provider and member. NTC will also implement Centene's best practice ED Diversion Program, which resulted in a decrease of average ED visits per member for our Georgia affiliate from 5.83 at the beginning of Q3 2013 to 2.8 by the end of the quarter. Through our ED Diversion program, NTC will identify high ED utilizers (three or more ED visits in the previous 90 days), and attempt to contact them to provide education and offer care management services. Our care management staff will educate them about the importance of a medical home and how to access it, appropriate options for non-emergent

health needs, and alternatives to utilizing the ED, such as the availability of after-hours appointments and urgent care clinics. We will also educate members about how to contact our 24/7 nurse advice line for questions and the availability of the State's transportation assistance program. Members who agree to participate in our care management program will be assigned a Care Manager who will complete a comprehensive assessment and care plan that addresses the member's full range of needs, including but not limited to behavioral needs. Care Managers will conduct additional education on covered benefits, availability of support services, and chronic condition management including planning for medication refills prior to the end of the prescription. Additionally, in collaboration with our Quality Management and Provider Engagement (PE) staff, we will identify and contact the 25 practices with the highest ED utilization, along with our network FQHCs, high volume behavioral health and other providers. PE staff will review with the provider information on their ED rates; and encourage them to contact their patients on the ED list to provide education, offer preventive and primary care appointments, and ensure their office schedules can accommodate our members. PE staff will also discuss the member's barriers that contributed to their high utilization rates to help the provider tailor their own outreach to the member. **Partnering with Providers.** NTC affiliates have also found that partnering with providers in the community such as FQHCs can also have positive impacts on decreasing inappropriate ED. For example, NTC's contracting team has met with Galen Bernadt from Lincoln ED Connections at Bryan Health to discuss opportunities for partnering on their emergency department (ED) super-utilizer program. Through this collaborative effort, Bryan East/West and St. Elizabeth's have joined together to track patients who frequently visit the ED and to offer those Member's care management services. They have identified many of these patients as 'drug seekers'. NTC discussed opportunities to share utilization data so that the ED has a broader perspective of the member's utilization of services and filled prescriptions and identify and conduct outreach to members who use the ED for non-emergent reasons who have not yet met the super-utilizer criteria as well as having the facilities refer members to NTC's pharmacy lock-in program.

Reducing Avoidable Readmissions. NTC will implement a Transition of Care program based on successful best practices implemented by its affiliate health plans. We will address transition of care between service settings using an approach founded on evidence-based and emerging best practices for care transitions such as Care Transitions Interventions developed by Dr. Eric Coleman, the Transitional Care Model developed at the University of Pennsylvania, and the vision and recommendations of the National Transitions of Care Coalition. NTC's Transition of Care (TOC) Program will provide proactive transition planning and intensive support to engage members in their care after discharge, preventing and reducing readmissions for high-risk members. Our staff will work to reduce admissions/readmissions and improve appropriate, cost-effective utilization by ensuring coordinated development and timely implementation of a transition plan; promoting medication adherence and compliance; increasing PCP visits; and improving self-management skills and self-efficacy. As part of discharge planning, our CRCs will use information from the facility, treating providers, and the member to identify members at increased risk for readmission. This includes but is not limited to members with complex medical and social needs, co-existing medical and behavioral health conditions, fragile infants (NICU), and members with a history of non-compliance or poor community supports. For members identified as moderate or high risk for post-discharge complications, NTC's CRC engages the member's assigned Care Manger or makes a referral to care management if the member is not already engaged. Our successful approach considers needs related to barriers and the member's social context on par with clinical needs, and we provide intensive support after discharge for those at high risk for readmission. For example, prior to discharge, the Care Manager will assist with referrals and scheduling post-transition visits or services, such as the 7-day follow-up appointment post discharge from a behavioral health admission. For members identified as moderate or high risk for readmission, the Care Manager will contact the member within two business days after discharge to confirm scheduled appointments and transportation and that ordered in-home services are in place and meeting the member's needs, as indicated.

Ensuring the Most Appropriate and Cost Effective Setting

NTC will ensure the most appropriate and cost effective setting of care with evidence-based practices and national criteria. Based on affiliate experience and historical data, NTC will develop a prior authorization list for services that can be favorably impacted by the prior authorization process. Ongoing, we will monitor for over- and under-utilization of services at summary levels as well as by specific region, facility, provider, member and diagnoses to identify patterns and implement interventions as indicated. For example, NTC will use 3M's Potentially Preventable Event (PPE) software, an integrated component of our Centelligence analytics platform, allowing us to systematically analyze claims data for our Heritage Health population and identify PPE (including Potentially Preventable ER Visits, Admissions, Readmissions) using 3M's industry leading risk scoring methodology: the Value Index Score (VIS). The VIS is comprised of 16 quality measures that look at the way a PCP manages care for their member panel with consideration for the range of health status in the panel: from healthy to chronically ill. Our use of PPE functionality, integrated within our Centelligence™ informatics platform, will allow us to monitor PPE rates amongst our providers (leading to education actions and/or policy adjustments) and inform our identification of likely factors leading to PPEs in our population. **Engaging Members as Partners in Care.** Member engagement is a key factor in controlling avoidable hospital and ED use and improving health outcomes. NTC will use a "meet me where I am" approach and evidence based engagement strategies, such as Motivational Interviewing and behavioral modification, to tailor outreach and education to the member's willingness and ability to understand and direct their services, as well as the goals that are important to them. We also realize that members may already have relationships with providers and community agencies and will leverage and build our efforts around these existing relationships to maximize our ability to engage the member. **Member Tools and Incentives for Appropriate Utilization.** We will promote our 24/7 nurse advice line to all members, using a variety of written, online, and in person methods. Our Member Portal will provide a wide range of information about NTC services, as well as self-management tools and the member's Care Plan. Our mobile applications will provide easily-accessible information to support appropriate utilization and personal responsibility for health. For example, our NTC member mobile application will provide interactive health and wellness resources, such as care gaps, personal health challenges, fitness and nutrition tracking, and smoking cessation tools to keep members engaged and help them set healthy living goals. Through our CentAccount program, we will reward members for completing preventive health and chronic condition screenings such as annual well visit and cancer screenings. **Whole-Person Care Management.** Our care management teams will include registered nurses, behavioral health clinicians, social workers, health coaches, a pharmacist, and non-clinical staff. We will use a primary point of contact model whereby a care manager develops and nurtures the relationship with the member while other team members provide input into care planning, monitoring, and other services based on their expertise. We will leverage existing resources and providers to maximize our ability to engage the member. Because we know that social determinants of care directly impact physical and behavioral health status and use of services, our care plans will address the entire range of covered/non-covered, out of plan, and community services the member needs.

Access to Primary Care and Patient Centered Care Approaches

NTC will promote member choice in selecting a PCP/medical home of choice because members are more likely to utilize care appropriately when they choose and establish a PCP relationship. We will educate members about the importance of a medical home beginning with our new member materials and welcome call. NTC Customer Service and care management staff will assist members to select an appropriate and convenient provider and will assist with a PCP change when needed. **Supporting the Medical Home.** NTC will educate and contractually require PCPs to manage and coordinate medical and behavioral health care needs of members to assure that all medically necessary services are made available in a timely manner. This includes, but is not limited to developing treatment plans to address risks and medical needs, and coordinating the members care, as needed, with other providers. We will educate and require PCPs to meet MLTC-required appointment scheduling standards to ensure members

have access to the appropriate setting for preventive and primary care services to prevent use of inappropriate settings. We will also educate and require that PCPs provide after-hours availability to members who need medical advice. At minimum, we require the PCP office to have a return call system staffed and monitored to ensure that members are connected to a medical provider within 30 minutes of the call. We will provide education on these requirements via our provider orientation process, the Provider Handbook, written and online materials, ongoing trainings, and targeted education. To proactively encourage the expansion of appointment availability, reducing wait times and increasing access to care, thereby reducing inappropriate ED utilization, we will institute value based contracting aimed at promoting preventive care services, person-centeredness, and extended office hours. **PCP Alerts and Reports.** We will provide timely information to providers about their members' utilization that may affect ED use. Physical and BH providers who have registered to access our provider Portal can access our member Encounter Report 24/7 to review member service utilization. In addition, our Care Gaps feature will inform the provider that the member is due or overdue for a check-up, screening, or immunization. We will notify the member's PCP after an ED visit. These tools will support the medical home relationship and facilitate the provider's outreach efforts. **Promoting a Patient Centered Approach.** NTC will employ a Medical Home Coordinator in Nebraska to support the implementation of patient centered care across our provider network. As a part of our network strategy and provider partnerships the PCMH Manager will enhance and promote needed service development and support providers in implementing patient centered care approaches including obtaining PCMH recognition from NCQA or other certifying agency.

Urgent Care Centers and Retail Clinics

Availability of urgent care and other easily-accessible locations for non-emergent care, such as retail clinics, can reduce unnecessary use of the ED. While the state does not establish a specific access standard for urgent care, our urgent care network will offer access in urban, rural and frontier areas where providers are available for our membership. For example, our Louisiana affiliate is recently expanded availability of urgent care by contracting with the 15 Take Care Clinic locations operated by Children's Hospital of New Orleans. In addition, NTC will support providers through value based contracting to offer after hours primary care, an appropriate setting for many urgent care needs. We educate members about the role and availability of urgent care providers in a variety of ways, such as:

- Our member Welcome Packet, Welcome Call, Provider Directory, Member Handbook and website
- When CM's work with members to complete assessments, care plans and provide member education
- When members contact the Member Call Center or Nurse Advice Line with urgent care needs

Interventions Targeted to Super-Utilizers

In a 2014 survey conducted by Health Intelligence Network, chronic disease accounted for 78% of the most frequently presented problems among the survey respondents' high utilizers. NTC will build upon the targeted interventions developed by its affiliates for high utilizers and members with chronic and complex conditions that put them at high risk for high utilization. We will identify 'super-utilizers' and those at risk for high utilization through ongoing review of enrollment, predictive modeling, utilization and other data. **Interventions for Members with Asthma, Diabetes or Other Chronic Conditions.** NTC will offer accredited disease management programs through are affiliate partner, Nurtur, Inc. These programs include asthma, diabetes and several other chronic conditions. Our disease management (DM) programs are founded on a Health Coaching approach which provides the tools and interventions needed to help individuals diagnosed with a chronic condition adopt healthy habits and decrease risk factors to slow progression of the disease. A truly effective health-coaching program engages as many members as clinically appropriate in the actual coaching process. Effective health coaching also motivates and supports at-risk members in making small, sustainable behavior changes that in turn result in measurable, positive health outcomes. DM interventions will include condition-specific education such as the importance of treatment plan compliance, and motivational interviewing/behavioral modification

techniques that encourage healthier lifestyles; prevent exacerbation and acute episodes; and engage, involve and empower members. Recognizing that each member's clinical condition and psychosocial situation is unique, the precise nature of intervention and information provided will vary significantly from one member to another, including members with the same diagnosis. Care Managers work collaboratively with members to set and monitor individual goals and to celebrate achievements. Goal setting begins during the initial baseline assessment call. Documented within the self-management plan, goals are specific, measureable, achievable, realistic and time sensitive. Care Managers follow up on goals during each coaching call, and when goals are met, new goals are set. **Interventions for Members with Chronic Pain.** Chronic low back pain is known to be a common diagnosis for avoidable ED visits. NTC will offer a Low Back Pain disease management program. In CY 2013, across Centene affiliate plans that use the Low Back Pain management program, 14% of those engaged were able to participate in an exercise program appropriate for their condition, and 100% of eligible participants reported a reduction of 20% or more on the pain scale index. An Exercise Physiologist conducts a baseline assessment call and based on the assessment, works with the member and their physician to develop a care plan that focuses on promoting recovery from low back pain and preventing future back pain episodes. Interventions may include instruction for the development of core muscle endurance, strength and flexibility; review of workstation ergonomics; optimization of body mechanics and posture; and a maintenance exercise program. Recommendations addressing medication understanding and adherence; and managing pain and stress are also included as elements of the care plan. **Interventions for Members with Behavioral Health Conditions.** In discussions with provider groups in all six behavioral health regions we have heard that a primary challenge is the communication between hospitals and outpatient BH providers. We believe there is an opportunity to reduce inpatient readmissions by improving the transition to outpatient care, including 7-day follow-up care, increasing medication adherence, and partnering with community resources to ensure our members have the needed support in the community, such as access to substance use treatment. We will also promote alternative BH care, for example, train PCPs to manage low acuity BH issues, such as by using SBIRT (screening, brief intervention, referral and treatment), an evidence based practice for SUD. We will also promote use of peer supports and ensure lower levels of care are available in the network and members are appropriately placed. For example, the Keya House is for adults with mental health and substance abuse issues who live in the Region V Systems service area. Staffed with trained peer specialists, the Keya House offers self-help and proactive recovery tools in a safe environment. As a value-added benefit, NTC will reimburse for and educate our providers about this service. We will also collaborate with all six regions to identify where additional mobile crisis capacity may be needed. This may involve supporting county or BH provider expansion, or collaboration to provide the expertise of our own telephonic and mobile BH crisis program used by Centene affiliates. Additionally, NTC staff have been in discussions with local providers on partnerships to implement ED diversion programs. For example, the FQHCs in Norfolk are very interested in a partnership and we have also spoken to Lutheran Family Services and Health 360 regarding opportunities for ED diversion pilots.

Other Interventions that Support Appropriate Utilization of Services Strategies

Below, we describe examples of other strategies and programs used by Centene affiliates to control avoidable hospital and ED use. NTC plans to incorporate these strategies for the benefit of the Heritage Health membership and will continuously monitor the member needs and utilization patterns to identify additional methods to ensure appropriate utilization. **ConnectionsPlus.** NTC's free ConnectionsPlus phones will be made available to high-risk members who would benefit from unlimited talk and text. These phones allow members to call, text or receive calls and text messages from their PCPs/treating providers, care manager, other health plan staff, nurse advice line and 911. NTC's ConnectionsPlus program empowers members to self-manage their condition and facilitates healthy lifestyles. Members are educated on observing their health status and calling promptly for advice rather than waiting until the next appointment. Our Care Managers may upgrade the free cell phone to a smart phone with data plan for high-risk members (e.g. high-risk pregnancy or uncontrolled diabetes) with a condition(s) where an

app exists to support the member in managing their health. ConnectionsPlus phones can also be used in conjunction with our home telemonitoring program (described below) available to high-risk members for whom intensive home monitoring is necessary and the condition is amenable to biometric telemonitoring, such as blood pressure or weight for a member with congestive heart failure. **Telemedicine.** NTC is working on a collaborative telemedicine solution to improve access to specialist providers in rural and underserved parts of the state. This program will allow us to ensure closer monitoring of members with post-discharge home health needs who also require specialty care, through increased member interaction with specialists from whom TOC and Care Management staff will solicit feedback on member progress. NTC is in active discussions with the University of Nebraska Medical Center Network (UNMCN) and their Munroe-Meyer Institute, which together have the single largest network of telehealth service providers in Nebraska. For our proposed telemedicine program, NTC will implement targeted telemedicine pilots with enhanced care coordination such as connecting psychiatric nurse practitioners through **Vest Psychiatric** in Lincoln to members referred through primary care in North Platte, and coordinating services and tracking outcomes through NTC integrated Care Team staff. We are actively working to expand telehealth, including point-to-point live video, through experienced telehealth providers like Avera Health, and working with the Great Plains Telehealth Resource Center that services Nebraska. Additionally, because NTC is partnering with both Catholic Health Initiatives (CHI) and ENHANCE Health Network (formerly RPN), we have robust network of physical and BH providers that are already providing or could easily be connected to telehealth and telemonitoring. NTC will also work with the Nebraska Statewide Telehealth Network (NSTN). NSTN is a collaboration of over 110 sites, including hospitals, health departments, mental health centers, physician offices and rural health clinics, with a common purpose of using video technology to extend health care resources to those in need. This includes clinical consultations, support groups, education and training, connectivity for administrative meetings among professionals and families. Reports from the NSTN indicate that over 60% of the services accessed through telehealth in Nebraska are for BH. **Home Telemonitoring.** Another strategy that will be employed by NTC that can assist in monitoring the care needs of home bound members as well as other high risk members is home telemonitoring. High risk members may receive these biometric monitoring devises that will allow care managers and treating providers to monitor key health indicators on a real time basis. This tool will allow NTC to quickly identify any deterioration in a member's status as well as provide opportunities for real-time, "teachable moment" moments that can help the member in the longer term. Telemonitoring is highly effective for members with diagnoses such as CHF or hypertension. The monitoring includes such things as weight and blood pressure for a member with CHF, which could identify early signs of exacerbation. In such cases the treating physician can be notified and, as necessary, adjust the member's medication or schedule an immediate office appointment for further evaluation. **Physician Home Visit Program.** In order to better address the needs of home bound and other at risk members, NTC will partner with US Medical Management (USMM), the management services organization to the Visiting Physicians Association and the nation's leader in house call medicine for over 20 years, with more than 500,000 in-home patient visits annually. The USMM model is the only physician house call practice to participate in one of the original pioneering ACOs and in the first year of participation, USSM has helped reduce hospitalizations by over 5% and reduced annual beneficiary medical expense in excess of 12%. When the Care Manager determines that a member would benefit from home services, they will discuss the option of a home visit by a USMM physician. If they are agreeable to such a house call, a physician will visit the member, perform an initial assessment, including wellness screens, and render any necessary care. The USSM physician will also discuss with the member whether a visiting physician model might be a better option for receiving ongoing care and whether they would like USMM to provide this care, serving as the member's PCP. The Care Manager will also be available to assist the member in helping to decide if this is the best alternative for receiving needed medical care and assist with transferring the member's care from the existing PCP to the USMM provider as indicated.

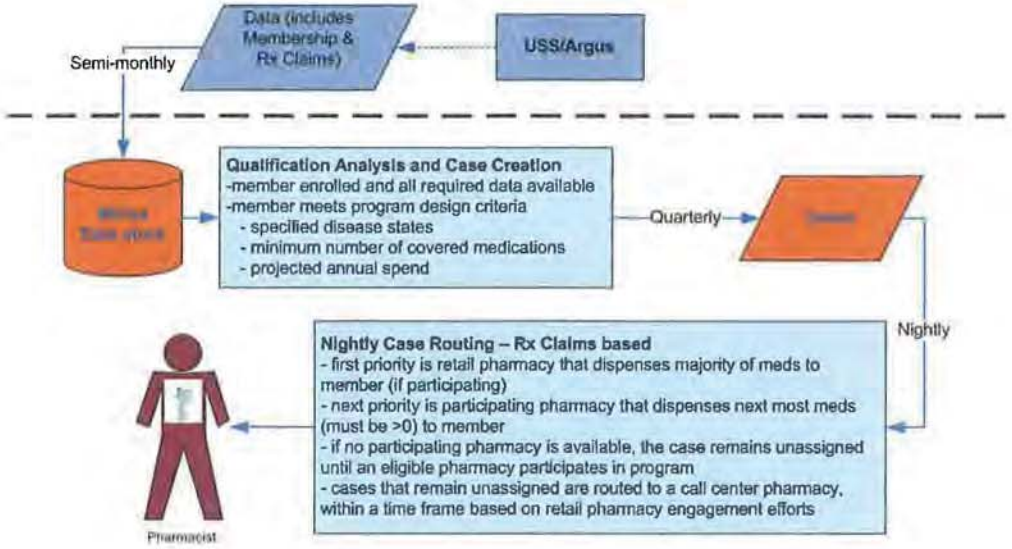
89. Describe the MCO's proposed MTM program, including a description of the inclusion criteria that the MCO proposes to use. Also, include any vendor(s) that will be subcontracted by the MCO to perform or support MTM services. Provide a detailed description of tools the MCO will use to ensure the active engagement of the retail pharmacies in the MTM program. (4 page limit)

Nebraska Total Care's (NTC) Medication Therapy Management program is administered by its affiliate pharmacy benefit manager US Script. The US Script Medicaid MTM Program is administered for members of health and benefit plan(s) to which US Script provides services. The program design is based on Mirixa's MTM program delivered via the MirixaPro℠ platform (***Figure Q89.A***). US Script determines which members qualify for MTM service based on information provided by US Script via data feeds and based upon the client's MTM requirements. Mirixa has approximately 43,000 participating pharmacies, of which 434 are located within the state of Nebraska. Nebraska retail pharmacies will be used to provide CMR services where possible, to leverage the existing pharmacist-patient relationship to maximize beneficiary acceptance and engagement. Services are provided by a pharmacist-staffed call center when a retail pharmacy is unavailable to provide CMR services.

Program services include:

- An annual Comprehensive Medication Review ("CMR") delivered by participating pharmacies, local retail pharmacies when available. CMR service includes: person-to-person medication review, including review of over-the-counter medications or any prescription medications that do not otherwise appear in the MirixaPro platform; identification and documentation of allergies and chronic conditions; high-risk medications; optional documentation of health goals and measurements; disease state specific questions; cost savings alerts (if appropriate); resolution of Safety Alerts, and Care Gap Alerts; completion of required worksheet documentation; and delivery of member handouts (notably, the Medication Action Plan and Personal Medication List in the CMS standardized format).
- Quarterly Targeted Medication Reviews ("TMRs") delivered via automated fax to prescribing healthcare provider(s). TMR analysis includes Safety Alerts; Care Gap Alerts; a list of medications and any unresolved alerts.

Figure Q89.A Program Overview Diagram- This overview includes participation by local retail pharmacies when available



For CMRs, Mirixa will attempt to assign each case to a contracted local retail pharmacy that has frequently served the member in the past. Mirixa will perform a claims analysis that prioritizes pharmacy eligibility according to the number of claims for the member in the most recent 120 days, as represented in the accumulated Rx Claims Data Feeds. US Script will use weekly program summary reports and a monthly client reporting package to ensure the active engagement of the retail pharmacies in the MTM program.

Claims Data Review.

US Script provides membership and pharmacy claims data to Mirixa bi-weekly and Mirixa provides quarterly analysis to identify members eligible for service. Once identified, an offer letter is sent to members, alerting them to the opportunity to participate in our MTM program. Cases are routed nightly to US Script's retail pharmacy network. Our first priority is identifying the local retail pharmacy that provides the majority of medications to the member, if they are participating in the MTM program, and the next priority is identifying the participating pharmacy that dispenses the most medications to the member.

Member Identification:

Members may be identified by having a chronic condition in which they are prescribed a medication in one of the five main targeted disease states or have a medication in two additional chronic categories in an expanded targeted disease (three classes/three drugs total). The targeted conditions, aligned with the MLTCs MTM program requirements are respiratory disease, mental health disorders, diabetes, hypertension, and viral disease. ***Table Q89*** provides additional information regarding the targeted conditions.

Table Q89

Chronic Condition	Therapeutic Description	Therapeutic Group (GPI)
Respiratory Disease (Asthma, COPD)	Antiasthma and Bronchodilator Medications	44
Mental Health Disorders (Depression, schizophrenia and other psychosis, autism)	Antidepressents Antipsychotics/Antimanic Agents	58 59
Diabetes	Antidiabetics	27
Hypertension	Antihypertensives Beta Blockers Calcium Channel Blockers Diuretics Cardiovascular Agents - Misc	36 33 34 37 4099
Viral disease	HIV/AIDS Hepatitis	1210 1235

Additionally, members prescribed a medication in two additional chronic categories within an expanded targeted disease state (three classes/three drugs total) may also be identified for participation in our MTM program:

- Alzheimer's Disease and Related Dementia
- Bone Disease (Arthritis, osteoporosis)
- Respiratory Disease (Asthma, COPD)
- Atrial Fibrillation
- Cancer (Breast, Colorectal, Lung and Prostate)
- Chronic Kidney Disease
- Mental Health Disorders (Depression, Schizophrenia, and other psychosis, autism)
- Diabetes
- Heart failure
- Hyperlipidemia
- Hypertension
- Ischemic Heart Disease

- Stroke
- Neuromuscular
- Viral Disease

Finally, members with eight or more unique prescribed medications (legend or non-legend) which have been dispensed at least three times in the last 120 days are also identified for program eligibility.
US Script's MTM program will target members who meet the State's disease criteria: specified chronic disease states and a minimum number of covered medications. Pharmacy claims data are then used to infer disease states and identify clinical issues for the pharmacist to address. Service to members is then provided by the local retail pharmacy that dispenses medications to members.
Comprehensive Medication Review (CMR) is an integral component of our MTM program. A detailed CMR workflow is provided below.

Comprehensive Medication Review (CMR) Workflow:

- Pharmacist is notified nightly of new cases and reminded of cases not yet completed weekly via email
- Pharmacist contacts member (or caregiver or other authorized person) to schedule appointment for service face to face or telephonically
- Pharmacist delivers and documents service using structured interview as defined by program design in MirixaPro℠ platform and described in Program Service Description (PSD)
- Member receives Medication Action Plan and Personal Medication List
- Member Opt-Out/Decline
  - Member may decline CMR services, or all MTM program services (including TMRs) at time of pharmacy outreach. Case is closed accordingly.
  - Cognitive Impairment
    - Pharmacist documents cognitive impairment if able to determine. If member is impaired, pharmacist may deliver the service to member's caregiver, prescriber, or other authorized individual such as a health care proxy or a legal guardian.
  - Recipient of Service
    - Using contact information provided by US Script, pharmacist attempts to reach all eligible members in order to deliver service in accordance with CMS guidelines. Service may be delivered to a caregiver or other authorized member representative if member is unavailable (e.g., members residing in LTC).
    - The pharmacist documents that service was delivered to member, caregiver, member's prescriber, or other authorized individual.

CMR Pharmacist Evaluation:

The pharmacist is a critical component of a comprehensive care management program. Our MTM program is designed to engage the pharmacist fully in the member's health and the pharmacist's CMR includes review for appropriateness of medication, dosage, frequency, route, and time of administration. This review includes review for adherence and persistence with medication regimen, potential gaps in care based on evidence-based treatment guidelines, possible safer alternative medications (e.g., alternatives to High Risk Medications; possible unnecessary duplications of therapy; possible medications to discontinue because they are no longer required; potential drug-drug, drug-allergy, or drug-condition interactions (***Figures Q89.B and Q89.C***). The pharmacist's CMR also includes possible physical signs of an adverse drug reaction including jaundice or slurred speech; possible untreated medical conditions that require treatment; known health measurements that may help evaluate effectiveness and appropriateness of drug therapy; follow-up on laps that may be required to monitor for safety; immunization history; preventative care and lifestyle factors that may require recommendations or referrals; and potential cost-saving alternatives to the member's medication regimen.

Examples of the alerts providers receive are shown below:

Figure Q89.B Safety alert resolution

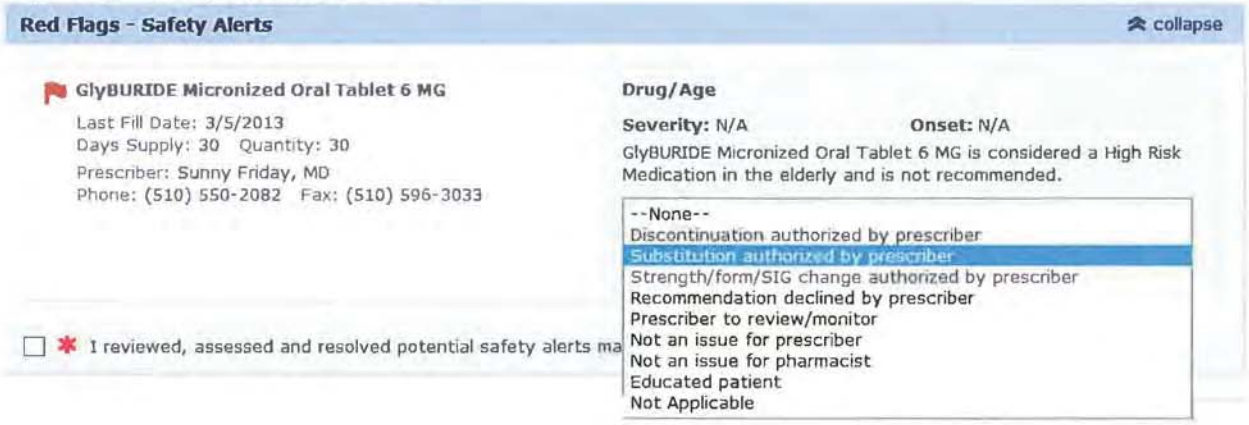
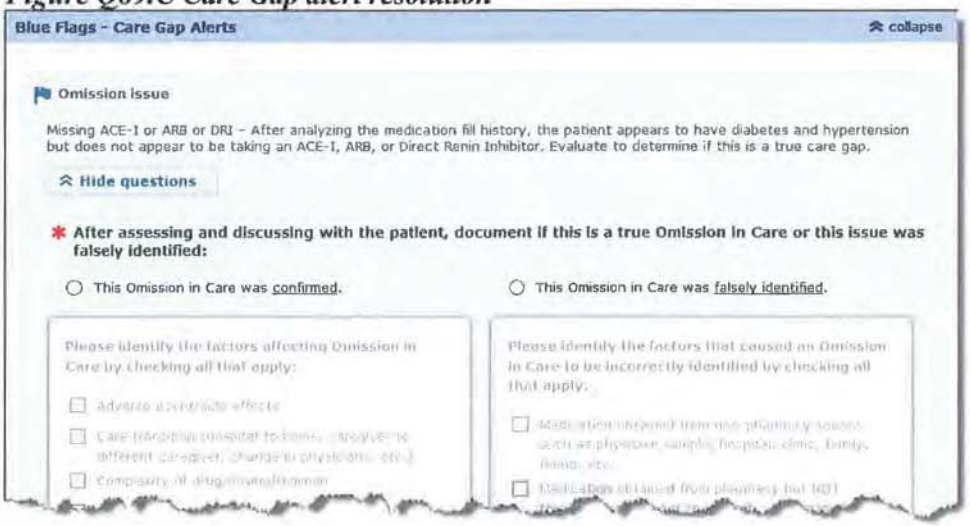


Figure Q89.C Care Gap alert resolution



Our MTM program platform is easy for all program participants to use, providing important information designed to support member care. NTCs program will be designed to ensure compliance with the MLTCs MTM program goals and to ensure active engagement of our Nebraska independent pharmacists as critical caregivers for our members.

(3 page limit)
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.***

NTC's Drug Utilization Review (DUR) program will reflect the experience of Centene affiliates in 23 states in developing, maintaining and refining RDURs and ProDURs specific and relevant to the medication trends and needs in each covered population, including psychotropic medications. We will conduct our DURs using criteria, protocols and procedures in accordance with federal and State requirements as well as URAC and NCQA standards as well as collaborate with MLTC's DUR program through quarterly meetings conducted between US Script's DUR Manager, NTCs Pharmacy Director, and MLTC's DUR committee.

Identifying DUR Opportunities

Our Nebraska-based Pharmacy Director, assisted by our P&T Committee and clinical staff, will target drugs and/or diseases for which safety and health risks may be improved by Member medication compliance and prescriber/pharmacist education on best-practice drug therapies or other interventions. Our DUR Program will also include reviews to ensure appropriate and medically necessary prescribing.

Using Recognized Sources. We will use clinical information and recommendations from recognized sources to identify opportunities to ensure the Triple Aim of Member health and safety and program quality and cost effectiveness. These will include but not be limited to:

- FDA's Center for Drug Evaluation and Research
- United States Pharmacopeia - National Formulary (USP–NF)
- Medi-Span ® clinical database
- Medical and Pharmacy peer-reviewed literature
- Nationally recognized compendia, clinical studies and guidelines
- Drug manufacturer dossiers

Additionally, our Pharmacy Director's participation on the ***State's DUR Board*** will help keep NTC staff and P&T Committee Members apprised of State-recommended utilization controls and other standards, so that we may make any necessary changes to our program to control costs and/or maintain access.

Using NTC and Centene Experience. NTC also will develop ongoing or ad-hoc DURs when we identify opportunities for drug utilization improvements through sources such as medical and pharmacy claims, utilization management reviews of medical services, feedback from Providers and Members, and recommendations from our P&T Committee. We also will continually evaluate opportunities for DUR improvements, such as in response to sudden drug cost increases and evolving industry standards. Our P&T Committee will at least annually review and update as needed our ProDUR and RDUR programs. Findings from our RDUR and ProDUR programs will also be used to inform MTM program enhancements through collaboration between NTC, MLTC, US Script's Drug Utilization Review Manager, and our MTM program partner. Members identified through DUR initiatives needing specific MTM services will be referred for MTM services.

One example of a ***specialized, ad-hoc DUR*** recently occurred with our Georgia affiliate in response to national trends regarding individuals seeking narcotics at emergency rooms (ERs). The affiliate used pharmacy and medical claim data to identify hospital ERs with high narcotic prescribing and contracted at least 10 hospital ER directors to educate them about our affiliate's findings, encouraging them to change prescribing policies and to participate in tracking frequent users.

Conducting Retrospective DUR (RDUR)

NTC's RDUR program will include, but not be limited to, monitoring utilization as required in the Contract agreement, such as therapeutic appropriateness, over/underutilization, and clinical Abuse/Misuse. In addition our RDURs will also monitor medication adherence for selected drugs, such as

for psychotropic, respiratory and specialty drugs. NTC will also monitor metrics about pharmacy program performance, such as whether services were delivered as prescribed and consistent with payment policies.
System Calibrations. NTC will identify explicit predetermined standards using nationally recognized compendia and peer reviewed medical literature. We will direct US Script to develop algorithms to meet each monitoring goal and to apply the algorithm across all pharmacy claims. We will also program our claims system, *PBM1*, to identify Providers who are network NTC Providers, BH MCO Providers or both to facilitate active, ongoing and appropriate educational outreach and BH MCO collaboration.
Review and Action. NTC's Pharmacy Director will review RDUR reports submitted by US Script that identify Members or Providers who fall outside acceptable parameters. These reports may be monthly or quarterly, depending on the metric and the time needed for an accurate measurement of a drug therapy and appropriate intervention.
As needed, the Pharmacy Director will notify staff to initiate interventions to improve drug use. Our interventions may include calls by the Medical Director to prescribers to notify them of DUR findings and possible prescribing improvements, and/or involvement of care management staff to educate Members. For example, Care Managers may reach out to Members identified as noncompliant with their *BH medications* and collaborate with BH MCOs and BH Providers in improving compliance. It may also include directing pharmacy staff to further investigate a Member's medical and other clinical data to determine whether the Member would benefit from our Recipient Lock-In program to help curtail inappropriate drug use. Members would be referred to MTM services if identified member would benefit from MTM.

Conducting Prospective DUR (ProDUR)

Calibrated, Automated System. US Script's POS electronic claims system adjudicates PA policies and clinical edits in real-time, and alerts pharmacists using the Medi-Span® clinical database, which continuously draws from updated, comprehensive drug information. Our system covers potentially dangerous or inappropriate prescribing by comparing prescribed medications against previous drug history, such as for drug-to-drug interactions, drug-disease contraindications, incorrect drug dosage or duration, drug-allergy interactions, and ingredient and therapeutic duplications. It also will identify possible clinical abuse or misuse, such as by identifying high or low dosing or age or gender contraindications. Our POS system also checks for potentially teratogenic drugs/agents, which are unsafe for Members who are pregnant. It processes all edits concurrently, including PAs for non-preferred drugs.
Review and Action. Our Medi-Span alerts or "soft edits" will require pharmacists to use professional judgment to determine the appropriateness and safety of the prescribed drug therapy. Our US Script-programmed clinical restrictions will stop a claim based on NTC's medical necessity and PA requirements and in general cannot be overturned by the pharmacy.
Our NCPDP-compliant point-of-sale (POS) messaging assists dispensing pharmacists advise prescribers and counsel Members in accordance with MLTC requirements. For example, for claims stopped by a PA requirement, the message will alert pharmacists of the needed clinical criteria for approval and the preferred, cost-effective drug alternative, which the pharmacists can convey to prescribers.

Examples of RDUR and ProDUR Initiatives, Interventions and Outcomes

Scheduled Drug Monitoring. NTC will conduct several DURs to identify Members going to multiple practitioners and pharmacies. We also will look for high morphine-equivalent dosing without a cancer or sickle cell diagnosis. If given access to the database, NTC also will monitor data and trends as evidenced by the State's Achieving Better Care by Monitoring All Prescriptions (ABC-MAP) program, to more comprehensively identify prescribers, pharmacies and Members who may be misusing, abusing or fraudulently using these drugs.
ProDUR Duplicate Therapy Clinical Edits. US Script's Duplicate Therapy Clinical Edit seeks to prevent unsafe and inappropriate use of medications using a hard stop limit in our PBM1 claims adjudication system. When the system identifies a multiple medications being filled within the same drug class an alert will require a PA to process. This ProDUR is both a cost-containment strategy and safety

initiative. The program has successfully prevented medication misuse and reduced claims throughout affiliate plans; see ***Table Q90*** for examples:

Table Q90

Georgia	**Peach State Health Plan, Inc.**
Population (1/2015)	385,310 TANF and SCHIP Members.
Successful Outcomes	20.1% of claims were avoided resulting in a 9.4% drug spend savings.
Louisiana	**Louisiana Health Care Connections (LHCC)**
Population (1/2015)	152,240 TANF, CHIP, ABD (non-duals) and Foster Care Members.
Successful Outcomes	23.5% of claims were avoided resulting in a 13.4% drug spend savings.
South Carolina	**Absolute Total Care**
Population (1/2015)	109,659 TANF and SCHIP and SSI Members.
Successful Outcomes	22.6% of claims were avoided resulting in a 13.2% drug spend savings.

Provider Interventions. NTC will use a range of interventions and educational approaches to inform Providers of DUR results, common drug therapy problems such as Over-prescribing of Narcotic Analgesics and ADHD medications, along with best practice prescribing. Some highlights include:

- Personalized outreach by our Medical Director to discuss their prescribing as identified in DUR reports that fall outside of utilization normatives or recommended practices and to educate prescribers on more effective drug therapies.
- Sharing via our Provider Relations staff or Provider Portal reports that demonstrate the Provider's prescribing patterns against peers to educate and incentivize appropriate changes.
- A pilot by our Mississippi affiliate to inform Providers of Members found by our DURs who have a diabetes condition and high blood pressure but are not taking ACE or ARB inhibitor medications to prevent chronic kidney damage. The pharmacy department sends letters describing the benefits of prescribing these medications. The affiliate is still determining the pilot's effectiveness, but to date about 10% of the Providers agree to the prescribing.

Member Interventions. NTC staff across plan operations will educate and support Members' appropriate use of medications using ***both concurrent and RDURs***. Highlights include:

- Personalized outreach to Members identified by DUR reports as showing potential drug over/under underutilization by our Care Managers to assess the issue and identify solutions.
- During each contact, our Care Management staff will review and assess a Member's medication use, and will educate Members and Caregivers as needed. They will also assist Members/Caregivers with resolving barriers to access and medication compliance. ***We will offer reviews and support in the home, Providers' offices, and other community locations.***
- NTC will provide an enhanced and individualized review of a Member's drug use with our multi-disciplinary case rounds that will also include the Members/Caregivers and Providers.
- Our Florida affiliate's palliative care program conducts a comprehensive mediation review that also reviews medications for potential discontinuation.

91. Describe the MCO's proposed psychotropic drug oversight program to ensure appropriate utilization…(4 pg limit)

Nebraska Total Care (NTC) brings a comprehensive psychotropic drug oversight program based on Centene's more than 30 years of experience delivering pharmacy benefits for Medicaid members, including expertise in serving child welfare systems and vulnerable populations. Our program offers proven approaches that integrate prescribers, pharmacies, members, caregivers/consenters and NTC's pharmacy, Medical Director and Care Management (CM) staff to set and maintain a high quality of pharmacy care. NTC's **data-informed process** is driven by the expertise of our Pharmacy Department, CM program and data analytics teams who will use targeted claims-based reports and other data to effectively perform Medication Therapy Management for NTC's members, including tailored approaches for individuals using psychotropic medications and children. Our CM, Disease Management Health Educators/Coaches and Pharmacy Coordinators will monitor member medication use and work with clinical pharmacy staff, Medical Directors and providers to ensure appropriate care. Key elements include prospective and retrospective Drug Utilization Reviews (DURs) to protect member health and safety; provide appropriate, cost-effective and timely medication therapy; and identify needed education to Members/Caregivers and Providers. NTC will use standards, criteria, protocols and procedures in accordance with State and federal requirements.

NTC will implement Centene's **recognized Psychotropic Medication Utilization Review** (PMUR) process that includes an in-depth review of member clinical history (e.g. medical, lab work, diagnoses) and not simply prescription claims histories. Our PMUR process specifically manages the prescribing of psychoactive medications to members age 20 and under. We will include in our review, as an enhanced service, confirmation of a Metabolic Screening for members taking atypical antipsychotic medication or other psychotropic medications known to increase risk of Metabolic Syndrome, in addition to:

- **Measuring psychopharmacology use** and prescribing patterns
- **Inclusion criteria** used in our PMUR program.
- **Outreach** to Members, Pharmacies, PCPs and BH Providers as needed based on results of reviews.
- **Specialized trainings** and other ongoing methods to engage retail pharmacies and pharmacists.

Psychotropic Medication Utilization Review (PMUR) Process and Outreach Overview.

NTC will monitor psychotropic medication use of all Nebraska members. Our PMUR program will use recognized clinical practice guidelines and inclusion criteria while respecting individual needs and treatment plans. PMUR is a proven process to ensure that psychotropic medications prescribed to children are being used appropriately and for the indicated diagnosis. Many psychotropic medications are not FDA-approved for use with children. PMUR will help PCPs in member oversight and treatment, reduce the incidence of polypharmacy, adverse drug effects (including obesity), unnecessary drug costs, and identify psychosocial interventions that may be effective or needed to complement drug therapy. In Texas since 2008, **Centene's PMUR process have reduced overall psychotropic medication use in foster children by almost 23%; class polypharmacy utilization by 36%; and use of 5 or more medications by 42%.** The key to our PMUR process is not to eliminate the use of medication, but to provide the right medication, at the right time in the right dosage to provide the least restrictive treatment that is effective.

Team Reviews. NTC will use a specialized PMUR Team comprised of the BHCD and local BH clinicians. NTC will identify Members receiving psychotropic medications using data from our initial and comprehensive health risk screenings and assessments of newly enrolled members, and monthly pharmacy claims reports. Our BHCD will review members identified by the screenings, assessments and monthly reports against medical, pharmacy and other clinical histories as shown in TruCare, and prepare member-specific profiles of medication use from pharmacy data to inform recommended interventions, and if more information is needed will direct PMUR Team clinicians to contact providers. NTC's PMUR program will include a Metabolic Screening Review to prevent avoidable member weight gain and other metabolic issues associated with psychotropic drug use. ***PMUR Outreach and Education. Team clinicians*** fax a provider-friendly form to help providers submit required additional information, such as lab results and notes from previous visits. When the member's drug use falls outside of criteria and is not

supported by medical histories, the BHCD will contact the provider and explain the purpose of the review and psychotropic medication prescribing standards. The BHCD will collaboratively formulate a plan of treatment with the provider, document the plan in TruCare, and send copies of the treatment plan to the provider and member's caseworker and/or juvenile probation/parole officer. For members identified through our Metabolic Review as being overweight or with abnormal glucose and lipid screenings, our PMUR Team will notify our CMs to facilitate appropriate screenings, weight management, and other interventions. We will educate Providers about the need for periodic lab work and monitor claims to ensure the labs are completed. ***Follow Up.*** After Provider outreach, the Team clinician will monitor the member's drug claims. The clinician is authorized to discontinue Provider monitoring when there is documented evidence that the treatment plan that was developed in collaboration with our BHCD is successfully followed, for example, when claims show a medication has been discontinued. The clinician will refer to the BHCD cases in which additional Provider outreach may be necessary.

Inclusion Criteria to Monitor Psychotropic Medication Use

NTC will adopt the most current inclusion criteria from recognized experts. NTC's BH Clinical Director (BHCD) is responsible for collaboration with the Drug Utilization Board, Division of Medicaid and Long-term Care (MLTC), Division of Behavioral Health (DBH), Division of Children and Family Services (DCFS), Office of Juvenile Services (OJS) and the Nebraska Psychotropic Medication Committee, will participate in interagency workgroups, and will develop additional interventions as necessary to ensure the program's & inclusion criteria consistently meet the needs of Nebraskans. NTC's pharmacy benefit management system includes specific edits that trigger inclusion in our DUR process. To meet the needs of Heritage Health we will add all edits in Attachment 8 PBM Claims Processing Edits for the Nebraska Medicaid Psychotropic Drugs and Youth Initiative.

In addition to standard and Nebraska-specific prior authorization and pharmacy edits for psychotropic medication use, our NTC BHCD, a psychiatrist, or as appropriate a State-licensed child and adolescent psychiatrist, will review psychotropic drug claims monthly to identify members receiving treatment for 60 days or more with a psychotropic medication(s) and meet any of the following **criteria**:

- Are under the age of 4 (and receiving an antidepressant or antipsychotic)
- Are under the age of 5 (and receiving a stimulant), or
- Appear to have class polypharmacy as defined by
  - Concomitant use within the same drug class of two or more: stimulant, alpha agonists, antidepressants and/or atypical antipsychotic medications
  - Three or more concomitant mood stabilizers; and/or
  - Four or more concomitant psychotropic medications[10].

Additional Outreach/Education Criteria. The BHCD directs PMUR Team to outreach to providers (including PCPs or BH providers) for additional information if medical record and claims data do not support the appropriate prescribing. Criteria the BHCD uses for Provider outreach, education and treatment planning include factors such as:

- Absence of an appropriate DSM-5 diagnosis
- Prescribed medication is not consistent with appropriate care for the diagnosis or with documented target symptoms usually associated with a medication being prescribed
- Medication dose exceeds usual recommended FDA and/or literature based dosages
- Two or more medications are prescribed for a diagnosis before using psychotropic mono-therapy.

Metabolic Screening Criteria. Our PMUR Team will also identify members taking antipsychotic medications for 180 days or more; assess height and weight to determine whether BMI falls within the

[10] In February of 2014, our PMUR parameters were modified from five or more concomitant psychotropic medications to four or more. This more stringent guideline was applied to enable closer monitoring of the use of psychotropics in children.

normal range; and monitor blood glucose and lipid screenings to ensure screenings occur every six months.

Tools to Monitor and Measure Psychotropic Prescribing Patterns and Usage

Prospective Pharmacy Reviews. ***Engaging Providers.*** Our prospective DUR starts with Provider education on conditions of coverage and the PDL and its updates to promote patient safety. Network pharmacists and prescribers are our eyes and ears for member needs and appropriate drug utilization. We offer several avenues to respond to any concerns they may have. For example, our Pharmacy Coordinator works directly with prescribers educating them about our coverage policies and processes, and resolving any issues. Our CMs will outreach to prescribers to seek their treatment advice when creating a service plan and to update them on a member's conditions, including any drug therapy issues or barriers. ***Point of Sale (POS) Support.*** NTC will use our internal pharmacy benefits manager's POS electronic claims system that adjudicates PA policies and clinical edits, and alerts pharmacists using the Medi-Span® clinical database, which continuously draws from updated, comprehensive drug information. Our system covers potentially dangerous or inappropriate prescribing by comparing prescribed medications against previous drug history, such as for drug-to-drug interactions, and ingredient and therapeutic duplications; and by identifying high or low dosing or age or gender contraindications, which may either require a PA or pharmacist oversight. Our POS system checks for potentially teratogenic drugs/agents that are unsafe for pregnant members. It processes all edits concurrently, including PAs for non-preferred drugs.

Retrospective Pharmacy Reviews. NTC uses an integrated team to monitor members' medication use and health. ***Monthly Medication Reviews.*** We will review monthly DUR reports to evaluate pharmacy program performance (e.g., whether services were delivered as prescribed and consistent with NTC's payment policies and procedures). Examples of these reports include narcotic and ADHD prescribing by Provider, dispensing rates by pharmacy, generic utilization rates, PA volume and denials, and 72-hour emergency supply dispensing rates. Examples of our monthly DUR reports that cover medications used by members include the use of all psychotropic drugs. We will review medication adherence reports for a range of drugs, such as those relating to respiratory, diabetes, and psychiatric conditions, using a Medication Possession Ratio of 80%. ***Monitoring Performance.*** Quality improvement is a NTC core business strategy. Our staff review monthly and ad hoc reports to help us identify: opportunities to educate prescribers on best practices, PDL drugs and our PA processes; indications of possible fraud, waste or abuse; and possible areas for improvement in our pharmacy program or other benefits and services.

Specialized Quality Reviews. Specialized data analysts in our QAPI department review customized reports of drug utilization and other data when investigating areas of interest. Our QAPI team will also conduct special reviews to detect unusual or inappropriate patterns of selected drug/pharmaceutical agents, e.g. inappropriate controlled substance prescribing patterns. ***System of Care Engagement***. NTC technologies will also empower providers and the system of care to oversee medication use of our members. NTC ***will make our Centelligence Health Record (CHR) available to qualified system of care users via our secure Portals; for providers, case workers, caregivers.*** NTC's Centelligence Health Record (CHR) offers a comprehensive view of a member's medical, BH, medication history, and care gap alerts. The CHR is based on current and historic medical and pharmacy claims information; lab test results, health risk assessments, and information received and processed via the Centelligence™ Health Information Exchange system (see Section 101 for detail). Because the CHR is integrated within our secure, web based, role-specific Portals, authorized users can view important contacts related to the member's care, including PCP, NTC CM, caseworker, caregivers. Since 2008, our affiliates have used CHR technology in the service of child welfare and community-based health services to support more than 10,000 providers, caseworkers, caregivers and others.

Process to Actively Engage Retail Pharmacies/Pharmacists in Oversight

Retail pharmacists play an important role in medication oversight. Below are some of the Nebraska-local approaches NTC will use to actively engage retail pharmacies in Member care. ***POS messaging.*** Our POS electronic claims system alerts pharmacists when claims histories show a potentially dangerous or

inappropriate prescribing that requires pharmacist oversight and judgment prior to dispensing, such as high or low dosing or age or gender contraindications. Our POS messages also inform pharmacists of PDL alternatives and/or step-therapy requirements for prescriptions requiring a PA, which the pharmacist may convey to the Prescriber as needed. Our messages also provide the toll-free phone numbers of US Script's call center. ***P&T Committee Involvement.*** NTC's Nebraska P&T Committee will include two local pharmacists to ensure local pharmacist input of our psychotropic medication use oversight program. ***Staff Support.*** NTC offers multidisciplinary staff to support pharmacists in medication oversight, such as our Pharmacy Director, pharmacy staff (including Pharmacy Coordinators),Network staff, Member Service Representatives, Medical Directors, CM and DM staff. Staff are trained to quickly respond to any medication issues or questions Members have about their retail pharmacy experience or pharmacists have about a member's medication use. Our Pharmacy Coordinator specializes in educating and assisting prescribers and pharmacists in our pharmacy benefits and processes. We also encourage pharmacist engagement in medication oversight during our pharmacy network contracting. We keep pharmacists informed of medication issues, trends, and PDL and PA changes through a variety of measures, such as faxes, pharmacy manual updates, and website updates. ***Specialized Education.*** We will seek collaborations with pharmacy organizations, such as the **Nebraska Pharmacists Association** to identify and develop educational resources. For example, collaborating for educational programs, developing information on common member diagnoses, and issues that occur when filling prescriptions.

Plans for Prescriber and Pharmacy Interventions

Based on our reviews, our clinical staff such as pharmacists, Pharmacy Coordinators, Care Managers and Medical Directors will educate prescribers of potential concerns by phone, fax, and/or mail. Our pharmacy, CM and DM staff may also educate identified members, caregivers, medical consenters and, as needed and with appropriate consent, others in a member's system of care about medication compliance and disease self-management, and assist members in obtaining needed drugs. Additionally, our staff educate each other about medication use trends in our management teams such as our Quality Assurance and Performance Improvement Committee, and in collaborative discussions such as those in our integrated case rounds. This practice is designed to further support a holistic approach to member health and care.

PMUR Reporting. Our PMUR Team will provide regular reporting to MLTC and will include details on interventions, approvals and denials of psychotropic medication requests for youth in accordance with eligibility categories and timelines (as specified in Attachment 6-Reporting Requirements). When finding evidence or risk of Member safety or serious side effects, the BHCD will immediately contact the designated MLTC representative. Examples of current monthly and quarterly reports include but are not limited to:

- ADHD and Narcotic Prescriber Profiling. These reports identify those physicians who prescribed ADHD medications or narcotics to 75% or more of their patients/members
- Adherence Tracking for Psychiatric Medications. Report tracks member adherence with Atypical Antipsychotics, SSRIs & SNRIs, and Anti-Manic Medications.

In 2016, we will be adding reports for required HEDIS Measures specific to psychotropic categories. ***Collaboration for Interventions.*** The experience of our affiliates indicates outreach and education are extremely successful interventions for reducing unnecessary or inappropriate psychotropic prescribing patterns, particularly in children. Should individual providers be unresponsive or repeatedly prescribe outside parameters, we will work with our QAPI team and MLTC to develop interventions (such as provider outreach/additional training) and/or corrective action planning up to and including termination from the network should the circumstance warrant. We will share PMUR reports with our P&T Committee and Clinical Advisory Committee to support understanding of Member needs and develop needed program improvements.

92. Describe the MCO's methodology to assess disparities in treatment among races and ethnic groups and correct those disparities. (2 page limit)

Overview and Methodology

As defined by the Minority Health and Health Disparities Research and Education Act of 2000, health disparities are differences in "the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates". NTC will use a data-driven approach to analyze and assess the presence of disparities among races and ethnic groups and develop programs that strive to correct those disparities. Our Centelligence™ reporting platform allows us to "drill down" into reports to further analyze potential barriers such as geographic location, which may affect accessibility to specialty provider services, often a barrier in rural communities, or timeliness of appointments. We will analyze data at the macro level to identify trends across populations (e.g., aggregate, region, county, city, race, ethnicity, culture and community) as well as by individual member and develop interventions that are customized to meet the needs of the population. Analyzing the data by race and language may identify potential barriers related to use of interpretive services or access to providers who are bi-lingual in the member's preferred language. Like our affiliates, NTC realizes that not all barriers can be identified by data alone and will use our local knowledge and community relationships to gain further insight into potential barriers our members face in accessing care. For example, our analysis to date has identified that Nebraska has a very diverse population with high areas of poverty, including rural and frontier, and a high proportion of migrants and refugees representing 25 different languages. According to the Nebraska Office of Health Disparities and Health Equity (OHDHE), health disparities identified in Nebraska include disproportionately high suicide rates among young American Indians and are four times more likely to have serve anxiety/depression than whites. Hispanics are 1.2 times more likely to have severe anxiety/depression than whites. African Americans in the state have higher rates of infant mortality than the rest of the nation; only about 50% of American Indian women received first trimester prenatal care in 2006-10 and Hispanics are two times more likely than whites to receive inadequate prenatal care. Heart disease is the second leading cause of death among Nebraska residents in 2010, with the majority of those being African American – the highest heart disease death rate was in Wheeler County. Stroke is more prevalent in African Americans and Asians. Our discussions with Chadron Community Hospital identified that new Samoan mothers often leave the hospital in the middle of the night following the baby's delivery. We also heard that male dominance in the Sudanese population can impede access to or treatment recommended by health care providers. NTC, like its affiliate health plans will also garner information and support from community representatives, leaders of local faith based groups, nonprofit associations and advocacy groups to help identify barriers associated with race and culture.

Correcting Health Disparities

We understand that moving from health disparity to health equity requires the engagement of the entire stakeholder community, including providers like Charles Drew Health Centers, the behavioral health regions, and community-based organizations such as the Nebraska Urban Indian Health Coalition, LiveWise Coalition, Lutheran Family Services, legislators, and members. A foundational component of our approach to address health disparities is to train our staff and providers about the different disparities in health among races and ethnicities in Nebraska and then work together to identify and implement interventions to address those disparities. For example, we will train all NTC staff on Cultural and Linguistic Appropriate Services (CLAS) standards as part of our new employee training and at least annually. NTC will also train staff on the culture of poverty. NTC will engage community-based organizations in tailoring our staff training curricula to ensure staff are familiar with cultural characteristics (particularly those related to health care access) of predominant groups in the area, for example engaging the tribal councils to ensure our staff is aware of the differences within the Native American tribes. We will provide similar training opportunities to our provider network such as links on our Provider Portal to the federal HRSA website for a course on health literacy and caring for patients with limited English proficiency (LEP). We will evaluate our network to ensure it aligns with the cultural diversity of our Heritage Health members and include language spoken in our Find a Provider interactive

provider directory. We will recruit staff that are bilingual in prevalent languages such as Spanish and other languages found to be prominent in the communities we serve. Based on affiliate experience, we realize that members, providers and stakeholders often do not that NTC offers all printed materials in English and Spanish and other languages upon request. We will contract with a telephonic interpretive service (Voiance and/or Language Line) to offer real-time interpretation when members call NTC's Member Call Center or care management staff and we will arrange free face-to-face interpretive services for health care appointments including American Sign Language. Below we describe programs and approaches successfully developed and implemented in our affiliate plans that NTC will adopt and adapt for our Heritage Health population. **Care Management Programs for Conditions Prevalent in African Americans.** Our Louisiana affiliate, Louisiana Health Care Connections (LHCC), evaluated health disparities related to member demographics and found that nearly 60% of their members identify themselves as 'Black'. As such, LHCC focused clinical initiatives and care management (CM) activities on conditions for which African-Americans are at higher risk (and subject to disparities in treatment and outcome), such as HIV, sickle cell disease, heart disease, stroke, and breast and cervical cancer. CM staff provides information about any increased risk for particular diseases related to the member's race or ethnicity, and provide information about behaviors that members can change to mitigate identified risks such as improved diet and exercise. We also engage our providers in educating members and monitor their compliance with adopted evidence-based treatment guidelines. Following these activities, LHCC notes that well over 80% of members who are African-American receive recommended screenings and treatment. **Teen Pregnancy in African Americans.** Our Georgia affiliate, Peach State Health, identified that the annual teen pregnancy rate for Dougherty County in the Southwest Region is almost two-times that of the state-wide rate. Social determinants were identified as age, socioeconomic status and geography. In collaboration with the Mirian Worthy Women's Health Center and the Network of Trust School Program, Peach State designed a Teen Education Awareness Movement (T.E.A.M) Outreach Program to improve pregnancy-related outcomes for African American teen-age girls living in Dougherty County. The T.E.A.M. interventions consisted of in-home learning sessions to increase communication between parents and teens on sex education; online courses focused on teen pregnancy prevention where participants earn credits toward their high school diploma; teen self-awareness classes focused on building self-esteem; and Healthy Lifestyle events about abstinence and various birth control methods. Peach State also collaborated with Taking Time for Teens Coalition and The Boys and Girls Club to host the Teen Maze event. This interactive event provided real life experiences and potential consequences of engaging in unhealthy behaviors such as pregnancy, sexually transmitted diseases, hospitalizations, parenthood, and death. It also taught them about the importance of positive decision-making. After the intervention, Peach State found Dougherty County's teen delivery rate decreased by 22% and the NICU rate decreased by 33% with a 2014 estimated cost avoidance of nearly $1 million. **Inadequate Prenatal Care and Poor Birth Outcomes.** As noted above, we have identified health disparities for African Americans, American Indians and Hispanic residents of Nebraska. Through our Tribal Network Liaison and Native American Health Advisory Committee, NTC will collaborate to determine the best approach specific to each tribe's cultural practices and preferences and tailor our Start Smart for Your Baby® programs accordingly. Similarly, we will engage faith based leaders and other community representatives to customize our programs to incorporate the cultural beliefs of the African American and Hispanic populations as well. For example, our Missouri affiliate partnered with Uzazi Village, a Center of Excellence for reducing inequities in perinatal outcomes. Home State supports their efforts to raise awareness of perinatal inequalities in the African-American community, steer women to providers and facilities that practice evidence-based care, and create culturally specific childbirth education with a focus on client and family empowerment and shared decision-making. Home State sponsored Uzazi Village's Community Pregnancy and Baby Fair and promotes their Sister Doula program, which offers face to face pregnancy coaching for high risk pregnant women in the Kansas City region.

nebraska total care TM

IV.O Program Integrity

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. (4 page limit)

Overview of the Nebraska Total Care Program Integrity Program

As part of our Compliance and Ethics Program, Nebraska Total Care (NTC) will operate a robust and comprehensive program integrity program, drawing upon our experience and best practices identified through our 20 affiliate health plans across the country. Our Program Integrity program is a component of our Compliance and Ethics Program, which meets the seven required elements described in the Federal Sentencing Guidelines. We have a proven track record of successfully adhering to program integrity and compliance requirements and meeting the goals of state compliance programs. Centene's Special Investigation Unit (SIU) conducts oversight activities and coordinates directly with all Centene plans. NTC's program integrity components of our Compliance Program will be composed of policies, procedures, a Fraud Waste and Abuse and Erroneous Payments Compliance Plan, and an oversight committee. For a detailed discussion of our Compliance Program, please see the answer to Question 10.

Compliance with Requirements RFP Section VI.O and State and Federal Requirements

The NTC Compliance Plan will adhere to all requirements outlined in section IV.O of the RFP, and will include all required components of the plan outlined in section IV.O.8. Our Compliance Program will also comply with all applicable State and federal requirements, including 42 CFR 438.1-438.812, relating to FWA and erroneous payments. NTC will work collaboratively with MLTC, specifically NMPI, and MFPAU, to prevent, reduce, detect, correct, and report known or suspected FWA and erroneous payments in accordance with all state and federal requirements, including reporting all allegations of fraud to NMPI. A detailed discussion of how NTC's Compliance Program will meet all RFP requirements is provided in the sections below.

Nebraska Total Care FWA and Erroneous Payments Compliance Plan. The NTC FWA and Erroneous Payments compliance plan (FWACP) will focus on the prevention, reduction, detection, correction, and reporting of fraud, waste, abuse, and erroneous payments among providers, members, and subcontractors. The FWACP will address all components outlined in section IV.O.8 of the RFP, such as:

1. ***Written Policies, Procedures and Standards of Conduct.*** NTC will document all policies, procedures, and standards of conduct related to FWA and erroneous payments as required by the RFP. These policies and procedures will detail procedures and methodologies related to preventing, detecting, and investigating FWA, proactive measures to detect FWA and erroneous payments, ongoing monitoring and auditing procedures, access to provider records, prompt response and corrective actions, suspension of provider payments, and prevention of payments to international accounts. We will review and update our policies, procedures, and FWA compliance plan at least annually. NTC will submit all policies as well as the designation of the compliance officer and committee to MLTC for review and approval at least 45 days prior to the contract start date, annually thereafter, and at least 30 days prior to the implementation of any material changes. NTC will also document that it will report all allegations of fraud to the NMPI. All policies and procedures related to FWA and erroneous payments will be reviewed and approved by NTC's Compliance Committee, which includes the Compliance Officer, CEO and NTC's senior management. Once the policies are approved, they will be loaded into Compliance 360 for immediate availability to all employees on the intranet.
2. ***Program Integrity Officer and Staff.*** NTC will designate its Vice President (VP) of Compliance as our Program Integrity Officer, who will report directly to the CEO. This position has the ultimate oversight, responsibility, and authority for the NTC Compliance Program. Hereinafter, this individual will be referred to as the Compliance Officer. The Compliance Officer will be located in and 100% dedicated to Nebraska. The Compliance Officer and local staff will be experts on the regulations related to health care fraud and abuse, and will interface with the State or MLTC, as the issue demands. NTC will be staffed with at least one investigator for every 50,000 members who each have qualifications as outlined in RFP section IV.D.3.i. The Compliance Officer and his/her staff will

routinely communicate with Centene staff and their colleagues at affiliate health plans on common issues, best practices, and training initiatives.

3. ***Compliance Committee.*** The Compliance Officer will serve as Chair of our Compliance Committee, which will meet at least quarterly and include leadership from every NTC department. This committee will review compliance issues and determine when further action is needed.
4. ***FWA Workgroup.*** The Compliance Officer will meet bi-monthly with representatives from Claims Research, Provider Relations, Provider Services, and Member Services, as well as Centene Corporation's SIU to review the work plan, share results, and discuss issues.
5. ***Corporate Support.*** Centene's Vice President of Ethics and Compliance has direct oversight over the SIU. The Director of the Special Investigations Unit is a member of the National Health Care Anti-Fraud Association's (NHCAA) Board of Governors.
6. ***Effective Lines of Communication.*** Our combination of new hire orientation, annual training by a Compliance staff member, and Compliance presence on our Quality Committees and workgroups will make our employees aware of and comfortable approaching our Compliance staff with any concerns. In addition, Centene has both a Compliance Helpline for employees to report Compliance Issues and a FWA Hotline for members, providers and other external individuals to report FWA issues.
7. ***Confidential Reporting Mechanisms.*** NTC will provide an internal and external toll-free hotline for employees, providers, members, subcontractors, or others to report suspected FWA or any type of compliance concern, available 24 hours a day/365 days a year. NTC will ensure that any individual who reports suspected FWA is not retaliated against either by NTC staff or subcontractors.
8. ***Disciplinary Procedures.*** NTC will also have in place well-publicized disciplinary guidelines related to FWA and erroneous payments that address employee violations of the Compliance Program, to help enforce policies and procedures.
9. ***Staff and Subcontractor Training.*** NTC staff and subcontractors will receive comprehensive training on preventing, reducing, detecting, correcting, and reporting on suspected cases of FWA and erroneous payments on an annual basis. Training is discussed in more detail below.
10. ***State Collaboration.*** NTC will ensure timely, complete, and consistent exchange of information and collaboration with NMPI, MFPAU, and the MLTC external quality review organization (EQRO) related to suspected FWA. NTC will also include in its Compliance Plan the method by which it will comply with requests from NMPI or the MFPAU to provide access to and copies of records or other information as necessary to which MLTC is authorized to have access.

Training for Employees and Subcontractors

Training for NTC Program Integrity Division Staff. NTC will ensure that the Compliance Officer and staff receive appropriate training that will assure they can effectively carry out roles and responsibilities. The Compliance Officer will attend the Centene Corporate Compliance Conference with Compliance Officers from other Centene affiliate health plans where each attendee receives training materials on how to improve compliance planning, implementation and monitoring, and FWA activities. In addition, the FWA Investigators will also receive ongoing training on CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks.

Training for NTC Employees and Subcontractors. NTC will require all employees, subcontractors, temporary staff, and consultants to annually attend Fraud and Abuse training sessions. Centene's Business Ethics and Conduct Policy includes specific discussion of federal and state laws and regulations governing FWA and erroneous payments as well as discussion of policies and procedures. This discussion will also include whistleblower rights and protections for employees.

Training for New Employees. NTC will require that new employees complete and attest to having completed compliance and FWA and erroneous payments training within 30 days of hire. This training will address: The NTC and Centene Code of Conduct; Privacy and Security - Health Insurance Portability and Accountability Act; Fraud, waste, and abuse and erroneous payments; Procedures for timely consistent exchange of information and collaboration with MLTC; NTC organizational chart including the Program Integrity Officer and FWA Investigators; and Provisions of 42 CFR §438.610 and relevant

State and federal laws, regulations, policies, procedures, guidance and standards including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks.

Enforcement of Standards and Corrective Action. NTC will use a number of different methods to notify and educate providers about our Compliance Program. This includes how NTC will enforce the program requirements. For example, we have the option to terminate a provider's contract for failure to comply with our contractual requirements or cooperate with quality monitoring and improvement activities. This option is in addition to those cases where NTC reports a provider suspected of committing fraud to the State. Similarly, NTC will enforce compliance by subcontractors through the use of corrective action clauses in our subcontracts, and will monitor performance through regular reporting and oversight meetings. Should we identify an issue, we will discuss it with the subcontractor and implement a corrective action plan. Severe or repeated concerns may result in termination of the subcontract and if warranted, a report to the appropriate authorities. If a member appears to be misusing his/her benefits, NTC will analyze member-specific or service-type claims reports and examine any existing case management files. If we think that member fraud has occurred, we will report the member to the State.

Internal Monitoring and Auditing. Based on affiliate health plan experience and emerging fraud trends, Centene's SIU, in collaboration with NTC's Compliance Officer, will develop provider and member claims audit plans. Audits may be focused on a random group of providers or particular providers with concerning billing patterns. Examples and explanations of the internal tools we use for detection and investigation are discussed in ***Tables Q93.A and Q93.B***.

Provider Credentialing and Exclusion Monitoring. A critical component of our Compliance Program is credentialing and re-credentialing of providers and ongoing exclusion monitoring. Our provider credentialing and ongoing monitoring process will comply with section IV.I.14 of the RFP and will identify and report within three business days any excluded providers in accordance with section IV.O.3-4. of the RFP. Compliance will maintain the monthly screening report as evidence of our compliance.

Detection/Investigation. NTC, in partnership with Centene, will utilize a two-pillar approach similar to that used by CMS, which takes advantage of both prospective and retrospective fraud detection methods. This two-pillar approach will allow NTC the flexibility to stop payment for potentially wasteful or abusive claims. By employing a robust prepayment editing system combined with clinician reviews, NTC will be able to stop payment on every potentially miscoded claim versus paying providers and then recouping or entering into a settlement. This includes those claims that present upcoding, modifier misuse/abuse, unbundling, and age/gender issues. NTC will carry out the following proactive and retrospective review processes to detect FWA and erroneous payments:

Table Q93.A: Proactive FWA and Erroneous Payments Processes	
ClaimsXten Claims Software Editing	ClaimsXten (CXT) is our primary code editing software. Centene will regularly review edit results, report concerns to NTC and Centene's SIU, and provide reports that assist with educating providers on appropriate coding practices. CXT reviews claims against coding standards established by the AMA, CMS, and various medical specialty societies. CXT identifies such FWA triggers as unbundling, mutually exclusive codes, procedure frequency-by-day, and age/gender discrepancies.
Physician Claim Clinical Review	Centene contracts with Verisk Health to enhance claims software editing by adding a clinical review component. Clinical review enables an additional screening of clinical billing discrepancies on a prepayment basis. Verisk uses thousands of edits to reduce wasteful billing and assess claims that cannot be identified by pure code editing software alone. This process will allow NTC to review claims before payment.
Fraud Finder Pro Predictive Modeling	Centene's SIU also uses Fraud Finder Pro (FFP), a predictive modeling tool that allows the SIU to identify aberrant provider patterns prior to payment. FFP compares provider billing habits by specialty, and flags outliers.
Proactive FWA and Erroneous Payments Processes	
EDIWatch	This innovative FWA detection software uses complex algorithms to identify suspicious billing trends, and contains hundreds of edits that identify billing outliers.

Intelligent Investigator	
Claims Payment Audit	Centene's Claims Audit Division (CAD) completes quarterly, comprehensive audits on statistically valid samples of processed claims, and validates whether a claim was authorized, entered and processed correctly, paid timely, and paid to the correct provider. Internal audit staff refers any suspicious claims to the Program Integrity Officer for further investigation. Claims audits produce error rate measurements including claims financial accuracy, claims payment accuracy, and claims processing accuracy.
Quality Control Audits	Centene's and affiliate health plan Medical Management Units will conduct quality control audits by reviewing various reports on a regular (usually monthly) basis. Examples of these reports will include: providers with a high number of referrals, providers providing outdated treatment, and member emergency room utilization.
Verification of Services Provided	NTC and Centene will engage members to verify services were provided. Monthly, we will use our Centelligence™ informatics platform to select a sample size of claims. The Member Services Department will send out individual EOB notices to the sample of members requesting that the member validate the listed service.
Hotline Referrals	The SIU maintains a Fraud Waste and Abuse Hotline (1-866-685-8664) that is available to NTC employees, members and providers.
Member Fraud	Centene's SIU continuously analyzes claims data to detect member fraud. If an instance of suspected member fraud is identified, staff will report it to the Compliance Officer, who in turn reports it immediately to MLTC and local law enforcement.

Include best practices the MCO has utilized in other states.

FWA and Erroneous Payments Best Practices Used in other States

NTC will draw upon Centene's significant clinical experience, expertise, and cutting edge analytical tools, as well as our 20 Medicaid affiliate plans, to discuss program integrity trends and to seek advice on best practices to prevent, detect, and eliminate Fraud Waste and Abuse and erroneous payments. Below are several examples of how our affiliate health plans have made improvements to Program Integrity processes based on identified needs in their markets.

Table Q93.B: Best Practices from Other Centene Affiliated Plans	
Peach State Health Plan	Peach State Health Plan, our affiliate in Georgia, instituted an assertive approach to a second medical record request letter. Changing this procedure to clearly explain the consequences of not timely submitting records has improved the response rate. Also, through use of prepayment review and edits, the plan saved nearly $13 million in 2014.
IlliniCare Health and New Hampshire Healthy Families	IlliniCare Health (IlliniCare) and New Hampshire Healthy Families, our affiliates in Illinois and New Hampshire, both changed their policies regarding desk audits of personal care cases to conduct them by in-state plan staff rather than SIU staff.
Louisiana Health Care Connections	LHCC, our affiliate in Louisiana, saved approximately $700,000 in fiscal year 2013 from avoiding payment of incorrect claims identified through prepayment review. In total, all of LHCC's proactive FWA services combined saved approximately $6.3 million, or $3.40 per member per month (PMPM) in 2013.
Magnolia Health Plan	Magnolia Health Plan, our Mississippi affiliate, performs 100% pre-payment claims review. A sentinel effect occurs when providers understand that prepayment reviews are conducted on ALL claims deterring filing fraudulent and/or abusive claims. In 2014, Magnolia saved Mississippi Medicaid nearly $445,000 through prepayment review, and the SIU opened 94 cases for investigation.

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? (2 page limit)

Approach to Working with Other Entities to Investigate and Prosecute Fraud, Waste, and Abuse

Nebraska Total Care (NTC) is committed to working collaboratively with the state, both with the Nebraska Medicaid Program Integrity Unit (NMPI) and the Medicaid Fraud and Patient Abuse Unit (MFPAU) within the state Attorney General's Office, to ensure that all suspected cases of FWA and erroneous payments are reported to the state, that all tips are reported timely to the state at least every two weeks, and that the state has access to documentation and records as needed to support any ongoing investigation. Drawing on the extensive experience of our 20 affiliate Medicaid plans in their effective prevention, detection, and reduction of fraud, waste, abuse, and erroneous payments across the country, NTC is well equipped to ensure all Program Integrity requirements for Heritage Health are met.

Procedures for Working with Other Entities to Investigate and Prosecute FWA

Policies and Procedures. All of Centene's 20 affiliate health plans currently employ a Compliance Program and adhere to a FWA compliance plan, consistent with state and federal requirements. These policies and procedures detail the collaborative processes in place for addressing suspected FWA, for investigation of FWA, and for providing access to information and records as needed to support ongoing investigations. Procedures in place related to working with other entities that investigate and prosecute provider and member fraud, waste, and abuse include:

- Responding to and reporting to the state on potential FWA
- Investigation of FWA upon approval from the state
- State reporting
- Collaboration with the state and other entities on ongoing investigations

NTC will apply these standard methods of working with other entities to investigate and prosecute fraud, waste, and abuse to the state of Nebraska.

How will the MCO apply methods in Nebraska?

Application of Methods in Nebraska

NTC will implement best practices for collaboration on investigating and prosecuting FWA that are based on the experience of Centene's 20 affiliate Medicaid plans. As outlined above, Centene's affiliate plans employ proven policies and procedures related to the investigation and prosecution of FWA. NTC will apply these best practices and experience to its implementation of the Compliance Program in Nebraska. NTC is committed to collaborating with the state on investigations for prosecutions of FWA including providing access to records and staff as needed, as well as participating in periodic FWA and erroneous payment training sessions, meetings, and reviews of providers or members. NTC will also participate in the quarterly Nebraska Health Care Fraud Task Force meeting by sending a dedicated FWA staff person.

State Collaboration in Response to Potential FWA.

Notifying NMPI and MFPAU of Suspected FWA.

Suspected Provider FWA: If any situation is believed to be fraud or abuse after review by the Internal Joint FWA Committee or the Centene SIU, our Program Integrity Officer and the Vice President of Network Development & Contracting are notified immediately. The Compliance Officer, who serves as the Program Integrity Officer, or his designee, will immediately notify NMPI and MFPAU of 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, as outlined in RFP Section IV.O. When NTC and the Centene SIU believe that a provider billing error exists, but the problem does not amount to fraud, we will work together to investigate and educate the provider to correct the situation. If it has not been corrected, the Compliance Officer is notified. He/she will work closely with MLTC to determine the next steps of each investigation. If the billing pattern has been corrected, the case is closed.

Suspected Member FWA: If found, member fraud is often on a smaller scale than provider fraud; however, it is critical to monitor our program, including care management data, member calls, and claims

data to deter, detect, and resolve any issue. Some of the "red flags" of which we train all our staff to be aware include:

- Treatments/medications prescribed by more than one doctor
- Members receiving similar treatment by more than one doctor
- Excessive doctor visits other than PCP
- High volume of ED visits

These "red flags," are not absolute proof of member fraud; in fact, they may simply be an indication that a member's chronic condition is not under control or the member has a condition that has not been properly diagnosed and requires some plan intervention, such as care management. If Nebraska has suspicions or knowledge of member fraud or abuse, we will report that to MLTC.

State Collaboration. Once we report a case of suspected FWA to NMPI and MFPAU, NTC will suspend all plan efforts to investigate, resolve, or take further action unless so directed by the state. The purpose of this process is to avoid interference with any ongoing state investigation or enforcement process. Our policy will be to verify with NMPI and MFPAU how they wish us to handle claims we may receive. For example, we will not put a reported provider on permanent pre-payment review without permission from the state. As needed, NTC will provide access to all necessary case information, computer files, and appropriate staff during the investigation or prosecution of FWA. NTC will allow authorized government agencies to interview NTC employees and consultants, including those with expertise in program administration, medical or pharmaceutical issues, or any other matter related to the investigation. NTC will respond to requests for access to records or data maintained by NTC in the form and manner specified and by the due date specified by NMPI. NTC and Centene will not disclose the existence of any investigation conducted by a state or federal law enforcement office.

Collaboration with other State and Federal Agencies. As necessary, NTC will collaborate with CMS, the US Department of Justice, or other entities as necessary to investigate and assist with the prosecution of fraud, waste, and abuse.

Monthly Reporting to the State. All of Centene's affiliate health plans report monthly to each state on our progress in accomplishing our compliance activities, including meeting our goals and objectives. We also report provider educational initiatives related to billing and medical records reviewed. We keep each state informed of important findings of our investigations, such as if we were to identify what appeared to be a trend in a certain type of billing error in one part of the state or an identifiable health system, or a group of providers that appeared to be billing members inappropriately. NTC will provide the following monthly reports to NMPI as specified in the RFP section IV.O.13:

- Cumulative report of all new referrals of potential FWA and erroneous payments received by NTC
- Update of all previously reported referrals of provider FWA and erroneous payments under review by NTC
- Claims adjudicated to finalization by NTC
- Overpayments identified and collected
- All providers that have left the NTC network, including provider name, NPI, Medicaid Provider ID number, provider type, address, and reason
- Report of NTC's efforts to detect and prevent FWA, including content on utilization review activities, member and provider hotline complaints, QA/QI meeting minutes and reports, and all site-visit reports

95. Currently, how does the MCO educate members and providers to prevent fraud, waste, abuse, and erroneous payments?

Compliance Education and Outreach

Education for Members. Across Centene's affiliate Medicaid plans, members are educated about methods for the prevention of FWA and erroneous payments. We educate our members about FWA prevention through the Member Handbook, quarterly Member Newsletters, the Member Portal, and new member orientation Welcome Calls. We provide these resources to all new members, including those who lose eligibility and re-enroll with the plan. Our materials provide guidance to members about proper use of the Emergency Room (ER), utilization issues, and how to report persons suspected of fraud or abuse. For example, NTC will review ER utilization data and may identify patterns of overutilization of the ER by certain members, constituting waste. A Case Manager will contact each member to determine why they are utilizing the ER. If needed, the member could be enrolled in a Care Management or Disease Management program to assist them in better managing their condition.

In addition, our interactive voice response systems will include a message that encourages members and providers to be alert for FWA. The message will provide callers with a toll free number to report instances of suspected FWA, and will allow callers to connect to the toll free number or speak to someone immediately. Our Special Investigations Unit (SIU) maintains a Fraud, Waste, and Abuse Hotline (1-866-685-8664). This hotline is available to employees, members, and providers. The hotline number is published in the Member Handbook, in newsletters and on the web portal. The hotline number is also provided during new member Welcome Calls. Members have called the hotline to report stolen member ID cards, issues with quality of care, falsified benefit determinations and family members abusing their privileges. Sometimes FWA issues are identified when a member or provider is filing a grievance.

Education for Providers. During orientation sessions, Centene's affiliate health plans educate providers about each plan's Fraud, Waste, and Abuse Compliance Plan (FWACP), which includes information about their obligations and how to report any concern directly to the health plan or via the FWA hotline. They also disseminate this information in each Provider Manual, through articles in quarterly Provider Newsletters, (also available on the web to both contracted and non-contracted providers), in letters, in classes, and during onsite visits to individual providers. These visits may be routine, the result of a random audit, an issue-focused audit, or an inquiry generated by some reported concern. Our plans educate our subcontractors and consultants, including personnel who work onsite, during their initial orientation and mandatory annual trainings. Our plans contractually require subcontractors and consultants to comply with all relevant laws, regulations, state mandates, and our Provider Manual. We also contractually obligate subcontractors to immediately report any concerns about noncompliance within their organization; or that they may have observed at the plan, at a provider's office, by a member, or by another subcontractor. At a minimum, our plans meet quarterly with each of their subcontractors or more frequently based on volume of business, criticality, sensitivity of responsibilities, or historical performance. During these delegated vendor oversight meetings, we review operational reports and reports on compliance and our Program Integrity efforts.

Practice Improvement Resource Center. In 2015, we expanded our online support for providers through our Practice Improvement Resource Center: a well-organized, searchable compendium of best practices and vetted documentation, communication channels (secure messaging, forums, etc.), multi-media content, and interactive tools to help providers across clinical, operational, and technology aspects of their practices. This online resource will include training information for providers about the FWA Compliance Plan and how providers can collaborate with NTC to identify any FWA concerns.

Addressing Provider Non Compliance. Our routine claims audit activities allow for the early identification of possible billing or coding issues. When issues are identified, NTC staff will work with providers to educate them via new provider orientations; phone calls to the provider's office; and during onsite visits. If trend analysis identifies a provider who is failing to adhere to billing and coding

requirements, the Provider Services Representative or local Claims Team member will refer their findings to NTC's Provider Network Team for further action. A Provider Relations Specialist from the Provider Network Team will immediately contact the provider, provide education on contractual requirements and administrative requirements, and offer the local Claims Team, our EDI specialists, or other relevant department to conduct retraining in person if necessary. The NTC staff will document all activities and trend follow up behaviors to determine if issues have been corrected. For continued billing or coding issues, the Provider Network Team may refer the provider to the Credentialing Committee and Clinical and Service Quality Improvement Committee (CASQIC) for consideration of additional action, including putting the provider on pre-payment review and requesting medical records on an ongoing basis. Should any NTC staff member suspect a provider of potentially fraudulent billing, they will immediately engage Centene's SIU and the Compliance Department, which provide oversight and guidance for the prevention, detection, and resolution of billing misconduct including inappropriate billing and coding.

Frequency of FWA Education for Providers. NTC will educate our subcontractors and consultants, including personnel who work onsite, during their initial orientation and mandatory annual trainings. NTC contractually requires subcontractors and consultants to comply with all relevant laws, regulations, State mandates, and our Provider Manual. We also contractually obligate subcontractors to immediately report any concerns about noncompliance within their organization; or that they may have observed at NTC, at a provider's office, by a member, or by another subcontractor. At a minimum, NTC meets quarterly with each of its subcontractors or more frequently based on volume of business, criticality, sensitivity of responsibilities, or historical performance. During these delegated vendor oversight meetings, we review operational reports and reports on compliance efforts.

Evaluation of FWA Education Methods. On an ongoing basis, the Compliance Officer will work collaboratively with Provider Relations, the Claims Team, and others to identify opportunities for additional provider training related to fraud, waste, abuse, and erroneous payments. As certain billing irregularities or other issues arise, and if patterns exist, this may indicate a need for additional provider training. In addition, the Compliance Officer and Provider Relations staff will identify strengths and weaknesses in training materials and make adjustments to strengthen provider education in these areas.

How will the MCO apply methods in Nebraska?

Application of Member Education Methods to Nebraska. Nebraska Total Care (NTC) will employ FWA training methods for members that have demonstrated success through Centene's 20 affiliate health plans in other states. NTC will apply the methods that are outlined above in the Education for Members section above. NTC will include content on preventing FWA and erroneous payments in its Member Handbook, on the Member Portal, in member newsletters, and in new member Welcome Calls. Content my include information about the proper use of the ER, how to utilize services appropriately, what to do if a member ID card is stolen, and how to report issues. NTC will ensure that all members know how to access the Fraud, Waste, and Abuse hotline and understand that they can contact NTC any time they suspect fraud, waste, abuse, or erroneous payments.

Application of Provider Education Methods in Nebraska. In Nebraska, NTC will build upon the best practices and procedures demonstrated by Centene's affiliate Medicaid plans to build its training program on FWA and erroneous payments for NTC contracted providers and subcontractors. Provider training on FWA and erroneous payments will be implemented in Nebraska as outlined in Education for Providers section above. NTC will provide upfront training to providers through orientation, onsite trainings, classes, via the Provider Portal and Provider Manual, and through the Practice Improvement Center.

(3 page limit)
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.

Capturing TPL and Payment Information

Centene has over 30 years of experience in public sector programs and has successfully carried out Third Party Liability (TPL) activities according to Federal and state requirements. Centene has a successful history of maximizing cost avoidance for its 20 affiliate Medicaid health plans, as well as recovering payments made for our members who were subsequently found to have other insurance (OI) with TPL. Centene structures its cost avoidance and TPL practices around a "Medicaid as a payer of last resort" principle. Nebraska Total Care (NTC) will implement these proven practices in Nebraska.

Identifying, Collecting, and Reporting TPL. NTC will take a proactive, comprehensive approach to identifying, collecting, and reporting third-party liability coverage (TPL) and cost avoidance. Experience from NTC's affiliate health plans has shown that the best approach to cost avoidance is to minimize the need to recover costs in the first place, and to do that, we will employ several methods to support our proactive strategy. Our TPL and subrogation processes will be configured with the guidance and support of our dedicated partner, Health Management Systems, Inc. (HMS). HMS is an established leader in TPL identification and post-payment recovery in the public sector. This strategy will be integrated throughout our claims automation, provider training, internal system configuration, and data exchange with our business partners, affiliate subcontractors, and TPL partners. Inquiring for sources of TPL is an ongoing process, taking place through multiple activities including through HIPAA 834 processing, member self-reporting, provider interactions via telephone, Provider Portal, or claims submissions; from HMS processes; and from clinical management staff.

Collection and Maintenance of Coordination of Benefit. NTC will bring other insurance (OI) information together in our Customer Relationship Management (CRM) system. CRM maintains a member record, including member eligibility. CRM is integrated with our claims processing sub-system to support the collection and maintenance of Coordination of Benefit (COB) information at the member level and, to enable accurate automated cost avoidance through prompt suspension of claims submitted without required Explanation of Benefits (EOBs) or payment information from a primary payer.

Taking a Pro-active Approach to Identifying and Collecting TPL. In ***Figure Q96***, we outline our proposed methods for capturing TPL:

Figure Q96

Reconciling the HIPAA 834 Eligibility File. Upon receipt of the 834 eligibility file from the state, COB data will be automatically loaded to NTC's CRM system. CRM houses current and historical member information and maintains our master member index to assure member data integrity. CRM systematically promulgates updated eligibility data, including COB data obtained from the 834, to other applications requiring that data, including the eligibility subsystems of all subcontractors. This is the first step in our approach to ensure the eligibility subsystem contains current information necessary to identify members who might have COB. If at any time, the COB data we receive from MLTC differs from the

information we have received from any other source, we will ensure that MLTC receives that updated information.

Accident and Trauma Related Diagnosis Code Edits. NTC will also load accident and trauma related ICD-10 diagnosis code edits into our claims processing system, creating another way for NTC to intercept claims that may be the liability of a third party. If a claim is received without documentation to support the liability or non-liability of a third party, and the claim contains an accident- or injury- related diagnosis code, and/or trauma indicator of "Y", we will pay the claim and request that the provider submit accident-related documentation or payment information from the third party. We will send this information to HMS, our partner for post-payment recovery services, for further investigation.

Data Mining. NTC and Centene's claims departments regularly identify TPL and COB cases by data mining through our Centelligence™ informatics platform and using diagnosis and trauma edits (see below for more information), in addition to member outreach, to confirm the presence of TPL based on these edits. We also validate TPL whenever we receive a first time claim with an EOB attached, or an adjustment request from the provider. Both of these situations are detected systematically through Centelligence™, and our web-based reporting and management KPI Dashboards capability.

Claims Analyst Oversight. NTC will have a Centene claims analyst dedicated to NTC operations who will be responsible for regularly reviewing standard claims operations reports focused on first time claims with EOB attachments and claim adjustments. The claims analyst will route this information (member contact information, plus other information from the EOB or adjustment request) to our COB team to verify enrollment with either the third party and/or the member to ensure we are coordinating benefits appropriately.

Health Management Systems (HMS). Each month, we will securely send member demographic data to HMS. This information is matched to HMS' database of national insurance eligibility information, which is updated regularly to identify other available coverage. HMS reviews access coverage information from government healthcare programs, such as Medicare. HMS's database contains over 1.2 billion unique current and historical segments of eligibility from various sources, including insurance carriers, Third Party Administrators, Pharmacy Benefit Managers, and unions used for identification of potential TPL. When a match is found, HMS verifies coverage directly with the carrier through a combination of online tools and telephone contact, and sends the resulting data back to NTC. We will then load this "members level" COB and updated carrier information into CRM and from there the data automatically, and electronically, feeds our claims processing system.

Identify and Address Billing Errors. Centene's Claims Department continuously examines claims submissions for patterns of billing errors from providers, including those related to COB, through the use of decision support tools within our Centelligence™ reporting system. When we identify providers having problems related to billing primary payers, our Provider Relations team and local plan claims experts reach out to the provider to offer targeted Provider education.

Provider Training. Through regular provider orientations, ongoing training meetings, and our online Provider Manual, NTC will educate providers on the importance of identifying COB/TPL information at the time the member receives services. We inform and educate providers about the importance and process for submitting denial notices from third parties, accident details, and medical records corroborating no other liable parties, or EOB or payment information from a third party where member liability exists in the TPL and other payer segments of their HIPAA 837 EDI claim submissions, or their paper claim submissions.

Secure Provider Portal. NTC's secure web-based Provider Portal will allow authorized provider users to see any current TPL information we have on record for a member, affording them a means to check for TPL as part of their routine member eligibility verification process prior to claim creation and submittal. The Provider Portal will also allow providers to submit TPL documentation by uploading images, PDFs, Microsoft Word documents, or other digitally formatted TPL related documents. This information is accessible to our claims processors to expedite finalizing claims with TPL. In addition, a provider may enter a claim directly via our HIPAA compliant Direct Data Entry (DDE) online claim entry facility

available through our Provider Portal. Our online claim entry application has logical field checks so that, for example, if a provider indicates that the member has other insurance, but no entry is made concerning third party payments, the application alerts the user to the missing information as they are entering the claim.

Notification from Nebraska Total Care Staff. NTC staff may also become aware of TPL during member and provider interactions, chart reviews, etc. When staff learn about TPL not already included in the member's eligibility record, this will be verified by a claims analyst and the member record updated to ensure accurate handling of future claim submissions.

Reporting TPL Coverage to MLTC. NTC will comply with MLTC requirements and federal regulations for the distribution and reporting of TPL recoveries. We understand that TPL information is a component of capitation rate development, and we will maintain records regarding TPL collections and report these collections to MLTC weekly in the format determined by MLTC. NTC's ability to collect, manage, analyze, and report data through one uniform production and reporting system allows us to offer an all-encompassing holistic view of the programs and benefits we administer. Our MIS stores and processes data in all areas necessary to support our operations, including but not limited to, claims, third party liability data, enrollee and provider services, authorization, care management, grievances, appeals, and eligibility. NTC will include collections and claims information in the encounter data submitted to MLTC, including any retrospective findings via encounter adjustments. At the request of MLTC, NTC will provide information not included in encounter data submissions that may be necessary for the administration of TPL activity, within 30 calendar days of request. This information may include, but is not limited to, individual medical records to determine liability for the services rendered. Also, NTC will report members with third party coverage to MLTC on a monthly basis, reporting additions and updates of TPL information in the form and manner specified by MLTC.

Data Analytics and Informatics. Centene's Centelligence™ enterprise platform integrates data from multiple sources, and provides actionable population and member level information to the right person, for the right task, at the right time, with the ultimate goal of improving clinical, operational, and financial outcomes. Our Centelligence™ Enterprise Data Warehouse (Centelligence™ EDW) integrates all major systems and applications in real time, including our claims processing system and CRM, and runs them through our Centelligence™ system to generate timely, accurate TPL reports. All the data we house is available for reporting and analysis using our comprehensive reporting tools. NTC will be fully compliant with MLTC and federal guidelines and regulations. Our Centelligence™ EDW, powered by Teradata Extreme Data Appliance high performance technology, receives, integrates, and continually analyzes enormous amounts of transactional data from our core systems including; medical, behavioral, and pharmacy claims; and provider information (participation status, specialty, demographics). It is with our Centelligence™ reporting tools, combined with information we exchange with HMS, that we capture TPL and subrogation data for our MLTC reports.

Providers as Key Stakeholders. NTC views our providers as key stakeholders in our cost avoidance and TPL processes. For example, when we encounter a claim that should be paid by a third party primary insurer, we will automatically deny the claim and follow up with detailed instructions and procedures on how the Provider should bill the correct party via the Explanation of Payment or Remittance Advice. We will also make available Explanation of Payment on our secure Provider Portal. We will use COB information to automatically recognize and prompt further review of potential COB liability by our specialized COB claims processing analyst within the claims operation team. Centene uses automated processes to support efficient and accurate cost avoidance by systematically identifying members with third party responsibility for payment.

nebraska total care™

IV.Q Provider Reimbursement

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: (6 page limit)

While the traditional fee for service model creates incentives for the *quantity* of services, incentive programs reward providers for behaviors that drive enhanced access, higher quality and cost effective care. Innovative provider incentives enable us to engage providers in both cost containment and quality improvement initiatives through various payment reform options that are consistent with our philosophy of incentivizing providers to provide the right care in the right place at the right time. As discussed below, we have already engaged key partners in Nebraska as a part of our mission to **meet providers where they are and take them to where they want to be**. Our program will include best practices and incorporate lessons learned in other states, and will build on our successful initiatives which have resulted in **more than 60+% of our Medicaid members receiving services from providers who participate in VBP arrangements throughout 20 states and has resulted in 22% better quality scores , 3% lower costs and 5% lower inpatient admissions**. Through partnerships already developed, we anticipate that approximately 80% of our providers will participate in VBP arrangements in the first year.

Nebraska Total Care has diligently worked with Catholic Health Initiatives, Enhance Health Network and all seven Nebraska FQHCs to enter into value-based contracts in the first year. These providers represent as many as 80% of the Nebraska Medicaid Market.

Nebraska Total Care understands and will comply with requirements for physician incentive plans as required in 42 CFR 422.208 and 422.210, Value-Based Contracting requirements in 42 CFR 434.6, and all requirements identified in Sections IV.Q Provider Reimbursement and IV.I Provider Network Requirements of the RFP. In accordance with Section IV.Q Section 6, we will notify MLTC of any risk-sharing agreements we negotiate with a provider within 15 calendar days of any contract signing containing this provision. We will submit any contract templates that include an incentive plan to MLTC no later than 60 calendar days prior to use and will obtain prior approval from MLTC before their use. We will provide information regarding our physician incentive plans to any Medicaid member upon request. In accordance with RFP Section IV.Q Section 7, we will not make payments directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to a member.

Philosophy regarding value-based purchasing and risk-sharing agreements and evidence of effective use in Nebraska or other markets

Value Based Purchasing Philosophy and Experience

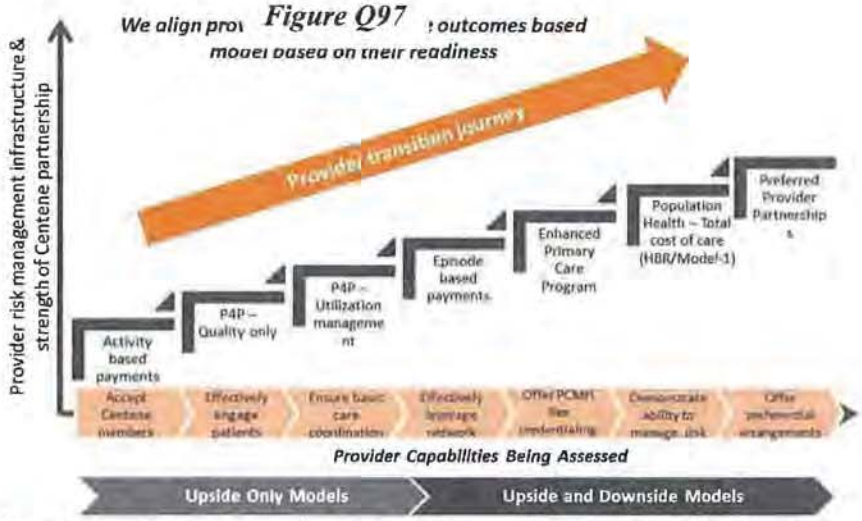
Encouraging and supporting provider success through recognition of superior performance are critical requirements for providing high quality health care. We value our provider partnerships and are committed to creating a collaborative environment that encourages and rewards high performance and supports providers' progress by offering a continuum of VBP arrangements. Our VBP philosophy is to evaluate providers' readiness and provide a tailored program of tools they need to accomplish quality goals, improve care coordination and health care outcomes, and engage patients in making good health care choices. Based on our national experience in 20 Medicaid programs, we have a developed a comprehensive provider education and support program to ensure our providers' succeed and benefit both professionally and financially from our VBP arrangement. Our payment models recognize regional variations in local health care systems, particularly in rural and urban areas, and include initiatives that reflect the availability of services and challenges providers face in their community. Our "on the ground" strategy will focus on building local collaborative environments to identify providers' strengths and weaknesses, maximize their skills and incentivize the development of innovative ways to improve health care delivery and create true partnerships with their patients. Our philosophy is to use positive reinforcement to encourage providers on a continual basis. We will provide one-on-one assistance to identify and build on providers' capabilities as opposed to complete delegation of these services to

providers. Through collaboration, we leverage both our experience and the expertise of our providers to successfully implement the four core components of our VBP initiatives:

- Aligning appropriate programs and creating a credible pathway for providers to gradually adapt to outcome-based payment models
- Providing meaningful and timely information and insights to providers on their populations and helping them identify opportunities for improvement
- Implementing provider engagement team and governance infrastructure that provides subject matter expertise in key areas
- Providing complementary skill sets (e.g., care coordination, UM) that are appropriately tailored to meet the needs of providers and support their efforts to care for their patients.

Our VBP opportunities will be available to all provider types: primary care, behavioral health and other specialists, FQHCs, tribal health providers and Indian Health Services, Rural Health Clinics, hospitals, academic facilities, and ACOs. Regardless of their current capabilities and readiness, NTC will provide a progressive pathway that supports providers at every level of experience. ***Figure Q97*** demonstrates how we will offer a carefully structured ladder of advancement that takes providers from where they are to where they want to be through a gradual, progressive strategy.

Figure Q97 *We align provi : outcomes based model based on their readiness*



Success with Value Based Payment in Other States.

Nebraska Total Care's affiliates have implemented payment reform strategies ranging from activity-based reimbursement to episode-based payments, gain sharing and risk-sharing initiatives. Company-wide, more than 60 percent of our membership is served by network providers that are contracted under value-based payment models, resulting in more than $40 million in value-based payments. Following are examples of some of our state-specific accomplishments:

- ***Georgia:*** In our Peach State Plan, 20 PCP groups participated in VBP in 2012; in 2013, participation grew to 25 groups representing 43% of our membership; in 2014, our VBP programs provided incentives for PCPs treating 62% of our members. In 2014, participating providers scored higher on all 13 HEDIS incentive measures compared to non-participants; had a Quality Index 3% higher than plan average; 8% lower ER utilization and 12% lower inpatient utilization than plan average.
- ***Louisiana:*** In our Louisiana affiliate, 72% of members are served by providers participating in VBP arrangements. Participating providers have experienced an 18% lower ER utilization and and a13% overall improvement in Quality Outcomes.
- ***Ohio:*** Our Ohio Buckeye Health Plan offers a comprehensive package of payment arrangements that includes Pay for Performance; Episode of Care and Risk Sharing arrangements (both upside and downside). Year to Date results show a 24% increase in prenatal care; 10% increase in Appropriate Treatment of Children with Upper Respiratory Infection; a 50% increase in HEDIS Childhood Immunization Combo rates and an overall Quality Index 17% higher than the plan average.

- ***Indiana:*** Our Indiana MHS health plan recently implemented a new gain-sharing program for large providers that covers 73% of our members in the state. To date in 2015, participating providers have an 18% lower ER utilization and a 19% lower inpatient admissions rate.

Approach to identifying initiatives and performance measures on which to focus

Identifying Initiatives and Performance Measures

Consistent with our philosophy of meeting providers where they are, we will use a variety of payment and performance measures that promote patient-centered care and provider accountability for improvements in health outcomes. Our approach is designed to support DHHS' priorities (including those identified in the Nebraska State Health Improvement Plan), increase providers' awareness of performance, motivate providers to establish and attain goals, improve patient health and satisfaction, and ensure care is delivered in the most cost effective and appropriate setting. Our model will be progressive, starting at activity-based reimbursement opportunities appropriate for all levels of providers, continuing through episode-based payments and moving into gain/risk sharing models. Based on our experience in other states, for those providers who are new to VBP, we will include process measures that evolve over time to support a gradual introduction into VBP and encourage provider retention. Performance measures will be selected consistent with MLTC's healthcare priorities, with an emphasis on behavioral health services, improved access to care, preventive health care services, chronic condition management, disease prevention, and improved pregnancy outcomes. We will measure improvement by comparing providers' performance against similar practices and community standards, establish performance targets, and provide incentives to meet or exceed the targets. Consistent with the State Health Improvement Plan (SHIP), we will select measures that correspond with the state's emphasis on 1) reduction in heart disease and stroke mortality, morbidity and associated risk factors and 2) reduction in cancer mortality, morbidity and associated risk factors. Providers will have input on performance measures and other improvements through discussions with PPMs, Provider Relations representatives, and through our Quality Committee and Provider Advisory Committee. We also will work with providers through our VBPEZ Care Collaboratives to make adjustments to reflect local priorities and conditions specific to the VBPEZ. ***Table Q97*** provides examples of measures we currently use in other states: ***Table Q97***

Adolescent Well-Care Visits	Comprehensive Diabetes Care – Eye Exams
Adult BMI Assessment	Comprehensive Diabetes Care – HbA1c Testing
Adults' Access to Preventive/Ambulatory Health Services	Comprehensive Diabetes Care – Medical Attention for Nephropathy
Breast Cancer Screening	Well Child Visits – 3rd, 4th, 5th, 6th year of life
Cervical Cancer Screening	Well Child Visits – first 15 months of life
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI percentile
Immunizations for Adolescents – Combo 1	Counseling for Physical Activity
Childhood Immunization Status – Combo 10	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Program performance will be assessed continually, using routine and ad hoc reports that identify results at all levels including statewide, by regions, by provider, or VBPEZs. Providers will receive monthly performance scorecards that allow them to track their own progress, see how they improve over time, and make adjustments in their practices as needed. Based on program performance and provider feedback, our strategies and initiatives will be modified to reflect changes in practice management, increase provider accountability, and incorporate new performance goals identified by DHHS and the Heritage Health Quality Committee. We also will use **pilot programs** to help us understand the effectiveness of new measures in sustaining improvement before introducing them to all eligible providers.

Program Incentives. NTC will use multiple reinforcing incentives to enhance the likelihood of provider participation and encourage retention. Our incentive programs are designed to appeal to a wide range of providers, and include small (often rural) practices with small panel sizes. Incentives will be evaluated regularly and will be designed to encourage solutions to local problems. For example, to address access to

care challenges that have been identified in our discussions with Nebraska providers, we will provide enhanced payments for urgent care and extended hours to encourage providers to offer additional appointments for our members. Following are other examples of the types of incentive programs we offer in other states and intend to offer in Nebraska, with MLTC's approval:

- Pay for Performance (P4P) Primary Care Incentive Model – provides a performance incentive that encourages appropriate and timely preventive health and disease monitoring services per evidence-based clinical guidelines, and incentivizes provider outreach to patients. This program is ***available to all PCPs***, including those who do not meet high volume thresholds (such as rural providers).
- Bonus Payment/Enhanced Payment Model for specialty care providers and independent pharmacies
- Primary Care Provider STI Screening Incentive: provides PCPs enhanced reimbursement for screening of STIs; proven effective in Louisiana, which also has a high STI rate, similar to Nebraska
- Primary Care Medical Home (PCMH) Bonus Payment and PMPM Incentive: bonus payments for achieving certain goals; PMPM enhancements for certain care coordination/care management services.

For more experienced providers such as Accountable Care Organizations and Patient Centered Medical Homes that have demonstrated success in VBP contracting arrangements, we will offer our Gain Sharing Model that incentivizes providers to reduce the total cost of care attributed to a given patient population while demonstrating continuous improvement in quality outcomes. Based on performance, providers that meet or exceed pre-determined targets will share in the cost savings.

In addition, our discussions with rural and independent physician groups has led us to believe that a more innovative approach is required to improve quality and better coordinate care in some regions. We have suggested a concept of creating Value Based Payment Enterprise Zones with many providers and have received positive response. We believe such programs will be pivotal to transforming care delivery paradigms in many regions within Nebraska.

Value Based Payment Enterprise Zones. After extensive discussions with Nebraskan providers to identify the challenges that may impact their ability to succeed in VBP arrangements, we propose to create Value Based Payment Enterprise Zones (VBPEZ). Zones will be created based on an assessment of regional health care resources, social determinants of health and local health care needs that impact the level of support providers need to provide effective care management. Within each VBPEZ, we plan to invest in infrastructure (e.g., IT, care-coordination) and develop skill sets to transition to successful rollout of value based purchasing programs. In addition our specially trained Provider Performance Managers (PPMs) will work with participating providers to discuss local challenges, identify potential community-based solutions and strategies for addressing the problems providers are experiencing. VBP initiatives will be designed to reflect local challenges and priority health needs and to incentivize providers to develop innovative solutions specific to their patients' needs.

Non-Financial Incentives: We also offer several non-financial incentives, including recognition in our provider directory and identification of high performers in our newsletters, on our website and in social media updates, and in national and local press releases. For practices that have achieved PCMH status, we also will provide preferential assignment of new members. For providers who achieve certain goals, we also provide enhanced operational and customer service support. We also will develop an annual awards program (similar to our Summit Awards in our Louisiana Healthcare Connections plan), to honor exceptional providers. Recipients receive an engraved plaque and a catered lunch for their office staff.

Member Engagement: Also worth noting, in addition to provider incentives, NTC will also offer our ***member incentive program***, CentAccount, to promote personal healthcare responsibility via financial incentives that reward members for healthy behaviors. Recognized as a best practice by Medicaid Health Plans of America, CentAccount rewards can be used to purchase healthcare items, groceries, baby and personal care items, and some over-the-counter medications. This program supports providers in VBP arrangements by encouraging patients to complete annual preventive health visits and other screening services, which are necessary in order for providers to meet certain performance goals.

Proposed engagement strategies to encourage provider participation

Strategies for Engaging Providers. NTC's value-based payment program supports practices of all sizes, levels of sophistication and readiness. During our contracting discussions with providers, we introduce them to our VBP opportunities, explain how the program works, describe the training and support we provide to ensure success, how they can improve patient care and outcomes, and how the program can lead to improved job satisfaction for the provider and their staff. Comprehensive documentation of our programs are included in provider orientation training and in our provider manual, and the program is routinely discussed during provider training, in newsletters, and in visits with Provider Relations staff. Providers who are interested in participating will receive a comprehensive cost-benefit analysis that includes an estimate of their potential for increased reimbursement. Providers are assigned a Provider Performance Manager (PPM), who will work with them to monitor their performance; provide education and training on the drivers behind their performance; provide assistance with HEDIS reporting, using our care management programs and web-based tools; identify practice-specific care gaps; and provide recommendations for improvements.

A frequent concern raised by providers in Nebraska is the lack of timely data and patient information to support care management that is critical to a successful VBP arrangement. We will address this barrier through comprehensive data and decision support tools available through the Provider Portal that is part of Centelligence™. The Portal will facilitate care management and coordination through information that includes a Member Panel Roster with disease registry, special needs, and ER utilization flags; Member Health Record with extensive medical, behavioral, and medication history; Online Care Gap Notifications (including HEDIS care gaps and health alerts); Provider Practice and patterns of care quality and cost information with peer benchmarks; member TruCare Care Plans; and online evidence-based Clinical Practice Guidelines. These health informatics are available to all providers and assist providers who are considering participating in VBP initiatives by allowing them to compare their practices with peers, benchmarks and national averages prior as part of their decision process. To ensure providers remain engaged in our program and continue to experience performance improvements, we also conduct periodic assessments, identify and resolve concerns, and discuss opportunities for advancement to the next level of VBP participation.

Methodology and timing for determining if providers have met requirements

Methodology and Timing for Determining if Providers have met requirements

Methodology and frequency of payment varies depending on the type of VBP initiative in which the provider participates.

- Care coordination payment and support for PCMH recognition – either paid once annually or structured as a Per Member Per Month paid on a monthly Basis
- Quality Programs: Care gaps provided on a monthly basis; incentive scoring on a quarterly basis, and, depending on size of the panel, payment semi-annual or annual basis allowing for 3 month run-off
- Our gain/risk sharing programs: Financial provider performance reports on a monthly/quarterly basis, payments on a quarterly basis and reconciliation annually with 180 days after the end of the year

Plan for entering into value-based purchasing agreements with 30% of its provider network by December 31, 2019

Plans for Meeting VBP Agreements with 30% of Provider Network

As previously mentioned, NTC has already engaged in extensive discussions, and in several instances, executed formal partnerships, to develop a network ready to participate in VBP from day one. NTC's key VBP partnerships include:

- ENHANCE Health Network (EHN): EHN's allied members – 65 individual hospitals and 3,500 individual providers – represent upwards of 35% of the state's providers. NTC's Strategic Alliance Agreement with ENHANCE and value-based purchasing agreements with ENHANCE's nine physician hospital organizations (PHOs) will include education and training and incent telemedicine opportunities, recruitment in rural and frontier regions, and access to specialists, many of whom are willing to travel (refer to question 38 for a more detailed description of ENHANCE)

- Catholic Health Initiatives (CHI): CHI has expressed interest in collaborating with NTC to develop value-based initiatives including its 15 hospitals, 150 employed physician practice locations. 2 standalone behavioral health facilities as well as telehealth, teleconsult and traveling specialist capabilities. CHI's behavioral health capacity is particularly notable as it employs as many as 80% of the behavioral health providers in the state.
- Avera: NTC and Avera have agreed to enter into a VBP contract that includes approximately 350 providers, 8 hospitals, 48 clinics and telehealth platform. Avera will further expand our ability to serve our tribal partners and underserved areas in northeast Nebraska by expanding access to behavioral health and other specialty services.
- FQHCs: Through our extensive outreach efforts, NTC identified specific areas for collaboration with each of Nebraska's 7 FQHCs. These partnerships will range from assistance in obtaining PCMH recognition to support staff embedded within clinics will be supported by innovative VBP strategies. These strategies will be supported by ongoing collaboration and communication to ensure our health center partners are equipped with the tools necessary to achieve success.

Based on our current agreements with these partners and others, we will have value-based contracts with over 80% of the Nebraska Medicaid provider network in our first year of operation. We believe that by the second year of operation, this statistic could improve by as much as 10-15%.[11]

Discussion of Best Practices and Lessons Learned from Other States

Best Practices and Lessons Learned

Centene's success in Value Based Purchasing is due in large part to our collaborative partnership with providers and our willingness to try innovative strategies that build on our lessons learned. We meet regularly with providers to discuss their experience, address challenges, identify additional support we can provide, and solicit providers' recommendations. These techniques ensure our program is sustainable, improves providers' satisfaction, and allows us to build on the strategies that work and modify those that need improvement. Best practices we will use in Nebraska include:

- Engage providers in design and implementation; actively encourage and support improvement efforts
- Include primary and specialty providers that have impact on specific targets (behavioral health providers and substance abuse treatment facilities, for example)
- Engage members, advocates and community organization in the program design and implementation
- Be open and honest in communicating among the participants to ensure they understand the operational requirements, provider responsibilities, risks and rewards
- Identify and work with the lead practitioner or administrator – the internal improvement champion
- Give providers frequent and timely feedback
- Begin with process measures and evolve to a broader set of measures that more heavily emphasize member outcomes (case mix adjusted as applicable)
- Use national and local benchmarking data to set fixed, objective performance targets to assess progress toward meeting targets
- Enable specific set of programs and support infrastructure to specifically work with Medicaid members (e.g., CentAccount, MemberConnections programs)
- Work with providers to identify and resolve unanticipated, adverse changes in outcomes.

[11] Centene experience (% of members enrolled in value based payment arrangements) 2013 ~35%, 2014 - ~50%, 2015 (~60%)

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. (6 page limit)

Nebraska Total Care will establish a MAC program through our affiliate pharmacy benefit manager, US Script. US Script's comprehensive MAC program has been established using industry best practices designed to promote cost containment strategies through generic utilization while ensuring fair reimbursement of our pharmacy network partners. Nebraska Total Care will provide a description of our MAC program for review and written approval by MLTC a minimum of 90 calendar days prior to the contract start date and will provide the MAC list to MLTC on a quarterly basis as well as relevant policies and procedures to ensure compliance with the MLTC's MAC program requirements and goals. The MAC list proposed for MLTC will include over 2,100 GPIs, representing approximately 92% of all available generics.

MAC pricing decisions consider fluctuations in AWP, WAC, and pharmacist feedback.

Nebraska Total Care and US Script understand how important local, independent pharmacies are to our Members and to ensuring Members have appropriate access to the medications they need and we know that local pharmacists are often trusted advisors. We are committed to a strategy that will result in the greatest participation of independent pharmacies in our network. To encourage open communication and feedback, US Script's Pharmacy Network Director will host weekly conference calls with the Nebraska Pharmacists Association in order to provide an open forum for our participating network pharmacies. This will enable US Script to proactively address questions or concerns and to adjust reimbursement strategies quickly, as appropriate.

Nebraska Total Care will require US Script to update all retail and specialty drug files at a minimum of every seven days as it does for all Centene affiliate plans, if not more often. US Script has honed its processes based on this experience, and its policies and procedures with Nebraska Total Care oversight will ensure pharmacists have accurate, timely information for all claims submitted.

Nebraska Total Care understands that there are times where a brand drug may be preferred over an available generic medication and will ensure a proactive communication process exists between Nebraska Total Care, US Script's MAC Management team, and MLTC.

Setting Prices and Dispute Resolution

Price Setting

Maximum Allowable Cost (MAC) pricing is based in part on AWP. After reviewing the AWP data, the Director/Manager of MAC Management at US Script determines MAC pricing, and sends MAC prices electronically to the MAC Pricing Team who enters the pricing data into the claims processing system. To ensure data accuracy, two Members of the MAC Pricing Department reviews MAC prices for accurate entry before they are uploaded into the claims processing system's price tables.

Daily Reviews

The process for updating the drug file begins with an automated daily electronic upload of data from Medi-Span, a leading provider of drug information databases, into the US Script claims processing system. Medi-Span data includes drug name, strength, therapeutic class, National Drug Code (NDC), Generic Product Identifier (GPI), and pricing measurements such as Average Wholesale Price (AWP) and Wholesale Acquisition Cost. It also includes new-to-market generic and brand name drugs and clinical data to support clinical decisions and POS safety screening. These daily reviews encompass adding, modifying, and deleting drugs from the MAC list, ensuring that the MAC list remains comprehensive and up-to-date at all times.

Weekly Review

On a weekly basis, the pricing specialist downloads the AWP and MAC tables to compare the most recent pricing to the previous pricing data to evaluate changes, such as any outliers and trends indicating excessive increases or decreases to past pricing. The pricing specialist forwards any identified concerns to the full MAC Pricing Team to evaluate and determine what action to take, if any. For example, a drug price increase of more than 10% would be flagged and discussed by the MAC Pricing Team. Because of the level of review that occurs in the daily development of prices, US Script experiences few issues during the weekly reviews.

Issue Resolution and Appeals Process

US Script has a defined process to allow dispensing Providers to contest a listed MAC price rate. To do this, the pharmacy goes to the US Script website to download the Pricing Inquiry form, completes the form and submits it to US Script along with the pharmacy's invoice for the disputed drug. The completed form must be submitted within 60 days of the claim fill date.

On average, US Script returns a response to a pharmacy's request for a MAC pricing change within seven days.

Once submitted, the US Script MAC pricing team receives and validates the submission of the request, logs the appeal information into their tracking system and evaluates the appeal against numerous conditions and metrics to determine if a price increase will be made. Examples of sources reviewed for making a pricing appeal determination include Medi-Span AWP pricing, fluctuations in WAC pricing and feedback from our pharmacy partners.

Once the appeals have been evaluated, the MAC Management team approves appropriate price increase determinations and then the MAC Pricing team creates a standardized file to upload to US Script's proprietary claims processing platform backdating the new price to the claim service date for all similarly situated pharmacies.

To ensure accurate and complete documentation of this process, US Script updates its tracking system to reflect the determination and sends a response to the pharmacy within seven days.

Additional Review

The Director of Network Operations forwards any concerns requiring further research and, if necessary, resolution, to the MAC Pricing Team for review. US Script resolves any exceptions identified during these reviews within two business days, and posts updates to the claims processing system accordingly. New drug prices are applied retroactively to dispensed drugs and all network Providers when US Script uploads the drug file.

Access and Updates

Pharmacy Providers are able to register for a secure login to a website where they can search for MAC pricing. The login page is located at **https://macprice.usscript.com.** This tool has been designed to reduce the administrative burden on pharmacists by requiring minimal input from the pharmacy in order to obtain current MAC pricing. Search results provide pharmacists with the most current pricing applied to that specific pharmacy for the Nebraska Total Care. The search ensures pharmacists always have access to the most up-to-date information.

The tool offers users the ability to verify a single MAC price or to obtain a comprehensive list. This list is updated on a weekly basis.

Pharmacy Payment

Pharmacies are paid based on the lessor of a discount off average wholesale price plus a dispensing fee, maximum allowable cost plus a dispensing fee, or usual and customary cost provided by the pharmacy.

Overall Program Strength

US Script has nearly 10 years' experience developing and implementing robust MAC programs tailored to meet the needs of our Managed Medicaid clients. The US Script MAC team is dedicated to reducing cost of care by partnering with the state. We will offer consultative collaboration to ensure the best solution is in place for Nebraska. Our solution to MAC program services is industry leading, utilizing technology, market intelligence, and to tap the knowledge and skillset of our world class MAC program team.

Key Strengths

- Regular review of MAC list and pricing to ensure completeness and competiveness
- Flexibility and customized pricing solutions
- On-going communication with the state managed Medicaid plan
- Customized reporting
- MAC appeals process for pharmacies to challenge generic drug pricing in accordance with applicable Laws

Challenges and Solutions

Legislative Challenges

Evolving state MAC legislation represents the biggest challenge to effective MAC management. US Script's MAC management team, along with US Script leadership, work collaboratively with our clients and state partners to maintain a process that adheres to the strictest MAC legislation for our entire client base.

Investment in Technology

In our Louisiana health plan, in response to requests for an electronic solution for MAC price look-up functionality, US Script developed the MAC pricing look-up tool described above. This tool was developed in collaboration with our health plan partner to meet the needs of our Louisiana network pharmacies.

Enhancements

US Script is in the process of developing a pharmacy portal, to be available in 2016, which will enhance our overall provision of services to our pharmacies. Anticipated enhancements include:

- A searchable PDL
- Enhanced MAC pricing lookup
- Online network contracting and credentialing
- Claim lookup, including rejection codes and messaging

Medical Necessity

Members, Providers and the general public will have access to our online pharmacy resources that show whether a drug is preferred and our medical necessity guidelines for all drugs that require PAs and step therapy, including non-formulary designations, appropriate utilization, quantity limits, or mandatory generic substitution. US Script's pharmacy network contract requires participating pharmacies to dispense medications to patients, even if they believe the reimbursement rate is low. In this instance, the pharmacist is advised to follow US Script's MAC pricing appeal process. In no instance is a pharmacist allowed to deny service to a patient due to low reimbursement rates.

Monitoring and Oversight

Although Nebraska total care will delegate pharmacy claims processing to our PBM affiliate, US Script, Nebraska Total Care will monitor compliance with drug file updates during meetings between the Nebraska Total Care Pharmacy Director and Pharmacy staff, and US Script's Account Executive, Account Manager, and Clinical Account Manager for Nebraska Total Care.

Day-To-Day Oversight and Monitoring of Pharmacy Claims Processing. Our Pharmacy Director will be responsible for day-to-day oversight and monitoring to assure that US Script pharmacy claims processing meets DHHS specifications. These review activities will be enhanced by US Script's encounter

submission and tracking system that will allow us to create customized reports and quickly review complete and accurate pharmacy data on DHHS members. If processing discrepancies are identified, our Pharmacy Director will expeditiously make corrections with US Script to assure that appropriate pharmacy services are available for DHHS members. Examples of ongoing monitoring and oversight activities include, but are not limited, to the following:

- ***System Testing.*** Our Pharmacy Director will closely review testing data to assure claims payment accuracy before the implementation "go-live" date of our DHHS pharmacy benefit and throughout our contract with DHHS when changes are made to the pharmacy claims processing system.
- ***MAC Pricing***. To further ensure appropriate monitoring and oversight as well as to encourage pharmacist input in our MAC pricing within the state of Nebraska, Nebraska Total Care and US Script will work together to convene a Pharmacy Network Committee which would provide guidance and feedback to US Script regarding MAC pricing policies within the state of Nebraska.
- ***Monitoring Quantity and Days' Supplies.*** Our Pharmacy Director and US Script staff will collaborate to implement POS edits to prevent payment of questionable values for quantity and days' supply billed by pharmacies. Our POS messaging system will stop a claim until a PA is received for drugs that have clinical monitoring, such as quantity limits, age limits, or duplicate therapy/dose consolidation concerns.
- ***Quarterly Joint Operational Meetings.*** Our Pharmacy Director will hold quarterly meeting with US Script staff to discuss operational and reporting issues along with potential enhancements, overall performance and contract compliance.
- ***Follow-Up on Reported Claims Processing Errors.*** Our Pharmacy Director will investigate pharmacy- and member-reported accounts of claims processing errors and assure corrective actions are made, as warranted.
- ***Random Review of Claims.*** At least annually, the Pharmacy Director will audit a random sample of pharmacy claims to verify payment accuracy.

Audits of the Claims Processing System. In addition to our Pharmacy Director's day-to-day oversight and monitoring, US Script undergoes an annual audit conducted by our parent company Centene Corporation (Centene) and an URAC reaccreditation audit every two years.

Centene Annual Delegation Audit. Centene's corporate Quality Improvement (QI) Department, in conjunction with the corporate Pharmacy Department, audits US Script annually. Health plans that subcontract with US Script, such as NTC, are invited to participate in the audit. Conducting a single audit, with health plan participation, ensures consistent application of standards and coordination of any corrective actions across all Centene health plans that manage pharmacy benefits as part of their state contracts. At the same time, this audit approach enables each health plan to ensure compliance with any state-specific requirements. Centene corporate QI staff will provide annual delegation audit results as a report, which includes any corrective action plan (CAP), to NTC and to US Script within 30 days following the audit. Our Quality Assurance Program Committee (QAPC) will review a received audit report at its next soonest quarterly meeting, and may require operational policy or procedure changes in response to audit findings. The QI Committee also reports the audit results to the NTC Board of Directors at its next soonest meeting following the audit's completion, along with any responsive action taken or recommended. Centene corporate QI staff will promptly advise NTC on any CAP updates and completion. In addition, the US Script QI Committee and US Script Board of Directors review the delegation audit results at their next soonest meeting following the audit's completion and take any appropriate responsive action.

Audits consist of an annual onsite visit, policy and procedure (P&P) review as well as file reviews, addressing at a minimum the following topics:

- DHHS contract compliance

- Network of pharmacy providers that meets access standards and has evidence of State licensing and a signed agreement by the "pharmacist in charge"
- Pharmacy provider call center and responsive customer service measures and protocols
- Processing of DHHS eligibility files within one business day of receipt
- Reporting that measures drug utilization and pharmacy drug expenditure trends
- Disaster recovery plan
- Policies and procedures for responding to any complaints from pharmacies and practitioners
- Personal health information (PHI) policies and procedures that address member rights to authorize or deny the release of PHI beyond uses for treatment, payment or health care provision of service
- Management of the preferred drug list (PDL) in accordance with DHHS coverage protocols, including PDL and prior authorization criteria
- Adverse coverage determinations communicated to both member and provider
- Point of service messaging to pharmacies on DHHS-specific requirements
- Policies and procedures for drug recalls that have the potential to produce harm, including limiting ongoing coverage and providing a notice to prescribers and members of potential risks regarding drugs in recent pharmacy claims submissions.
- Quality Improvement Program including requirements for assessing performance, tracking issues, and setting improvement goals
- Pharmacy audits triggered by claims submissions for identifying potential fraud and abuse

If NTC determines that US Script is out of compliance with contractual or regulatory requirements, NTC will require a written and signed CAP that spells out a detailed action plan, expected, measurable results, and a due date for completion. US Script must provide the CAP within two weeks of receiving NTC's notice, and must complete the CAP within 30 days of NTC's approval of the CAP, unless another period is agreed to in writing. If US Script fails to complete the CAP as specified, NTC may suspend or revoke delegation of PBM services. NTC may issue a notice of material breach of contract and opportunity to cure, based on US Script's breach of contract, allowing 60 days to cure. Finally, for specified reasons such as loss of insurance, NTC may terminate the contract immediately.

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. (2 page limit)

Nebraska Total Care (NTC) will offer an expansive network of providers to meet the needs of our Heritage Health members and will strive to exceed minimum access requirements outlined in this RFP However, NTC realizes our members may require out-of-network (OON) services on occasions when members are unable to obtain necessary services from an in-network provider or to maintain continuity of care. NTC's policies and procedures ensure members can obtain timely authorizations for necessary services, and that providers are paid accurately and timely. We take prompt payment requirements seriously and make every effort to simplify the claims process for all providers, and look forward to working with Heritage Health's Administrative Simplification Committee to identify additional measures for simplifying and expediting all claims payments, including OON services. NTC will comply with all requirements related to payments to OON providers as required in 42 CFR and described in RFP Section IV.Q 8 – Payments to Out-of-Network Providers. Emergency services and family planning services do not require prior authorization regardless of whether or not the provider is an NTC contracted provider.

Established Members. When an established member needs OON services, NTC will adequately and timely process authorizations and reimburse the provider in accordance with RFP Provider Reimbursement, Payments to OON provider requirements. Consistent with our policy, authorizations for OON providers are based on continuity of care, complexity of the case, and/or the lack of an available in-network provider of the same or similar specialty. When services cannot be reasonably obtained from a network provider, we will authorize OON services if the services are a covered benefit and are medically necessary. As appropriate, we may develop standing referrals or Single Case Agreements with OON providers who agree to treat a member but who are unwilling to contract with NTC.

New Members. When new members are identified as being in an active, ongoing course of treatment or within the second or third trimester of pregnancy, NTC will timely authorize continuation of medically necessary covered services with an OON provider for up to 90 calendar days or through the postpartum period or until the member can be safely transition to an in network provider.

Continuing Out-Of-Network Care Beyond the Transition Period. For certain types of care, transitioning to a new network provider during a course of treatment may pose a risk to the member's health. Additionally, network providers may not accept the member as a new patient when they are in the middle of a course of treatment with another provider. For these situations, we will timely authorize continuation of services with the OON provider to ensure continuity and avoid disruption in care, such as when the member is receiving:

- ***Transplant Services.*** For members ***actively*** receiving transplant services at the time of enrollment, we will authorize continuation with the OON transplant provider through one year, post-transplant. Our Transplant Care Manager will work with the OON transplant provider to ensure coordination with other services the member receives.
- ***Chemotherapy.*** For members receiving chemotherapy, we will authorize continued treatment with the current OON provider until the treatment is completed. Our care management staff will work with the chemotherapy provider to ensure coordination with other services the member receives.
- ***Special Health Care Needs.*** For members with special health care needs such as children with intellectual or developmental disorders, who have an established relationship with an out of network provider, NTC will authorize continued treatment with the established provider.

Processing Requests from OON Providers. NTC's public Provider website clearly states that all OON services, except Emergency services and family planning services, require prior authorization and includes information on how to submit requests for prior authorization. OON providers may submit requests for authorization by calling or faxing our prior authorization department. Authorizations from OON providers are processed using the same policies and procedures and medical necessity criteria as those submitted by in network providers and will be reviewed within the same timeframes. As required in

RFP Section IV.H Grievances and Appeals, decisions on authorization requests will be issued as expeditiously as possible, but no later than 14 calendar days following receipt of a standard request for services. If an expedited review is necessary, we will make a decision as quickly as possible, but no later than 72 hours of receiving the request. NTC will make every effort to issue decisions as quickly as possible and minimize administrative requirements for our providers and ensure members receive timely care. At the time an authorization for OON services is issued, NTC's Utilization Management staff will contact the OON provider to educate them on our policies, the scope of the authorization, and any requirements for submitting clinical information or collaborating with other providers to manage transitions of care. Providers will receive instructions for submitting claims and can obtain additional information on our website.

Resolving Payment Issues Expeditiously. NTC will process claims from OON providers using the same processes and timelines used for in network providers. Consistent with RFP Section IV.Q – Provider Reimbursement and the Deficit Reduction Act of 2015, NTC will reimburse OON providers at 100 percent of the published Medicaid rate for covered emergency and post-stabilization services. During the initial 90 calendar days of the contract, NTC will pay other covered and authorized OON services at 100 percent of published Medicaid rates. After the initial 90 days of the contract NTC recognizes that it is not required to reimburse OON providers at more than 90% of the Medicaid rate in effect on the date of service to providers with whom/which we have made a minimum of three (3) documented attempts to contract. All claims, regardless of provider contracting status are adjudicated in AMISYS Advance (AMISYS), our core claims processing system. AMISYS accepts Julian time stamps indicating when a claim is received. This "date stamp" is part of the control number used to identify each unique claim, allowing us to link all available information and track our adherence to claims processing timelines. During claim adjudication, AMISYS will check for the participating or nonparticipating status of the provider before pricing, where we apply the appropriate contractual and financial agreement of that provider. Providers can check on the status of a claim or discuss any concerns they have by contacting NTC's Provider Services Call Center. All payment inquiries by OON providers will be addressed as quickly and efficiently as possible, and will be treated the same as inquiries submitted by contracted providers.

(1 page limit)

100. Describe the MCO's proposed process for the annual year-end cost settlement process with critical access hospitals.

Nebraska Total Care (NTC) will annually submit required cost settlement reports for Critical Access Hospitals (CAH) in accordance with MTLC cost reporting instructions and requirements in effect for the State Fiscal State Year for which the cost settlement is required. Based on requirements outlined in 471 NAC 10-010.03F Payments for Services Furnished by a Critical Access Hospital and 10.010.06A, Payments for Outpatient Hospital & Emergency Room Services Furnished by a Critical Access Hospital the payment for services of a Critical Access Hospital is the reasonable cost of providing the service, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges rule, ceilings on hospital operating costs, and the reasonable compensation equivalent (RCE) limits for physician services to providers. We understand that payment rates will be determined annually by MLTC, based on available funds appropriated by the Legislature. We agree to make all CAH inpatient payments utilizing interim per-diem rates with an annual year-end cost settlement that occurs at the end of each CAH's fiscal year. Outpatient rates will be paid according to MLTC's calculations based on a cost-to-charge basis with an annual year-end cost settlement.

Process for Year-End Cost Settlement with Critical Access Hospitals

We understand the complexities of developing annual year-end cost settlement processes with critical access hospitals and have successfully been submitting required reports in all states in which we operate. Our cost settlement process is overseen by qualified accountants who understand the information requirements and have established policies and procedures to ensure the report is accurate and complete. We will work with CAH in Nebraska and (or) their accounting firm or designee in order to attain and process all documents (files) required for the annual cost settlement. We will address any required cost settlements in accordance with MLTC cost reporting instructions that may be issued and in accordance with all applicable requirements in effect at the time the cost settlement is required. MLTC or its designee will analyze the Medicaid costs of Hospitals and advise NTC of the interim amount due to the hospital or the amount to be collected from the hospital. We will use the same methodology as MLTC to reconcile settlement amounts with the hospital. Our calculations will reflect the annual adjustment and applicable payment rates determined by MLTC as required by the available funds appropriated by the Nebraska Legislature. Any payments that may be required by NTC will be paid within 120 days after receiving the all required documentation from the CAH desk revies. If it is determined overpayments have been made by NTC and payment is due by the Hospital, we will set up an invoice in accounts receivable and, if necessary, work with the provider to set up a payment plan. As necessary, based on information from MLTC, we will update base rates and effective dates.

Complete and Accurate Reporting

Our reporting documents will be subject to our standard quality control through a series of desk reviews. We will internally log all relevant documents, track completion and submission of all required reports to ensure compliance with all timeframes for reporting. Reports will be reviewed by multiple staff to confirm reported costs are allowable and reasonable and calculations of final settlement are accurate. We will ensure accuracy and completion of all applicable fields. NTC will establish a point of contact with each CAH, either the Chief Financial Officer or their designee and create an email inbox for the sole purpose of receiving and logging cost settlement correspondence. We will also ensure NTC designates staff from the Network Operations department to serve as primary point of contact for questions on the status of annual CAH cost settlement.

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IV.R Systems and Technical Requirements

IV.R Systems and Technical Requirements

(12 page limit, not including the systems diagram)

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.

An Enterprise Management Information System Built for Managed Medicaid

Nebraska Total Care (NTC) will use an enterprise MIS provided to us by our parent company, Centene Corporation (Centene), with support from over 980 IT professionals. Our ability to meet all RFP requirements stems from an MIS comprised of standards based, best-of-breed modular components, integrated via our Service Oriented Architecture (SOA) in a design informed by CMS' Medicaid Information Technology Architecture. We have reviewed in detail the RFP, including Section IV.R and all Addenda, and our MIS meets all requirements called for in this RFP. In the discussion that follows:

- We offer a **systems diagram** that depicts our MIS components, and using that diagram, walk through, by component, a **general system description** of our MIS and its interfaces.
- We then tabulate how information sharing between MLTC's systems and our MIS **avoids duplicative efforts** on the part of MLTC, NTC, and providers.
- We then affirm that our MIS currently meets all RFP requirements without the need for custom modifications, and explain **how we will configure our MIS with the specific specifications** in this RFP through our disciplined Agile based change management process.

Nationwide, Centene's scalable MIS serves more than 4.8 million Americans in government funded health plans across 23 states, including Managed Medicaid plans in 20 states.

MIS Components and System Diagram

For the discussion that follows, please refer to ***Attachment Q101: Systems Diagram.***

MIS Components for Data and File Exchanges. Through the file communication component of our MIS we will support all our file receipt and transmission operations with MLTC, and MLTC's enrollment broker, including our receipt of the daily and monthly HIPAA 834 enrollment and eligibility files, as well as the monthly proprietary Supplemental Enrollment File and Unborn File, our transmission of the HIPAA 837 encounter reporting data, weekly provider files and more. We will use Coviant Diplomat Transaction Manager (Coviant) (item A in Attachment) to handle our automated file exchanges (transmission and receipt) with MLTC. We will exchange data with MLTC via Secure FTP, but we can and do support all standard industry data communication protocols. Coviant protects our file exchanges with access control, authentication, and secure configuration features for total data integrity protection during transmission. From an internal data networking perspective, our network backbone is highly redundant through a mesh design that provides multiple paths to and from each point, allowing maximum network *availability* for NTC and enabling us to meet MLTC file transmission and receipt schedules.

Transmission Integrity. EDIFECS (A), in conjunction with Coviant, supports a wide range of *transmission acknowledgement* protocols, including proprietary formats as well as HIPAA standard 999 Functional Acknowledgements, TA1 Interchange Acknowledgements, and 277 Claims Acknowledgement formats. We will use these acknowledgements for exchanges with MLTC as a further control for assured delivery, data integrity, and record balancing. We support the use of Public Key Infrastructure (PKI) security not only for encryption but for *sender authentication* - ensuring not only that the file was transmitted un-tampered, but that the receiver (e.g. MLTC) can validate *who the sender was* (e.g. NTC). EDIFECS checks for HIPAA codeset compliance of inbound and outbound transactions, as well as for Health Level 7 (HL7) transactions such as those needed when interfacing with a Health Information Exchange (see Section 53 for our plans to work with the Nebraska Health Information Initiative (NeHII)).

Inbound and outbound data flows to and from our ***Centelligence™ Data Service Bus*** (B), the heart of our Service Oriented Architecture (SOA).

Routing Data Systematically and Efficiently. The Centelligence™ Data Service Bus electronically routes data to and from our integrated *Core Processing System Components*, which include:

- **Customer Relationship Management** (CRM – item C) for member and provider service and data management.
- **TruCare** (D) for clinical care management and utilization management.
- **AMISYS Advance** (E) for processing both physical and behavioral health (BH) claims.
- **Encounter Data Management** (EDM – item F) for encounter reporting to MLTC.
- **Centene Document Management System** (CDMS – item G) for document receipt, indexing, data conversion and storage.
- **Centelligence™** (H) data warehousing, analytics and reporting.

Standards Based Middleware. Informed by Medicaid Information Technology Architecture (MITA) design principles, the Centelligence™ Data Service Bus (B) is an integrated set of open interoperability middleware services, including Java Messaging Services (JMS), implemented through TIBCO standards based SOA Messaging Software, Request/Reply and Publish/Subscribe transaction messaging services (implemented through our Informatica Change Data Capture (CDC) middleware), Extract / Transform and Load (ETL) processes (also implemented with Informatica), and open database connectivity interfaces including Open Database Connectivity (ODBC) and Java Database Connectivity (JDBC).

Components for Member and Provider Service and Data Management Requirements. The Customer Relationship Management (CRM) component of our MIS (item C in Figure 97.1) will support Heritage Health requirements for member and provider service inquiry *and* data management.

Customer Relationship Management (CRM) Service Support. As an integrated component of NTC's enterprise MIS, CRM enables a responsive service experience for our members and providers, no matter which "communications door" they use to contact us: telephone, web, mobile device, fax, letter, e-mail or (starting in 2016) instant messaging. CRM maintains a complete and instantly accessible customer correspondence history, including all outbound communications from our targeted phone, e-mail, fax and letter campaigns. CRM's integration with our eligibility, clinical, claims, document management, web and mobile applications greatly enhances the ability of our Customer Service Representatives (CSRs) to resolve member and provider queries quickly and accurately. Via our SOA, CRM interfaces with our other core systems (TruCare, AMISYS Advance, etc., described below) for data integration between business functions, including: enrollment and eligibility, claims processing and payment, care and utilization management, encounter processing, web applications, and reporting. There are multiple benefits to NTC's CRM approach to integration and service management including the facts that:

- CRM provides our Customer Service Representatives (CSR) with the functionality and information they need, within a single application at their workstation, to enable us to resolve a call inquiry in one call ("first call resolution") whenever possible.
- CRM has both member and provider data, and stores each member's assigned Primary Care Provider (PCP) information in the eligibility date span for which it applies.
- CRM also supports integrated document workflow, including the unique type of processing required for Complaint, Grievance and Appeal (CGA) applications. Formal, written complaint, grievance and appeal paper or fax documents are indexed to appropriate member or provider records in CRM; scanned; and electronically assigned for follow up. We will use CRM to track and manage the CGA item throughout the CGA process; in line with NTC and MLTC guidelines. Complaints, grievances and appeals are tracked using specific codes, allowing us to manage these events in a timely fashion through to resolution, and report data in an efficient manner.

[redacted]

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Member Data Management Component. MDM (also symbolized as [redacted] in the Attachment) supports all informational aspects of our member's relationship with NTC, such as member identifiers, address and contact information, confirmed or potential family linkages, special needs, member preferences (e.g., communication options such as e-mail, phone, and/or mail), along with a history of any change to each attribute. Similar in design to a Master Patient Index application, MDM employs a *master data management* approach to member data. This design provides processes for collecting, aggregating, matching, consolidating, quality-assuring, persisting, and distributing the member data we receive through HIPAA 834 files (as well as proprietary files such as the Supplemental Enrollment File) throughout our organization to ensure consistency and control in the maintenance of member data. Once in MDM, member data is electronically distributed to all systems requiring that data, e.g. to AMISYS for claims processing, TruCare for utilization management, and to our subcontractors' systems.
Unified Member View. In 2014, we introduced our Unified Member View (UMV) capability into our MIS, which gives us the automated ability to link an inbound member record with historic "eligibility spans" we may have on that member, (e.g. prior history as a NTC Heritage Health member). UMV also features enhanced capabilities for validating Member address and contact information, through integrated address standardization from ***SmartyStreets*** (a leading real time US Postal Service approved address validation service); and Identity Verification & Authentication data services from ***LexisNexis®***, enhancing the accuracy and quality of member data we house and analyze. However, as we do today, we will never overwrite eligibility information we receive from MLTC but rather store alternate contact information we receive about the member as a complementary attribute of the member data we house. UMV will enhance our ability to offer MLTC accurate member contact and address information, while allowing us to house address information sent to us by MLTC.
Provider Data Management (PDM). Through PDM (symbolized as [redacted]), CRM provides a repository for NTC's core provider functions, including prospecting and recruiting; contracting; enrollment; credentialing; financial affiliation configuration; data management; and provider directory management. Our Provider Data Management Department enters and updates provider data in CRM's PDM component, ensuring that all Provider data comes from one governing source. PDM stores multiple provider numbers logically tied together including Tax ID, state specific identifiers such as Nebraska's 11 digit Provider ID number, the HIPAA National Provider ID (NPI), provider's language information, locations, office hours, etc. Through its integration with Quest Analytics, PDM provides geo-access mapping for NTC's Contracting staff, and Google Map capabilities to assist call center and outreach staff in matching members with providers who meet members' requirements. PDM provides electronic storage

of provider contract information, and issues reminders to NTC Contracting staff when documentation and other such contract updates are needed. Using PDM, we will send to MLTC a weekly provider file as specified in RFP Section IV.R.8.a. This is a process PDM supports today with our affiliate health plans. Please see Section 46 for more information on how PDM supports MLTC's provider file requirements.

Component for Care and Utilization Management Centered on the Member. TruCare (item D in the Attachment) is our member-centric health management platform for collaborative care coordination as well as physical and BH care management and utilization management (UM). NTC's Medical Management Department uses TruCare to automate care management workflows and to apply clinical decision support criteria for utilization management. We have integrated InterQual medical necessity criteria into TruCare to assist in making appropriate medical decisions based on nationally accepted, evidence-based standards of care.

TruCare's design centers on the member's care as a whole versus isolated clinical cases, permitting our care and utilization management staff to more easily collaborate and focus on the member's care in a holistic manner. We integrate care plans created by Care Management staff in TruCare with our Provider Portal (J) so that Providers have access to one care plan for monitoring goals and progress. We also integrate Health Risk Screenings completed by our members on the Member Portal (also symbolized in box I), or by health plan staff, as well as Health Risk Assessments with TruCare (via our Centelligence™ Enterprise Data Warehouse (EDW)) where they are available for use by our Centelligence™ predictive modeling system.

TruCare has electronic interfaces with CRM and EDW (H) for automated exchanges of provider, member, physical, BH, and pharmacy claims utilization data.

TruCare Mobile Application. For the Heritage Health program we will also utilize our *TruCare on the Go* mobile enabled, HIPAA compliant software; integrated with our enterprise TruCare platform. Using tablet technology, our Care Managers (CMs) in the field will use TruCare on the Go when meeting directly with members to facilitate interaction with the member, family, and caregivers, by showing them real time information such as assessments, care plans, and other important data. TruCare on the Go will also allow our CMs to provide on-screen video education; and conduct real-time assessments, thus enabling CMs (particularly CMs embedded in major provider/hospital sites) to spend more of their time in the field, face to face with members, caregivers, and providers. Additionally, we will use TruCare on the Go's TruScan feature to take photos of documents, tag them for the appropriate member record and securely upload to TruCare linked to the member's record.

In recognition of TruCare's use of mobile technology, Microsoft named Casenet, LLC (TruCare's developer), as its 2014 Health Plan Partner of the Year

Components for Heritage Health Claims Submission, Processing, Payment and Encounters. AMISYS Advance ("AMISYS" - item C in the Attachment) provides claims processing in compliance with the requirements and timeframes mandated by MLTC and Federal government regulations, and employs HIPAA compliant code sets. AMISYS delivers accurate claims payment with configuration capabilities to price according to fee schedules, per diem rates and other pricing arrangements. AMISYS maintains claims data at detail service line, claim header, and batch levels, facilitating auditing of individual claim records as well as batch audits. Our AMISYS system currently processes approximately 60 million physical and BH Managed Medicaid claims per year through a scalable, integrated platform.

Clinical Editing. Our ClaimsXten software, integrated with AMISYS, reviews adjudicated claims prior to payment for bundling and unbundling of services, incidental services, mutually exclusive codes, global surgery follow-up days, duplicate claims, invalid procedures, bilateral services, and incorrect age/gender validation. Also, through electronic integration with Healthcare Insight (a unit of Verisk Analytics, Inc.), NTC systematically identifies potential fraud, waste and abuse (FWA) in claims using a nationwide database of provider billing patterns.

Electronic Payment and Payment Reporting Options. NTC offers providers Electronic Remittance Advices (ERA) directly to our providers, or through a clearinghouse, or through the PaySpan service (free to Providers). We also offer providers the option of CAQH CORE compliant EFT electronic payment via PaySpan (also free to Providers), and we offer paper check and paper Explanations of Payment (EOP) for providers not interested in electronic transactions.

Using Technology to Dramatically Increase Claims Processing Efficiency. In 2016, we are introducing a *Real-time Editing & Pricing module* (RTEP) on our secure Provider Portal. This module, integrated with AMISYS, will provide real-time claim editing, including clinical code editing, and estimated pricing for professional claims submitted through our Provider Portal. When a provider enters a professional claim on our Portal and clicks the "submit" button, RTEP will instantly apply the multiple steps of our adjudication process: validating member and provider eligibility for the dates of service, matching prior authorizations applicable to the services on the claim, identifying "other insurance" and applying Third Party Liability / Coordination of Benefits (TPL/COB) amounts, determining if benefits apply, enforcing other advanced edits and Heritage Health business rules, applying clinical edits, and finally pricing the claim - all performed during the provider's online session. Our Provider Portal will then display back to the Provider whether we will pay the claim and an estimated amount to be paid, with clear notice that the estimated paid amount displayed is subject to adjustment after our Fraud, Waste and Abuse (FWA) checks (discussed above). As always, our objective is to lower administrative burdens for providers without sacrificing program integrity.

Faster Payments. Additionally, NTC will offer two business day claim payment turnaround time from claim finalization to provider payment for professional claims submitted via our Provider Portal. This enhancement means improved cash flow for Providers, as well as an incentive for Providers to submit their claims to us as soon as possible after the date(s) of service – which translates to timelier, more accurate, and more complete encounter data to NTC and MLTC.

MLTC Encounter Processing. Once claims are adjudicated to a finalized (paid/denied) status, they will be prepared for submission to MLTC as encounter data through our Encounter Data Manager (EDM) system (item F in the Attachment). Designed specifically for Medicaid encounter processing, EDM is our workflow-enabled encounter reporting system that we will configure for all MLTC encounter submission edits, rules, and timeframes, providing encounter tracking, history, and resubmission functionality. EDM will apply edits and mapping routines to the Heritage Health claims that we process in AMISYS and translate that claims data into HIPAA compliant 837 transactions that conform to MLTC's specific content, format, and transmission specifications. Our encounters include all critical data elements such as state Medicaid ID numbers, National Provider Identification (NPI) numbers, SSN numbers, member name, and date of birth, and because EDM is an integrated component of our MIS, these critical data elements will match and conform to the State's eligibility and provider files (e.g. the weekly MLTC file of Nebraska Medicaid provider types and specialty codes) sent to us by MLTC.

EDM's rules based configuration flexibility, in conjunction with its integration with AMISYS, allows us to 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.

Component for Receiving, Indexing, Storing and Retrieving Electronic Document Images.

The Centene Document Management System (CDMS – item G in the Attachment) employs high performance optical character recognition technology and stores indexed electronic images, such as member letters and provider correspondence as well as paper claim submissions, in the CDMS Enterprise Content Management system relational database. All such images, whether outbound "images" or inbound scanned paper or faxes, are indexed by metadata information, for example: Member ID, Provider ID, and/or Claim ID number, allowing us to trace data back to original documents. This allows users to search for, and retrieve, images of pertinent correspondence and materials from within their primary functional applications (e.g., CRM, TruCare, AMISYS) in the context of a particular business situation, such as interactions with a particular member about a reported problem.

Records Retention. Our standard *online* retention policy for claims and encounter data is a "current year plus ten years" retention period, exceeding the RFP requirements both in duration and in the fact that data is not purged to archive but retained online for this period. To systematically apply our records retention policies, we use IBM Tivoli Storage Manager (TSM), an automated hierarchical storage management system that we also use for data recovery operations if needed. TSM, in conjunction with AMISYS (support for claims with once-in-a-lifetime indicator), and CDMS, allows us to comply with RFP requirements in Section IV.R.13.

Component for Meeting Reporting Requirements. Our Centelligence™ platform (item H), provides reporting and analytic capabilities and is *fully integrated* via our SOA with the MIS components described above for data integration of enrollment and eligibility, clinical care management, EDI, claims and encounter records, member and provider service and data, document storage, web portals and mobile applications. Centelligence™ integrates data from internal *and* external sources, producing actionable information and reports, everything from care gap and wellness alerts to key performance indicator dashboards, provider clinical profiling analyses, population level health risk stratifications, and NTC operational reports as well as reports for MLTC.

Data Warehousing Component. At the heart of Centelligence is EDW (item H in the Attachment) powered by *Teradata's Extreme Data Appliance* high performance relational database management system technology. EDW will receive, integrate, and continually analyze an enormous amount of Heritage Health transactional data, such as:

- Physical, BH and pharmacy claims.
- Health assessments.
- Service authorizations.
- Member information, including current and historical eligibility, demographics, PCP assignment and more.
- Provider information, including participation status, specialty, demographics, and more.

EDW is SQL and Open Database Connectivity (ODBC) compliant, and will allow NTC reporting analysts to efficiently extract and upload to our MLTC Portal (see discussion below), or send directly to MLTC via SFTP or secure e-mail; any file, dataset, or ad hoc report MLTC requests in the manner (i.e., XML) and frequency MLTC specifies.

Reporting and Decision Support. Our Centelligence™ Informatics suite (also depicted as item H) is a comprehensive family of integrated decision support and healthcare informatics solutions. For example, Centelligence™ provides:

HEDIS Reporting. Centelligence™ includes NCQA Certified Quality Spectrum Insight (QSI) for HEDIS reporting. Our reported HEDIS rates are audited annually by Attest Health Care Advisors, licensed by NCQA to conduct HEDIS Compliance Audits™. EDW feeds member and claims data into its QSI component, which then delivers NCQA-Accredited HEDIS reports.

Predictive Modeling. Centelligence™ provides our multidimensional, episode-based predictive modeling and care management analytics tool, which uses clinical, risk, and administrative profile information obtained from physical, BH, and pharmacy claims data and lab test value data to identify members who may need Care Management.

Flexible Reporting Presented in Compelling Fashion. Powered by MicroStrategy technology, Centelligence™ offers desktop reporting and online key performance indicator dashboards with "drill down" capability.

Components for Web & Mobile Support of Members, Providers, and MLTC. Items I and J in the Attachment represents our public websites, secured Member, Provider, and MLTC Portals, and Member Mobile Application. We enforce a consistent "look and feel" in our web and mobile enabled applications through the use of standard templates on open source JBOSS and HTML5 application servers that support all popular user browsers including Internet Explorer, Firefox, Safari, and Chrome. Our websites and

portals are compliant with Federal "Section 508" standards as well as guidelines developed by the Web Accessibility Initiative. Our websites and portals are *mobile optimized*, meaning that when users visit us using their mobile device browsers, our web servers present our pages in "mobile friendly fashion" for easy touch screen navigation and viewing. Our Portals are integrated with Centelligence™ so that information presented to Portal users (claims data, clinical data, demographics, etc.) is coming from and going to one source, and in synch with all of our core systems through EDW's integration with our Centelligence Data Service Bus ([redacted]).

Performance. We use Google Analytics to monitor the utilization of each portion of our website, Portals, and mobile applications. We monitor transaction logs on our JBOSS Web Servers, to report on the volume of Portal transactions (e.g. claim submissions, claim status inquiries, PCP change requests), which informs our capacity planning efforts. For example, this approach has allowed us to maintain an average response time on our Portals of approximately 350 milliseconds, measured from the time a request enters our Portal to the time our Portal issues a response to the user.

Support for Members. NTC's Member website, Member Portal, and Member Mobile Applications can and will meet all Heritage Health Member Website RFP requirements. All materials and member web pages will comply with MLTC's guidelines and HIPPA regulations, and we will seek MLTC approval for any updated material, in line with RFP Section IV.F.10. Through targeted outreach and proactive communication, we will seek to maximize utilization of our Member Portal and Member Mobile Application. For example, our affiliated Managed Medicaid health plan in Georgia has registered 30% of their member households on their Member Portal, generating approximately 144,000 page views each month.

In 2014, Centene won the Gold Web Health Award from the Health Information Resource Center recognizing high-quality digital health resources for members and health professionals.

New Functionality for Members. Some of the new features we have introduced (or are introducing in 2016) on our Member Website, Portal and Mobile Applications, subject to MLTC approval for Heritage Health, are designed to increase member engagement and meet quality goals, and include:

- **Caregiver Resource Center**: information for caregivers on identification of symptoms, managing illnesses, and balancing other needs.
- [redacted]
- **Click to Chat:** allows member to have a secure instant messaging session with our Customer Service Representatives (CSRs), offering an additional communication channel for members to quickly connect with us and resolve questions they have.
- **Email Alert Notifications:** at the member's option, Centelligence™ will automatically e-mail the member a link to sign on the Member Portal to view a newly identified care gap or health alert.
- **MyNTC:** our Member Mobile Application for Heritage Health, MyNTC, will offer a number of interactive member functions, including a mobile Member ID Card, Find-a-Provider with GPS-powered directions, Health Risk Assessment, CentAccount® Rewards (allowing members to view their CentAccount® health incentives program rewards status), symptom checkers, health trackers and more.
- **Mobile Start Smart for Your Baby (Start Smart Mobile):** this application (already deployed at some of our affiliated Centene health plans) will provide support for NTC's pregnant members from their first positive pregnancy test through the post-partum period. Start Smart Mobile will help NTC expectant moms stay on track with key prevention milestones, set personalized reminders, proactively identify and take action on health issues, and tap into NTC's other programs, such as, telephonic Care Management and 24/7 nurse advice hotlines.

Support for Providers. Our Provider Portal is a secure web-based platform that supports a number of provider administrative "self-service" capabilities, including eligibility inquiry, authorization submission, claim submission, claim status inquiry, and a growing number of clinical applications. These clinical applications include: Online Care Gap Notifications (alerting providers to health alerts as well as gaps in care); Emergency Department high utilizer flag (alerting providers if a member has had three or more emergency room visits in the past 90 days); Centelligence™ Member Health Record (CHR) delivering advanced capabilities for clinical care management; ability to view a member's TruCare Care Plan; practice-level clinical quality and cost reports; and clinical practice guidelines.

Specific Examples of Additional **Provider Portal Features:**

- 24 hour accessibility for member communication for all described features
- PCP assignment
- Member Allergies
- Detailed claims information (including the last 3 ER visits)
- Inpatient admission information
- Provider office visit information (BH and PH)
- Reoccurring diagnosis information
- Prescription history (pharmacy fill activity)
- "One-stop-shop" for provider administrative functions
- TruCare Plan provider viewing (helpful as it is a comprehensive plan of the member's goals, barriers, and interventions to achieve optimal outcomes)

We will also offer our Primary Care Providers, Patient Centered Medical Homes, and Health Home Providers access to new clinical analytic capabilities via our Provider Portal, to empower them with population health management, expanded Member registry functionality, and online practice level quality and cost dashboards, risk adjusted with peer comparison capabilities. These advanced informatics tools are built upon our Centelligence™ analytics platform, and empower our providers with the information they need as NTC and our providers move progressively further with Value Based Purchasing arrangements.

Strategic Functionality for Providers. We continually introduce new functionality in our Provider Portal, informed by our state clients as well as our providers. We highlight here some key features we will deploy for our Heritage Health providers for enhanced administrative efficiencies as well as additional clinical decision support for Providers in line with our Value Based Purchasing provider contracting initiatives:

Enhanced Provider Reporting for PCPs and PCMH Practices: For our PCPs and Patient Centered Medical Home (PCMH) Practices, we will offer two advanced online capabilities: Centelligence Patient Analytics and Centelligence Analytics Insight:

- The ***Centelligence™ Patient Analytics*** (CPA) application is a web-based tool that NTC will make available to providers through our Provider Portal. CPA allows practice managers or individual providers to instantly access an expanded version of our online member health registry as a *patient registry,* allowing the user to view critical information to better identify evidence-based care gaps, understand quality improvement opportunities, and improve their care management functions. Through a streamlined interface, providers can easily access the information they are looking for by utilizing interactive, search, drill-down, and export capabilities.
- ***Centelligence™ Analytic Insights*** (CAI) dashboards bring together a collection of the most important medical cost and utilization, pharmacy, emergency department, potentially avoidable events, clinical, population health, and quality data to help NTC and providers form a cohesive understanding of provider performance and membership trends. The dashboards available to users allow for, among other uses, provider performance analysis, provider peer group comparisons, cost and utilization trending, quality measure performance, active and non-active member pattern analysis, disease state prevalence, readmission analysis, and population health trend analysis.

Users are also offered many of these metrics on a risk and severity adjusted basis. Authorized users can interact with the dashboards through extensive custom selection, drill-down, and export capabilities, to help identify potential casual factors behind clinical and cost performance. As providers shift to pay-for-performance and pay-for-outcome measures, the availability of such data to assist in determining contract performance will become paramount. By using CAI, providers will be better able to monitor their performance versus Value Based Purchasing contractual or bonus goals.

- **Real-time Editing & Pricing**: as discussed above this feature will allow providers entering Professional Claims into our Portal to obtain claim adjudication results while still logged on.
- **Practice Improvement Resource Center (PIRC)**: To further support our Providers and make it more convenient for them to find resources, we will offer expanded support through PIRC: a well-organized, searchable compendium of information and training modules on evidence-based practices and best practices, practice guidelines, and tools to help providers manage the clinical, operational, and technology aspects of their practices, including the use of Electronic Health Records, information exchange with NeHII, and our EHR initiatives (see Section 53 for details).

Portal Support for MLTC. Several of our affiliates support (or are planning to support in 2016) their state Medicaid Agencies with a secure Client Portal expressly for access by authorized state personnel, for a variety of reporting and collaborative applications. We will configure a Client Portal for MLTC (MLTC Portal) to support functions to enhance MLTC's ability for oversight and compliance monitoring, document library functionality and collaborative workflow support with NTC. The MLTC Portal will offer access for qualified MLTC (and other Nebraska State Agency staff as necessary) to these resources:

- Updated Library Systems Documentation (per RFP Section IV.R.1b), Systems Design & Management Manuals, User Manuals, and Quick Reference Guides, with content and update frequency prescribed in RFP Section IV.R.3. If an update or change to our MIS is needed that pertains to material in our documentation, we will forward the relevant updated documentation to MLTC 45 calendar days prior to our intended implementation, and we will post approved MLTC updated documentation on the MLTC Portal and have printed revisions ready within ten business days of the change.
- Updates on any System Unavailability events and related problem resolution activities. Note that this does not limit MLTC in any way from contacting our Systems Help Desk, and NTC will proactively contact an MLTC designate for system issue communications as prescribed in RFP Section IV.R.10.
- Other applications, such as online access to reports and data to be defined in detail with MLTC.

In addition to above, NTC will facilitate live access to all of our live systems for MLTC at any time, and this is a request that many of our affiliates satisfy for their state Medicaid Agency clients.

Components for NTC Telecommunications to Meet Call Center Related Requirements. Item K in Attachment Q101: Systems Diagram represents our enterprise Avaya Telephony and Voice Portal (AVP) platform with Avaya's Call Manager System (ACMS) software. ACMS provides automatic call distribution (ACD) across our member and provider call queues. ACMS tracks and reports information processed through the ACD and enables efficient call answering, monitoring, and reporting capabilities. Additionally, CRM is integrated with our Avaya system for Interactive Voice Response (IVR) support with phone keypad or voice recognition capability for optimal customer service. Our IVR allows both self-service options and live person assistance. For example, when providers call our main toll-free number, they have the option to select or say 'claims information, 'utilization management', 'behavioral health', etc. Our AVP system also includes *Proactive Outreach Management* (POM), which allows our Call Center staff to create and execute automated outbound campaigns providing valuable information and enabling members to take immediate action live with our CSRs. For example, we perform campaigns to enlist members to register to use our Member Portal, and/or to encourage them to make appointments to close care gaps, etc.

Texting Functionality. In conjunction with Voxiva, a leading mobile health company, we extend our integrated member engagement capabilities by incorporating phone text campaigns customized for individual Member needs. We plan to deploy our texting program (subject to MLTC approval) with timely, targeted messages designed to engage members in ongoing healthcare services, such as appointment reminders, screening checks, and other activities to improve the health of our members who use SafeLink phones. These text messages will also contain specific health information a member needs based on their diagnoses and conditions, driven by our Centelligence™ health analytics platform. Centelligence™ Engage: Using Analytics for Effective, Targeted Member Communications. As part of our Heritage Health program, we will deploy our Centelligence™ Engage platform (encompassed in item H in the Attachment). As noted above, Centelligence™ integrates data from multiple sources, for a wide variety of actionable information, reporting and analytic needs. The Engage component of Centelligence uses member information from our Enterprise Data Warehouse (EDW), to determine what information needs to be targeted (e.g. Health Alert, EPSDT Gap, Medicaid Redetermination Due) to which member using the member's preferred method (phone, e-mail, web, text, letter), and in the most effective manner (e.g. culturally attuned for specific ethnicity, health status, time of day). Engage will orchestrate NTC's outbound administrative and clinical communications with our members in a unified communications approach, so that we can focus the member's attention on the most important items concerning his or her health. Engage also tracks each outbound attempt to determine contact success, and uses Machine Learning and Big Data technology to suggest to NTC management alternative contact strategies (e.g. use phone instead of e-mail) to help guarantee outreach success. For inbound calls, Engage also supports our Concierge Service operations model (see Section 28 for more information) whereby a member calling our Member Call Center will be connected with his or her preferred Customer Services Representative (CSR) if that CSR is available. Our affiliate in Texas, Superior Health Plan, piloted Engage earlier this year and has seen preliminary evidence of improvements in unaudited HEDIS rates of 15 to 20% due to enhanced engagement. In short, Centelligence™ Engage helps us drive targeted member communication, care management outreach, and healthy behavior to ensure the right member gets the right message, via the right method. Subcontractor Systems. Item L in Attachment 101: Systems Diagram depicts the platform of our affiliate and Prescription Benefits Manger (PBM) subcontractor, US Script. PBM1 is an integrated pharmacy claims, prior authorization and prescriber and pharmacy service system. Item M symbolizes the systems of our affiliate Vision Benefits Manager subcontractor OptiCare, with claims and authorization support through their Risk Manager platform, as well as HIPAA EDI processing capabilities. NTC and our affiliates US Script and OptiCare share the same data center facilities, leveraging the same enterprise datacenter services including physical security, systems management, data backup, business continuity, and redundant networking. Among other advantages, this means NTC's affiliated subcontractors share a common communications platform, enabling them to detect when a colleague is online, whether on e-mail, or available for instant messaging or phone conference, or logged into our CRM system - all fostering quicker communication, multi-disciplinary teamwork, and rapid, coordinated response to issues or requests demanding immediate attention. Sharing Information between MLTC's Systems and Our System to Avoid Duplication of Effort. There are several ways we will share information with MLTC's systems to avoid duplication of effort. Please see ***Table Q101*** for examples:

Table Q101

Process	How Information Sharing Avoids Duplicative Effort
Member Contact Information	In our daily interaction with members, we often capture new contact information. CRM allows us to capture this data without writing over the member records we receive from MLTC or the enrollment broker. We will electronically send new member contact information to MLTC, in a format and method designated by MLTC, giving MLTC accurate information if the State needs to contact the member, and saving MLTC the effort of determining new contact details.
Third Party	We will report members with third party coverage to MLTC monthly in any format MLTC

Process	How Information Sharing Avoids Duplicative Effort
Liability (TPL) Information	specifies, a process that the majority of our affiliate health plans perform today. Today our MIS systematically captures Third Party Resources information from inbound claims, and in addition, our MIS is integrated with our vendor, Health Management Systems, Inc. (HMS), so that we receive updated TPL and Coordination of Benefit (COB) data on our members. HMS is a leading cost containment company specializing in the systematic collection of TPL/COB information using a nationwide database. By sending MLTC TPL/COB information that we capture from claims as well as from HMS, we will help MLTC avoid duplicative efforts to obtain that same information.
Provider Data Exchanges	Per RFP Section IV.8.a, we will send a weekly provider file to MLTC in a format prescribed by MLTC. We will also use the weekly MLTC list of Nebraska Medicaid provider types and specialty codes that MLTC sends to us. If the weekly list from MLTC is a file of specific providers, including the 11 digit Nebraska Medicaid Provider Number of each provider in the list, we will be able to identify any of our providers who we might otherwise not have a Medicaid ID number for (e.g. missing on the provider's application). Similarly, our transmission of the weekly provider file to MLTC allows MLTC to systematically validate our new providers against MLTC Medicaid ID files without having to contact the Provider. This process saves effort for MLTC, NTC and providers.
Provider Inquiries	For providers who have a question concerning FFS Medicaid, but not related to NTC, we will supply a link directly to any MLTC designated website or web page – or post contact information on our website as instructed by MLTC. This will allow providers to make inquiries directly to MLTC and/or the designated MCO awarded "claims broker services" per RFP Section Z and receive responses directly from MLTC or the claims broker, avoiding delay and possible confusion for the provider, MLTC, the claims broker, and NTC.
Electronic Health Records	NTC is currently working on a Participation Agreement with NeHII to allow us to access and use NeHII for purposes associated with this RFP. We anticipate that this contract will be executed prior to the beginning of contract operations. Once connected to NeHII, we will be able to contribute clinical data on our members to NeHII, eliminating the need for MLTC to contribute that data to NeHII, while helping to enhance the utility of NeHII's offering to participating Nebraska providers.

An important aspect of sharing data with MLTC is carefully defining which system, ours or a MLTC system, is the authoritative host for any particular type of data, and which system (ours or MLTC's) maintains a copy of that data. This is a critical consideration, for example, when sharing updated member contact information. We will ensure absolute clarity on this topic of master data governance as part of our implementation plan with MLTC, the enrollment broker, and other MLTC intermediaries.

An MIS Ready to Operate according To MLTC's Scope of Work without Custom Modifications Ready to Support Heritage Health. Our MIS currently operates in support of Managed Medicaid programs in 20 states, with information processing needs similar to Heritage Health contract requirements. As demonstrated in this Section, our MIS is already capable of supporting the RFP contract requirements, particularly those related to core processing functions such as eligibility and enrollment, claims processing and payment, provider data information exchange, encounter data submission, reporting, etc. In all cases, our MIS performs these or similar functions for our affiliate health plans today, and we will *configure* our MIS, without custom modifications or system updates, to meet all exact, detailed Heritage Health requirements through table driven parameters and templates. For example, we routinely customize encounter processing business rules per state requirements in our Encounter Data Management (EDM) system via configuration utilities, we configure our EDIFECS EDI system for specific processing rules surrounding our state client eligibility needs using standardized translation maps, including the use of maps for proprietary file processing – such as the Supplemental Enrollment File (RFP Attachment 30), as well as, of course, for HIPAA 834 files.

In terms of Federal mandates, we successfully commenced processing the ICD-10 codeset throughout our MIS on the effective date of 10/1/2015, and we have met all CAQH CORE processing requirements to date, and remain on target for all identified future CORE requirements. **Standard and Disciplined Approach to Change Management.** We will implement all Heritage Health configurations as part of our *normal change control process*. We regularly introduce clearly defined configuration changes to our system via an Agile standards based "system release" change process to address new business needs, implement innovative new functions, or to meet new compliancy or contractual requirements. Agile is an industry best practice discipline that incorporates a collaborative, iterative approach for consistently successful change implementations. Change Process. We use a rigid, workflow enabled change promotion process from iterative development, unit test, integration test, through User Acceptance Test (UAT) to assure changes are accurate, and with full regression testing to determine how changes in one system component impacts other components. All system changes are controlled by our Change Review Board (CRB) and we orchestrate all changes through our ServiceNow change workflow platform, with detailed and auditable record of changes. The CRB is our change governance body which serves as the prime "gateway" of a system change from development and test, and into production. The CRB consists of a blend of IT operational professionals and managers from application, hardware and subsystem, security and data communications areas. From a software control perspective, our version control system offers us a system-inherent mechanism for recording any change to a software module or subsystem. **Communicating System Changes.** For any system changes affecting NTC, the CRB will ensure that we have an appropriate communications plan, both for internal and external stakeholders (including MLTC), implemented for the change. We will provide MLTC prior notice of any major upgrades, modifications, or application updates in our core systems (claims, eligibility/enrollment, service authorization, provider data management) or conversions a minimum of 90 calendar days prior to such a change. **MLTC Testing Initiatives.** We can and will work with MLTC on any testing initiatives required by MLTC, and will provide sufficient system access to allow appropriate MLTC staff to participate in the testing. Centene and our affiliate health plans have a tradition of cooperative testing, particularly for implementation activities prior to the start of contract operations. **Electronic Messaging.** Our MIS supports a continuously available email system, based on Microsoft Exchange technology, and we use the Microsoft Office (Office) suite of document tools. We will maintain a version of Microsoft Office compatible with MLTC's installed version. We use Transport Layer Security (TLS) to encrypt the transmission of e-mail with any host that supports it. Any attempts to send electronic mail containing unencrypted privileged data (e.g. PHI) is intercepted and automatically encrypted by our Data Loss Prevention (DLP) system, accompanied by a message that is sent to the sender informing them of the policy violation and educating them on how to properly encrypt protected data. Where a partner is unable to transmit email securely, we use our Secure Email Gateway services. Through interfacing with a simple web-based application, parties are able to encrypt content and transmit their email securely using FIPS 140-2 compliant encryption. We can also establish Site-to-Site Virtual Private Networks (VPN) through our Check Point boundary firewalls and IPSec encryption protocols. We use industry best practices including the principles of least privilege to ensure that all communications remain protected. Please see Sections 102 and 105 for additional information. **Policies and Procedures.** As part of our adherence to Information Technology Infrastructure Library (ITIL) standards, we ensure that our system documentation is current, accurately describes systems operation, IT services and processes, and is inclusive of the most current system changes. We also use our Compliance 360 (C/360) Governance, Risk Management and Compliance (GRC) software system for workflow enabled Systems Policy and Procedure (P&P) formulation (with history of documentation and sign-offs), to ensure we have System P&P's for our MIS processes. **Systems Refresh Plan.** We maintain a best practices approach to our Annual Technology Refresh Process, informed by continual capacity monitoring and forecasting, vendor release status, and business needs, and which includes the formal publication of a refresh plan each year. We will submit to MLTC a copy of our Annual Systems Refresh Plan, which ensures that all of our software is maintained at current and tested versions, and meets requirements per RFP Section IV.R.4.

(3 page limit)
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.

Longstanding Experience Supporting Federal Standards

Nebraska Total Care (NTC) will administer MLTC's Heritage Health program in full compliance with HIPAA and other Federal and Nebraska information exchange standards, on an enterprise scale Management Information System (MIS) operated by our parent, the Centene Corporation (Centene). We have been compliant with HIPAA on or before the effective dates of each HIPAA rule, including all applicable privacy, security, file and transaction standard regulations originating from the original HIPAA legislation, as well as all subsequent regulations, including the 2013 HIPAA Omnibus Final Rule. We also comply with applicable Federal National Institute of Standards and Technology (NIST) security guidelines. Through our continuously updated and regularly audited *Security Program*, we employ an array of administrative, technical, and physical controls to ensure that information exchanges with our constituents (including MLTC and MLTC intermediaries) follow all HIPAA standards. Please see Section 105 for more information on the scope and governance of our Security Program.

We employ HIPAA compliant encryption strategies for e-mail and file exchanges, and best-in-class Data Loss Prevention (DLP) solutions to safeguard electronic Protected Health Information (ePHI) from inappropriate transmission in any *information exchange*. Through automated *system access management*, job role based access security controls, and other safeguards discussed below we support ongoing compliance to 42 CFR Part 431 Subpart F (Safeguarding Information on Applicants and Beneficiaries), and 42 CFR Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records) and assure that *information accessibility* by internal and external users is appropriate per HIPAA.

The integrated Electronic Document Interchange (EDI) component of our MIS allows us to affirm ongoing support for the use of *HIPAA compliant files and transaction standards*, including all current HIPAA transaction standards and codesets, and we maintain CAQH Committee on Operating Rules certification, in compliance with Affordable Care Act (ACA) mandates. We have also been fully compliant with CMS' ICD-10 mandate since the 10/1/2015 effective date.

As Centene does for Managed Medicaid programs in 20 states today, we can support daily and monthly, inbound and outbound, eligibility file exchanges with MLTC and MLTC's enrollment broker for eligibility, PCP assignment, disenrollment, member record reconciliation, and address update purposes. Our MIS can and will reconcile HIPAA 820 Premium Payment detail information with our own internal membership records for MLTC, as it does in most of the states Centene supports.

Information Exchange Controls Support Access without Compromising Security

We support Federally compliant encryption technologies to protect information when exchanged outside our span of control. As we do in other states, we can, with MLTC approval, enforce automatic encryption of all e-mails between NTC and MLTC using Transport Layer Security (TLS), a standard protocol for securing communication designed to prevent eavesdropping, tampering, and message forgery as well as authentication and communications privacy. We use Websense data loss prevention (DLP) tools to control Protected Health Information (PHI) data usage through automated content analysis for identifying PHI in structured and unstructured files and documents, and monitor data in motion as well as at rest. These Websense DLP capabilities enable us to guard against potential HIPAA violations by preventing unauthorized transmission or access of such data as Social Security Numbers, medical account numbers, dates of birth, and dates of admission or discharge.

Enhancing Protection of Sensitive Data. Today, all data in motion is fully encrypted by our use of industry standard and HIPAA compliant technologies, including SFTP, Secure Sockets Layer (SSL), Transport Layer Security (TLS), Virtual Private Networks (VPN) and other forms of secure information exchange. Our IT Security department is proactive in monitoring for malware, threats, and vulnerabilities.

For example, we assessed and eliminated any exposures to the HeartBleed SSL vulnerability within days of announcement of that threat in 2014. We continue to update and expand our controls and safeguards and harden our security infrastructure, particularly in light of recent highly publicized security breaches within both the Commercial and Government sectors. For example, we are implementing new safeguards such as Digital Rights Management to further ensure only intended data recipients can access PHI, and a tokenization strategy to secure our PHI data at rest.

System Access Management and Information Accessibility for Appropriate User Access

Through a blend of administrative, technical, and physical controls, our HIPAA Security Program helps assure that all user systems access to our systems and information is appropriate for member service and care, and follows the HIPAA Minimum Necessary Requirement for information accessibility. Our HIPAA compliant Business Continuity Plan and highly available IT architecture help us ensure that we maintain the highest possible level of information *availability* so that all authorized users of our MIS can access the information.

Role Based Access Control. We implement Role-Based Access Control (RBAC) for all applications that process ePHI. RBAC addresses security risks by defining employee access rights based on the employee's job responsibilities, including whether that employee has access rights to update information or view only. For all applications, individuals responsible for granting access do not themselves have rights to perform transactions within those applications (e.g. the security administrator who manages login profiles to our claims system cannot himself process claims). Individual security change requests are recorded through a documented security authorization and implementation process.

Auditing Systems Access and Usage. Our IT administrators check system log files to help identify any unauthorized login attempts. We use *Tenable Security Center* to record the regular certification by our managers of appropriate subordinate access to systems. Our IT Security staff use *Spector* software for Data Loss Prevention (DLP) and audit the appropriate use by personnel of systems, email, and the Internet. Access to critical applications, databases and operating systems are reviewed by system owners on a periodic basis to ensure that employees have access to resources they need for their jobs. Please see Section 105 for more information.

Controlling Access through Physical Safeguards. NTC's MIS is housed in two enterprise datacenter facilities, both wholly owned by Centene, which house NTC data and voice communications systems and are securely connected to NTC via our internal Wide Area Network (WAN). As is the case with all NTC's offices, each datacenter is secured via proximity card access on all external doors, elevators, and the internal entry doors on each floor. Security guards at our datacenters require that all visitors sign in and out at the front desk, utilize a temporary badge, and are accompanied by an employee when visiting. We also use digital security cameras, multiple security guards who are on duty at all times, and panic switches installed at each reception desk. Our card key system records all access attempts/card swipes whether successful or not.

Additional Security Safeguards Ensure HIPAA Compliant Systems Access. In addition to above, we comply with HIPAA's Security Rule and other Federal standards via a *comprehensive* set of administrative, physical, and technical safeguards that ensure information accessibility to qualified users and information exchange partners. Please see Section 105 for more information.

Affirmation of HIPAA Compliant File and Transaction Standard Support

We support all currently Federally mandated HIPAA Version 5010 transaction formats (***Table Q102***):

Table Q102: Through Centene, NTC Supports all HIPAA Transactions and Associated EDI Acknowledgements
Enrollment/Eligibility: We use the **HIPAA 834** for receiving daily & monthly eligibility and enrollment data and will support receipt and processing of these files from MLTC or MLTC enrollment broker.
Premium Payment Detail Advice: We use the **HIPAA 820** and will use this file from MLTC per RFP.
Enrollment Verification: We use the **HIPAA 270/271** and will support it per RFP.
Authorization Request: We use the **HIPAA 278** and will support it per RFP.
Claim Status Inquiry and Response: We use the **HIPAA 276/277**. We can also support the 277U transaction and will use the 277U as required by MLTC for encounter data processing per RFP Addendum Question & Answer #279.

Claims: We use the **HIPAA 837**, and via our affiliated PBM, US Script, we use the HIPAA 5010 compliant version of the **NCPDP** pharmacy transaction.
***Remittance Advice*:** We generate **HIPAA 835** transactions for electronic remittance advices.
Encounter Submissions: We submit encounter data to our state clients (who request this format) in the **HIPAA 837** standard, and will use this standard for MLTC per RFP.
Electronic Funds Transfer: Although not a HIPAA standard, we fully support and use **EFT** payment methods for provider claim payment today, and in compliance with Federal Affordable Care Act (ACA) CORE requirements, as noted above.

We support all HIPAA 5010 codesets, including CPT and HCPCS procedure codes, ICD diagnostic and procedure codes, Explanation of Payment Remark Codes, Claim Payment Adjustment Codes, etc.

Resolving Discrepancies between Member Eligibility Files and Internal Records

In a process very similar to what Centene performs in 20 Managed Medicaid states, we will receive HIPAA 834 transactions daily from MLTC or the enrollment broker, systematically loading these files into our integrated EDIFECS EDI middleware, which validates and maps data in the 834 file to the membership input format of our MIS. Our eligibility pre-processing software then edits for duplicate Member records, date criteria validity, field data integrity, and valid date spans, and then loads "passing" records into the master member files of our Member Data Management (MDM) system. We will work with MLTC and the enrollment broker on a protocol for resolving issues with records that do not load due to a discrepancy (e.g. update transaction for a member whose record we do not have in our files). We will also perform a weekly reconciliation per RFP requirements with the enrollment broker, to cross-check and resolve any differences in eligibility changes reflected in daily files received in the week and our internal records.

Monthly File Process. Subject to detailed discussions with MLTC, we will use the monthly 820 file from MLTC to reconcile our records with those members listed in the 820. We will ensure our records reconcile to the monthly 820 file, and will report discrepancies to MLTC for mutual resolution.

Resolving Member Address Discrepancies with MLTC. On any given day, our members, or their caregivers or providers may report corrected address or updated phone number information while on the phone to our Customer Service Representatives (CSRs). Our CSRs record that updated information in alternate contact data fields in the member's online record in our enterprise Customer Relationship Management (CRM) system, allowing us to capture the information **without** overwriting any member contact information we receive from MLTC or the enrollment broker via the HIPAA 834 daily or monthly eligibility and enrollment files. Subject to approval from MLTC, we can securely send a file in a MLTC-prescribed format to MLTC or the enrollment broker, with member updated address and phone number information in the file. MLTC and/or the enrollment broker can then decide whether to apply the change, and if MLTC applies the change we will receive that change information back in the daily or monthly HIPAA 834 file from MLTC or the enrollment broker. At no time will we edit address information sent to us from MLTC or the enrollment broker.

Unified Member View. In 2013, we introduced our Unified Member View (UMV) capability into our MIS, which gives us the automated ability to link an inbound member record with historic "eligibility spans" we may have on that member, (e.g. prior history as a NTC Heritage Health member). UMV also features enhanced capabilities for standardizing member address and contact information, through integrated address standardization from *SmartyStreets* (a leading real time US Postal Service approved address validation service); and Identity Verification & Authentication data services from *LexisNexis*®, enhancing the accuracy and quality of member data we house and analyze. However, we will never overwrite eligibility information we receive from MLTC or the enrollment broker but rather store alternate contact information we receive about the member as a complementary attribute of the member data we house. UMV will enhance our ability to offer MLTC and the enrollment broker accurate member contact and address information, while (as today) allowing us to house address information sent to us by MLTC and the enrollment broker.

(2 page limit)
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.

MIS Engineered for Availability

Nebraska Total Care (NTC) will use a highly available, enterprise Management Information System (MIS) operated by our parent, Centene Corporation (Centene). Through an approach based on redundancy in hardware, software and network design, in conjunction with an Event Monitoring Architecture (EMA) we mitigate, identify, and address availability issues. Our MIS design eliminates single points of failure through the use of virtualized servers, storage area networks, disk mirroring, database clusters, database replication between our two datacenters, a fully meshed, multi-path enterprise wide area network (WAN) sourced from multiple independent communications carriers, and other HIPAA compliant security strategies, to help ensure scheduled availability and seamless recovery of applications and databases in the event of unexpected failures. Our availability management approach is also coordinated with our Business Continuity Plan/Disaster Recovery Plan (BCP) so that system availability threats *outside* our span of control are mitigated and addressed rapidly (see Section 106 for more information). Our systems and process based approach to availability and incident management will allow us to support RFP requirements in Section IV.R.3 and 10 for the Heritage Health program.

Best Practices and Automated Systems Monitoring Assures High Availability

We take a best practice, ITIL based service management approach, along with automated systems monitoring, for availability issue identification, management and resolution. The Information Technology Infrastructure Library (ITIL) framework is a key component of our overall information technology (IT) management process. ITIL is a process-based, best practice framework for delivering and managing day-to-day IT services, and we require MIS management to obtain certification in ITIL v3 and incorporate these practices into their service areas. All production systems and applications are systematically monitored 24/7/365 for service availability, by our ITIL grounded Information Technology Operations Center (ITOC), which uses EMA to ensure scheduled availability of all systems, and in particular critical systems.

Systems Monitoring Technology. Our EMA technology includes system monitors, incident management tools, and software agents from leading suppliers that monitor subsystems, applications, data and voice network, capacity, and end user experience. In addition to other system monitoring components in our EMA suite, SolarWinds and CA Wily Introscope provide applications and service level monitoring. SolarWinds emulates client access to critical applications, providing metrics that assist in the prediction, isolation, and diagnosis of application events, and provides data that aid in capacity planning, performance measurement, and service level reporting activities. CA Wily Introscope runs on our web servers, enabling visibility into complex transactions for application performance monitoring. Our EMA suite, including the use of network heartbeat agents, and in conjunction with our redundant network deployment, will also help us assure that the systems and processes within our span of control related to data exchanges with the State remain available per MLTC and enrollment broker specifications and data exchange schedules. See ***Attachment 103 Samples of Availability Reports*** for examples of our Availability Dashboard, which displays system availability and average response times in real time for ITOC monitoring. The combination of EMA, ITOC and our Systems Help Desk (discussion below) will also help us to identify and resolve unscheduled availability issues within our control and restore services of critical member and provider telephone and Internet based applications within 60 minutes.

Issue Identification and Resolution

If there is a system or network service interruption, EMA systematically notifies ITOC, which takes appropriate actions including resolution and recovery, root cause analysis, communication through our System Help Desk, and corrective action plans if needed. Through our System Help Desk and NTC Director of External Relations, NTC will notify MLTC of any problem *within our span of control* that may

jeopardize availability of RFP defined critical systems and information within 60 minutes of discovery. If an issue delays report distribution or access to critical systems during a business day, we will notify MLTC within 15 minutes of discovery. As part of our Business Continuity Plan, we will also provide information on system unavailability events, as well as status updates (at minimum hourly until resolution) to MLTC via phone and/or email.

System Help Desk (SHD). As is the case today for NTC's affiliate health plans, we will support NTC staff and authorized users of our MIS systems (including MLTC and other authorized State agency users), with our fully staffed Systems Help Desk (SHD). The SHD is available to users 24 hours a day, seven days a week through a dedicated toll-free number, or internally through an eight-digit extension, and the SHD can and will operate according to MLTC requirements in Section IV.R.3.

Upon notification of an incident from any source (e.g. ITOC, internal or external (e.g. State) end users), our Service Help Desk staff responds with a well-defined ***incidence management process*** with the primary objective of managing and restoring unexpectedly disrupted or degraded services as soon as possible to minimize negative impacts or potential threats to scheduled availability. Our SHD staff are always available to respond and address an incident as quickly and efficiently as possible. The SHD classifies incidents by severity (SEV) incident level:

- **SEV 1:** If an incident is extremely serious, such as a significant network problem or a loss of service for one of our production applications, SHD responds immediately.
- **SEV 2:** If the incident involves a loss of service for portions of an application, or a specific group of users is impacted, we categorize this as a SEV 2 incident, but the SHD still responds immediately.
- **SEV 3:** These are incidents where application functionality or data is impacted, but users are able to do their jobs and workarounds can be used. Examples of a SEV3 incident are an issue identified within the MIS, but not impacting business processes or end users, or an interruption of service to a single user (e.g. single user can't access application even though application is available).
- **SEV 4:** These are incidents such as interruptions caused by a scheduled outage or an event such as a security request, access request, backup request, or how-to questions.

When an incident occurs, our On Call IT Support Resources (who can be reached by the SHD and/or ITOC) convene to begin troubleshooting the issue until it is resolved, and our designated system vendor support contacts are called in as necessary to assist. Once we resolve the incident, we document the root cause and solution into our ServiceNow system so that we can develop an action plan to eliminate such issues in the future, and/or use as a reference in future incident troubleshooting and analysis. ServiceNow is an ITIL standard collaborative workflow system for coordinating all aspects of MIS helpdesk support and change management. We also use ServiceNow for our change management process to ensure that IT software modifications are effectively managed with smooth change initiation results, in an auditable fashion. We never introduce changes into production without functional and regression testing, along with user acceptance testing and management sign-off (including MLTC for our Heritage Health program), and changes are put into production with mitigating roll-back plans. See Section 101 for additional information on our change management approach.

Documenting, Tracking, and Resolving System Related Issues and Recurring Problems

ServiceNow is also used by ITOC for monitoring and mitigation of any system related issues, as well as by our Service Help Desk (SHD) to record, manage, trend, and report on all questions and problems reported to the SHD. We also proactively review the SolarWinds Frequent Alerts Report from SolarWinds to help prevent an incident from re-occurring. ServiceNow's ability to index incidents using multiple criteria, in conjunction with its database design, allow us to quickly spot recurring issues, thus allowing us to ensure that recurring problems are rapidly identified and reported to NTC within one business day of recognition so that deficiencies can be corrected. In addition, we maintain a project management process, informed by our tiered SEV incident management approach, to conduct root cause analysis for recurring issues, including problems not specific to system unavailability, that are trending from ServiceNow reports.

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). (2 page limit)

Enterprise Capability. Nebraska Total Care (NTC's) parent, Centene Corporation (Centene) supplies our Management Information System (MIS) which processes eligibility/enrollment files and membership file reconciliations for 4.8 Million Americans for *publicly funded health programs* in 23 states.

Eligibility/Enrollment Database. Our MIS employs a Master Data Management and Service Oriented Architecture (SOA) design, in which each software component (eligibility/enrollment, claims processing, etc.) serves as the *system of record* for its "data subject area" and all core systems exchange transactional data via a middleware-enabled SOA data bus. In the case of eligibility/enrollment data, the *system of record* is our **Member Data Management (MDM)** eligibility/enrollment database. MDM supports all informational aspects of our member's relationship with NTC, such as member identifiers, contact information, special needs, member preferences, etc., along with a history of any change to each attribute. Similar in design to a Master Patient Index application, MDM uses a Medicaid Information Technology Architecture (MITA) informed design for collecting, aggregating, matching, consolidating, quality-assuring, persisting, and distributing the member data we receive from MLTC or the enrollment broker throughout our organization to ensure consistency and control in the maintenance of member data. Thanks to our Master Data Management/SOA design, our MIS uses a common key, the Master Member ID, systematically linked to the member's Medicaid ID as well as other identifiers (e.g. Social Security Number), to identify each member across all of the systems and populations under our span of control.

[redacted]

Completing Updates within Timeframes. Our Data Communications (DC) subsystem will handle our automated file exchanges with MLTC and the enrollment broker. We will work with MLTC and the enrollment broker and configure schedules in our DC subsystem so that our system will "know" when to expect daily and monthly transmissions of eligibility/enrollment files, and alert our EDI department if a file has not been received per plan, so that we can follow/up with designated contacts.

Data Transmission Protocols for Exchange Integrity. We support Secure FTP, but we can and do support all standard industry data communication protocols. Our network backbone is highly redundant through a mesh design that provides multiple paths to and from each point, allowing maximum network availability and enabling us to meet contract file exchange schedules. Our EDI subsystem can process HIPAA834 and the non-HIPAA Supplemental Enrollment and Unborn files (*per RFP Attachments 30 and 31)*, and our EDI subsystem can translate this data for populating/updating MDM. Our EDI subsystem supports a wide range of transmission acknowledgement protocols, including ASC X12 TA1 Interchange Acknowledgements and ASC X12 999 Functional Acknowledgements, as well as proprietary formats. We use these acknowledgements for exchanges with Trading Partners (such as MLTC) as a further control for assured delivery, data integrity, and record balancing.

Daily File Processing. Once we receive an eligibility/enrollment file, our job scheduling software manages membership data load processes. Inbound files are automatically processed through our EDIFECS system for HIPAA 5010 compliance validation. EDIFECS, in conjunction with our middleware, edits for duplicate member records, date criteria validity, field data integrity, and valid date

spans. Any membership records that trigger edits default into an Exception Report where they are systematically corrected using data correction routines prior to subsequent processing. Membership update records not on the Exception Report are then loaded into MDM through "Add, Delete, and Modify transactions" with accurate begin/end dates. Once member data records populate MDM, they are systematically promulgated to our other systems, including claims, care and utilization management, member and provider portals, data warehouse and analytics, and customer service systems, via our SOA data service bus mentioned above, using standards based middleware. Today, all of our integrated MIS systems (MDM, claims, etc.) are updated within 24 hours of receiving eligibility and enrollment files. Every 24 hours we send eligibility/enrollment updates to our affiliate subcontractors, including our Pharmacy Benefits Manager US Script, and our managed vision benefits subcontractor, OptiCare.

Identify Members across Populations and Systems. MDM's Unified Member View (UMV) capability gives us the automated ability to link an inbound member record with historic "eligibility spans" we may have on that member, (e.g. prior history as an NTC member, or in another affiliate health plan). UMV also enhances our ability to systematically identify duplicate records for a single member, and, thanks to the Master Data Management/SOA design of our MIS, upon confirmation of a duplicate record by MLTC, we can resolve the duplication so that the enrollment, service utilization, and member interaction histories of the duplicate records are linked or merged. UMV validates member address and contact information, through integrated address standardization from ***SmartyStreets***; and uses the Identity Verification & Authentication data services from ***LexisNexis***®, enhancing the accuracy of member data we house. However, we will never overwrite eligibility information we receive from MLTC or the enrollment broker but rather store alternate contact information as a complementary attribute of the data we store in MDM. Similarly, if a member, their caregiver, or provider gives us updated member contact information, we will capture that data in MDM without overwriting the member information sent to us via the eligibility/enrollment process. We will transmit to MLTC, in a format and method specified by MLTC, member address and/or telephone number changes we identify in any of the above processes.

Monitoring, Tracking and Resolving Discrepancies. As outlined above, we load eligibility/enrollment files in a two phase process. In the "pre-load" EDIFECS process, the file is run through a validation routine, so that our NTC Eligibility Specialists (ES) can review a report and ensure a) overall member counts are as expected, b) action types (number of adds, term and changes) are as expected, c) any errors or warnings are resolved. If the ES cannot resolve any identified errors, we will notify MLTC or the enrollment broker (depending on agreed to protocol) immediately of the errors that would prevent NTC from proceeding to the next step (final load to production MDM). The ES will then initiate the production load and review a load report to ensure that all members were successfully loaded into MDM. The ES will resolve any errors or warnings (e.g. potential duplicate) until there are no load errors or warnings, and contact either MLTC or enrollment broker (as above) if there are unresolvable issues. We also track load errors over time to spot any regularly recurring errors and use this information to identify potential issues and (if needed) work with the sender (in this case MLTC or the enrollment broker) to resolve the issue.

Resolving Discrepancies Between Eligibility Files and Internal Membership Records. We will configure our MIS specifically for reconciliation of eligibility/enrollment data from MLTC and the enrollment broker as compared to our membership records. NTC will conduct weekly reconciliations of the daily enrollment/disenrollment activity against our records, and we will notify the enrollment broker of any discrepancies found within the data on the file within 10 calendar days via written notification. We will also use MLTC's 820 file each month to reconcile the member level information in the 820 detail premium remittance data with our membership records in MDM, and we will then address any discrepancies via an Exception Report with MLTC (or as otherwise directed by MLTC). Our MIS supports very similar reconciliation processes in many of the 20 states where our affiliates administer Managed Medicaid programs. NTC will also work with the enrollment broker and MLTC to reconcile enrollment and disenrollment issues at the end of each month, using an agreed upon written procedure.

(3 page limit)
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.

Comprehensive Security Program in Place Today

Nebraska Total Care (NTC) will administer MLTC's Heritage Health program on an enterprise Management Information System (MIS) operated by our parent, the Centene Corporation (Centene). Through a regularly audited *Security Program*, we employ administrative, technical, and physical controls to ensure that Protected Health Information (PHI) creation, storage, update, and exchange processes safeguard the confidentiality, integrity and availability of PHI and follow all best-practice security standards. We will provide access to MLTC to our data processing facilities upon request, and make system information available to authorized representatives of MLTC, State or Federal agencies to evaluate, the quality, appropriateness, and timeliness of services we perform.

Information Security Management Functions

Security Program Governance. NTC and Centene will oversee our *Security Program*, under the supervision of the Centene Chief Information Security Officer (CISO), NTC Compliance Director, General Counsel, and our IT Security Management Committee. Our CISO holds Certified Information Systems Security Professional (CISSP) and Certified Secure Software Lifecycle Professional (CSSLP) designations and is an Adjunct Professor for the Masters of Cyber Security Management graduate program at Washington University. Under this leadership we employ policies, controls, and monitoring tools for compliance to security standards for information exchange, system access management, and appropriate information accessibility, including all requirements in Section IV.R.9 of the RFP. We perform regular, formal security risk assessments, and we will communicate results of our most recent assessment to MLTC prior to operational start date.

Information Exchange. We support HIPAA compliant encryption technologies to protect information when exchanged outside our span of control. As our Centene affiliates do with their state Medicaid Agencies, we can enforce automatic encryption of all e-mails between NTC and MLTC using Transport Layer Security (TLS), a protocol designed to prevent eavesdropping, tampering, and message forgery as well as endpoint authentication and communications privacy. We use Websense data loss prevention (DLP) tools to control PHI data usage through automated content analysis for identifying PHI in structured and unstructured files and documents, and monitor data in motion as well as at rest. These DLP capabilities enable us to identify and prevent potential HIPAA violations by preventing unauthorized transmission or access of data such as Social Security Numbers, medical account numbers, etc. We support Secure FTP (SFTP) for file exchanges to/from NTC and will also support two-factor authentication and the use of Virtual Private Networks (VPN) for remote user access to our MIS. Through the use of Access Control Lists (ACL), Demilitarized Zones (DMZ), firewall rules, and a security domain "enclave" approach to sub-networks, we prohibit access to our internal MIS applications over the internet.

Enhancing Protection of Sensitive Data. Today, all data in motion is fully encrypted by our use of industry standard and HIPAA compliant technologies, including SFTP, Secure Sockets Layer (SSL), Transport Layer Security (TLS), Virtual Private Networks (VPN) and other forms of secure information exchange, including those using Public Key Infrastructure (PKI) technologies. Our IT Security department is proactive in monitoring for malware, threats, and vulnerabilities. For example, we eliminated any exposures to the HeartBleed SSL vulnerability within days of announcement of that threat in 2014. We continue to update, expand, and harden our security infrastructure, particularly in light of recent highly publicized security breaches within both the Commercial and Government sectors. For example, we are implementing in 2016 additional best-practice data encryption strategies. Similar advanced strategies have been successfully used across the US financial sector and generally for other large scale enterprises handling sensitive information. Unstructured data such as e-mail and documents containing sensitive information (including ePHI) will be protected by our *Digital Rights Management* (DRM) technology which ensures that transmitted reports, documents, spreadsheets, text files, etc.

containing ePHI are only accessible by the intended recipient and cannot be forwarded to or shared with any unauthorized recipients. Sensitive data in our entire MIS will be further protected through the use of a sophisticated *tokenization strategy*, which protects *data at rest* while ensuring it remains available for authorized users.

Access Restrictions for Hierarchical Functions

Through administrative, technical, and physical controls, our Security Program helps assure that all user systems access to our systems and information is appropriate for member service and care, and follows the HIPAA Minimum Necessary Requirement for information accessibility on a "least privilege basis".

Role Based Access Control. We implement Role-Based Access Control (RBAC) for all applications that process PHI. RBAC addresses security risks by defining employee access rights based on the employee's job responsibilities, including whether that employee has access rights to update information or view only. We use our RBAC controls to also enforce hierarchical responsibilities that reflect our organization. For example, a Care Management Supervisor may see information related to his subordinates, but those subordinates may not see all the information accessible by the Supervisor. For all applications, individuals responsible for granting access do not themselves have rights to perform transactions within those applications (e.g. the security administrator who manages login profiles to our claims system cannot himself process claims). Individual security change requests are recorded through a documented security authorization and implementation process. We will seek approval from MLTC for any staff we seek to grant access to all MIS functions and NTC data.

Our access management controls automatically "lock out" users attempting to access PHI bearing applications after three unsuccessful attempts.

Audit Trails: Auditing Systems Access and Usage

Our IT administrators check system log files to help identify any unauthorized login attempts. We use *Tenable Security Center* to record the regular certification by our managers of appropriate subordinate access to systems. Our IT Security staff use *Spector* software for Data Loss Prevention (DLP) and audit the appropriate use by personnel of systems, email, and the Internet. Access to critical applications, databases and operating systems are reviewed by system owners on a periodic basis to ensure that employees have access to resources they need for their jobs. We use our *LogRhythm* security intelligence and analytics system to maintain full audit logs and associated transaction reports on user login activity, records viewed/edited/deleted, as well as the movement of data files from source to processed results. Our LogRhythm system, in conjunction with our relational database logs and journals, allow us to track user access, trace data from final place of recording to source data file, and comply with all functions enumerated in Section IV.R.9.d of the RFP. We maintain our audit logs online for two years, and (if not online) logs can be retrieved within 48 hours.

Information Integrity

There are four general sets of controls we use to ensure information integrity: secure access controls to ensure that only authorized users are entering data appropriate to their "role" (discussed above), edits for online entry and update of information, file exchange protocols with assured delivery controls, and a Master Data Management / Service Oriented Architecture (MDM/SOA) design for the control of application to application data exchange within our MIS. We will jointly develop with MLTC a process and methodology for periodic spot audits of our data integrity controls.

Data Entry Field Level Edits. All of our applications - including those on the web, enforce an appropriate degree of field level edits - ranging from simple alphanumeric formats (e.g. HIPAA standard lengths for name fields), to more sophisticated edits (NPI check digit validation), to (wherever possible) the use of drop down lists to prompt valid field data choices, to situational field logical checks (e.g. if user enters a value in one field, this drives the mandatory entry of data in another field).

Data and File Communication Controls. Our data communications controls and supporting systems allow us to send and receive formatted data (including HIPAA and HL7 transactions, and state proprietary formats) using audit controls at the file and data level. At the file level, we use automated scheduling software to monitor if inbound and outbound files are being received and transmitted per configured

schedule and to alert us if files are not being exchanged per schedule. At the data level, we use EDI standard TA1 Interchange and 999 Functional Acknowledgements, as well as balance reports and state proprietary formatted reports to assure that we systematically account for records sent and received.

MDM/SOA Design. Our MIS design is informed by Medicaid Information Technology Architecture (MITA) principles, where each core system (eligibility/enrollment, provider data, customer service, care and utilization management, member/provider portals, and data warehouse/reporting) is integrated with each other via an SOA data bus, using standard middleware interfaces. Each core system (eligibility/enrollment, etc.) is also the "master" of specifically designated data using MDM governance and controls. For example, our Member Data Management system is the master ("system of record") for member demographic and identifier information, our Provider Relationship Management system is the master of provider identifiers/demographic/affiliation information, our Claims Processing system is the master of claims adjudication and payment information, etc. The combination of SOA & MDM principles allows us to enforce specific data integrity controls within the appropriate system of record while allowing each application to interface with each other via our message oriented middleware architecture supporting service calls, automated Extract / Load / Transport (ETL) processes, database interfaces such as Open Database Connect (ODBC), and Change Data Capture (CDC) processes, whichever interface is appropriate for the specific interface. Once data is received into our MIS, it is not logically duplicated, and only the system of record can alter that data - an approach that assures the highest possible level of integrity for downstream reporting and information support. In addition, in our MDM design, no finalized records can be altered, and we maintain change history on records for a variety of uses (e.g. research on claims, audit, historical analyses).

Physical Safeguards

NTC's MIS is housed in two enterprise datacenter facilities, both wholly owned by Centene, which house NTC data and voice communications systems and are securely connected to NTC via our internal Wide Area Network (WAN). Both datacenters feature advanced environmental controls, including automated fire detection, alert, and retardant systems, which alert our IT staff on a 24 by 7 basis. As will be the case with all NYC offices, each datacenter is secured via proximity card access on all external doors, elevators, and the internal entry doors on each floor. Security guards at our datacenters require that all visitors sign in and out at the front desk, utilize a temporary badge, and are accompanied by an employee when visiting. We also use digital security cameras, multiple security guards who are on duty at all times, and panic switches installed at each reception desk. Our card key system records all access attempts/card swipes whether successful or not. When requested, we will provide escorted access to our datacenter for authorized MLTC staff.

Additional Security Safeguards Ensure HIPAA Compliant Systems Access

In addition to above, we comply with HIPAA's Security Rule via a *comprehensive* set of safeguards. We cite only a few examples in ***Table Q105***, to offer perspective on the scope of our controls:

Table Q105: ADDITIONAL EXAMPLES OF SAFEGUARDS WE EMPLOY
Password changes enforced every 45 days. Our system **enforces password length** and **complexity** minimums.
Inactive PC's are automatically **locked**. Our Security Event Monitoring software **tracks failed** and **successful logins**.
We have **anti-virus software** and host-based **intrusion software** on both PCs and servers for malware protection.
Security Risk Assessments updated quarterly; all subcontractors have **HITECH Business Associate Agreements**.
Desktop **PC's** are **diskless**; **Laptop** hard drives are **encrypted**. **Mobile** devices systematically **tracked/monitored**.
Desktop machines are **physically locked**. Users **attach laptops** to desk with **cable locks**, or **lock** in **filing cabinets**.
Movement and disposal of **all PCs** and **mobile devices tracked** through our **Asset Management System**.
Intrusion Prevention Systems (IPS) for advanced **network monitoring** and **defense**. IT Security staff are automatically alerted to IPS events and follow industry best practice incident response procedures.
Vulnerability management system continuously assesses our **MIS** against a library of existing and new exploits. Risks are addressed using approaches such as firewall rules, administrative controls, and other safeguards.

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: (3 page limit, excluding sample plan)

Integrated Approach to Planning. Nebraska Total Care's (NTC's) parent, Centene Corporation (Centene), works in conjunction with each of our affiliates (including NTC) to deploy an *integrated* Business Continuity Plan (BCP) encompassing contingency planning, emergency response, continuity of operations, and disaster recovery that is formulated, refreshed and tested at least annually in conjunction with Centene's Business Continuity Department (BCD). Our HIPAA compliant BCP covers NTC offices, backup sites, Centene datacenter facilities, and our affiliate subcontractor offices serving NTC. The BCD includes a full time staff of five, including three Certified Business Continuity Professionals (a designation from the *Disaster Recovery Institute International*), who use their combined 52 years' experience in emergency response to support NTC in maintaining and testing our BCP.

Actionable Plans with Clear Focus. Our BCP minimizes the number of ad hoc decisions that must be made during any incident threatening normal operations, as well as limiting dependence on any one single person. Through an anticipatory approach, we reduce the need to develop new procedures once the emergency has occurred. The BCP's clear protocols minimize any exposure to errors, omissions and unnecessary duplication of effort. The overall result is the quickest response possible to an emergency event, implementation of emergency mode operations, and restoration to normal business operations.

- ***Operational and system redundancy in place to reduce the risk of down-time***

Redundant Infrastructure. Our voice and data information technology (IT) architecture is engineered for high availability and real time telephone system recovery. It is centered on two mutually redundant enterprise datacenter installations, both wholly owned and controlled by Centene, which operate in a "hot backup" contingency mode for critical business functions. Both facilities employ redundant environmental, power, and networking systems, and backup capability. A site-disabling event in our primary datacenter, in which the datacenter was destroyed or damaged, would immediately result in the redirection of critical voice and networking processes to the secondary datacenter.

Management Information System (MIS) Engineered for Availability. Our MIS makes extensive use of redundant hardware, software, and networking technologies such as virtualized servers, database clustering, data and storage replication, network services from multiple, independent vendors, disk mirroring, backup power, and other controls. These safeguards prepare us for scenarios such as system outages that could compromise transaction and/or data integrity in a live or archival system as well as other interruptions not threatening to transaction or data integrity, but that could limit access to our MIS.

- ***System and operational back-up sites.***

System back-up. As mentioned above, our dual datacenter strategy, where either datacenter can take on the full system processing load of our enterprise, offers us full redundancy for back-up site processing. In addition, and in compliance with RFP Section IV.R.12, Centene will perform backups nightly on all NTC data using IBM Tivoli Storage Manager, an automated hierarchical storage management system that we also use for data recovery operations if needed. All our production software applications and data are backed up daily to an off-site storage facility provided by our HIPAA compliant vendor: *Recall Data Protection Services* (Recall). Centene stores this data offsite as an additional safeguard, supplementing near real-time data replication between our datacenters to ensure availability. In the event of a site-disabling event in either of our datacenters, we can recover data and operate production systems from the data tapes stored off-site in fireproof data vaults. Access to these tapes is restricted to individuals authorized by Centene management. Data recoverability from these tapes is tested regularly by fulfilling restore requests. We will provide MLTC with a list of all back-up files we store at Recall and the frequency of which these files are updated.

Operational Back-up Sites. Through our network of geographically dispersed *Regional Service Centers*, multiple claims processing offices, sister company offices, and our mobile temporary work location logistics partner, *Agility Recovery Solutions*, (Agility) we are able to rapidly react to work location

disruptions. Our redundant telephone networking and automated call rollover capability ensures smooth continuity of telephone service for our members and providers.

- ***Contingency and recovery planning including resumption of operations.***

Contingency Plans for Essential Business Functions. *NTC Office Closed or Incapacitated.* If there is a phone or data network outage, and/or if the office needs to be closed (e.g. weather conditions), inbound calls can be re-routed to staff trained to serve NTC callers including an alternative NTC location or one of our RSCs, as needed. If the community itself is inaccessible (e.g. flood, snow), trained staff at our RSCs, augmented by staff at our sister companies if needed, can continue serving calls until NTC staff can access temporary work areas supplied by Agility. NTC would continue to operate out of Agility supplied temporary offices until permanent facilities are re-established.

Our Mobile Workplace Business Continuity Partner ***Agility*** *has earned the exclusive endorsement of the American Hospital Association for its disaster recovery solutions.*

Datacenter Closed or Incapacitated. If a site-disabling event occurs at either of our two datacenters, the alternate datacenter can assume critical voice network operations and resume critical business systems (eligibility, care management, claims, website and portals) within 24 to 36 hours. In terms of disaster recovery, our dual datacenter approach allows us to maintain a Recovery Time Objective (RTO) for system restoration of 36 to 48 hours after disaster declaration (that is: a return to normal operations and conclusion of emergency mode operations). Our Recovery Point Objective (RPO) for data restoration is one workday (24 hours), an objective that is eminently practical in many scenarios thanks to our real time data replication between our two datacenters.

Claims Processing Center Outage. Centene supports NTC's claims operations from Centene owned processing centers in Missouri, Montana, Arkansas, and Texas. The centers are securely networked for voice and data connectivity with both datacenters, as well as NTC offices, and the RSCs. Our automated claims workflow system can instantly route NTC claims workload amongst these centers, with staff to handle NTC claims. In addition, as part of our BCP, all of our claims centers have a program for quickly training additional staff if needed to process NTC claims.

NTC's pharmacy claims will be processed by US Script, NTC's affiliate and Prescription Benefit Manager (PBM). US Script's claims system is housed in the same two datacenters as NTC's claims systems, and capitalizes on the same contingency planning infrastructure.

Pandemic Planning. Our approach to an infectious disease epidemic, or pandemic event, calls for a *unique* approach in contingency planning. Thus, we developed the *Pandemic Operations Plan* component of our BCP based on protocols established by the World Health Organization (WHO), the Centers for Disease Control (CDC), and the National Institute for Standards and Technology (NIST).

- ***Prioritized business functions for resumption of operations and responsible key personnel.***

We support continuous operations for frontline member and provider facing employees supporting member and provider services and care management functions through Agility. In the event the NTC community *itself* is inaccessible (e.g. regional disaster), recovery services would be initiated at alternate NTC locations or other NTC sister companies. Additionally, our two complementary Regional Service Centers (RSC) in Atlanta, Georgia and Tucson, Arizona are prepared to take NTC calls in the event that all NTC locations are closed due to an emergency. Any combination of these recovery options may be utilized in a crisis situation as needed.

- ***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.***

NTC employees will be trained in the use of our BCP as part of their employee orientation, under the oversight of our Human Resources Manager and Compliance Director, with the support of the BCD. The BCD ensures that ongoing training is also available, on demand, through Cornerstone Learning, our online training system. In addition, the BCD and NTC will conduct annual disaster drills for BCP testing and re-training of all NTC management staff, including training on the assigned roles and responsibilities

of key personnel (see discussion below on testing). During these exercises, the BCD highlights any recent updates to the BCP. We also review our BCP with key suppliers, and ensure that we have contacts and protocols with those suppliers for coordination if and when our BCP is invoked. Key suppliers are included as needed in our annual data center DR exercises. Although our BCP defines roles and responsibilities anticipating that communications may be unavailable, we mitigate the risk of communication outages through the use of our externally hosted *Send Word Now Emergency Notification Service* to communicate instantly to employees and subcontractors no matter what happens to traditional communications systems.

- ***Approach to provider preparedness for continuity of member care and assurance of payment for services rendered in good faith.***

As part of overall preparedness for care continuity, our approach is to communicate to our Nebraska providers that we will suspend the need for prior authorization requests during an emergency where providers are unable to reach NTC for an extended period and when, acting in good faith, providers need to deliver services to our members. This policy will also be documented in our Provider Manual. In addition, and if necessary given the emergency/disaster, we will issue block payments to providers based on a six month history of claim and/or capitated payments. We will include a letter with these payments that we require claim support for all services rendered during the disaster, and that we may recoup any payments not substantiated with claims. We will educate providers about our Provider Portal, which has important information on members. This data is housed securely in our datacenters so that in the event of an emergency, providers can access this information as long as an internet connection is available.

- ***Testing approach and regular schedule to improve and update the plan over time.***

As is current policy with all Centene health plans, NTC, Centene and NTC's affiliate subcontractors will test our BCP annually and whenever there have been substantial changes to the BCP. Annual tests of our data recovery capabilities simulate the disabling of our primary data center. As part of this test, we perform a Disaster Recovery Exercise (DR Exercise). The last DR Exercise was conducted successfully in June, 2015. We also perform "scenario specific" tests throughout the year, including testing the restoration of IT operations and data recovery, as well as our ability to restore local operations.

Centene health plans have successfully implemented their BCP an average of 60 times a year since 2012 to address events such as winter storms, floods, and power outages. In each case, the BCP ensured employee safety and minimal impact on members & providers

NTC Disaster Recovery Review. Under the guidance of our BCP team, NTC offices will participate in annual desktop scenario business continuity exercises to further prepare for unforeseen events that might impact the ability of NTC staff to work from their offices. Our program focuses on engaging management and employees in planning, as well as training, on pre-assigned responsibilities in emergency conditions. BCP changes are made based on exercise results to ensure the plan reflects the ideal response to an event. Crisis events, which include man-made, natural events or epidemic events, are used for annual scenario-based exercises. Examples of exercises that have been conducted include flood, fire, hurricane, pandemic, terrorism, *severe winter weather, and workplace violence incidents.*

A Thoroughly Documented Plan. Copies of BCP's are available on our Intranet and through an externally hosted web site supported by our Business Continuity Service partner, *SunGard Recovery Services* (SunGard). SunGard provides our Business Continuity Software tool Living Disaster Recovery Planning Software in which we house pertinent business continuity information in a common repository. Each member of the response team and department managers must keep a hard copy of the respective area's BCP offsite to ensure accessibility, regardless of the particular emergency situation. Please see ***Attachment Q106: Nebraska Total Care BCP Document Components***, which summarizes our BCP document components with a brief description of each. We will submit a final contingency plan to MLTC for review and approval no later than 45 calendar days before the contract start date.

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IV.R ATTACHMENTS

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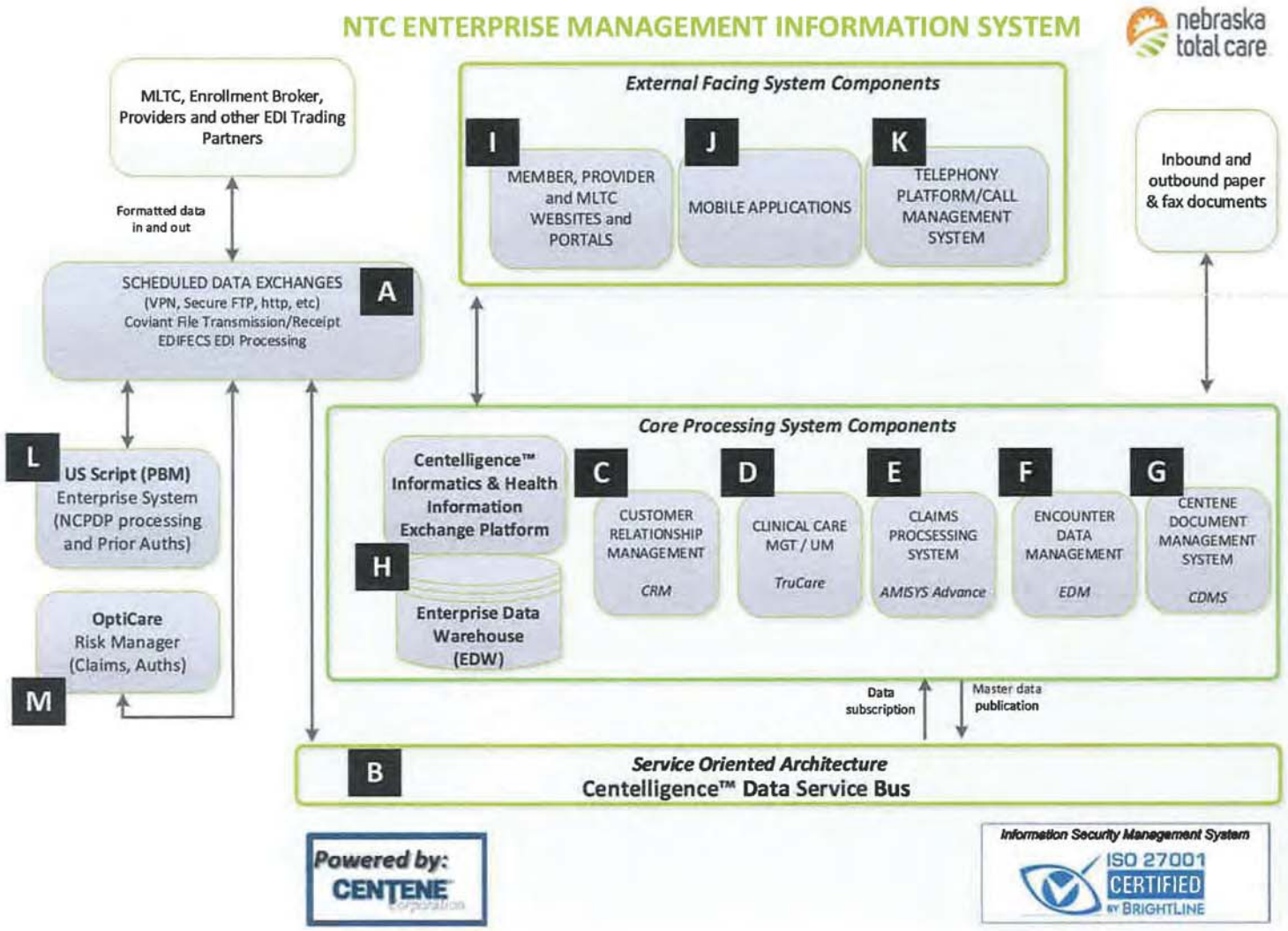
Attachment
101 Systems Diagram

Attachment Q101: Systems Diagram



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Attachment
103 Samples of Availability Reports

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Attachment 103 Samples of Availability Reports

A. System Availability Dashboard: NTC can view Availability of all our operating systems.

B. Application and System Performance Dashboard: NTC can also view application and system performance as it relates to the user experience.

Application Performance Report

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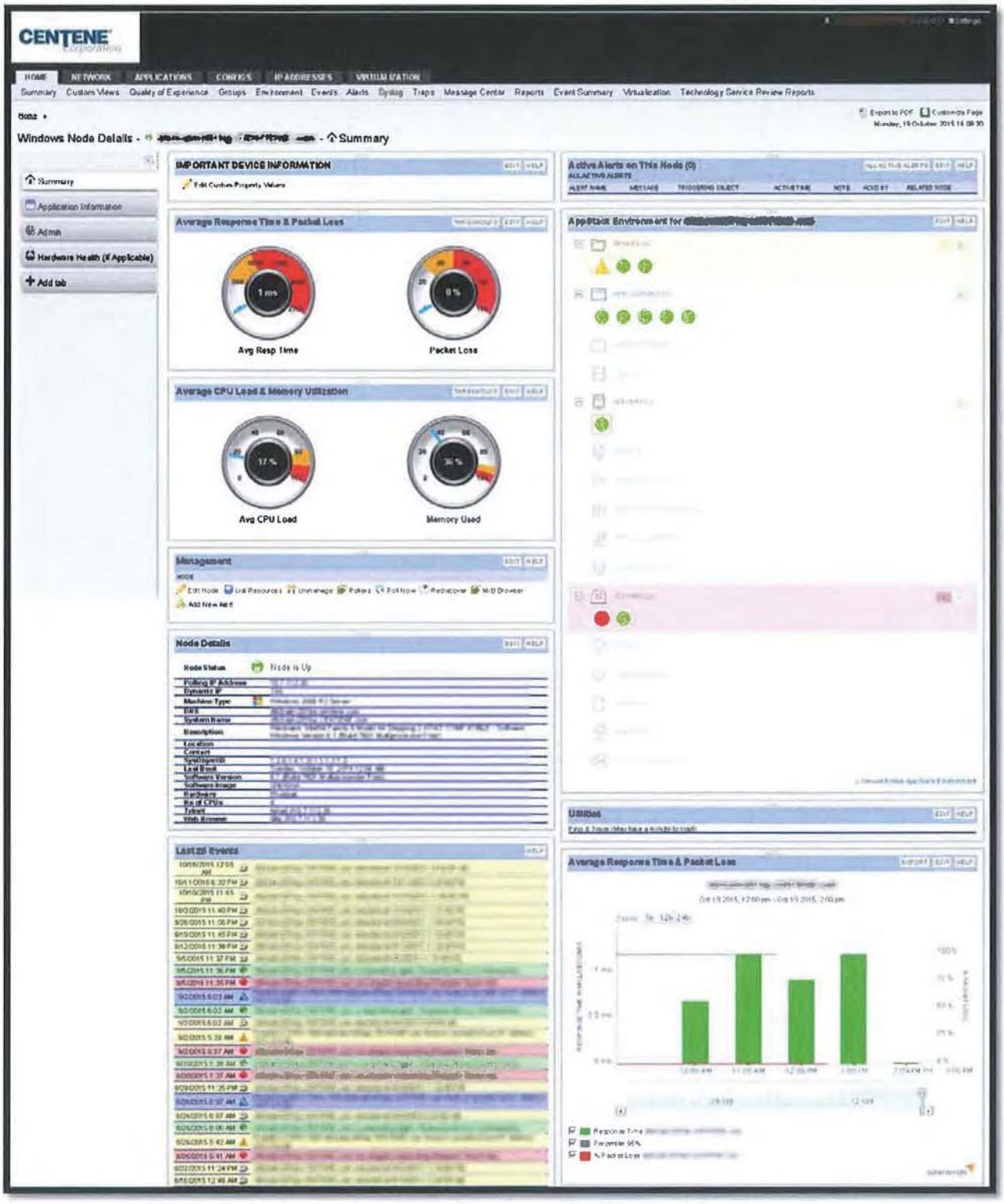
Attachment 103.A: Samples of Availability Reports

Systems Performance Report



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Attachment 103.A: Samples of Availability Reports

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Attachment
106 Business Continuity Plan

Nebraska Total Care BCP Document Components

BCP Documentation Categories	Description
Nebraska Total Care Health Plan Management Team/Emergency Response Procedures	Details on considerations, assignments, and tasks necessary for the Nebraska Total Care Management Team to declare, respond, manage, and recover from an incident following any unplanned disruption or systems interruption at a Nebraska Total Care location. The plan details the relationship, roles, and responsibilities for Nebraska Total Care working with Centene's Crisis Management Team (CMT). The CMT is a multi-disciplinary team of BC Department, Information and other Centene departments (Facilities, Security, etc.) and NTC staff that orchestrates quick, accurate, yet coordinated communications during emergency events or when normal systems are not available. The CMT uses internally dedicated phone lines or, if necessary, our externally hosted Send Word Now Emergency Notification Service to communicate instantly to employees no matter the status of normal communication systems.
Centene Corporate Crisis Management Plan/ Emergency Response Procedures	Covers the who, what, when, where, and how with respect to an organized and consolidated approach for response and recovery activities at our corporate location following an unplanned incident or systems interruption to data or telecommunications.
Business Unit Continuity Plans	A Business Unit includes Centene Departments supporting Nebraska Total Care (e.g. Centene Claims Centers supporting Nebraska Total Care). The Business Unit recovery plans detail the specific steps to be taken by the Business Unit teams after an incident has been declared. Plans detail the processes, tasks, contacts, vital records, workspace requirements, and alternate work locations needed.
Disaster / System Recovery Plan	This Plan component of our BCP outlines proactive mitigation through a highly available architecture; procedures and prioritization to recover Information Technology infrastructure, data, systems, services, and tools needed by Nebraska Total Care and its members and providers in the event of an incident impacting IT resources, including relocation or repair of physical site and equipment to our secondary datacenter, and an annual Disaster Recovery test and test evaluation.
Pandemic Operations Plan	Procedures to recover the business following a disruption due to an epidemic or pandemic affecting NTC and/or Centene & affiliates.
Employee Awareness & Training	Presentations to Nebraska Total Care and Centene new hires are available on our Intranet to educate employees about BCP at Nebraska Total Care, Centene and our sister companies. Annual BCP refresh including a plan walk-through and scenario exercises.

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IV.S Claims Management

IV.S Claims Management

(2 page limit)

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.

Experience in Successful Claim Processing Implementations

Nebraska Total Care (NTC), in conjunction with our parent, Centene Corporation (Centene), will ensure claim processing readiness at time of contract implementation through a strategy grounded in 30 years of Medicaid experience, and incorporating a best practice deployment of *staff, process*, and *technology* mobilized through a coordinated plan. We have reviewed the RFP, and associated Appendices and Addenda, including Sections IV.R, IV.S, IV.X, and NTC will support all RFP claim processing readiness, implementation, operational and reporting requirements. Centene affiliates continue to successfully support very similar requirements across 20 states where we have Medicaid plans today.

Staff with Implementation & Processing Expertise. Centene consolidates core Medicaid claims operations to realize efficiencies for fast processing turnaround times (TAT), ensure training consistency, and develop a critical mass of specialized Medicaid claims processing expertise. The staff in our claims operations division have an average of 12+ years of claims experience per processor, including extensive readiness and implementation experience – the latter a natural consequence of our successful implementation of Managed Medicaid in nine new states in less than the past four years. Our centralized approach also allows us to continually improve, and adapt to changing federal mandates by applying consistent best practices and lessons learned from all affiliates.

Training. We will ensure that all staff processing Heritage Health claims are current with their training, which will include topics for specific Nebraska Medicaid needs. Our claims training curriculum covers all aspects of processing, with specialized staff receiving up to 14 weeks of classroom and hands-on training. Along with claims processors assigned to NTC, NTC's Claims Administrator, Claims Analysts, Contract Implementation Manager, and Provider Claims Educator will undergo claims training appropriate to their respective job functions.

Process to Assure Readiness. Informed by 30 years' implementation experience, our Enterprise Business Implementation Model (EBIM) is a best practice framework for planning, organizing, communicating and mobilizing resources to ensure smooth, low risk, and on time program implementations. Our *claims* implementation team uses EBIM tools including; pre-populated templates; carefully defined checklists, configuration procedures, project communication (both internal and external) and more. EBIM allows for claims eligibility, benefit plan, adjudication rules, and other key readiness configuration and test activities. NTC's claims processing and system configuration implementation teams will be dedicated to the successful implementation and meet MLTC established goals (e.g. claims TAT requirements). Once NTC is live and performing according to MLTC standards, the claims implementation team will smoothly transition to our claims operations teams, with support from the NTC Claims Administrator, Claims Analyst and Contract Implementation Manager who will ensure that MLTC requirements are implemented correctly on an ongoing basis.

Technology for Claims Processing Success. Our MIS features table-driven, parameter-based configuration utilities that minimize, if not eliminate, the need for custom software development and its associated implementation risk - and yet meet the specific rules and processing needs of each of our state partners. This will allow our claims implementation team to configure our existing claims processing capabilities quickly and reliably for MLTC and our providers, and allow them to focus on detailed analysis, precise definition of business rules and MLTC-specific data edits, which represent *incremental* changes to processes, edits, and interfaces that we already support today.

Claims Submission, Processing, and Payment Configured to MLTC Requirements. Our claims processing system, AMISYS Advance (AMISYS), along with our HIPAA EDI infrastructure, and Claims Workflow Management system will be configured with the claims requirements and timeframes mandated by MLTC and Federal government regulations. AMISYS employs multiple, systematic data

edits to ensure claim processing accuracy and a high claim auto-adjudication rate. AMISYS delivers accurate claims payment, with configuration capabilities to price according to benefit coverage information, authorization requirements, fee schedules, per diem rates, capitation payments, and other complex pricing arrangements.

Pre-adjudication Edits. Our Management Information System (MIS) uses a Service Oriented Architecture (SOA) with middleware that maps, translates, and validates claims data against member and provider information data in our MIS prior to adjudication, ensuring common edits, such as member, billing and rendering provider identifiers are applied. If a transaction is rejected, our middleware issues an ANSI 277 Unsolicited notification citing the specific MLTC-approved reason(s) responsible. In the event a paper claim fails pre-adjudication edits, our middleware automatically generates and sends a letter to the submitting provider, rejecting the claim and citing the specific edit(s) responsible. NTC will monitor rejection reasons to identify potential problem areas for rapid response.

Claims Processing System. Once claims pass the above edits and validation routines, they are loaded into AMISYS for adjudication through a combination of edits examining diagnosis and procedure codes including HCPCS data, Medicaid Correct Coding Initiative edits, and use and validation of National Provider Indicator (NPI), state Medicaid Identifiers and Tax ID numbers for provider payment. Our ClaimsXten software reviews adjudicated claims prior *to payment* for bundling and unbundling of services, incidental services, mutually exclusive codes, global surgery follow-up days, duplicate claims, invalid procedures, bilateral services, and incorrect age/gender validation. AMISYS assigns each claim a unique control number incorporating the Julian time stamp upon receipt that allows us to monitor, audit, and trend claims processing metrics, including turnaround times and payment accuracy.

Configuration Testing. All configuration changes for the Heritage Health Program will go through a comprehensive testing process as part of our EBIM strategy. Changes are first configured in our development environment before being promoted to the testing environment for integrated and regression test. This enables us to anticipate significant processing scenarios prior to go-live. Issues are immediately communicated to the configuration team to be addressed. Once resolved, the configuration moves back to integrated testing. Upon successful completion of integrated testing, the configuration moves to user acceptance testing (UAT). In UAT, the tester will review the integrated testing results and run 'real life' scenarios through the system, and review results for accuracy before sign-off by NTC and MLTC and production. Our implementation schedule is designed so that *at least 30 days prior to go-live*, the claims operations and IT staff are able to jointly test hundreds of claim scenarios using test claims with MLTC "like data" or actual MLTC data if available. We conduct joint meetings which include staff from the claims implementation, contracting, configuration and provider data management implementation teams.

Provider Validation. We also will share configuration testing results with NTC providers to ensure reimbursement and denials are in line with expectations. Partnering with providers will help build confidence in the provider community that NTC is ready to process claims correctly and timely.

Our Ability to Monitor Continuous Improvement and Direct Rapid Response

Our Centelligence™ data warehouse and informatics platform is the heart of our data integration capabilities, capturing *transactional data in near real time* from core applications for subsequent analytics, aggregation and reporting. It enables an end-to-end view on claims processing, from the point of provider and member data loading, through service authorizations, claim submission, adjudication and payment, and encounters reporting. Through Centelligence™, we are readily equipped to identify, isolate, and rapidly respond to problem areas. Each department in this continuum has access to the same comprehensive database, with flexibility to customize each report from the vantage of their own "operational lens" in order to identify root causes and impacted functional areas upstream or downstream for efficient, effective resolution by the NTC Claims Team. NTC coordinates the expertise from each area, including analyses from our Claims Liaisons and Contract Implementation team, Encounter Business Operations, Finance, Compliance, Provider Relations, and subcontracted vendors to collaboratively provide creative, comprehensive, and innovative solutions with effective, accurate, and efficient claims processing for our provider network and MLTC.

(3 page limit)
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. "***

Audit Methodologies from Multiple Vantage Points. Nebraska Total Care (NTC) and our parent, Centene Corporation (Centene) will achieve high standards of payment accuracy through a combination of regular, formal quality reviews, independently performed internal and external audits, and best practice oversight and governance of our subcontractors. We can and will comply with all RFP requirements, including those in Section IV.S.9 and IV.S.13, and we will coordinate audits with MLTC as detailed in Section IV.S.13.c. and respond within the timeframes and in accordance with existing laws or regulations. Our Managed Medicaid affiliates comply with similar requirements across several of the states where Centene subsidiaries operate Managed Medicaid plans today.

We ensure accuracy & processing timeliness through our audits. For example, so far in 2015, we have paid 96% of clean claims sent to us electronically in 15 days, with an average turnaround time for these claims of less than 7 days.

Claims Audit Division (CAD). Centene's Internal Audit Department (IAD) is independent of our Claims Department and is led by a Chief Audit Executive (CAE) who functionally reports to the Audit Committee and Centene's Board of Directors; and administratively reports to Centene's Chairman, President and Chief Executive Officer (CEO). IAD includes a Claims Audit Division (CAD) that is responsible for providing an independent and objective evaluation of claims payment accuracy. CAD audits encompass claim entry, adjudication processes, as well as whether determinations on enrollment, benefit, and payment, are accurate. CAD reports audit results through regular status updates and claims quality dashboard reports which are posted to our secured internal intranet. On a monthly basis, we will submit claims payment accuracy percentage reports to MLTC. CAD's status as independent from NTC and the Claims Department, enables unbiased and objective evaluations.

Claim Sampling and Accuracy Audit. Our CAD staff will perform statistically valid audits based on a random sample from processed electronic and paper claims, to assess claims for processing, payment and financial accuracy, as well as compliance with contract obligations. On a weekly basis, CAD will audit a sample extract of finalized claims processed from initial claim submissions. Claims are stratified into provider and financial quartiles; this stratification allows us to isolate different systemic factors. We focus higher dollar quartiles and higher volume provider quartiles. When reviewing the claims sample, CAD staff review factors such as whether the claim was entered correctly, whether the claim was associated with the correct provider, whether proper authorization was obtained for the service (if required), and all other attributes described in RFP Section IV.S.9.d (duplicate payment checks, modifier code use, etc.). Our CAD staff will document the audit results for each attribute reviewed. When an error is found, we document the specific error reason and if applicable, dollar amount incorrectly processed for both over payments and underpayments. These errors will be communicated back to the responsible department. CAD will track the error through final resolution, documenting the reason for the error and the solution that was implemented to correct the error.

Quality Review Analysts, Claims Liaisons and Claims Implementation Analysts. In addition to the monthly Financial and Payment Accuracy Audit (above) conducted by CAD, the Claims Department Quality Review Analysts (QRA) conduct Staff Audits to evaluate the performance of all staff involved in claims processing *before and after* claims are paid. These include the following:

Targeted Audits to evaluate specific areas, including claims paid with high financial impacts, high rates of denials for individual Claim Processors, and key provider claims review.

Claims Staff Audits. Our approach to staff audits focus on determining if staff have successfully completed training; know their performance benchmarks; know how their job as a claims processor impacts the entire claim life cycle; and the role of CAD.
Claim Processor Accuracy. QRAs review all Mail Production Specialist tasks to confirm the accuracy of the claim form sort and scanning preparation for input into our Centene Document Management System.
Targeted Audits. QRAs conduct *targeted audits* to monitor a claim processor's accuracy, efficiency, and any systematic errors that could call for corrective action.
Audits on Every Claims Payment Cycle. In addition to our sample-based internal audits, NTC will monitor every weekly claims payment cycle. Each week NTC's Claims Team (comprised of Claims Analysts and Contract Implementation Analysts) will monitor payments about to be released.
External Audits. Centene undergoes two major annual external audits.
SOX Management Report on Internal Controls over Financial Reporting. Centene's management is responsible for establishing internal controls over financial reporting and supporting MIS controls, including those related to claims processing. Each year, management conducts evaluations of internal controls over financial reporting according to Sarbanes-Oxley Section 404 (SOX) regulations. Centene's assessment of the effectiveness of internal controls is also audited by Centene's external auditor.
SSAE 16 SOC 1 Type II. Centene's external auditors perform this annual audit for Centene to test controls related to Claims Processing and Data Center Operations and their operating effectiveness. In its most recent SOC 1 Type II report (2014), Centene received an unqualified opinion from our external auditors, indicating controls operated effectively with no significant deficiencies identified.
Subcontractor Audits. Our Quality Improvement Department monitors subcontractor performance (including encounter submissions) formally via quarterly Joint Operating Committee (JOC) operational reviews with each subcontractor. Subcontractor JOCs will include executive and operational staff from NTC, Centene and the subcontractor. The JOC monitors all functions delegated to the subcontractor. The JOC also helps facilitate health plan - subcontractor partnerships, encouraging operational efficiencies and delivering support to our subcontractors. We will submit a monthly claims payment accuracy report for claims processed by our subcontractors. The audit will review and report on the same attributes as those listed above. In addition, we perform an annual subcontractor delegation audit related to claims and encounter administration. Audits will be conducted using predetermined audit tools that incorporate contractual, NCQA, CMS, and MLTC requirements.
Audit Documentation. Audit reviews and any identified issues are documented in our Governance, Risk Management, and Compliance (GRC) system, Compliance 360. Compliance 360 allows NTC to systematically track compliance activities (with auditable records of management approval), and effectively administer and monitor our internal governance, as well as our contractual and regulatory oversight responsibilities. Compliance 360 also enables workflow routing per policy and procedure formulation (with history of documentation and sign offs), and allows ongoing, proactive assessment of compliance risk. Within Compliance 360 we are able to route issues or action items to the appropriate internal departments and subcontractors for follow up. We also track and monitor the status of corrective actions, following issues through to resolution.
Identifying and Enabling Correction Actions. All audit reports are reviewed by the coordinated expertise from our Claims Liaisons and Contract Implementation Analysts, Encounter Business Operations, Finance, Compliance, Provider Relations, and subcontractors to provide comprehensive and innovative solutions for ongoing effective, accurate, and efficient claims processing for our provider network. Upon identification of a potential systemic process deficiency, we employ tools such as Lean Six Sigma to determine root cause. Through cross-functional dialogue with all affected departments, we evaluate and recommend process improvement plans. Our reports, analyses, and committees are developed to drive actionable behavior, meaning once an issue is identified, we implement corrective methods to fix the root cause. The following are some of the corrective methods and tools we employ:
Provider Claims Scorecard Report. Claims processing is not a payer specific process, but a shared responsibility between both the payer and provider. To facilitate that shared responsibility, the Provider

Claims Scorecard Report is designed to deliver meaningful metrics directly to the provider. This front-line resource is available through the web, and is designed to optimize claims from point of care to claims submission. This report displays information to the provider on their claim submission patterns, to help guide them towards a more efficient process.

Provider 90 day Audits. Upon implementation, NTC will conduct claim audits for 90 days for all new providers to assist in identifying any configuration or billing issues. Early outreach and education promotes good relationships with providers and fosters long standing business relationships.

Education and Retraining. Claims processing issues related to claims staff performance or provider billing errors are typically remediated through education and retraining. QRAs communicate all staff deficiencies to the immediate Supervisor who establishes a retraining plan. After retraining, the QRA or Supervisor may implement a targeted audit to confirm that additional training or action is not warranted. QRAs will communicate all provider billing problems to NTC's Provider Services Department where outreach and education can be arranged and conducted by their Provider Relations Specialist (PRS).

Change Request (CR). If an audit finds that the error is due to configuration, our NTC Claims Liaison and our Configuration team will review the logic causing the error and will file a detailed CR to have the configuration changed. All CRs go through our standard, best practice change management regimen, with testing and validation that the correct outcome was achieved, followed by User Acceptance Testing (UAT). After successful UAT, the change is promoted to production.

EDI Claims Submission Analysis. Along with Centene's Electronic Data Interchange (EDI) Help Desk, the NTC Claims Team will identify providers who submit paper claims and encourage electronic submissions via our Provider Portal or EDI clearinghouses. NTC's Provider Relations staff will also evaluate top claim denial reasons and intervene with providers if billing patterns reveal potential errors.

Claims Xten® and HCI Reviews. Our Claims Xten® software and HCI claims review partner use industry standard edits based on nationally recognized guidelines, such as the National Correct Coding Initiative, for professional services. Centene will configure these rules in our Claims Xten® software for the specific coding, reimbursement policies, and benefit criteria for Health Heritage, and we will communicate any specific coding requirements to HCI for fraud, waste, and abuse detection. The NTC claims team will monitor the Claims Xten® and HCI activity through our Centelligence™ reporting and analytics platform to determine if a provider is consistently billing with unbundled, incidental or retired codes. If identified, the Provider Claims Educator will outreach to and educate the provider's office.

Addressing Provider Non Compliance. Our audit activities allow early identification of possible billing issues. When issues are identified, NTC staff will work with providers to educate them via new provider orientations; phone calls; and during onsite visits. If trend analysis identifies a provider who is failing to adhere to billing requirements, the Provider Services Representative will refer their findings to NTC's Provider Network Team for action. A PRS from the Provider Network Team will immediately contact the provider, provide education on contractual requirements, and offer the local NTC Claims Team, our EDI specialists or other department to conduct retraining. The NTC staff will document all activities and monitor subsequent performance. For continued billing issues, the Provider Network Team may refer the provider to the Credentialing Committee and Clinical Advisory Committee for additional action, including sanctions and possible consideration of continued network status. Should any NTC staff member suspect a provider of potentially fraudulent billing, they will immediately engage Centene's Special Investigations Unit (SIU) departments, which provides oversight and guidance for the prevention, detection, and resolution of billing misconduct including inappropriate billing and coding.

Subcontractors. Through the JOC, we will monitor our subcontractors to ensure that any material audit findings are addressed by the subcontractor with any of their staff or affected providers. The process of monitoring our subcontractors is facilitated by the fact that our two 'claims paying' subcontractors are also affiliates, and share the same communications and general IT infrastructure as does NTC.

(3 page limit)
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.***

Verifying Service Delivery through a Comprehensive Approach

Nebraska Total Care (NTC), through the use of on an enterprise Management Information System (MIS) operated for us by our parent Centene Corporation (Centene), and in conjunction with Centene's Payment Integrity Department, will implement best-practice processes, including member surveys (surveys), to verify services are provided to our members. We will administer these surveys in coordination with other, complementary controls to identify and act on instances of suspected Fraud, Waste, and Abuse (FWA).

Service Verification Surveys.

Proven EOB Survey Approach in Use Today. NTC will use a survey approach (customized per MLTC's specific requirements) based on the strategy employed by many of our affiliates operating Managed Medicaid programs today in 20 states, in which our affiliates randomly select a stratified sample of members on a monthly basis to receive an Explanation of Benefits (EOB) statement along with survey instructions to the member requesting service verification. Specifically, NTC's Member Services Department will send individual survey and EOB's via mail to a randomized sample of members to determine with statistical validity service delivery. Through our MIS we track which members have been sent surveys. The survey will request that the member validate the services listed on the EOB by calling the Member Call Center, including confirmation of:

- Description of the services provided
- Name of the provider furnishing the services
- Date of services
- Amount of payment made for the services

Sampling to Ensure Representative Provider and Claims Activity in Member Surveys.

NTC's random sampling methodology will assure that NTC member survey samples are proportionately reflective of all provider types and billed services of our overall member population so that we can monitor our entire program with statistical confidence. In a process very similar to our affiliates, NTC will randomly sample data from our Centelligence™ informatics platform to select a claims sample size no less than 2% of claims processed per month, of claims paid in the previous 45 calendar day period (as mandated by Federal regulation). NTC claims sampling will stratify the selection based on provider specialty, and the range of services provided, including random sampling of rare, high-cost services, claims from high-abuse categories (e.g. DME, radiology), etc., as well as a broad random sample across all claims. All claim types will be proportionally represented in the sample member survey pool, from the entire range of covered benefit services. As our affiliates do today, we enhance our claim sampling methodology based on lessons learned from each sampling cycle. Informed by the best practices of Centene's Payment Integrity Department and our affiliates, we will target and/or *over sample* as needed particular areas for surveys, such as members who are neighbors receiving the same service on the same day.

Sampling Software. We use RAT-STATs sampling software (also used by the US Department of Health & Human Services Office of Inspector General) to determine with a 95% confidence level (plus or minus 2.5%) that a statistically valid sample size is selected each month for each stratified level in the sample. We review sample sizes annually (at a minimum) to ensure our sampling strategy is reflective of the full member population, changing our sample sizes when necessary.

Acting on Survey Results. When members respond to our survey to tell us that they have not received the service(s) listed on the EOB, our Member Service Representatives (MSRs) capture that information in the Customer Relationship Management (CRM) component of our MIS and forward the information to the NTC Compliance Director (who has the role of NTC's Program Integrity Officer) for further review. Upon suspicion of fraud, we will forward suspected cases to MLTC within three business days after discovery by NTC. Our Compliance Director will also engage as necessary FWA investigative staff in our

Special Investigation Unit (SIU), part of our Payment Integrity Department. The SIU will conduct a preliminary investigation and, if needed, submit additional requests for member surveys via telephone. We will track responses from members and resolve identified issues through member and provider education.

Reporting Quarterly Results

Technology Powered Data Integration. In a process similar to what our affiliates do today, we will use the Centelligence™ reporting component of our MIS to produce quarterly Service Verification Detail and Summary Reports as outlined in Attachment 6 of the RFP. As noted above, we track which members have received surveys, and (through CRM), we track which members have notified us with concerns and/or complaints related to our survey and/or FWA, and this information comes together in our Centelligence™ system. Centelligence™ is our family of integrated data warehousing, decision support and health care reporting solutions. Centelligence™ provides expansive business intelligence support, including flexible desktop reporting and online dashboards with "drill down" capability.

Supporting MLTC's Quarterly Reporting Needs. NTC, through our Compliance Director (who serves as our Program Integrity Officer), will report monitoring activities per Attachment 6 on a quarterly basis to the Nebraska Medicaid Program Integrity Unit (NMPI), per RFP IV.O.10. Reports will include the total number of survey notices sent out to members, number of surveys completed, total number of services requested for validation, and number of services validated. Because we use CRM to manage all member complaints, we are also able to provide an analysis of interventions related to complaints or other service validation issues.

Additional and Complementary Methods to Detect FWA

Internal Fraud, Waste, and Abuse Activities. The NTC Director of Compliance or her designee, will inform MLTC of known or suspected cases of fraud, abuse, waste, neglect, and overpayment, that we detect via several ongoing processes:

Service Utilization Patterns. Our Medical Management Department will conduct quality control audits by reviewing various reports on a monthly basis. Examples of these reports include providers with a high number of referrals, providers delivering outdated treatment procedures, and member emergency room utilization.

Subcontractor Oversight. As is the standard practice of all our affiliate Medicaid plans in 20 states nationwide, NTC will require all subcontractors to have comprehensive FWA detection programs in compliance with the Heritage Health contract. Each subcontractor will be required to report any suspected FWA to the NTC Compliance Director, who will include these subcontractor cases in her regular reporting to MLTC and the Nebraska Medicaid Payment Integrity unit (NMPI).

FWA Investigative Staff. The NTC Compliance Director will be backed by the Centene Special Investigations Unit (SIU), which includes associates with a judicious mix of multi-disciplinary backgrounds needed for a comprehensive approach to identifying and pursuing instances of Fraud, Waste and Abuse (FWA) in health care programs. Our SIU includes staff who are RNs, certified coders, pharmacy technicians, Accredited Health Care Fraud Investigators (AHFIs), an attorney, former police officer, Certified Fraud Examiner (CFE) and former Medicaid Fraud Control Unit (MFCU) associates. If SIU investigators identify suspected fraud, the information will be immediately shared with the NTC Director of Compliance who subsequently will report the case to the MLTC. NTC will be supported with FWA investigative staff resourced per RFP IV.d.3.i.

MIS to Support Service Verification. In addition to the roles that CRM, Centelligence™, and RAT-STATS plays in verifying services, we use several other integrated tools to further supplement our service validation strategy and our overall approach to FWA identification and prevention.

ClaimsXten® (CXT). We use CXT prepayment auditing software to review outpatient facility and physician claims that have been adjudicated but not yet paid. CXT is integrated for real time processing with our AMISYS Advance claims system, and determines clinical appropriateness of claim coding. CXT plays a role in identifying claims for services whose actual delivery is questionable by applying clinical edits: for example procedures relevant to females only but billed for males, or age-inappropriate

procedures, etc. CXT contains a comprehensive set of rules based on nationally recognized coding guidelines, which address coding inaccuracies such as unbundling, fragmentation, upcoding, duplication, over-utilization standards, invalid codes, and mutually exclusive procedures. CXT ensures claims are in compliance with national coding guidelines published by CMS, the American Medical Association and various specialty organizations (i.e., CMS' National Correct Coding Initiative), and can identify potentially abusive claim coding practices, along with over-utilized or wasteful services.

Fraud Finder Pro (FFP)® In addition to CXT, we use FFP prepayment review software and services from Health Care Insight (HCI, a unit of Verisk Health, Inc.), a leading specialist in FWA detection through claim and clinical analytics. Among other FWA detection capabilities, FFP helps us identify claims where actual service delivery may be in question. FFP identifies various billing behaviors, billing patterns, known schemes as well as new and emerging billing patterns by taking into consideration a provider's prior billing history in addition to claims contained in each subsequent daily, weekly or monthly batch claim submission from providers. FFP statistically identifies what is expected based on prior claims history as well as billing norms, including recognition of pattern changes from those identified in profiled historical paid claims data and ongoing daily claims batches. One to two years of claims data is utilized to gather statistical baselines to determine expected billing behaviors, as well as score providers of the same specialty. If a score deviates significantly from the appropriate norm, the provider is placed on a list for further review by Verisk Health's Clinical Investigators. Once Verisk Health's review is completed, Centene's SIU will validate the finding, determine the appropriate course of action, and seek NTC's approval.

Physician Claim Insight (PCI)®***:*** This additional Verisk Health prepayment review software complements CXT (above) with supplementary analytic claim edits that protect NTC from unnecessary expenditures resulting from fraudulent, abusive and wasteful claims. PCI focuses on individual member and provider prior patterns and compares each submitted claim service line to the existing claims history of each member and the provider's previous billing history. Inappropriate or unusual billing patterns detected by the program are then clinically reviewed by skilled nurses and claim coding analysts to evaluate the validity of any reported anomalies.

EDIWatch: We use EDIWatch software for *post payment* claims monitoring to help us identify potentially fraudulent cases for further investigation. EDIWatch provides quick analysis of suspicious claims and edits used to identify outliers, such as mutually exclusive codes billed together, ambulance up-coding, add-on codes without primary CPT codes being billed, and non-emergency procedures that are billed on Sundays or holidays. Furthermore, EDIWatch flags instances when procedures are billed on separate claims, that if billed on one claim, the subcode would have been denied as a component of the primary code. In addition to known fraud schemes, EDIWatch utilizes both CMS and American Medical Association (AMA) guidelines for these edits.

Enterprise Data Warehouse (EDW): Our SIU analysts create ad-hoc reports using information from this data warehouse, which stores payment, provider, member, claims, and other insurance information. The reports are utilized to analyze providers' billing habits and determine outliers of suspected FWA activities. We use this tool to develop reports that help identify members engaged in "doctor shopping" activities as well as frequent users of emergency rooms.

NTC will require that all its providers and subcontractors take all the necessary actions to comply with the FWA and erroneous payment requirements included in the contract with MLTC, and State and Federal regulations. NTC will delegate oversight responsibilities to a third party and require that the third party comply with all provisions of the contract relating to FWA and erroneous payments. NTC agrees to require, via contract, that providers comply with regulations and any enforcement actions directly initiated by MLTC under its regulations, including but not limited to, termination and restitution.

(2 page limit)
110. Describe the drug reference database used in pharmacy claims processing, and the update schedule, including term dates, obsolete dates, and rebate status.

Claims Processing Capabilities

US Script will provide all pharmacy-related technology systems and services in support of NTC's pharmacy program. US Script uses one proprietary claims processing platform, PBM1, which will include NTC's specific program design, such as preferred drugs, restrictions and continuity of care requirements. NTC will also direct US Script to configure its claims processing platform in compliance with MTLC's PDL and rebate program requirements.

US Script's state-of-the-art claims processing system is a proprietary package built from the ground up by industry professionals. It is written in C, Perl, PL/SQL and ProC. This software has been developed and is supported in-house by the original development team. Our production adjudication server is a mainframe class Sun Microsystems Sunfire 3800 running 64 bit Solaris. PBM applications are hosted on Oracle 10g Forms and Reports Runtime using a distributed process model. This server supports our Oracle 11g Enterprise database and the US Script proprietary adjudication and eligibility software.

US Script's NCPDP D.0-compliant point-of-sale (POS) electronic claims processing system uses Medi-Span® alerts as its clinical database and messaging system, which continuously draws from updated, comprehensive drug information for both prescription and over-the-counter drug products. It also includes new-to-market generic and brand name drugs and clinical data to support clinical decisions and POS safety screening. More than 99% of all transactions are processed in less than four-tenths of a second. Our online, real-time system processes all edits concurrently, including eligibility, drug coverage, benefit limitations, formulary status, and prospective/concurrent drug utilization review edits and 340B pharmacy claims based on Medicaid guidelines. Claim and encounter history is retained indefinitely, exceeding all current generally accepted retention timeframes, and will be provided on a scheduled basis to MLTC.

File Updates

NTC will require US Script to update all retail and specialty drug files at a minimum of every seven days as it does for all Centene affiliate plans, if not more often. US Script has honed its processes based on this experience, and its policies and procedures with NTC oversight will ensure pharmacists have accurate, timely information for all claims submitted.

Daily Reviews

The process for updating the drug file begins with an automated daily electronic upload of data from Medi-Span, a leading provider of drug information databases, into the US Script claims processing system. Medi-Span data includes drug name, strength, therapeutic class, National Drug Code (NDC), Generic Product Identifier (GPI), and pricing measurements such as Average Wholesale Price (AWP) and Wholesale Acquisition Cost. It also includes new-to-market generic and brand name drugs and clinical data to support clinical decisions and POS safety screening.

Rebates

Supporting MLTC's Rebate Program.

In accordance with the Affordable Care Act and federal supplemental drug rebate program, US Script will submit NCPDP-compliant encounters in claim-level detail to MLTC in the file format and layout determined by the MLTC on a weekly basis. The encounters will include all attributes in the format as indicated on the Systems Companion Guide, including the Member name, dosage form, strength, package size, and NDC of each covered outpatient drug dispensed for NTC Members, including recognizing claims for drugs purchased through the 340B discount drug program.

Supplemental Rebates. Each quarter US Script will run pharmacy claims data against contract provisions to determine the appropriate rebate amounts and bill pharmaceutical manufacturers. The system incorporates both automated and manual functions to ensure all information is accounted for and accurate. Manufacturers pay according to their own calculations, and NTC will apportion to MLTC the rebates attributed to NTC member utilization. If NTC does not agree with the manufacturer's payment, we will seek resolution, which may involve an independent auditor. Upon receipt of payment, US Script

will create a payment summary for each NTC program describing overall discounts as well as by drug manufacturer.

Through Centene's years of supporting state public sector healthcare programs, we understand the dynamic nature of both healthcare and technology. Collaboration, adaptation and change are necessary for continuous process improvement. For this reason, Centene created a centralized Encounter Business Operations Unit (EBO) to define and establish best practices in encounter submission processes. The EBO is an agile organization able to learn and share expertise based on the variations in requirements across our affiliate health plan operations and the states they serve. The EBO will support US Script and NTC's encounter submissions to MLTC and Centene's Management Information System (MIS) offers MLTC best-in-class technology that is configurable to meet NTC's specific needs. NTC and US Script are prepared to assist the State with data, reports, and policy support to ensure their rebate goals are achieved. US Script has direct experience supporting federal rebates due to States. Before submission of drug encounters to MLTC, US Script has procedures in place to review, calculate, submit, and report on rebates. Designated US Script personnel review and reconcile rebate eligible claims for accuracy prior to submission to MLTC.

Processing Physician Dispensed Claims

Since several NDCs are often linked to a single HCPCS code, the correct use of NDC numbers is critical to correctly identifying drugs and manufacturers in order for the State to invoice and collect rebates.

Our Claims Configuration Team maintains a table of allowable HCPCS and NDC values in our claims system that cross references HCPCS codes for appropriate NDC codes. Please note that we can customize this table if necessary for MLTC. Our claims system uses this table to validate that the HCPCS codes on the inbound claim are appropriate for the NDC codes present on the claim. If there is a mismatch of HCPCS and NDC codes on the claim, the claim will pend for follow/up by our claim specialists. In addition, our Encounter Business Operations (EBO) unit configures our system to validate that the units billed are in line with State rules. This latter configuration process not only ensures that we adjudicate claims for physician-administered drugs accurately, but that resulting encounters for MLTC follow MLTC guidelines.

Our system will report to the Provider the reason for this pend or denial via the secure Provider Portal and on the Provider Electronic Remittance Advice (ERA).

Additionally, our ClaimsXtenTM (CXT) software analyzes drugs billed as medical claims to determine clinical claim coding appropriateness and potentially fraudulent billing practices, including NDC and HCPCS coding.

Today, Centene maintains an industry leading overall average of 84.1% for automatic adjudication of electronic submitted medical and behavioral claims. This means our claims processing system is accurately configured to process claims efficiently.

(2 page limit)
111. Describe how the State Medicaid PDL will be integrated into the MCO pharmacy claims system.

PDL Implementation and Experience

Nebraska Total Care (NTC) will use Centene experience and the clinical needs of our Members to maintain the State's Preferred Drug List (PDL). Centene has experience operating in markets where there is a requirement to use State PDLs and will establish a P&T committee to work collaboratively with the State's P&T committee to ensure the State's PDL is updated and implemented within our claims processing system within established timelines. As the PDL is established by the State and outside the scope of the plan, NTC will nominate a non-voting member to attend the Nebraska Pharmaceutical and Therapeutics Committee's biannual meetings during the term of this contract. ***Centene offers 30+ years' experience in completing successful implementations in new and highly penetrated markets, with minimal disruption to participants.***

Implementing Nebraska's State PDL and Formularies: Core Components

Implementation

NTC will follow the Nebraska Medicaid PDL with preferred drugs being adjudicated as payable without prior authorization, unless they are subject to clinical or utilization edits, as defined by NTC. Centene will leverage the experience that it has working in markets where there are requirements to use State PDLs. NTC will cover medications that meet the definition of outpatient pharmacy services eligible for Medicaid coverage as defined under Section 1927 of the Social Security Act and will provide coverage for all therapeutic classes of drugs covered by the Nebraska Medicaid pharmacy benefit. NTC will submit the formulary for review and approval by MLTC a minimum of 90 calendar days prior to the contract start date. NTC will cover the OTC drugs listed in the Medicaid State Plan.

Maintenance

NTC will work closely with the State to implement the initial files for go-live. After initial implementation, NTC will use the file the MLTC PDL vendor provides to NTC weekly that has national drug codes (NDC), delegating the preferred or non-preferred status of each NDC to maintain the PDL. US Script will update its pharmacy claim system within one (1) business day of file receipt of the PDL file. At the direction of MLTC, US Script will perform off-cycle PDL file updates within one (1) business day. NTC will 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. NTC will submit all proposed formulary changes, excluding formulary expansion changes, to MLTC for review and written approval prior to the implementation of such changes. NTC will 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 will be submitted to the MLTC for approval. NTC will update the formulary files at a minimum on a weekly basis.

Our Pharmacy Network

US Script analytically established its network to ensure access, deliver culturally and linguistically competent care, and improve cost-effectiveness. US Script works with chain and independent pharmacies, organizations of independent pharmacies, and PSAOs and to-date contracts with over 66,000 pharmacies nationwide and approximately 450 pharmacies within the state of Nebraska. US Script will obtain active agreements from any pharmacy or pharmacist that is licensed and in good standing with MLTC and that accepts the terms and conditions of the contracted offered to them by US Script. We understand the role independent pharmacies play in their communities and will make extra efforts to reach out to them, for example as we did working with the Mississippi Independent Pharmacy Association prior to our Medicaid plan operationalization in that state. As part of the contracting and credentialing process, US Script confirms that each pharmacy is not under sanction or by contract, US Script requires all network pharmacies to fill prescriptions for covered drugs ordered by licensed prescribers regardless of network participation. To meet evolving or localized health care trends and needs, US Script may also offer pharmacies the opportunity to contract as a specialized network Provider, such as to provide Members

with a 90-day instead of 30-day drug supply or with flu vaccines. We will also provide an optional home delivery service to Members using our wholly-owned mail order pharmacy in Troy, Michigan. In rural areas where access to retail pharmacy may be a problem for some Members, we will work with pharmacies to support prescription delivery services. For specialty pharmaceuticals, US Script contracts a Specialty Network with pharmacies that meet our quality standards and other requirements, since these drugs, such as injectable medicines used for cancer care, tend to be expensive, have stringent handling and storage requirements, and are often unavailable through retail pharmacies. Because pharmacists can play an important role in Member health maintenance, we will offer opportunities to pilot Medication Therapy Management (MTM) programs to network pharmacies, as appropriate to Member needs and pharmacy interest and expertise. To ensure accountability, US Script continuously audits its network pharmacies according to provisions as specified by contract. We will help keep our pharmacists current on relevant program and pharmacy issues using high-impact faxed bulletins targeted to all or a subset of our network and, as necessary, supported by direct contact by our Network Coordinators.

Prior Authorization (PA) Processes

US Script will provide timely, accurate responsiveness to PA requests and will require our network pharmacies to comply with state and federal requirements regarding the dispensing of a 72-hour emergency supply.

Continuity of Care Protections

Members who enroll with NTC will have undisrupted access to needed medicine, plus prompt, supportive interventions when needed. We will honor new NTC Members' prescriptions and pre-program when necessary PA approvals for non-preferred or restricted drugs for a minimum of 90-day time period corresponding to the medication, Member's condition, age and other factors. We will monitor incoming claims, and if available, historical clinical and pharmacy data to identify Members who may be candidates for our Care or Disease Management Programs or who may benefit from adjustments in their pharmacy regimen.

Other Outpatient Drug Utilization Strategies to Improve PDL Adherence

A Comprehensive Approach to PDL management and adherence

Integrated within our PDL approach are clinical, safety and education strategies to promote appropriate, cost-effective utilization and timely access through PDL prescribing. These approaches include, if approved by the MLTC, effective and judicious use of prior authorizations; step therapy programs; quantity and age limitations; refill-too-soon limits; point-of-sale edits; and prescriber and member outreach and education programs.

Rebates

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

(5 page limit)
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.

Proven Encounter Experience and Approach

Nebraska Total Care (NTC) benefits from 30 years' experience of our parent, Centene Corporation (Centene), in successfully supporting encounter data requirements for Managed Medicaid health care programs. Today, Centene submits over nine million encounter transactions per month and over 96 million encounter records per year. NTC will submit accurate and timely encounters to MLTC and the NTC CFO, or designee, will attest to the truthfulness, accuracy, and completeness of all encounter data we submit to MLTC per RFP requirements.

Strong Partnership Approach to Drive Encounter Quality. Our encounter success is grounded on:

- ***Enterprise Support Teams.*** Centene's Encounter Business Operations Unit (EBO) and Encounter IT Teams will provide day-to-day support, and the EBO will be staffed with an Encounter Specialist dedicated to successful NTC operations, enabling NTC to leverage the EBO's nationwide expertise and bring best practices and lessons learned from affiliate health plans.
- ***Local NTC Expertise.*** Our local NTC Claims Analysts will have in-depth understanding of MLTC-specific claims processing rules, and provide critical feedback to claim configuration and encounter reporting processes. The Claims Team will also work with NTC Provider Relations specialists to support provider education to resolve issues related to provider claim submissions.
- ***A Coordinated Team Approach.*** The EBO also coordinates regular encounter meetings, which will include NTC Claims Analysts, dedicated Encounters IT staff members, and various teams related to encounter submissions as needed (such as Finance, Compliance, and representatives from our subcontracted vendors), to ensure encounter performance requirements are consistently met. Agenda items include (1) overall encounter status including pass rates, paid claims to encounters reconciliation, as well as outstanding and upcoming business concerns; (2) any underlying claims issues; and (3) subcontractor encounter reporting status. See ***Attachment 112.A: Encounter Roles and Responsibilities*** for a chart on team responsibilities.

Technology Powered Processes to Ensure Encounter Data Accuracy & Timeliness

Software Specifically for Medicaid Encounter Data. We use an industry leading encounter workflow system, Encounter Data Manager (EDM). Fully integrated with our enterprise Management Information System (MIS), EDM is configurable to meet program requirements as defined by MLTC. For every clean claim, our encounter data displays the same line item detail as received on the claim, regardless of claim type, and disposition (e.g. paid, denied, adjusted, voided), we include diagnosis, DRGs as appropriate, and MLTC standards regarding the definition and treatment of certain data elements captured on claims, counting methods, units, etc. We provide all rendered services, rendering provider's identification numbers, and billed amounts, as well as an indication whether the claim is original, adjusted, voided, denied, replacement, or from a capitated service. Please refer to ***Attachment 112.B: Claims to Encounter End to End Processing*** for a summary flowchart of our encounter process – from claims submission to encounter reporting.

From Claim to Encounter. Our front-end controls help ensure complete, timely, and accurate claims submission to support back-end encounter data preparation. Our compliance software validates data against ASC X12 HIPAA Version 5010 syntax, for data structures, tests for conditional rules requiring secondary fields, and will ensure all data is in compliance with MLTC Companion Guides as we process the claim. This assures that the downstream encounter data we produce is compliant with MLTC standards. All received claims, including paper claims that are translated to data via our Optical Character Recognition Technology (OCR) and stored in our Centene Document Management System (CDMS), are mapped, translated, and validated, ensuring that common edits are consistently applied and all critical claim data elements are present. If any transaction is rejected, we will notify the EDI trading partner or submitting provider and convey the reason (e.g. an error due to violation of

an MLTC-approved edit) that did not pass validation processing. Prompt notification to providers enables the provider to correct and resubmit the claim so we can process and submit the encounter to MLTC in a timely fashion.

Aggregating Encounter Data within Centelligence™ Enterprise Data Warehouse (EDW). Our claims processing system retains snapshots of all transactions and includes date span logic, historical claims tracking, operator ID stamping, and other audit parameters for operational monitoring and retrospective review. Our Centelligence™ Enterprise Data Warehouse (EDW) will retain all data elements billed by the provider as well as the claims detail history necessary for creating encounters in compliance with MLTC. EDW also supports access to data necessary to manage the entire encounter process including any need for extended encounter data reporting, with capabilities to identify encounter trends, monitor acceptance rates, and produce operational analytics.

Encounter Data Extraction and Preparation. We will create encounter files per RFP schedule requirements. Manual (ad hoc) requests are used for file creation outside of the normal scheduled processes. EDM systematically extracts claim data from EDW based on the claim paid date to minimize bottlenecks and the need for manual intervention, as well as ensure we meet reporting timeliness requirements. EDM configuration of MLTC-specific business rules allows us to "scrub" the data prior to encounter data submission, to check data elements and that the format is in accordance with MLTC requirements. EDM then produces Professional and Institutional Encounter files for MLTC in HIPAA compliant 837P (Professional) and 837I (Institutional) formats.

Encounter Submission via SFTP and Response. Our COVIANT Transaction Manager handles our automated, scheduled file exchanges between NTC and MLTC to ensure delivery of encounter submissions. To confirm successful transmission, NTC monitors EDI acknowledgements issued by our state partners upon each monthly submission for encounter data (as well as weekly submission for pharmacy). All files, including those of our subcontractor encounter files (pharmacy, vision, transportation) are checked for HIPAA compliance before MLTC submission.

Encounter Error Processing. EDM receives and processes encounter response file reports from MLTC. EDM facilitates encounter reconciliation workflows and prioritization of encounter correction activities for timely error resolution. Encounter errors (or encounters that fail encounter "scrub" edits) are parsed out by the EBO to the appropriate team for root cause analysis and resolution. We also use EDM's encounter data extract and transmission features to minimize bottlenecks and the need for manual intervention. NTC and the EBO will monitor and ensure all timely standards are met. Our EBO Business Analysts will use our reporting functionality to identify encounter trends (e.g. volumes processed, work in process, encounter record aging, rejects and scrubs by specific "edit" type, etc.) to monitor our acceptance rates with MLTC and to proactively correct issues.

Encounter Correction and Resubmissions. EDM provides a platform by which each error can be researched by the EBO. If an erred encounter record requires the claim to be reprocessed, corrections will be made at the source (i.e. in our AMISYS Advance claims system) and the encounter is then resubmitted through EDM. If an identified error requires a configuration change, we submit a configuration change request to correct program logic issues at the source, and using our Agile change management approach, these changes are quickly approved, tested, and implemented. Encounter submission errors processed by our subcontracted vendors are corrected by the vendor in collaboration with EBO. Once corrected, those encounters will be resubmitted in the next encounter cycle. Weekly encounter data from EDW is combined with corrected encounters that need to be resubmitted. Batch files containing fatal errors preventing processing of the file or "exceed the threshold" record levels, are corrected and resubmitted within one business day of receipt.

Using Feedback. NTC will leverage operational feedback to inform continuous improvements of each step in the process. The guiding approach to our encounter data preparation is our end-to-end framework, where we identify and resolve issues at the root cause (preventing downstream encounter reporting issues). For example, one of the most important systematic "feedback" actions we take is to continually monitor MLTC encounter edits and rules (known as "scrubs") that we have configured in EDM. We

regularly examine the highest encounter "scrub" reasons as reported in EDM. Wherever possible, we use that information to move encounter edits that occur frequently on the "back end" (in EDM) – to the "front end" of our MIS, at the point of claim submission, including our EDI subsystem and AMISYS Advance claims software, to enforce those edits and reject or deny inaccurate claims as early as possible in the process so that the claim can be corrected and submitted accurately by the provider. EDM also allows us to identify an encounter issue from the batch level down to the individual service line detail level, as well as the processing history of an encounter record and corresponding claim record. This allows EBO to rapidly identify the issue and any needed follow-up work including subsequent resubmission to the state.

Subcontractor Encounters. NTC and EBO will monitor, verify and submit encounters to MLTC from our affiliated subcontractors (vision and pharmacy benefit managers). We currently support the HIPAA NCPDP format and will support this format per MLTC's required schedule (weekly).

Systems and Controls for Data Quality and Timeliness. Our successful approach is predicated on the emphasis we put on front-end controls that assure data quality in our encounters. In addition to our encounter process above, we leverage several effective controls, strategically positioned throughout NTC's encounter data production lifecycle.

HIPAA Compliance. We systematically apply HIPAA compliance checks, validate the provider NPI, submitter, member and provider information on the inbound claim via the middleware components of our integrated MIS. Once converted into data, paper claims are processed through the same data validation routines and edits as electronically submitted claims. This process verifies all data are in compliance with HIPAA, Federal mandates, and MLTC payment rules. We deny provider claims due to a lack of sufficient or accurate data required for proper adjudication.

Instant Verification through Real Time Editing and Pricing (RTEP). Through our Provider Portal, the RTEP tool will allow providers to enter professional claims online with interactive assistance (e.g. look up and validation assists for codes, validation of member and provider data, and online help). The RTEP module *instantly* applies adjudication logic validating member and provider eligibility for dates of service, matching authorizations to services on the claim, applying TPL/COB amounts, determining if benefits apply, enforcing edits, and pricing the claim – all within the single online session. An estimated paid amount is provided subject to adjustment after Fraud, Waste and Abuse checks, as well as any pre-payment encounter edits. This results in instant feedback on any claims submission issue, promoting clean claim entry, and thereby helping NTC facilitate timely, accurate, and complete encounter data.

Configuring EDM for MLTC Compliance. EDM's table driven configuration utility allows us to implement MLTC-specific business rules to "scrub" encounter data prior to submission to MLTC. The EBO uses EDM to identify any encounters that fail our pre-submission scrubs prior to transmission so the issue can be corrected. NTC configures scrubs to prevent processing issues on MLTC's end by ensuring adherence to NTC requirements, HIPAA compliance, data completion and accuracy, national industry standards and code sets, NPI edits, etc. If an encounter record does not pass an EDM "scrub" the system holds the encounter for review and correction. Wherever possible, encounter scrubs that occur frequently on the "back end" through EDM – are also added to the "front end" of our MIS, to enforce those edits at the point of claim receipt and reject or deny inaccurate claims submissions as early as possible in the process so that the claim can be corrected and submitted accurately by the provider. If errors are identified, NTC works closely with providers to correct any issues and/or reprocess the claims for a valid encounter submission.

Systematic Methods to Ensure Timeliness. NTC will validate that encounter submission files are successfully delivered to MLTC through our support of EDI Functional Acknowledgements as well as the 277 Claims Acknowledgement transaction. We automate scheduled processing runs out of EDW on daily, weekly, or monthly cycles through our TIDAL Enterprise Scheduler job scheduling software. Our COVIANT Diplomat Transaction Manager then executes automated, scheduled file *exchanges* (transmission and receipt) with MLTC's agent, using any secure data transmission protocol (e.g. SFTP) needed by MLTC.

Verifying Throughput. Our EDI Operations Department monitors day-to-day throughput of inbound EDI claims from providers to ensure smooth and timely flow of claim data, and will alert NTC if high volume providers have lower than usual submission volumes for follow/up by NTC Provider Relations staff.

Training and Supporting Providers to Facilitate Clean Data Submissions. NTC will use a coordinated blend of targeted communications, training, and support strategies to help ensure that our providers submit timely, accurate, and complete claims (including encounter claims from capitated providers or for capitated services) so we may in turn, submit timely, accurate, and complete encounter data to MLTC.

Monitoring Data Completeness and Non-Submissions

Monthly Claims to Encounter Reconciliation Review for Accuracy & Completeness. To ensure completeness of encounter data submitted, on a monthly basis, NTC will compare financial data from paid claims with corresponding encounter submissions to ensure encounter data is a complete representation of the services provided, matching paid dollars by date of service month. Using this process, we can account for every paid claim, verifying finalized claims have been processed as encounters, inclusive of all payment adjustments. For several of our affiliate health plan state partners, we work with the state's third party auditor to reconcile financial reports against received encounters and assess completion of the encounter data.

Subcontractor Oversight. In addition to encounter data we produce, NTC and the EBO will also monitor and facilitate encounter submissions to MLTC from our affiliated subcontractors. Our subcontractors will submit their processed claims data to NTC in MLTC-compliant encounter data format (including NCDCP format for pharmacy encounter data) via SFTP. All of NTC subcontractors who receive claims submissions from providers on behalf of MLTC programs are contractually obligated to submit encounter data to NTC in accordance with MLTC requirements, with financial sanctions and Corrective Action Plans as applicable if documented service level agreements related to encounter submissions to NTC are not met. In addition, Centene also holds its subcontracted vendors responsible for the integrity and quality of claims data and encounter transactions provided to MLTC. We oversee our subcontractors' encounter submissions and we require and monitor them to address issues regarding incomplete, inaccurate, or untimely data.

Weekly Acceptance and Reject Review. Upon receipt of the subcontractor encounter submission files by the EBO team, the encounter file is processed through EDIFECS, our HIPAA compliance checking system, to ensure that the encounter file has been produced in accordance with the State companion guide. We perform a weekly analysis to understand the acceptance rates received on the encounter submissions that week. This allows us to support our subcontractors by identifying trends that require attention before they compromise the integrity of encounter timeliness, accuracy, and completeness. If at any time the weekly acceptance rate is at risk, our encounter resources (NTC, EBO, Claims and IT Teams) will work together to quickly identify and resolve the issue with our subcontractors in order to meet or exceed MLTC's acceptance rates. If MLTC returns records to us for research and resolution, we will act quickly to research and resolve encounter data issues.

Bi-Weekly Vendor Inventory Report. We will require our subcontractors to reconcile encounter submission files with separate paid claim reports to ensure all encounters are submitted. All subcontractors will be required to submit this Encounter Inventory Report on a bi-weekly basis. This will enable us to proactively monitor the subcontractor's encounter inventory and identify potential issues that puts our encounter data quality at risk. When an issue is identified, the EBO will meet with NTC and subcontractor to address and resolve the issue immediately. All teams will meet regularly until the issue is addressed and any necessary process refinements are implemented. Should control totals not match between the paid claims report and encounter files, we perform root cause analysis with the subcontractor and implement a solution prior to submission to MLTC. If necessary, we ensure that the subcontractor develop a corrective action plan.

Non-Submission of Claim and Encounter Data. NTC will validate and assess the non-submission of claims and encounters by providers and subcontractors and implement corrective actions if needed.

Mitigating and Addressing Provider Non-Submission of Claim or Encounter Data. NTC utilizes several strategies designed to *mitigate* against non-submission of claims from providers including support for electronic submissions, reporting, dedicated staff support, and provider training. Per Centene policy, our standard provider contracts require submission of complete, timely, accurate claims (or provider submitted encounters for capitated services) per Nebraska regulations. NTC Provider Relations (PR) staff will use a monthly claims submission scorecard, produced by our Centelligence™ reporting platform, listing the top providers by claim count and dollars billed, as well as top denial and adjustment reasons related to submission quality. This report allows our PR staff to identify and work with providers requiring assistance in claims preparation and submission.

Electronic Claim (EDI) Submitters. Our EDI Operations Department produce daily reports on submissions from providers that will enable NTC Provider Relations (PR) staff to monitor and identify providers who systemically submit incorrect information (thus impacting encounter data quality), allowing PR staff to assist via targeted training. PR staff will also monitor high-volume EDI submitters in case support is needed (e.g. atypical error rates, or drop-offs in normal submission volumes).

Paper Claim Submitters. NTC PR staff will promote the benefits of facilitated claim submission via our online Direct Data Entry (DDE) offering, with RTEP functionality, available through our web-based Provider Portal. We help providers see how online submission leads to quicker payment, and, through RTEP, the ability to manage their Accounts Receivables more accurately, while simultaneously leading to higher quality claim submissions, and ultimately quality encounter data to MLTC.

Training and Supporting Providers. NTC will use a coordinated blend of training and support to ensure that providers realize the importance of submitting complete, accurate, and timely claim data, including the need to submit claims for all services rendered, whether NTC pays for those services on a Fee-for-Service (FFS) basis or on a capitated schedule. Our PR department will offer providers face-to-face claims training at both regional and onsite venues; our EDI Help Desk will assist providers with a toll-free "800" number; and providers can turn to our website for scheduled and on-demand webinars and other online assistance. Through our Provider Portal, we will offer access to McKesson's Clear Claim Connect application, where providers can check our adjudication logic prior to claims submission. Providers will also have access to our online Ramp Manager EDI system, which allows providers to "on board" through interactive EDI testing and certification for direct EDI HIPAA file submissions to NTC; with additional support from the EDI Help Desk, NTC PR staff and Provider Service Representatives.

Progressive Approach for Subcontractor Non-submission. NTC's approach with our subcontractors involves early communication of a deficiency related to reporting requirements, performance, or other contract or service issues. Our pre-delegation and annual re-assessment process consistently reviews and enforces the policies and procedures specific to subcontractor delegated activities, including encounter submissions. All of the NTC contracts with our subcontractors will include provisions to ensure the successful fulfillment of all NTC's contractual obligations to MLTC. Our subcontractor agreements outline our ability to enforce performance requirements and we include provisions requiring our subcontractors to self-disclose if they are aware of any areas where they are not meeting requirements. We require monthly and quarterly reports from our subcontractors demonstrating compliance with performance metrics. Per contractual agreements with our subcontractors, a Corrective Acton Plan with financial sanctions may be applied if service level agreements related to encounter submissions to NTC are not met. Through this approach, as well as through regular status calls and meetings of our Joint Operating Committee we can identify concerns at an early stage and immediately communicate our expectations for how to correct concerns within a 30-day timeframe. If we do not see a correction of the deficiency within that 30-day timeframe, we will then implement a Corrective Action Plan.

(2 page limit)

113. Describe the MCO's proposed processes for coordination of benefits for dually-eligible members.

Experience Coordinating Benefits with Medicare Payers and Providers

Nebraska Total Care (NTC's) parent company, Centene Corporation (Centene), has the systems and expertise to coordinate Medicare and Medicaid benefits for dually-eligible members. Our Centene affiliates currently serve over 134,000 dual eligible members in our Medicaid Managed Long Term Services and Support (MLTSS) and Medicare-Medicaid Programs (MMP) in seven states. In addition, Centene affiliates also serve approximately 7,500 dual eligible members in Medicare Advantage Special Needs Plans. Many of our affiliates' members are also dual eligible Medicaid members with Medicare services provided through another payer, including Medicare as well as Medicare Advantage plans. Centene and our affiliates coordinate benefits in all these scenarios, and NTC will leverage the technology and established processes below to handle Medicare crossover claims, coordinate benefits, and administer Medicaid as the payer of last resort, while coordinating care for our dual eligible Heritage Health members.

An Opportunity to Coordinate Care In Addition To Benefits. When we coordinate benefits, we also conduct care coordination with other payers when necessary, especially among vulnerable populations and/or those with special health care needs, as allowed under HIPAA privacy rules. The NTC Care Manager will serve as the dually eligible member's regular point of contact and will be actively involved in coordinating the member's full range of benefit delivery, regardless of which program pays for the service. We include all services the member needs in their care plan (as well as those funded under Medicare) and coordinate with the member's providers, including the member's Medicare providers to support integration of care. NTC will also provide medically necessary covered services to dual eligible members if the service is not covered by Medicare. See Section 62 for more information on our approach to coordinating care for dually eligible members.

We will use the following processes to manage Medicare crossover claims and benefit coordination:

Coordination of Benefits Agreement (COBA). NTC will execute a COBA with the CMS Benefits Coordination & Recovery Center (BCRC) and participate in the automated crossover process for dual eligible individuals enrolled in Heritage Health. Our enterprise Management Information System (MIS), operated for us by Centene, currently supports the COBA based claims crossover process for several of our affiliates. We support the COBA Eligibility Record Layout format as provided by CMS. If a provider submits claims for an NTC dually eligible member to Medicare or a COBA participating Medicare Advantage plan for claims processing, NTC will coordinate with the BCRC for Medicaid as the "payer of last resort" so that the provider need file their claim only once.

Adjudication of Medicare Crossover Claims. NTC will use our AMISYS Advance claims system (AMISYS), an integrated component of our MIS, for claims processing which will be configured to meet all MLTC specific requirements for Heritage Health. When we receive a HIPAA 837 claim file from the BCRC, AMISYS (integrated with MDM) will identify the member with Medicare as the primary payer, validate Coordination of Benefits (COB) identification information on the claim, and adjudicate the claim for remaining Heritage Health benefits using the COB segment information in the 837 (which contains adjudication results as processed by Medicare) for secondary payment information. We will process payment for all providers participating with Medicare who see our dually-eligible members, including those providers not a part of our network.

Identify Members with Medicare as the Primary Payer. Upon receipt of the 834 eligibility file, Third Party Liability (TPL) is automatically loaded to the Member Data Management component of our MIS, and distributed to our claims paying affiliated subcontractors for administration of pharmacy (US Script) and vision benefits (OptiCare). In addition, today our MIS systematically captures TPL and "Other Insurer" information from inbound claims, and our MIS is integrated with Health Management Systems, Inc. (HMS), so that we receive updated TPL and Coordination of Benefit (COB) data on our members, including Medicare and Medicare Advantage coverage. HMS is a leading cost containment company specializing in the systematic collection of TPL/COB information using a nationwide database. Through

our integrated Centelligence™ reporting platform, we will report members with third party coverage to MLTC monthly in any format MLTC specifies, a process that the majority of our affiliate health plans perform today, and we can and will supply MLTC with TPL information to MLTC weekly in a format required by MLTC and we will cooperate in any manner necessary with MLTC or its cost recovery vendor. See Section 101for more information on our Centelligence™ data warehouse and reporting system.

Unified Member View – Where TPL Follows the Member. Among Centene's 4.8 million members, we often see individuals move across different affiliate programs and/or states, and we have the capability, from an MIS perspective, of centering on a person rather than on separate "eligibility spans". Transitions through multiple Centene affiliate programs and associated member and provider activity, are all invaluable information that helps us better manage the member. MDM's Unified Member View (UMV) functionality stores and maintains a member's complete eligibility history, enrollment and eligibility spans, and TPL information. In other words, all proactive efforts to maintain up to date TPL information will follow the member regardless of program transition across Centene plans, supporting the continuation of efficient coordination of benefits, coordination of care, cost avoidance, and overall member management.

Key Partnerships to Identify COB/TPL. Centene affiliates takes a proactive, comprehensive approach to identifying, collecting, and reporting third-party liability coverage (TPL) and cost avoidance. As mentioned above, we use HMS, an established leader in TPL identification and post-payment recovery in the public sector. We also use providers as well as our own staff to help identify TPL for members, including those members dually-eligible for Medicare and Medicaid. Of course, when we use COBA arrangements, the BCRC also supplies us with Medicare enrollment information via crossover claims themselves.

Provider Support. Our provider agreements include language requiring identification of any other coverage prior to submitting claims to us. Through regular provider orientations, ongoing training meetings, and our online provider manual, we will educate our providers on the importance of identifying TPL information (including Medicare) at the time the member receives services. We inform and educate providers about the importance and process for submitting to us denial notices from third parties, accident details, and medical records corroborating no other liable parties and to include payment information from a third party where member liability exists. We ask for this latter information in the TPL/COB payer segments of their HIPAA 837 EDI claim submissions, or third party EOBs with their paper claim submissions.

NTC Staff Support. All NTC staff that interface with members will be trained and provided with appropriate tools and resources to assist dual eligible members with questions about their Medicaid and Medicare covered benefits, appeals and grievance rights, and other topics and issues that are unique to dual eligible members. Our staff will be trained to assist dual eligible members across a continuum of member interactions that include but are not limited to: member welcome calls, member outreach and education, health risk screenings, care management and transition of care.

Sharing, Exchanging, and Reporting TPL through Centelligence™. We realize that TPL information is a component of capitation rate development and other administrative activities. We will maintain records regarding Medicare coverage, and other TPL information, as well as TPL and COB recoveries to MLTC in the timeframe and format determined by MLTC. NTC's ability to collect, manage, and report data through one uniform production and reporting system, Centelligence™, allows us to offer an all-encompassing holistic view of the programs and benefits we administer. Centelligence™ is a comprehensive family of integrated decision support and health care informatics solutions. As an integrated component of our MIS, the Centelligence™ enterprise platform integrates data from multiple sources, and provides actionable population and member level information to the right person for the right task at the right time, with the ultimate goal of improving clinical, operational, and financial outcomes.

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IV.S ATTACHMENTS

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Attachment
112.A: Encounter Roles and Responsibilities

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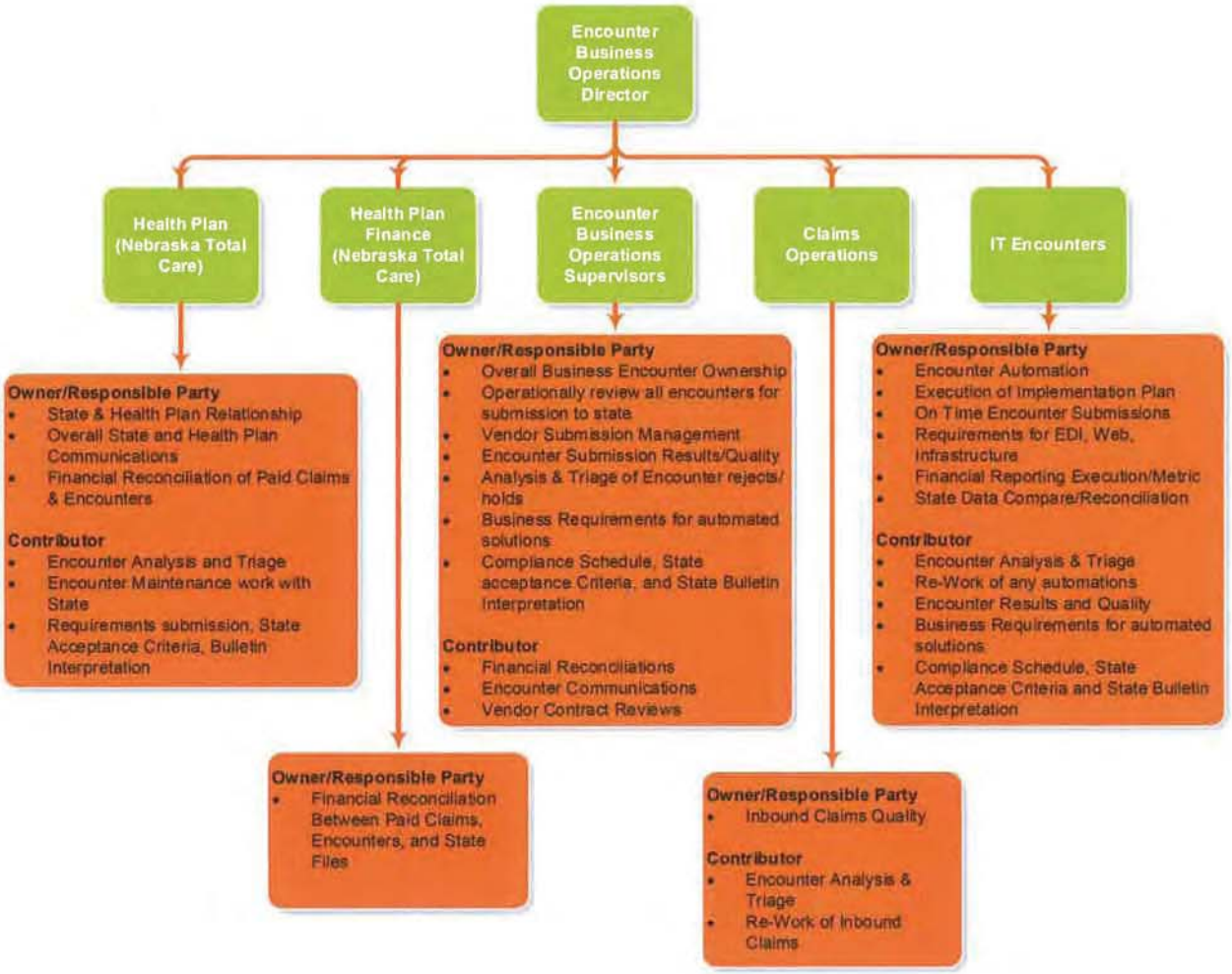
Attachment 112.A: Encounter Roles and Responsibilities



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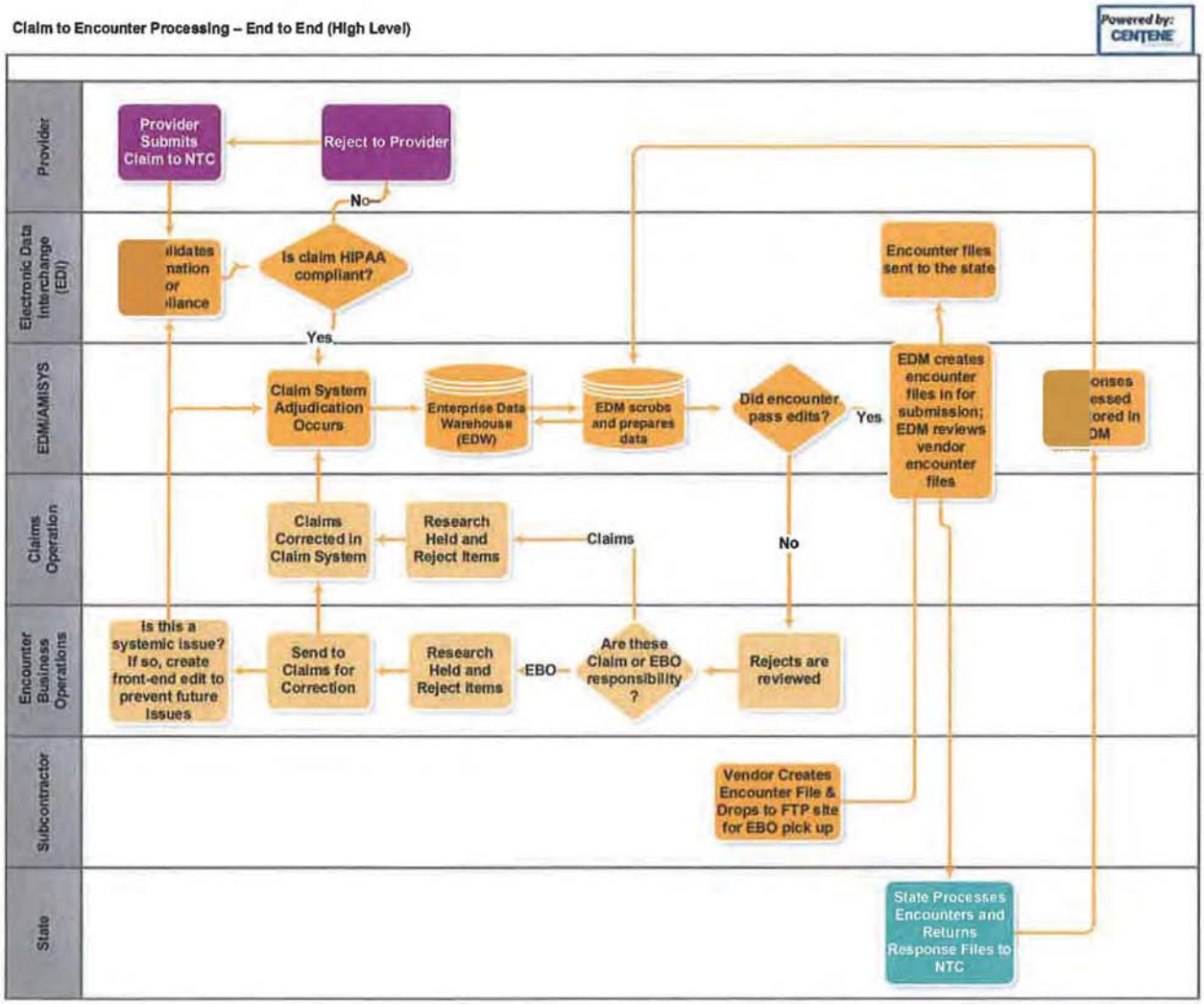
Attachment
112.B: Claims to Encounter End to End Processing

Attachment 112.B: Claims to Encounter End to End Processing



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IV.T Reporting and Deliverables

IV.T Reporting and Deliverables

(page limit N/A)

114. Provide an example of dashboards that the MCO will use to track MCO performance for MCO leadership and the QAPI Committee.

An MIS Focused on Medicaid Data and Information

Nebraska Total Care (NTC) will use the enterprise Management Information System (MIS) of our parent Centene Corporation (Centene). Our MIS is focused solely on publicly funded healthcare program administration, supporting 4.8 Million Americans in 23 states, including Managed Medicaid programs in 20 states with analytics and reporting needs quite similar to those of Heritage Health, along with capabilities to support specialized programs such as Long Term Services and Supports, health programs for children in Foster Care, and Medicare Special Needs Programs.

Centelligence™ Dashboards

A key component of our modular MIS is the Centelligence™ system. Centelligence™ is a comprehensive family of integrated decision support and health care informatics and dashboard solutions. The Centelligence™ platform integrates data from multiple sources, including the internal core transaction components of our MIS (eligibility, claims, authorizations, etc.) as well as external data sources, and provides actionable health plan operations, population and member level information to the right management and staff for the right task or decision at the right time, to track and trend MCO performance with the ultimate goal of improving clinical, operational, and financial outcomes.

Example Dashboards. On the following pages, we offer a sample, amongst a wide breadth of Centelligence reports and dashboards, that NTC leadership and our QAPI Committee and sub-committees will use to inform collaborative decision making (***Figures Q114.A through Q114.J***). Our dashboards feature "drill down" capability, allowing users to explore potentially causal factors underlying more summary statistics and measures.

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Figure Q114.A: Member Enrollment

Figure Q114.B: Call Center Statistics

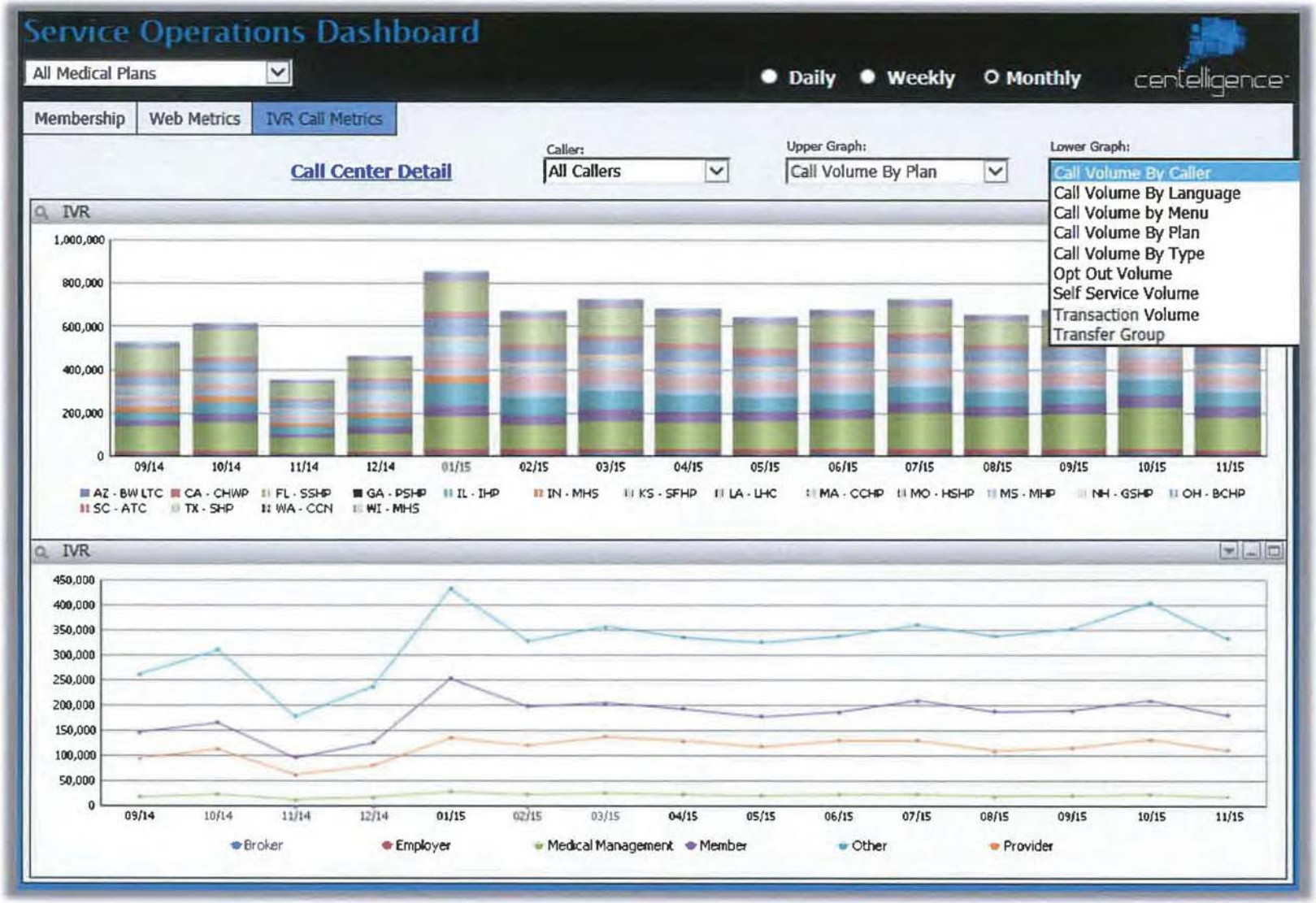

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Figure Q114.C: Call Center Statistics, Details

	Monthly Call Statistics														
	3/1/2015	2/1/2015	1/1/2015	12/1/2014	11/1/2014	10/1/2014	9/1/2014	8/1/2014	7/1/2014	6/1/2014	5/1/2014	4/1/2014	3/1/2014	2/1/2014	MTD TOTAL
Inbound Call Volume															
XXXXX Line (394,309)	-	55	48	38	44	45	48	38	65	61	53	46	45	-	846
XXXXX Line (1043, 1044)	-	33	25	30	30	21	25	30	43	35	40	29	34	-	545
Call Volume Total	0	342	283	292	272	233	283	292	385	327	343	294	241	245	5,578
ASA (goal <30 Sec)															
XXXXX Line (394,309)	-	3	6	8	7	13	6	8	5	11	5	8	6	-	17
XXXXX Line (1043, 1044)	4	8	4	4	4	9	4	4	5	10	8	5	4	-	10
Average Speed of Answer	6	8	8	6	7	7	8	6	8	9	6	8	6	8	14
Abandon Rate (goal <5%)															
XXXXX Line (394,309)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.8%	0.0%	0.0%	-	1.4%
XXXXX Line (1043, 1044)	0.0%	3.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.7%	2.9%	0.0%	0.0%	0.0%	-	1.7%
Abandon % Total	0.0%	1.8%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.8%	0.3%	1.2%	0.0%	0.0%	0.6%	1.2%
Service Level (goal >80%)															
XXXXX Line (394,309)	90.9%	100.0%	97.9%	94.7%	90.9%	95.6%	97.9%	94.7%	98.5%	90.2%	94.3%	95.7%	95.6%	-	89.8%
XXXXX Line (1043, 1044)	100.0%	93.9%	100.0%	100.0%	100.0%	95.2%	100.0%	100.0%	93.0%	91.4%	97.5%	100.0%	100.0%	-	92.5%
Service Level % Total	94.9%	94.7%	96.5%	97.9%	94.9%	97.9%	96.5%	97.9%	95.3%	94.5%	97.1%	96.3%	97.5%	96.2%	91.6%
Average Talk Time (sec)															
XXXXX Line (394,309)	322	356	396	281	282	275	281	282	365	322	289	221	300	-	313
XXXXX Line (1043, 1044)	577	533	452	408	465	305	408	465	414	577	476	343	422	-	469
Average Talk Time	372	398	390	336	337	294	336	337	348	372	368	326	348	345	354
Average Handle Time (sec) - includes Ring Time, Hold Time, Talk Time															
XXXXX Line (394,309)	562	562	636	410	443	423	562	636	560	504					
XXXXX Line (1043, 1044)	732	732	561	557	706	401	732	561	617	702					
Average Handle Time	585	585	582	478	513	436	585	582	495	510					

Sample Report
(Dummy Data Used; PHI Removed)

Figure Q114.D: Status of Credentialing Applications

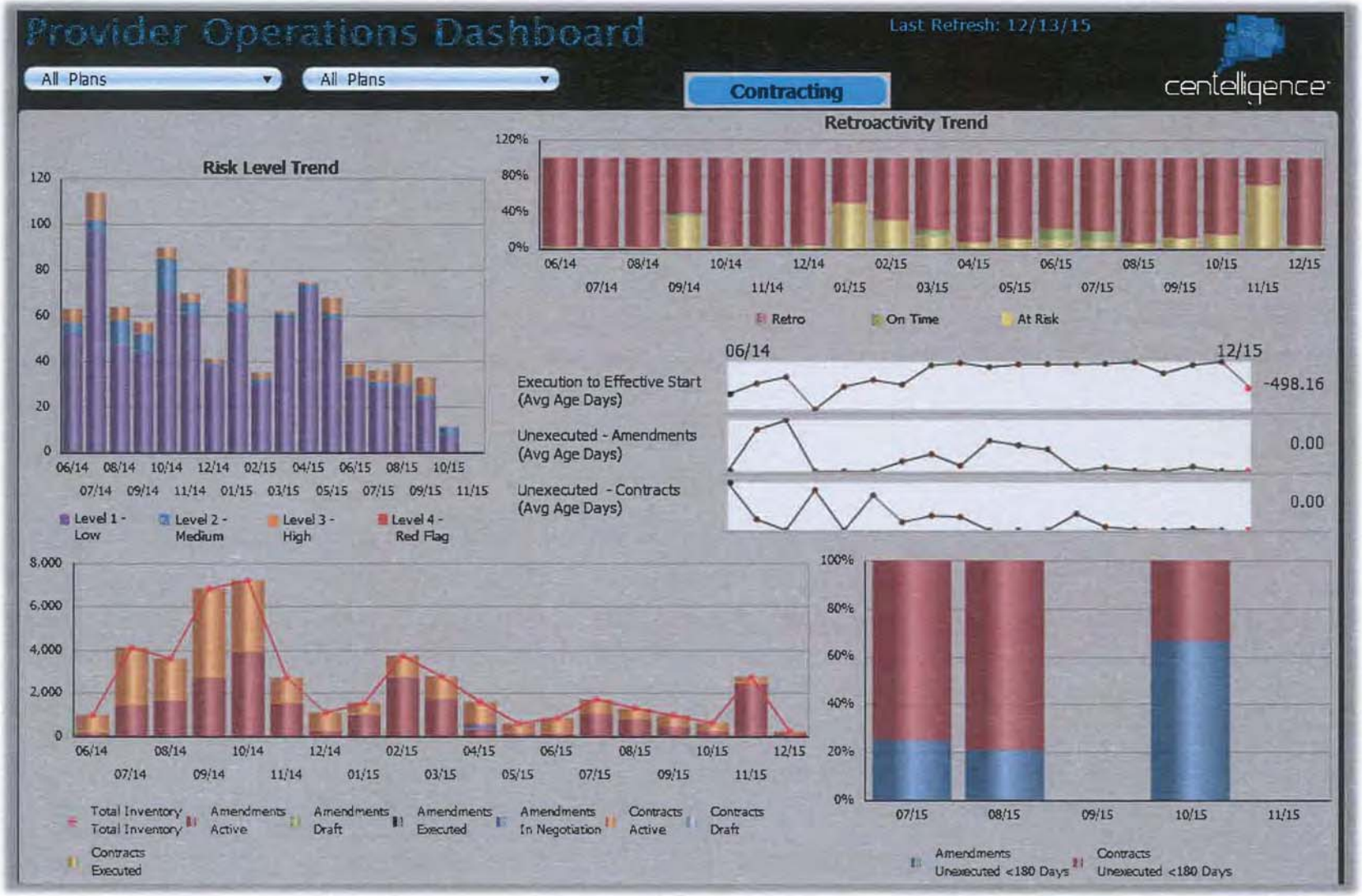

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Figure Q114.E: Care Management

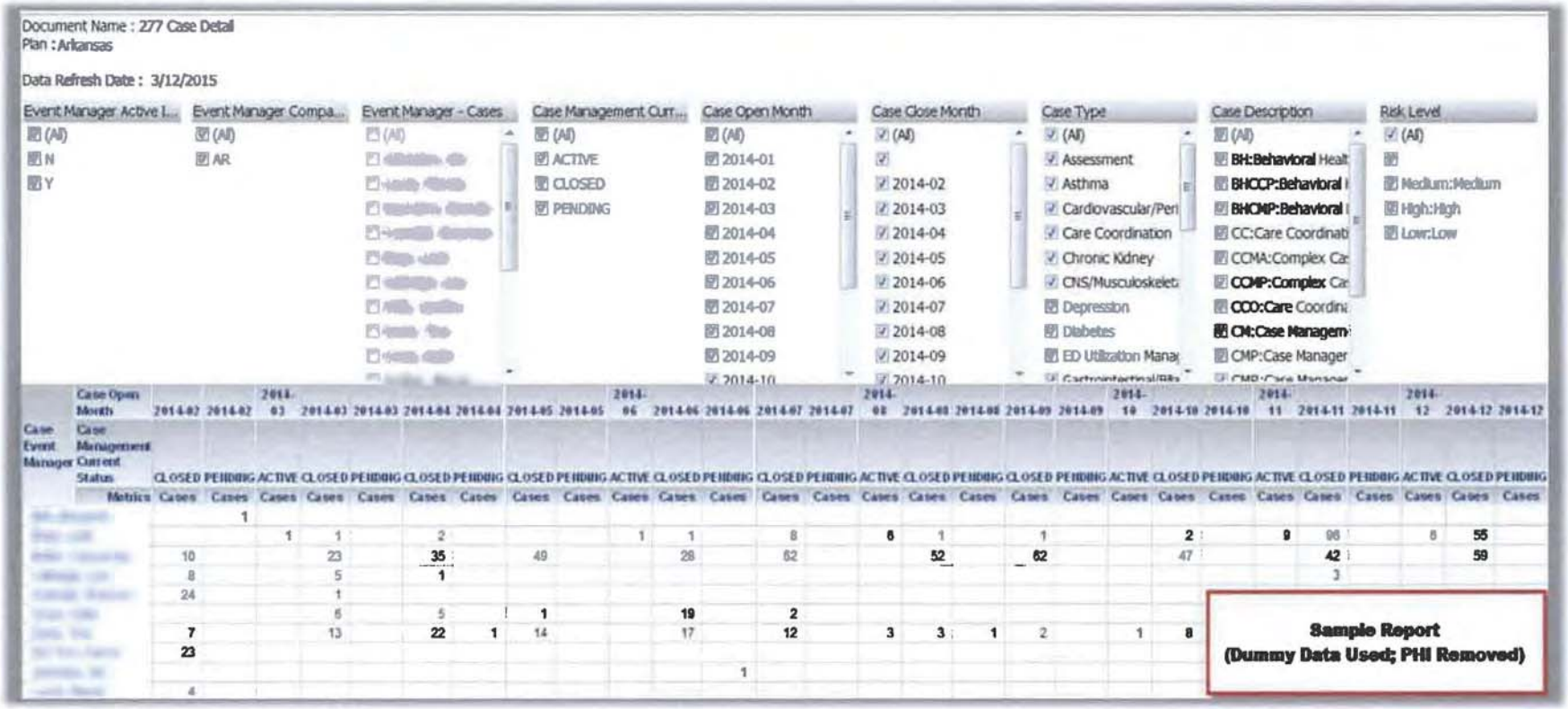


Figure Q114.F: Drug Utilization

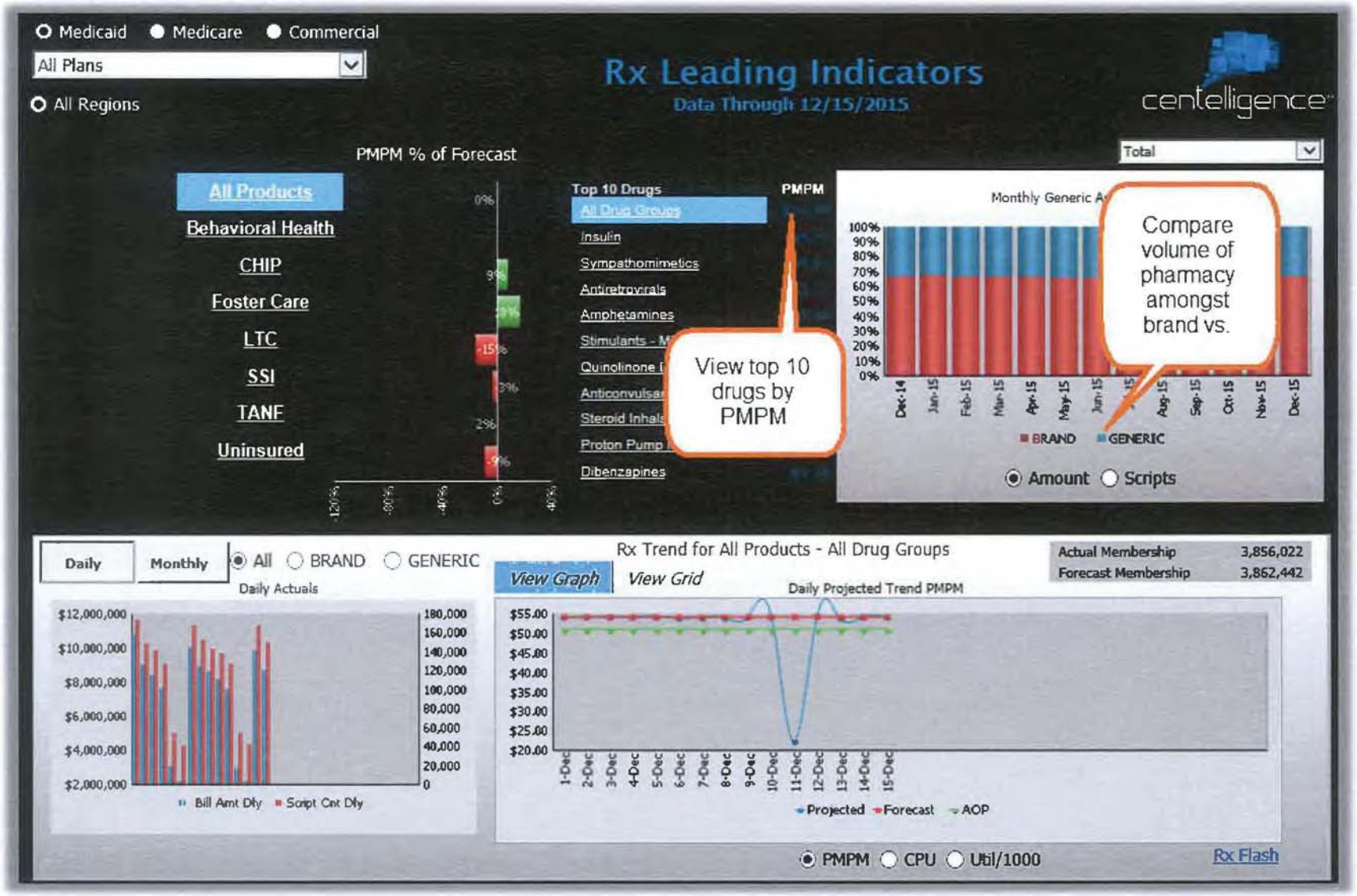


Figure Q114.G: Claims Operations

Figure Q114.H: Clinical Neonate Indicators

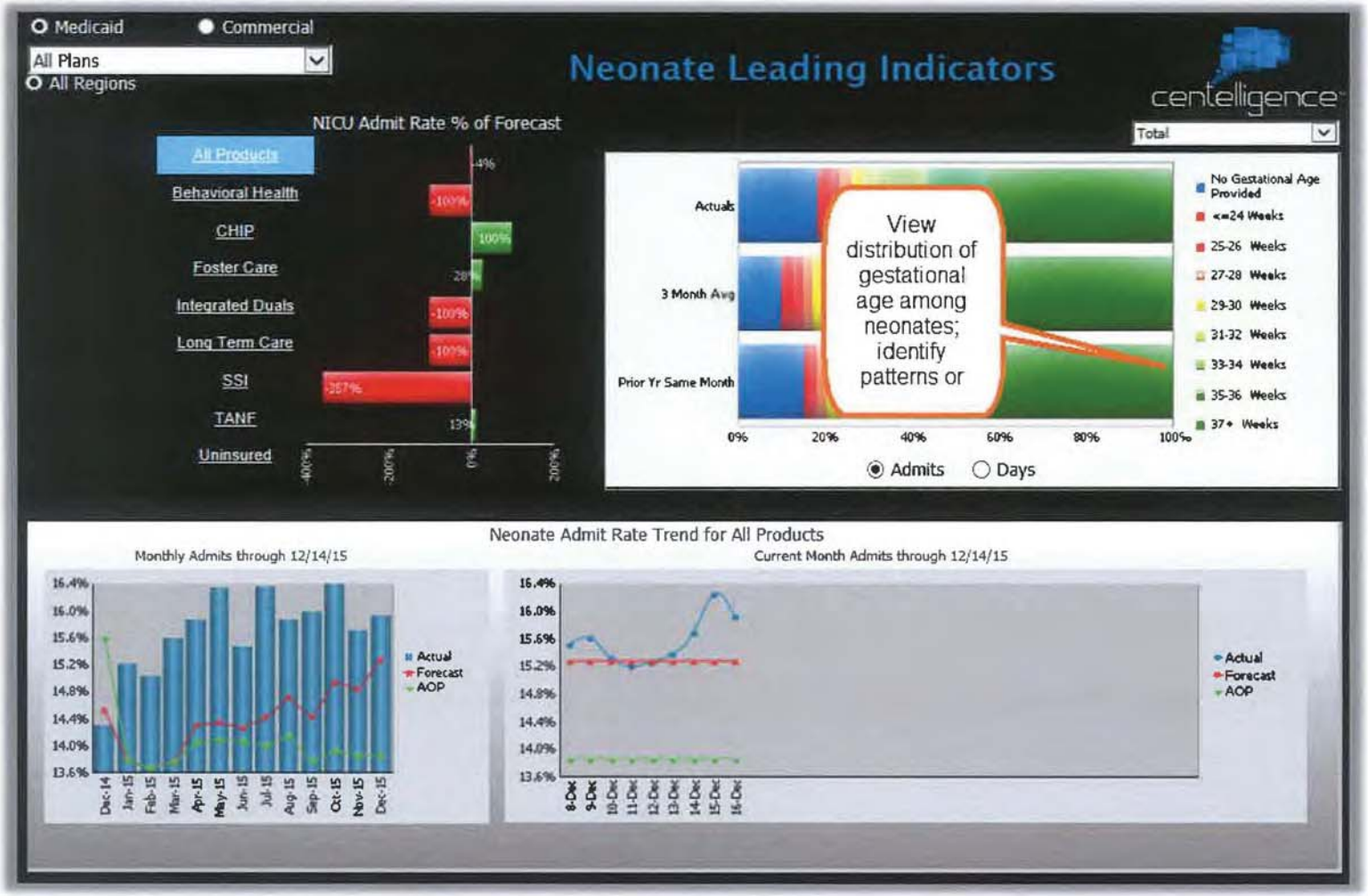


Figure Q114.I: Population Health Management: Flu Prevention

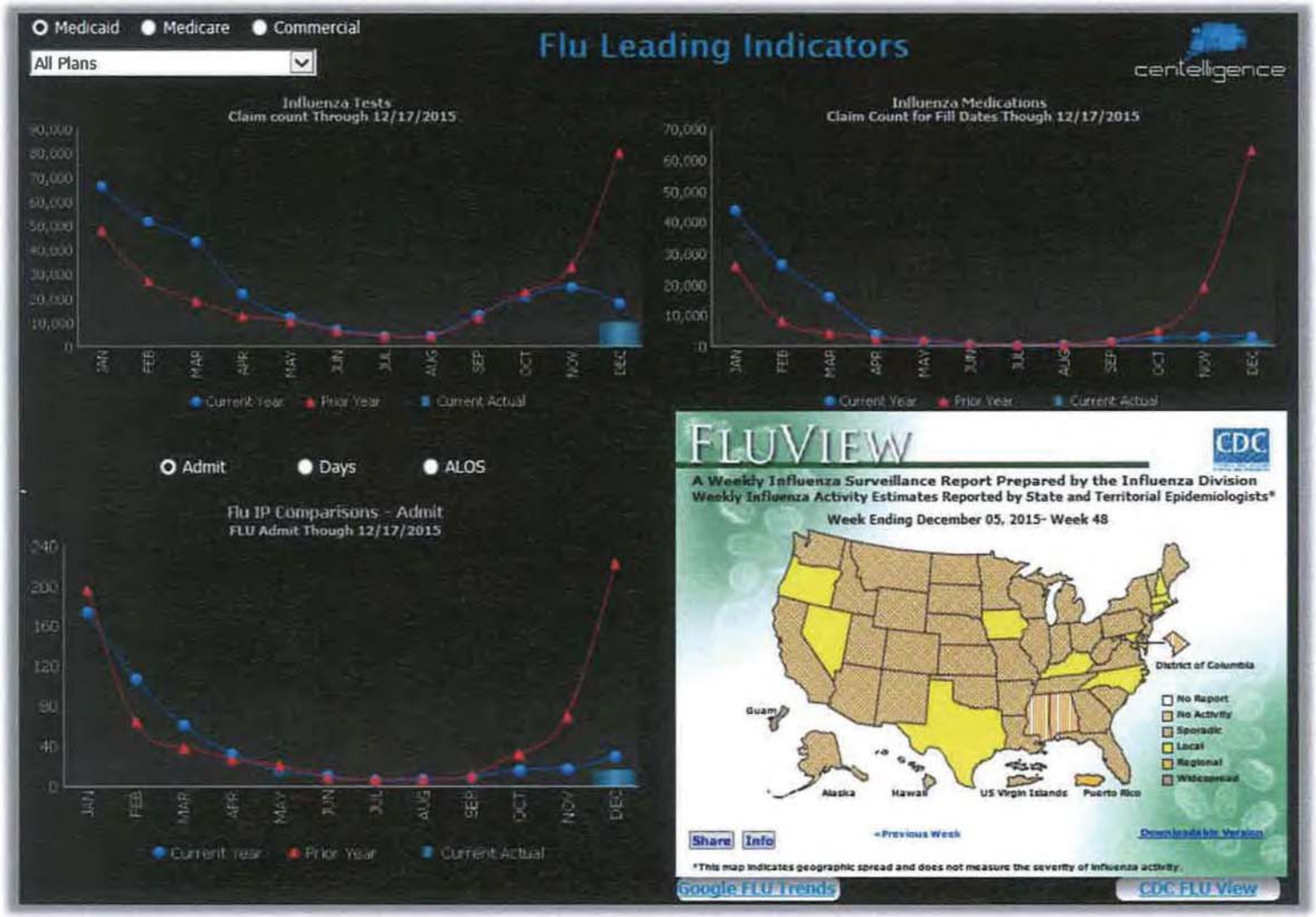
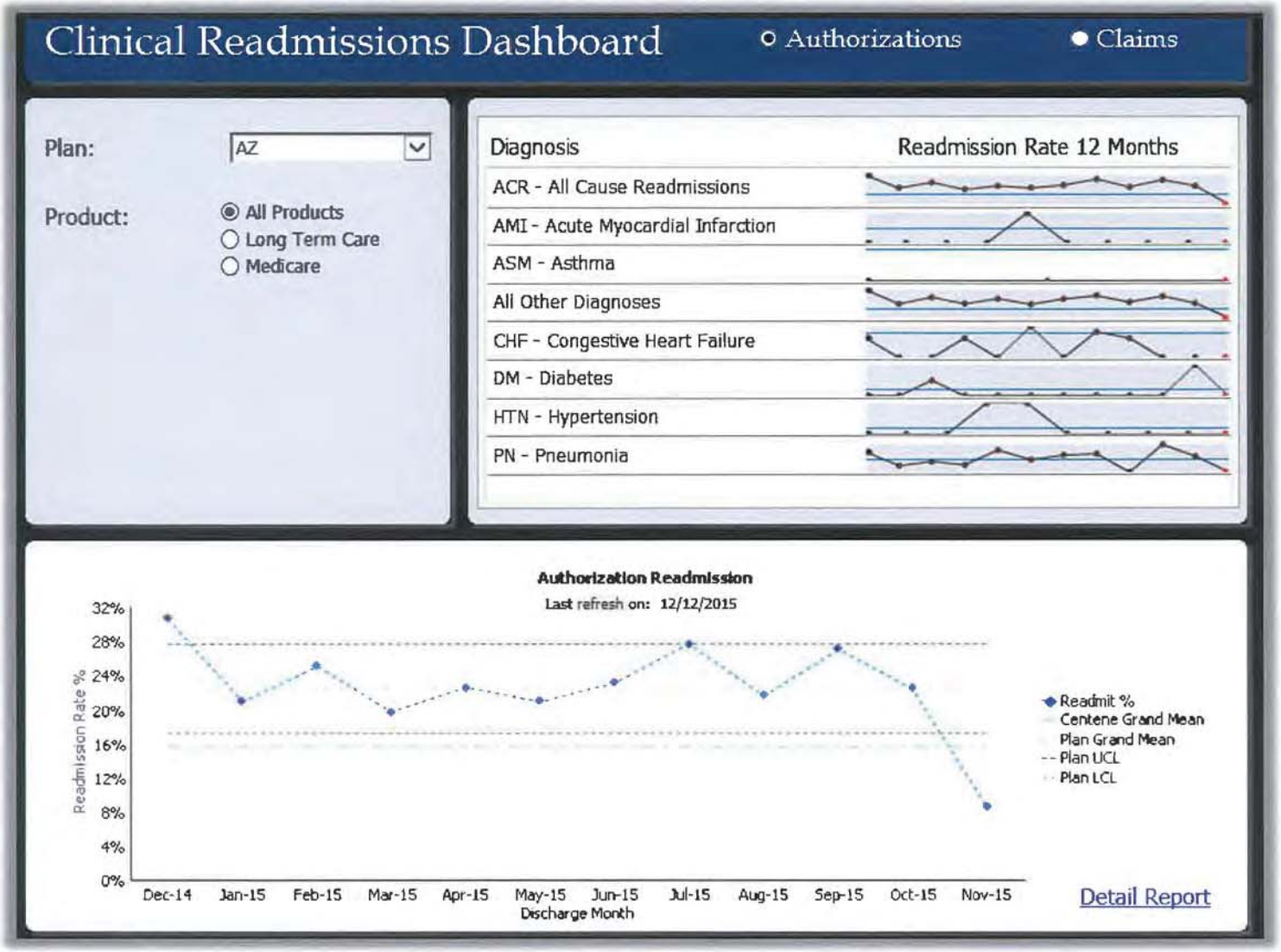


Figure Q114.J: Clinical Quality: Readmissions



(page limit N/A)
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?"

Use of Required Reports in Day to Day Management and Operations

The following sections outline the procedures Nebraska Total Care (NTC) will utilize related to required and ongoing reporting under the three areas highlighted: Member Grievance System, Performance Improvement Projects, and Care Management.

Member Grievance System Reports. Nebraska Total Care will utilize Member Grievance System reports according to the procedures outlined below.

Staff Accountability. Complaint, grievance, and appeals data will be reviewed by appropriate NTC staff and committees for action on an ongoing basis as needed. The Grievance Manager (GM) will be responsible for running reports on the member grievance system and will utilize these reports in day-to-day management of the member grievance process and the member appeals process. The Quality Improvement Committee (QIC) will review all inquiry, appeal, complaint, and grievance summaries, including any handled by subcontractors under a delegated agreement, on a quarterly basis to identify issues requiring follow up or improvement. The GM will utilize required reports as outlined in ***Table Q115.A***.

Table Q115.A: Required Reports

Monthly Reports (transitioning to quarterly after six months)	
Grievances	Summary of new grievances, resolved grievances, and status of unresolved grievances
Appeals	Summary of new appeals, completed appeals, and the status of each ongoing appeal
Expedited Appeals	Summary of expedited appeals, completed expedited appeals, and the status of each ongoing expedited appeal
State Fair Hearings	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing

How Required Reports will be Used and Frequency of Review. NTC recognizes that tracking and trending of member expressions of dissatisfaction provides valuable information about what may be problematic for a member and what changes need to occur to provide optimal service to members. To meet this goal, monthly grievance and appeals reports as outlined above, as well as several other management reports, will be used by the GM to identify trends and patterns that require attention. Any trends that are discovered which are specific to a department or service will be submitted to the appropriate department for review and corrective action. Trends in grievance data are reviewed monthly by the Performance Improvement Team (PIT), a sub-team of the QIC. A quarterly report will be presented to the QIC based on trends addressed during monthly PIT meetings, where further review and recommendations occur as needed. NTC's PIT will perform a monthly in-depth review of complaint, grievance and appeal data to identify trends or issues requiring follow up or improvement. Those areas will include whether NTC and MLTC standards for timeliness and other processing issues are being met; identifying patterns related to specific issues, providers or NTC departments; and targeting any needed corrective actions. Certain trends in grievance data may identify member education needs or changes to member-facing procedures, such as member service call routing or access to certain information on the Member Portal. Regular grievance and appeals reporting and data analysis will enable NTC to identify these issues and develop and implement solutions.

The Utilization Management Committee (UMC) will review appeals data to identify trends that indicate when specific utilization guidelines should be updated, developed or clarified or that there is a provider

education need. NTC will incorporate aggregate data for the member and provider experience analysis for the annual QI Program Evaluation.

Table Q115.B summarizes how grievance and appeal data will be used to identify performance issues and to develop performance improvement initiatives, and which department will be involved in developing and implementing the initiatives.

Table Q115.B

Performance Issue	How Data will be Used	Department
Access/Availability Deficiencies	Identifying Network Gaps; Provider Wait Times, Compliance, and Training	Provider Relations and Network Contracting
Quality of Care, Member Safety, Abuse of Member – Adult and Child	Training/Re-credentialing/Peer Review	Medical Director, QI
Benefit Questions	Improvements to Written Materials	Member and Provider Services, and Marketing
Service Levels	Staffing Adjustments/Training Technology Enhancements	Member/Provider Services
Customer Service Deficiencies	Business Process Improvement	Applicable Functional Area
Inappropriate Billing Practices	Prevention of Fraud, Waste, and Abuse	Compliance/Special Investigations Unit

Identification of Training Opportunities and other Interventions. Grievance data is categorized according to subcategories that will allow NTC to identify and monitor trends in certain areas of NTC's operations. For example, review of grievance data may identify a pattern of a high number of complaints about call wait times or call routing issues with the call center. Grievance data can help NTC identify if there is an issue with staff performance at the call center, with the interactive voice response system (IVR), or if there is a staff knowledge gap. These grievance report trends would then be shared with the applicable functional area to identify the root cause of the grievances and to develop potential solutions to these issues. In this case, Customer Service participates on the PIT, so leadership of this functional area would hear information on grievance trends through regular PIT meetings. Based on this information, they could implement training for call center staff or make changes to the IVR as appropriate to alleviate the member issue that is generating grievances.

Report Examples

Please see ***Attachment 115.A_Sample Member Grievance System Reports*** for examples of Member Grievance System reports.

Performance Improvement Project Reports

Staff Accountability. Performance Improvement Projects (PIPs) will be managed internally within the NTC Quality Improvement department and led by the Vice President of Quality Improvement. Results of PIPs are tracked internally on an ongoing basis, at a minimum quarterly, and are reviewed by the Performance Improvement Team (PIT), a sub-team of the Quality Improvement Committee (QIC).

Results of PIPs are also regularly reported to the State and the External Quality Review Organization as applicable, per State reporting requirements (***Table Q115.C***).

Table Q115.C: Required Reports

Annual Reports	
Performance Improvement Projects	Data summarizing annual results of each new and ongoing PIP.

How Required Reports will be Used and Frequency of Review. NTC will continuously monitor its performance on a variety of dimensions of care and service for enrollees. We will identify opportunities for improvement, implement performance improvement projects (PIPs), and evaluate the effectiveness of those interventions. Per the RFP requirements, NTC will implement quality improvement projects in both clinical care and non-clinical services such as system or service initiatives. NTC will conduct at least ***two*** clinical and one non-clinical PIPs. At least one clinical PIP must address an issue of concern to the Heritage Health population. A second clinical PIP will address a behavioral health concern. NTC will also participate in one joint PIP with the other Heritage Health MCOs. Improvement in PIP measures will be demonstrated through ongoing measurement and intervention. Our PIPs will include those required by MLTC as well as those identified by analysis of NTC-specific data.

At least quarterly, the results of PIPs will be reported to the PIT for review and discussion. The PIT reviews the progress of each PIP, preliminary results of each PIP, and what improvements could be made to improve interim results. PIT review of PIP progress may include ensuring that the PIP will be completed on time, identification of interventions to achieve quality improvement, and successes and challenges and barriers encountered in conducting each PIP. Real, sustained improvements in care result from a continuous cycle of measuring performance, analyzing performance, and developing and implementing system-wide improvements in care or service. Improvements in care or service depend on thorough analysis and implementation of appropriate solutions.

Once the QIC analyzes PIP study results and collects and identifies additional information to explain results, it must develop a quality improvement plan. Depending upon the nature and scope of identified problems, the QIC may involve more people or form subgroups to address specific issues. Other issues in implementing the action plan may include: clearly defining specific tasks to be accomplished, identifying persons responsible for the tasks, establishing timelines, and determining how and when the quality improvement plan's effectiveness will be measured.

Annually, the QI team will report on the results of all new and ongoing PIPs as part of the annual QI Program Evaluation and will provide required reports to the state.

Identification of Training Opportunities and other Interventions

The ongoing evaluation and tracking of progress and measure performance through PIPs may identify the need for additional provider or NTC staff training. For example, performance on a particular PIP related to a specific HEDIS measure may uncover the need for enhanced provider training related to identifying gaps in care and providing outreach to members to help close care gaps. At the completion of a PIP, NTC may identify system interventions that are needed to improve measure performance, which may include operational changes or training.

Report Examples

Please see ***Attachment 115.B_MHS Health Wisconsin Diabetic LDL-C Screening and Performance Improvement Project*** and ***Attachment 115.C_ 2013–2014 PIP Report***, for sample Performance Improvement Project reports.

Care Management Reports

Staff Accountability

Care Management managers utilize regular reports and ad hoc reporting to manage the day-to-day operations of the Care Management department. These reports include views into utilization such as ER utilization and inpatient admissions, as well as reports that track performance of the Care Management program against performance targets and help managers identify gaps in care management and staff training needs (***Table Q115.D***).

Table Q115.D: Required Reports

Quarterly Reports	
Care Management	Summary data and metric results as determined by MLTC.

How Required Reports will be Used and Frequency of Review

NTC will utilize a variety of care management reports to manage the day-to-day operations of our care management function. These reports will assist NTC in meeting the goals of our integrated care model and will promote effective and efficient care delivery. NTC will utilize several care management reports as outlined below. This list is not exhaustive but rather presents an overview of the primary reports that will be utilized to support care management.

- Reason Detail Report – This report provides information to the health plan on the sources of referrals into care management. Managers will utilize this report at least quarterly. For example, if all referrals are being generated by UM, the health plan may need to engage Provider Relations to provide education to providers. NTC will compile quarterly reports at the end of year to develop an overall quality report on the sources of referrals and whether the plan is tapping into all available sources to get members in need of care management into care management services.
- Emergency Room Frequent Flier Report – This report assists the Care Management department with identifying members who have high utilization of the ER over a specific time period. This report is utilized by Care Managers to identify members in need of outreach, including those members already in care management and those who may need to be enrolled in care management. The Care Managers then work with members to provide guidance about accessing care via a PCP or urgent care when a condition is not an emergency, or reaching out to the Nurse Advice Line to receive help via phone. A Care Manager may also identify that a member went to the ER in an ambulance due to a transportation issue that could be addressed by arranging alternative transportation.
- Inpatient Discharge Report – This report lists members who were recently discharged from the hospital. Care Managers utilize this report on a weekly basis to drive members into care management who were recently discharged from the hospital to help with transition of care issues, setting up follow-up appointments, accessing prescriptions, and ensuring that members follow their discharge instructions.
- Notes Summary Report – This monitoring report is generated from the care management system to identify members in care management who are due to receive contact from a Care Manager. This report helps ensure that no members in care management go too long without outreach.
- Case Detail Report – This report provides detail on open case management cases and sorts cases by acuity level, i.e. high, medium, and low. The report identifies the plan for frequency of contact with each member, what type of case it is, and what conditions each member has that are managed through care management.
- Care Plan Summary – This report identifies any members with an active, open TruCare Care Plan and also shows the last time the Care Plan was revised. Managers utilize this report to monitor individual Care Manager outreach to assigned members and the ongoing activity focused on assisting members to achieve their goals.
- Ad hoc state reporting – NTC will have the capability through Centene's care management system to run reports utilizing specific care management parameters, as needed. For example, NTC may generate a report showing the status of Health Risk Screenings and the percentage of members who have received a Health Risk Assessment, or a report that tags members who have certain health conditions

that the state wants to monitor. NTC may also generate reports to identify candidates for disease management programs. For example, NTC may identify members who smoke and drive those members into the smoking cessation disease management program.

NTC will have the ability to report on the following care management metrics in addition to those outlined above:

- Number and % of enrolled clients receiving the Health Risk Assessment (HRA)
- Number and % of enrolled clients identified for care management
- Number and % of clients receiving care management
- Number and % of clients by client group (AABD, special needs, etc.) receiving care management
- Number and % of clients receiving care management by medical condition-overall and by age group (0-18, 19-64, 65+)
- Number of % care management outcomes achieved-overall and by age group
- Number and % of care management cases closed with reason for closing-overall and by client group

Identification of Training Opportunities and Other Interventions

Across Centene's 20 affiliate health plans, Care Management managers continually utilize care management reports to identify patterns in care management performance and operations. When patterns of performance issues or process challenges are identified, interventions are developed and implemented. NTC will utilize the reports outlined above, as well as other ad hoc and state reporting, to continually improve its Care Management program. Should patterns of performance issues be identified, training will be implemented for impacted Care Managers. For example, in the case of a high acuity member who, based on the Case Detail report, would benefit from additional outreach, a manager would coach a Care Manager on the need for this additional outreach. Operations or training programs are continually evaluated and quality control is conducted to ensure high performance of the Care Management program.

Report Examples

Please see ***Attachment 115.D_Care Management Reports*** for examples of the care management reports outlined above.

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IV.T ATTACHMENTS

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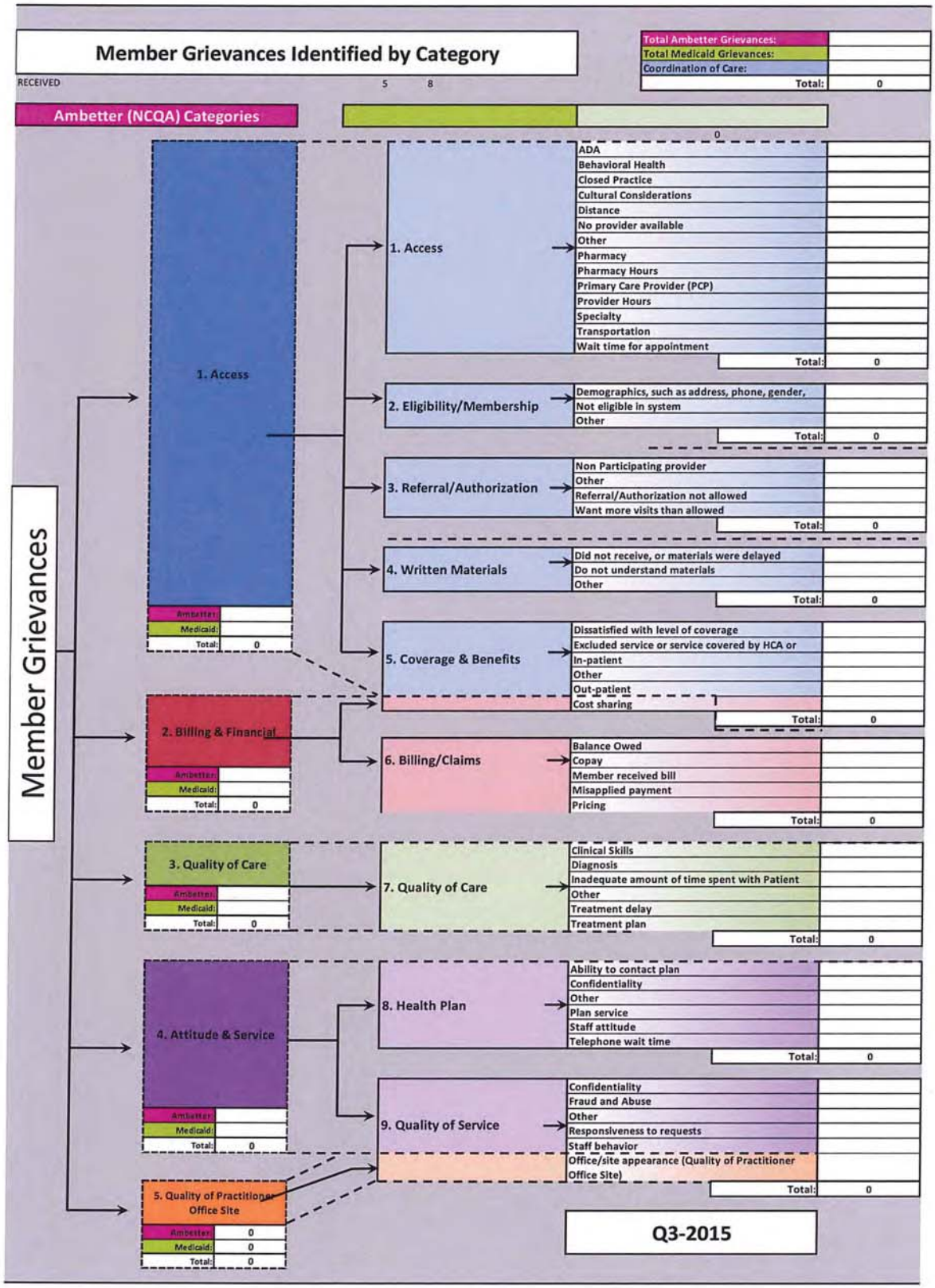
Attachment
115.A_ Member Grievance System Reports


Member Grievances Identified by Category
RECEIVED
5 8
Total Ambetter Grievances:
Total Medicaid Grievances:
Coordination of Care:
Total: 0
Ambetter (NCQA) Categories
0
Member Grievances
1. Access
Ambetter:
Medicaid:
Total: 0
2. Billing & Financial
Ambetter:
Medicaid:
Total: 0
3. Quality of Care
Ambetter:
Medicaid:
Total: 0
4. Attitude & Service
Ambetter:
Medicaid:
Total: 0
5. Quality of Practitioner Office Site
Ambetter: 0
Medicaid: 0
Total: 0
1. Access
ADA
Behavioral Health
Closed Practice
Cultural Considerations
Distance
No provider available
Other
Pharmacy
Pharmacy Hours
Primary Care Provider (PCP)
Provider Hours
Specialty
Transportation
Wait time for appointment
Total: 0
2. Eligibility/Membership
Demographics, such as address, phone, gender,
Not eligible in system
Other
Total: 0
3. Referral/Authorization
Non Participating provider
Other
Referral/Authorization not allowed
Want more visits than allowed
Total: 0
4. Written Materials
Did not receive, or materials were delayed
Do not understand materials
Other
Total: 0
5. Coverage & Benefits
Dissatisfied with level of coverage
Excluded service or service covered by HCA or
In-patient
Other
Out-patient
Cost sharing
Total: 0
6. Billing/Claims
Balance Owed
Copay
Member received bill
Misapplied payment
Pricing
Total: 0
7. Quality of Care
Clinical Skills
Diagnosis
Inadequate amount of time spent with Patient
Other
Treatment delay
Treatment plan
Total: 0
8. Health Plan
Ability to contact plan
Confidentiality
Other
Plan service
Staff attitude
Telephone wait time
Total: 0
9. Quality of Service
Confidentiality
Fraud and Abuse
Other
Responsiveness to requests
Staff behavior
Office/site appearance (Quality of Practitioner Office Site)
Total: 0
Q3-2015

A .hment 115.A_ Member Grievance System Reports

Medicaid Grievances Received by Type
(CY 2015)

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Total	Total % Received
Quality of Care	10	6	4	8	8	6	4	3	8				57	11.5%
Eligibility & Membership	3	0	0	1	0	1	0	0	0				5	1.0%
Referral & Authorization	3	2	1	5	2	1	0	2	2				18	3.6%
Written Materials	2	0	1	0	0	0	0	1	0				4	0.8%
Coverage & Benefits	3	1	2	0	2	0	0	0	1				9	1.8%
Quality of Service	12	6	3	3	0	4	0	3	2				33	18.8%
Access	2	3	1	8	3	3	0	0	0				20	4.0%
Billing & Claims	66	50	49	37	32	23	32	22	12				323	65.4%
Health Plan	6	5	2	3	5	1	2	0	1				25	5.1%
Total	107	73	63	65	52	39	38	31	26	0	0	0	494	

Page 1

Plan Name	Delegated Entity	Reporting Period (month, year or Quarter)	Enrollee ID or Provider One ID	Enrollee Last Name	Enrollee First Name	Enrollee Middle Initial	Enrollee Birthdate (MM/DD/YYYY)	Practitioner Last Name	Practitioner First Name	Practitioner Middle Initial	Practitioner Specialty	Practitioner NPI	Type/Level 1. Grievance 2. Denial/Action 3. Appeal 4. IRO 5. State Hearing	Expedited (X if Yes)	Description of Grievance, Action/Denial, or Appeal by Category	Description of Grievance, Action/Denial, or Appeal by Subcategory	Resolution	Date Received (MM/DD/YYYY)	Date Reviewed (MM/DD/YYYY)	Date Resolved (MM/DD/YYYY)	Date written notice sent to enrollee and practitioner (MM/DD/YYYY)
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Nebraska Total Care																					
Nebraska Total Care																					
Nebraska Total Care																					

Member Complaints/Grievances							
NCQA Category	**Attitude/Service by Health Plan**	**Attitude/Service by Provider**	**Billing/Financial**	**Practitioner Office Site Quality**	**Access to Care & Services**	**Quality of Care Issue**	**Delegated Vendor/Service**
NCQA Subcategories	UM - Auth/referral process; problem getting care approved	Rude/unprofessional office staff	Claims payment	Adequacy of exam room (site visit required)	Lack of facility - IP/OP services	Rude/unprofessional provider or clinical staff	Behavioral health vendor issue
	Cultural awareness issue	Cultural awareness issue	COB issue	Adequacy of waiting room (site visit required)	Lack of Primary Care Provider	Did not explain treatment/medications	Dental vendor issue
	Dissatisfaction with CM/CM process	Delay in referral	Co-payment/co-insurance/ deductible issue	Physical accessibility issues (site visit required)	Lack of specialist	Provider refused to treat member	Vision vendor issue
	Excessive telephone wait time	Excessive telephone wait time	Member Premuim Billing issue	Physical appearance/office not clean (site visit required)	Out-of-network provider	Suspected fraud or abuse	Home health/DME vendor issue
	Failure to respect member's rights	Did not return telephone call	Eligibility issue	Privacy/confidentiality issue with site	Transportation issue	Privacy breach	Pharmacy vendor issue
	Incorrect PCP assignment	Failure to respect member's rights	Provider billing member	Office site - other	Specialist - appointment availability	Poor care received	Radiology vendor issue
	Language barrier with health plan	Discrimination by provider	Billing - other		PCP - appointment availability	Quality of Care - other	PT/ST/OT vendor issue
	Member materials not received	Language barrier with provider			After hours access		Transportation vendor issue
	Member materials difficult to understand	Provider service - other			Distance to Provider		Vendor issue - Other
	Rude/unprofessional health plan staff	Excessive wait time in office			Unable to obtain medications		
	Service/benefit limitations or exclusions				Access - Other		
	Privacy/confidentiality						
	Sales information/ staff/website						
	Member website portal						
	Discrimination by health plan						
	Health plan service - other						

Member Appeals					
NCQA Category	**Quality of Care Issue**	**Problem w/Access to Care & Services**	**Billing/Financial**	**Practitioner Office Site Quality**	**Attitude/Services by Health Plan**
NCQA Subcategory	Pre-Service Denial - MNC (Pharmacy)	Admin Denial - Out of Network	Post Service - Claim		Post Service - Lack of Prior Authorization
	Pre-Service Denial - MNC (DME)	MNC Denial - Out of Network			Post Service - Failure to adhere to requirements
	Pre-Service Denial - MNC (OP Medical Services)				
	Pre-Service Denial - MNC (OP PT/ST/OT)				
	Pre-Service Denial - MNC (Behavioral Health)				
	Pre-Service Denial - MNC (Dental)				
	Pre-Service Denial - MNC (Non-Covered Services)				
	Pre-Service Denial - MNC (Inpatient Services)				
	Concurrent Denial - MNC (Inpatient Services)				

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Attachment 115.B_MHS Health Wisconsin Diabetic LDL-C Screening and Performance Improvement Project

Attachment 115.B_MHS Health Wisconsin Diabetic LDL-C Screening and Performance Improvement Project

Diabetic LDL-C Screening Performance Improvement Project

MHS Health Wisconsin
Milwaukee, WI

Submitted July 01, 2015

Diabetic LDL-C Screening Performance Improvement Project

LDL-C Screening is part of the Comprehensive Diabetic Measure for the State Pay for Performance Program and was chosen as a Performance Improvement Project so we as a Health Plan can improve our screening rates and meet the projected 2014 goals as established by the State.

Study Topic

Diabetes is a common, controllable, life-long condition affecting over 475,000 adults in Wisconsin. Diabetes is a metabolic disorder characterized by high blood glucose levels resulting from defects in insulin production, action or both. People with diabetes are at increased risk of complications including blindness, kidney disease, foot and leg amputations, heart disease, stroke, depression, poor oral health, and death from influenza and pneumonia. Many of these complications may be prevented, delayed, and/or progression slowed, by optimizing glycemic control and providing ongoing preventive care to include early identification of problems, intervention, and treatment.[1]

The costs of diabetes in Wisconsin are high. In 2009 direct costs for adults were estimated at $4.07 billion, indirect costs for adults were estimated at $2.14 billion for a total of $6.21 billion.[2]

The Wisconsin Diabetes Prevention and Control Program, Bureau of Community Health Promotion, Division of Public Health, Department of Health Services has written the Wisconsin Diabetes Mellitus Essential Care Guidelines, (last updated in 2012). Under cardiovascular care it is recommended that adults receive annual Lipid Profiles. The Lipid Profile includes: Total Cholesterol, Triglycerides, HDL, Non-HDL and LDL. LDL-C Screening is the focus of this project. The optimal goal for the LDL is for less than 100 mg/dL. For very high risk diabetics the goal for the LDL is for less than 70 mg/dL.

MHS Health Wisconsin met the State Pay for Performance goal for 2012 for half of the Diabetic Measure HgbA1C, but did not meet the State Pay for Performance goal for LDL-C screenings and is now focusing on how to meet/exceed this State Pay for Performance goal in 2014. Both measures are part of the five-step NCQA HEDIS 2014 Comprehensive Diabetes Care description:

- HbA1c testing and level of control
- Eye Exam (retinal) performed
- LDL-C screening and level of control
- Medical attention for nephropathy
- BP Control

These five parameters are an important standard of compliance and determine "diabetic control" as established by the clinical practice guidelines. It is important for all diabetic

members of the Health Plan to achieve the highest level of care for their own personal gain and improved quality of life. Hyperlipidemia is a treatable condition with diet modification and cholesterol lowering medication.

MHS Health Quality Improvement Committee (QIC) approved a Diabetic Guidance Program focusing on outreach to Practitioners and Members about the importance of obtaining HgbA1C and LDL-C screenings for all diabetic members by reviewing and revising interventions and outcomes of the program.

Study Question

The project aim is to increase the percentage of MHS Health members with a diagnosis of Diabetes (type 1 and type 2) that are compliant with an annual LDL-C screening to meet the goal established for the 2014 State Pay for Performance Measure of 74.4% for BC+ members and 76.3% for SSI members during the measurement period (calendar year 2014).

Study Indicator

Current interventions of the Diabetic Guidance Program include the following:

- Quarterly member outreach through mailings, preventive health reminder postcards and outreach calls informing them of the importance and need to receive their biannual HgbA1c, annual LDL-C screening, annual retinal eye exam and nephropathy screenings.
- Practitioner and member newsletter articles on the importance of screening and follow-up.
- Annual reminders to obtain flu vaccines via a postcard mailing and outreach phone calls.
- Educational information available at Health Fairs/Community Events and through the Medical Case Management Department.
- Referral to Case Management program.
- Referral to StartSmart for Your Health program for diabetics, this program includes a letter, magnet, and journey book informing members of needed routine screenings, documenting blood sugar and BP results.
- MHS website enhancement which allows both practitioners and members to access the 2012 Wisconsin Diabetes Mellitus Essential Care Guidelines.
- Case Managers were provided the web address for an online directory of community resources that promote and support healthy behaviors for people with diabetes.
- CRM (software program) enhancement that shows any "gap in care" for members. This allows Member Services representatives to provide a verbal reminder to the member during any telephone contact.

- Collaboration with large provider groups that would contact their non-compliant clients who were in need of a HgbA1c and/or LDL-C screening and the clinic would assist them to receive the needed tests.

Measurement Period: 01/01/14 – 12/31/14.

Numerator: Number of MHS members aged 18 – 75 years of age that have a diagnosis of Diabetes that have obtained a LDL-C screening (Lipid Panel) in the measurement year by review of claims data and/or chart reviews and that meet enrollment criteria.

Denominator: Number of MHS Health members aged 18 – 75 years of age that have a diagnosis of Diabetes (type 1 or type 2) in the measurement year by review of claims/encounter data or pharmacy data and that meet enrollment criteria.

Baseline Data:

MHS Health	LDL Screening	Denominator
BC+ - 2012	71.57%	313
SSI - 2012	73.30%	429
BC+ - 2013	75.14%	362
SSI - 2013	76.74%	430

Study Population

All MHS Health members that are:

- Between the ages of 18 – 75 years of age;
- BadgerCare Plus (BC+) or SSI (Non-duals only);
- Diagnosed with Diabetes (type 1 or type 2) as determined through claims/encounter data or pharmacy data;
- Continuously enrolled during the measurement year with no more than a 1-month gap in enrollment.

Sampling Methods

The sampling method will be Hybrid based on the NCQA HEDIS 2014 Technical Specifications for Health Plans. 411 claims data and/or medical records will be reviewed to determine the numerator; if the number is less than 411 the entire denominator will be reviewed.

Data Collection Procedures

The project will follow HEDIS 2014 Technical Specifications for Health Plans - Volume 2, for:

- Numerator: Identifying members with LDL-screening utilizing claim data with CPT codes 80061, 83700, 83701, 83704, 83721 during the measurement year.
- Denominator: Identifying members with Diabetes (type 1 or type 2) through claim/encounter data and by pharmacy data. The claim/encounter data will include at least two outpatient visits, at least one acute inpatient encounter or one ED visit during the measurement year or the previous measurement year. Pharmacy data will be based on members that were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year or the previous measurement year.
- MHS Health will utilize the following reporting tools to measure improvement over time during the measurement period. The final state rates for 2014 will be the final data for 2014 submission of results.
- Amisys – claims based reporting system used by parent company for storing member, provider and encounter data for historical viewing.
- QSI (Quality Spectrum Insight) – HEDIS software used by parent company as a NCQA certified HEDIS Data Repository.
- TruCare – Clinical Management documentation software developed by the parent company.

The data will be processed on a monthly basis as a 12 month rolling review. The data will be processed through the above software programs by the Quality Improvement Department HEDIS Coordinator. The data will then be analyzed on a monthly basis for improvement (increase in percentage) and proximity to goal attainment by the Quality Improvement Department staff.

Improvement Strategies

- Current diabetic members in case management that are noncompliant for annual LDL-C screening will be contacted by their Case Manager and encouraged to comply with their annual LDL-C screening.
- Referral of diabetic members to a telephonic disease management program that includes: medication comprehension and compliance, self-blood glucose monitoring, recognizing signs of low and high blood glucose levels, nutrition counseling for carbohydrate counting and weight management, recommended annual screening for diabetic complications, blood pressure and cholesterol management, optimizing physical activity levels to meet recommended guidelines, supporting tobacco cessation, consults with specialty health coaches and sending out educational materials.

- Referral of diabetic members that are noncompliant for LDL-C screening to Exam One (Quest Labs) for telephonic and/or face to face outreach including on site (home) lab draws that is coordinated with the member's PCP.

Data Analysis and Interpretation of Study Results

Percentage of LDL Screening Numerator / Denominator

MHS Health	2012	2013	2014 Goal	2014 - Preliminary
BadgerCare Plus	71.57%	75.14%	74.4%	67.80% 179/264
SSI	73.30%	76.74%	76.3%	77.85% 334/429

The results show a positive gain for MHS Health SSI members but a negative loss for MHS Health BadgerCare Plus members. The SSI members showed a 1.11% gain from 2013 to 2014 and a 1.55% increase over goal. The BadgerCare Plus members showed a 7.34% loss from 2013 to 2014 and a 6.6% decrease below goal.

The outreach activities conducted by MHS Health during 2014 are as follows:

- **Member Calendar** with monthly health reminders
- **MHS Health Website**
  - Member resources has patient education related to Diabetes care
  - Provider resources has a link to the most current ADA Standards of Medical Care in Diabetes
- **Newsletters**
  - Member – Winter 2014 article on "Live Well With Diabetes"
  - Provider – Winter 2014 article on "HEDIS for Diabetes"
- Information provided to participants on diabetes care at 21 **community events**
- **Individual Member Contact** discussing Diabetes Care Gaps:
  - Connections Staff
  - Case Managers
- **CentAccount Healthy Rewards Program** provides a $50 reward for annual comprehensive diabetes care (HbA1c test, LDL-Cholesterol test, Kidney Screening and Dilated Eye Exam)
- **Weekly** multi-departmental **meeting** discussing HEDIS, NCQA, P4P and STARS. Meeting started in 2014 and led by Senior Leadership to review monthly reports and plan improvement strategies and interventions.
- **USMM (U. S. Medical Management)** provides in-home primary care services including lab testing.

- **Lab - Exam One (Quest)** providing in home lab services to non-compliant members.

2014 MHS Health	
Members referred by MHS Health	384
Contact made with member	103
Number of completed specimen collections	37

- Corporate (Centene) sent an annual **mailing** in September 2014 to **members** who were non-compliant with at least one diabetic screening. The mailer was designed to include a tear off card with space for members to track their results and doctors' appointments.
- Corporate (Centene) developed a **provider letter** in September 2014 to encourage providers to review member diabetic screenings. It included:
    - list of members recently seen by the provider but still missing a diabetic screening
    - graph that showed provider compliance rates compared to NCQA rates
    - provider billing cheat sheet

- **Member Services** staff working in CRM reminded diabetic members during telephonic assistance if they were in need of one of the recommended tests.
- **MemberConnections** staff would assist and remind diabetic members during home visits and during telephonic outreach when completing HRA forms about the importance of recommended diabetic screening tests. They would offer to assist members to obtain an appointment.
- Case Managers and Program Coordinators would mail members a **Preventive Checklist** which included diabetic requirements.
- Worked with **Health Systems** MCW and Affinity to outreach to noncompliant patients for a financial incentive to the Health System.
- Participation in **State Diabetes Advisory Group**.

MHS Health met the goal in LDL-C screening for SSI members but not the BadgerCare Plus population and would answer the **Study Question:** The project aim is to increase the percentage of MHS Health members with a diagnosis of Diabetes (type 1 and type 2) that are compliant with an annual LDL-C screening to meet the goal established for the 2014 State Pay for Performance Measure of 74.4% for BC+ members and 76.3% for SSI members during the measurement period (calendar year 2014).

MHS Health's next steps include recognizing the importance of cholesterol management in future diabetic care. This is no longer a HEDIS (NCQA) or P4P measure.

Real Improvement

- The same methodology for LDL-C Screening was used to determine the baseline data for 2012 and 2013 as reporting current data for 2014.
- MHS Health demonstrated improvement through active participation at the health plan level through ongoing and new outreach activities as described above which for the most part will continue because of the components of diabetes care such as HbA1c, Nephropathy Screening, Blood Pressure and Dilated Eye Exam.
- Because we showed improvement in SSI members and not BadgerCare Plus members you wonder if Providers were following the recommendations from the 2013 American College of Cardiology/American Heart Association guidelines on the treatment of blood cholesterol and not ordering annual lipid profiles.

Sustainability

- This measure is no longer sustainable because it no longer represents a valid measure in HEDIS (NCQA) and as a State P4P measure.

- This measure is no longer sustainable because of a change in practice guidelines. According to the ADA Diabetes Care Standards of Medical Care in Diabetes 2015: Summary of Revisions the recommendations for statin treatment and lipid monitoring were revised after consideration of 2013 American College of Cardiology/American Heart Association guidelines on the treatment of blood cholesterol. Treatment initiation (and initial statin dose) is now driven primarily by risk status rather than LDL cholesterol level. With consideration for the new statin treatment recommendations, the Standards now provide the following lipid monitoring guidance: a screening lipid profile is reasonable at diabetes diagnosis, at an initial medical evaluation and/or at age 40 years, and periodically thereafter.

References

1. Wisconsin Department of Health Services, Division of Public Health, Diabetes Prevention and Control Program. Wisconsin Diabetes Surveillance Report, 2012. September 2012.
2. Wisconsin Department of Health Services, Division of Public Health, Diabetes Prevention and Control Program. Wisconsin Diabetes Surveillance Report, 2012. September 2012.
3. Wisconsin Department of Health Services, Division of Public Health, Bureau of Community Health Promotion, Wisconsin Diabetes Prevention and Control Program. Wisconsin Diabetes Mellitus Essential Care Guidelines, 2012.

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Attachment
115.C_ 2013–2014 PIP Report

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Attachment
115.D_Case Management Reports

Referral Reason Report

Member First Name	Member Last Name	Address 1	Address 2	City	State	Member ID	Birth Date	Gender	Medicaid ID	Product	Referral Source	Request Datetime	Referral Action	Referral Assigned To
Assignee Company Name	Determination Date	Determination By	Referral Created By	Referral Final Decision Created By	Description	Additional Referral Comments	Screening Notes	Referral Reason 1	Referral Reason 2	Referral Reason 3	Referral Reason 4	Referral Reason 5	Referral Reason 6	Referral Reason 7
Referral Reason 8	Referral Reason 9	Referral Reason 10	Referral Reason 11	Referral Reason 12	Referral Reason 13	Referral Reason 14	Referral Reason 15	Other Referral Reason	Decline Reason					

Top ER Reason Report

275 Top ER Diagnosis
Plan :

Data Refresh Date : 11/30/2015 3:30:15 PM

Status - Member	Risk Population	Region	Count (Service Start Date)
(All)	(All) ** MISSING **	(All) ** NO MATCH FOUND ** Region 2 - Southern Region Region 3 - Central Region Region 4 - Northern Region Region 5 -- Western Region	

Service Start Month	Product
(All) 2015-08 2015-09 2015-10 2015-11	(All) MA - MP - SHOP - Celticare-BRONZE MA - MP - SHOP - Celticare-SILVER

Plan Business Line	Status - Member ID	Member Numbers Amisys	Member Numbers Medicaid	Name - Member First	Name - Member Last	Member Current Age	Address - Member Line 1	Address - Member Line 2	Address - Member City	Address - Member State	Address - Member Zip Code

Phone Number - Member Primary	Alternate Phone Number -	Standard County - Member	Product Description	Region Description	Health Status Code	Health Status Description	Premium Level Code	Premium Level Description	Risk Population Code	Risk Population Description	Count (Service Start Date)

Notes Summary Report

Document Name : 312 Notes Summary				
Note Type	Note Month	Entered By Event Manager - No	Entered By Event Manager Company -	Note Category
All Note Types	(All)	(All)	All Companies	

Case Detail Report

Document Name : 277 Case Detail
Plan :

Data Refresh Date : 12/4/2015

Event Manager Active Inc	Event Manager Company - Cases	Event Manager - Cases	Case Management Current Status	Case Open Month	Case Type	Case Description
(All)	(All)		(All)	(All)	(All)	(All)

Metrics	Count of Cases
	1,172

Plan Unified Plan Code	Plan Business Line Description	Plan Plan Description	Case Event Manager Name	Case Event Manager Company Name	Case Event Manager Active Indicator ID	Member Numbers Medicaid	Member ID	Member Name Last	Member Name First	Member Birth Date	Latest HRA/HRS Completed By Event Manager Formatted Name	Latest HRA/HRS Completed By Event	Member Current Age	Member Sex	Address - Line 1	Address - City	Address - State

Eligibility Effective Date	Eligibility End Formatted Date	Eligibility Status - Member ID	Case Diagnosis Formatted Code	Case Diagnosis Formatted Description	Case Management Current Status ID	Case Activity Group ID	Case Description Name	_ Case Type	_ Contact Frequency	Risk Level Formatted Description	Case Close Reason Formatted Description	Case Last Update Formatted Date

Case Open Month YYYY-MM	Case Open Date	Case Close Month Formatt	Case Close Formatted Date	Length of Case ID	Product Description	Region Description	Health Status Code	Health Status Description	Risk Population Code	Risk Population Description	Premium Level Code

Readmission Detail Report

088 Auth Readmission Detail													
State Code	Admission Year Month	Admission Month	Admission Year	End Year Month	End Year	Member Amisys Number	Member Full Name	Product	Region	Date of Birth	Authorization Number	Attending Prov Number	Institution Name
Admit Date	End Date	LOS	Primary Diagnosis Code	Diagnosis Desc	Discharge Status Desc	Next Attending Prov Number	Next Instution Name	Next Admit Date	Next End Date	Next LOS	Next Diag Code	Next Diag Desc	Next Authorization Number
Next Discharge Status Desc	Type of Admission	End Month	Generic Product	Disease Desc	Next Disease Desc	UM Service Type	Diagnosis Type						

nebraska total care™

IV.X Transition and Implementation

IV.X Transition and Implementation

(5 page limit)

116. Describe how the MCO will coordinate the initial transition of individuals in the follow situations to ensure continuity of care:

A Record of Successful Member Transitions

Collaborative Approach with Agency Partners to Plan for Implementation and Operations. The foundation for facilitating the immediate delivery of services to Heritage Health members starts many months before implementation, during the planning stages. It is during this time that the key leaders from MLTC and other impacted agencies meet with Nebraska Total Care (NTC) and we plan for a seamless transition for these important and vulnerable populations. During this time, we plan for historical data transfers, new provider assignments, and transitional support processes that hinge on our ability to build trusting relationships and solid communication protocols. NTC is committed to ensuring continuity of care for members who transition into our plan. To aid in the successful transition of members into NTC, we will leverage the experience of affiliate Centene health plans which have transitioned large numbers of members in other states from fee-for-service (FFS) into managed care and from another MCO into a Centene plan. ***Figure Q116*** provides an overview of the 27 successful new implementations Centene and its affiliate health plans have completed since 2011, with several of these transitions involving transitioning from FFS to managed care. ***Figure Q116:***

NTC will build on this experience to ensure continuity of care for Heritage Health members who transition into our plan from other MCOs providing physical health coverage, behavioral health coverage, or both, or FFS. Given that Heritage Health will transition members into an integrated physical/behavioral health program, it will be especially important that this transition is managed carefully and executed smoothly to maintain continuity of care and services and minimize disruptions to the member. Our model of care places members at the center of an Integrated Care Team, which is comprised of physical and behavioral health (BH) Care Managers and clinical and non-clinical staff to meet the individual needs of the member. The lead Care Manager serves as the key point of contact between NTC and State agencies including MLTC; the member; caregivers; and providers to integrate all efforts to coordinate, manage, and ensure continuity of care. Our plan and policies for ensuring continuity of care, described in more detail below, will include the following:

- Coordinating with other MCOs to obtain information on existing authorizations, care plans, and providers
- Coordinating with MLTC to obtain needed information on FFS members
- Coordinating with providers involved with the member's care to obtain information about existing services

- Transitioning members seamlessly into our plan through outreach, assessments, and new Care Plan development, and ensuring new members have a medical home, and, as applicable, a BH home
- Authorizing and continuing services with participating and non-participating providers

Given that Heritage Health will also include the ABD population, we recognize that this particularly vulnerable population will require careful attention to continuity of care to ensure that member needs are being met. NTC will coordinate with providers across the care continuum to minimize any disruptions in services and to also ensure the member is well informed and comfortable with the transition as it occurs.

Dedicated Transition Coordinator. NTC understands the importance and complexity of transitioning members into, out of, or between health plans, especially for members with complex conditions and disabilities. With this in mind, NTC will designate a Program Coordinator to serve as a Transition Coordinator (TC). Our affiliates have found that this designated contact both promotes and streamlines communication between entities during transitions of care in or out of the health plan. The TC will assure that all relevant information, as described in this section, is retrieved and entered into our TruCare system and is sent to another MCO as needed.

Priority Outreach to Vulnerable Populations

NTC staff will prioritize outreach to new members to ensure those receiving current services, or who are at highest risk, are contacted quickly to assure there is no disruption in services during transition. These high priority members include, but are not limited to those who:

- Are **hospitalized** at the time of enrollment
- Have a prior authorization for **scheduled surgeries**
- Require **post-discharge follow-up** and therapies after transition or **out-of-area specialty services**
- Have **complex conditions or treatments** such as enteral feedings, oxygen, wound care, ventilators, medical supplies, or chemotherapy and/or radiation therapy
- Have **conditions requiring ongoing monitoring or screening**, such as elevated blood lead levels
- Have **significant medical conditions**, such as a high-risk pregnancy or pregnancy within the last 30 days, the need for organ or tissue transplantation, or chronic illness resulting in hospitalization
- Are in **out-of-home placement**
- **Meet criteria** or are referred for, or request, **Case or Chronic Care Management**
- Are **receiving medical supplies**
- Have **multiple providers** or are **receiving multiple medications**
- **Need to change** to a participating **PCP**

From another MCO.

Successful Transitions from another MCO to NTC

In the case of the Heritage Health program, members who were enrolled in managed care may be transitioning from an MCO that was providing coverage for physical health or from the single behavioral health MCO. Some individuals receiving behavioral health services through a managed care plan are also currently receiving physical health services through Nebraska's FFS Medicaid program. Given these complexities, it will be critical for NTC to approach each transition according to the specific member's situation and care needs. Our proposed approach to ensuring continuity of care for Heritage Health members transitioning from another MCO includes the following components:

- Identification of the member via the MLTC eligibility file
- Identification of prior program enrollment, i.e. physical health managed care or behavioral health managed care, and whether the member was enrolled in FFS for physical health
- Identification of existing services
- Outreach to the previous physical health MCO or behavioral health MCO to obtain additional information about the member's services and needs
- Outreach to providers to obtain information on current treatment needs and existing authorizations

- Coordination of a transition plan
- Completion of a comprehensive assessment and development and authorization of a new TruCare Care Plan
- Facilitation of continuity of care including service authorizations and out-of-network services

Identifying Existing Services. NTC will identify new members needing transition of services from a variety of sources primarily: 1) information obtained through new member Health Risk Screening (HRS) forms; 2) historical claims, authorization and service plan information; 3) incoming communication from providers requesting information and service authorizations for our new members in active care; and 4) phone calls or communications from members who are in active care. For Heritage Health, we will also utilize current pharmacy data and prior authorization records from MLTC or its designee.

Coordination with the Previous MCO. Our Care Management staff will outreach to the previous MCO to ensure a smooth transition to NTC. Key information we request includes, but is not limited to the following.

- Service history, particularly recent utilization (such as hospitalization, substance use treatment)
- Diagnoses, both physical and behavioral health
- Current PCP and input from the PCP and other treating providers
- Provider treatment plans
- Results of any recent care management assessments and the current care plan including medications, member goals and preferences
- Pregnancy status and as applicable, OB and hospital planned for delivery
- Current contact information for caregivers and any authorized designee
- Other information on the member's needs and barriers to care
- Administrative information such as previously filed grievances and appeals and provider issues

Coordination with Providers. Our Care Management staff will also reach out to all providers servicing the member to obtain all current authorizations as well as additional information to assist in coordinating care and prioritizing the member for assessment and new TruCare Care Plan development. Requested information includes service history, particularly recent utilization and open authorizations, results of any recent assessments, and the current treatment plan, including medications and member goals. Our Care Management staff work closely with providers to ensure they understand the type, scope, and duration of the previously authorized services and the need to ensure continuity of care.

Member Engagement in the Development of a New TruCare Care Plan. For new members with ongoing services, our Care Managers will first provide service information, emergency telephone numbers, and instructions on how to obtain additional services to every member impacted by a transition. Our Care Managers will then complete a comprehensive assessment and develop a new Care Plan in conjunction with the member, caregiver, existing network and non-contract providers including the PCP, BH providers, specialists or other providers, in-home supportive service providers, and any Care Manager from the previous MCO, to identify and address the member's medical, BH, social, supportive services, and other needs. For members who are inpatient at the time of enrollment, our onsite concurrent review nurses or Transitional Care Unit staff will coordinate with the Care Manager to contact the member in the hospital to discuss their care and enrollment into NTC, and coordinate the discharge planning process with the member and outpatient/home care providers as applicable. The Care Coordinator also initiates follow-up contact with the member to ensure the member agrees to the Care Plan and that all services are initiated according to the plan and are meeting the member's needs; forwards the new Care Plan to the member's PCP; and documents the Care Plan in TruCare.

Continuity of Care for Members Transferring from another MCO

Continuation of Existing Services and Authorizations. NTC will authorize all previously authorized services identified through claims data and provider coordination to ensure that there is no disruption in care. During the initial 90 calendar days of the contract, NTC will pay out-of-network providers 100% of

the Medicaid FFS rate to support this continuity of care. NTC will also ensure members can continue treatment with any prescribed medications for a minimum of 90 calendar days. NTC will authorize the member to continue care with his or her providers and current services, including the issuance of an out-of-network authorization to ensure the member's condition remains stable and services are consistent to meet the member's needs. We will also ensure continuity of medications, which is critically important for maintaining health status, including provision of a 72 hour emergency supply of prescribed medication as needed. NTC will work with out-of-network providers and connect them with our Provider Relations department. We will seek to contract with out-of-network providers if a member needs to access their services. If the provider chooses not to contract with NTC, we will explore entering into a single case agreement with the provider.

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.

Successful Transitions from Fee-for-Service

NTC, through the experience of Centene, has more than 30 years of experience managing and transitioning services for members of varying ages and acuity levels including members with complex, chronic health conditions and those receiving long term services and supports (LTSS). We recognize that many members within this population will come to us with established provider relationships, including relationships with community-based case managers and LTSS providers. It is therefore imperative that we assure a smooth transition of services in order to prevent any disruption in care. Based on the extensive experience of our affiliated health plans, NTC proposes that MLTC or its designee provide each managed care organization with historical medical, behavioral health, and pharmacy data, listing of approved/open authorizations, current service plans for members receiving LTSS and the most recent case management assessment using a secure, HIPAA compliant transmission process, such as an FTP site. We look forward to working with MLTC and the other MCOs to determine the necessary data elements, file formats and transmission processes for Heritage Health.

Our proposed approach to ensuring continuity of care for Heritage Health members transitioning from FFS includes the following components:

- Identification of the member via the MLTC eligibility file
- Identification of existing services
- Outreach to MLTC and providers to obtain current treatment needs and existing authorizations
- Coordination of a transition plan
- Completion of a comprehensive assessment and development of a TruCare Care Plan
- Continuity of care

Coordination with MLTC and the State PBM. In order to successfully transition FFS members into managed care, including the ABD population who will be entering managed care for the first time, NTC will work closely with MLTC to obtain detailed claims and authorization information as requested above. NTC will use this information to identify existing services being accessed by the member, as well as current treating providers. NTC will also work closely with the state's PBM to obtain information on current prescriptions and authorizations in order to ensure there is no disruption in a member's access to prescribed medications. Particular attention will be paid to identifying existing services and providers for the ABD population for whom interruptions in treatment and access to particular providers can be especially disruptive.

Coordination with Providers. Based on historical claims data, member calls, and provider calls, NTC will coordinate with existing providers to ensure that existing services accessed by new managed care enrollees are captured and continued. Our Care Coordination staff will also reach out to all providers servicing the member to obtain all current authorizations as well as additional information to assist in coordinating care and prioritizing the member for assessment and new TruCare Care Plan development. Requested information includes service history, particularly recent utilization and open authorizations, results of any recent assessments, and the current treatment plan, including medications and member

goals. NTC will also ensure continuity and consistency of care by leveraging existing aging and disability provider networks through partnerships with organizations that serve these populations.

Member Engagement in the Development of a New TruCare Care Plan. For new members with ongoing services, our Care Managers will first provide service information, emergency telephone numbers, and instructions on how to obtain additional services to every member impacted by a transition. For new members with ongoing services who are transitioning into managed care, our Care Managers will complete a comprehensive medical and functional assessment and develop a new Care Plan in conjunction with the member, caregiver, existing network and non-contract providers including the PCP, BH Providers, specialists or other providers, and in-home supportive service providers to identify and address the member's medical, BH, social, supportive services and other needs. For the ABD population, it will be critical to ensure that all types of care, including LTSS, are accounted for and incorporated into the Care Plan. Additionally, the Care Manager will work to incorporate Medicare services and providers for dual eligibles. The Care Plan should also incorporate a person-centered approach. For members who are inpatient at the time of enrollment, our onsite concurrent review nurses or Transitional Care Unit staff will coordinate with the Care Manager to contact the member in the hospital to discuss their care and enrollment into NTC, and coordinate the discharge planning process with the member and outpatient/home care providers as applicable.

Continuity of Care for Members Transitioning from Fee-for-Service

NTC will authorize all previously authorized services identified through claims data and provider coordination to ensure that there is no disruption in care. During the initial 90 calendar days of the contract, NTC will pay out-of-network providers 100% of the Medicaid FFS rate to support this continuity of care. NTC will authorize the member to continue care with his or her providers and current services, including the issuance of an out-of-network authorization to ensure the member's condition remains stable and services are consistent to meet the member's needs. We will also ensure continuity of medications, which is critically important for maintaining health status. NTC will work with out-of-network providers and connect them with our Provider Relations department. We will seek to contract with out-of-network providers as necessary to continue services. If the provider chooses not to contract with NTC, we will explore entering into a single case agreement with the provider.

Special Considerations for the ABD Population. NTC will take steps in addition to those outlined above to ensure that transitions for the ABD population take place smoothly with minimal disruption to ongoing services and supports. First, NTC will educate members who are new to managed care about the transition process through our Care Managers and new member materials including the Member Handbook, Member Portal, and the New Member Welcome Call. The information provided will emphasize the importance of continuing existing services to prevent unnecessary gaps in care, the timeframe for honoring authorizations, and the process for obtaining authorization for continuation of medically necessary services. In addition, understanding that family members will have a significant impact on whether transitions are successful, our Care Managers will create mechanisms to encourage ABD members' families, advocates, caregivers, and their other natural supports and community affiliations to be actively involved in the member's person-centered planning process, including assessment, individual service plan development, accessing needed services, and evaluating services received. Our Care Managers will also work proactively to coordinate with providers to ensure access for our disabled members and to help providers be better equipped to provide services to these members. In addition, our Care Managers will work collaboratively with service providers such as the Nebraska Parent Training and Information Center and the Nebraska ADRC to explain the shift to managed care to ease the transition for members accessing these services. For the IDD population, we will designate an IDD Provider Relations specialist to assist providers in providing care to this population.

State of Nebraska Medi[illegible] Implementation Plan

State of Ne[illegible] Medicaid Implementation Plan (Dates and Tasks will be further defined upon Contract Award)

Task Name	Start	Finish	Status	Resource Names
Implementation Milestones				
NE Proposal Submission and opening/review for conformance of mandatory requirements		1/5/2016		Business Development
Proposal Evaluation Period	1/12/2016	1/29/2016		Business Development
Oral Presentations		TBD		Business Development
Letter of Intent to Contract		2/5/2016		Business Development
Contract Finalization	2/5/2016	3/15/2016		Business Development
Contract Award		3/15/2016		Business Development
Obtain Certificate of Authority (COA) as HMO in State of Nebraska		12/1/2015		Business Development / Compliance
Hire Executive Management and other Admin staff. Submit resumes to State for approval		1/1/2016		Business Development
Internal Contract and Operating Model Review	3/15/2016	4/1/2016		HP/Corp
Provider Contracting Adequacy Completed	1/1/2016	3/15/2016		HP/Corp
Internal Operations readiness review		9/30/2016		HP/Corp
Nebraska Readiness Review (DHHS and/or MLC)	10/1/2016	10/30/2016		Business Development
Open Enrollment	10/1/2016	12/1/2016		HP/Corp
Member Auto Assignment	12/1/2016	12/15/2016		HP/Corp
Implementation Go-Live / Member Effective Date	1/1/2017	1/1/2017		HP/Corp
Project Management				
Review Contract Requirements and Build Detailed Implementation Work Plan, Structure and Resources	1/1/2016	3/15/2016		Business Implementation
Weekly Integrated Lead Meetings	3/15/2016	1/1/2017		Business Implementation
Cross Functional Workgroups	3/15/2016	1/1/2017		Business Implementation
Implement Steering Committee	3/15/2016	1/1/2017		Business Implementation
Establish recurring meetings with State and other state agencies	3/15/2016	1/1/2017		Business Implementation
State Q & A Grid, Issues / Risks Logs	3/15/2016	1/1/2017		Business Implementation
Compliance / Grievance and Appeals				
Customize Policy & Procedures for NE Contract requirements (42 CFR, Part 438, Title 471 NAC, Title 477 NAC, Title 482 NAC)	3/15/2016	8/1/2016		Compliance
Manage policy and procedure process: If MLTC determines P&P inefficient or unnecessary burden, work with MLTC	3/15/2016	8/1/2016		Compliance
Analysis & compliance with CMS 2390-P (submit with NE Contract response)		12/1/2015		Compliance
Collaborate and designated contacts for Division of Behavioral Health, Division of Children & Family Services, Division of Developmental Disabilities, NE Dept. of Education Early Development Network, Identified Community Agencies, Office of Probation, Others key agencies	3/15/2016	1/1/2017		Compliance
Participate in MLTC Committees (Administrative Simplification, Behavioral Health Integration, Quality Assurance Performance)	3/15/2016	1/1/2017		Compliance
Submit any subcontracts for review and approval a minimum of 120 days prior to implementation	3/15/2016	8/1/2016		Compliance
Implement subcontractor oversight process	3/15/2016	1/1/2017		Compliance
Hire/Train Compliance/Regulatory Staff	8/1/2016	1/1/2017		Compliance
Conduct State contract load and initial assessment / compliance dashboard	3/15/2016	1/1/2017		Compliance
Identify state document approval requirements and manage submission	3/15/2016	1/1/2017		Compliance
Establish Program Integrity / Fraud, Waste, and Abuse Programs; Collaborate with Nebraska Program Integrity Unit and MFPAU	5/1/2016	10/1/2016		Compliance
Submit compliance plan to MLTC 45 days prior to implementation and annually, thereafter	3/15/2016	10/1/2016		Compliance
Develop Complaint, Grievance and Appeals process and recordkeeping consistent with Federal and NE regulatory requirements	5/1/2016	10/1/2016		Compliance
Develop communications in support of Grievance and Appeals such as Service Authorizations and Notices of Action	3/15/2016	1/1/2017		Compliance
Prepare and submit monthly Complaint, Grievance and Appeals report to MLTC (monthly for first 6 months; quarterly thereafter)	3/15/2016	1/1/2017		Compliance
Processes consistent with access to state fair hearings	3/15/2016	1/1/2017		Compliance
Identify and capture all data and reporting requirements	3/15/2016	1/1/2017		Compliance
Support audit requirements	3/15/2016	1/1/2017		Compliance
Assure Disaster Recovery / Business Continuity Plan meets State of NE requirements	3/15/2016	1/1/2017		Compliance
Customize/develop reports (Internal & State)	3/15/2016	1/1/2017		Compliance
Develop Board Strategy and Meeting schedule	3/15/2016	1/1/2017		Compliance
Begin delivery of reports with appropriate data certification (42 CFR 438.606)		Ongoing		Compliance
Human Resources				
Develop Organizational Chart/Structures (Overall & NE Health and Wellness) Drafts	3/15/2016	4/1/2016		HR
Assure compliance with NE employee work eligibility status requirements, background checks, etc.	3/15/2016	6/1/2016		HR
Finalize staffing plan included key positions located in State	3/15/2016	6/1/2016		HR
Submit staffing plan to MLTC (minimum of 45 days prior to contract); names, resumes and contact information 30 days prior)	3/15/2016	10/1/2016		HR
Submit list of officers and BOD to MLTC prior to contract start date; changes within 10 days	3/15/2016	12/1/2016		HR
Process in place for notification of any changes defined by NE Contract	3/15/2016	1/1/2017		HR

Post Appro[illegible]sitions / Recruitment Strategy Implementation	3/15/2016	1/1/2017		HR
Conduct Job Fairs and Interviews	3/15/2016	8/1/2016		HR
Begin extending offers and start dates	3/15/2016	1/1/2017		HR
Develop training plan and identify resources	3/15/2016	8/1/2016		HR and Functional Teams
Train staff including cultural competency and state defined training(MLTC overview, requirements, advance directives, social determinates, LTSS, State geography): includes subcontractors	6/1/2016	1/1/2017		HR and Functional Teams
Provide MLTC list of training dates, times and locations 14 day prior to occurrence	3/15/2016	12/31/2017		HR and Functional Teams
Facilities and Infrastructure				
Identify temporary and training space	1/1/2016	5/1/2016		Facilities & Infrastructure
Identify permanent space	1/1/2016	9/1/2016		Facilities & Infrastructure
Any offsite locations approved by MLTC must have toll free w/ MLTC Staff	1/1/2016	12/30/2016		Facilities & Infrastructure
Meeting space onsite, as requested by MLTC	9/1/2016	12/30/2016		Facilities & Infrastructure
Assure IT infrastructure in place for temp / training area	1/1/2016	9/1/2016		IT
Assure IT infrastructure in place for permanent location	5/1/2016	9/1/2016		IT
Member Services				
Customize Policy & Procedures for NE requirements including member rights consistent wit 482 NOC 7-001, Indian Health Protections and notice of provider termination	3/15/2016	1/1/2017		Member Services
Set-up nurse urgent care triage, 911 emergency and transfers to case manager for immediate assistance	3/15/2016	1/1/2017		Member Services
Hire and Train Service Center Staff	3/15/2016	1/1/2017		Member Services
Set-up oral interpretation and written translation materials available (4% of members; MLT notice)	3/15/2016	1/1/2017		Member Services
Produce Member Handbook with all NE minimum requirements, obtain approval	3/15/2016	9/1/2016		Member Services
Set-up processes for other member notifications including disenrollment, updated member handbook, updated provided directory	3/15/2016	10/1/2016		Member Services
Set-up processes for member newsletter	3/15/2016	1/1/2017		Member Services
Maintain provider directory in hard copy, web-based (Find A Provider - FAP) and electronic submitted weekly to MLTC; contents and updates consistent with NE Contract	3/15/2016	1/1/2017		Member Services
Develop and distribute ID cards / welcome packets consistent with NE Contract including RX related requirements	10/1/2016	1/1/2017		Member Services
Setup telephone systems, monitoring and reporting (IVR, PaySpan, EMDEON)	3/15/2016	1/1/2017		Member Services
Determine need for supplemental Call Center (Overflow / Peak Times) - Regional Call Center	3/15/2016	3/1/2017		Member Services
Set up Service Center Technology (CRM, Quality Monitoring, Secure Portals)	3/15/2016	1/1/2017		Member Services
Member website specific to NE Medicaid program and contract requirements	3/15/2016	1/1/2017		Member Services
Medical record policies consistent with NE contract - member rights and work with providers re: documentation /content	3/15/2016	1/1/2017		Member Services
Revise CNC quality monitoring and reports consistent with NE performance standards	3/15/2016	1/1/2017		Member Services
Develop Training /Call Center Materials	3/15/2016	8/1/2016		Member Services
Develop Benefit Quoting Guides	3/15/2016	8/1/2016		Member Services
Confirm Specialty/Vendor Customer Service Training	3/15/2016	8/1/2016		Member Services
Member and Provider Websites Complete	3/15/2016	1/1/2017		Member Services
Member education plan (submit to MLTS 45 day prior to contract start)	3/15/2016	10/1/2016		Member Services
Member advisory board established	3/15/2016	1/1/2017		Member Services
Develop member newsletter and obtain approval	3/15/2016	1/1/2017		Member Services
Member welcomes calls begin (15 business days from welcome packet)	12/1/2016	3/1/2017		Member Services
Documentation and reporting to MLTC of new member contact attempts	12/1/2016	Ongoing		Member Services
Marketing/Communications				
Update Policies and Procedures consistent with marketing guidelines and NE and MLTC guidelines	3/15/2016	6/1/2016		Marketing / Communications
Hire and Train Marketing / Communications Staff	3/15/2016	1/1/2017		Marketing / Communications
Determine Local Market Resources (Print Vendor, PR Firm - approval of all subcontractors through MLTC)	3/15/2016	1/1/2017		Marketing / Communications
Develop marketing plan with MLTC approval including calendar, value-added benefits, other requirements defined in NE Contract	3/15/2016	1/1/2017		Marketing / Communications
Policies specific to provider marketing guidelines and communication	3/15/2016	10/1/2016		Marketing / Communications
Web Content and Approval (member and provider)	3/15/2016	1/1/2017		Marketing / Communications
Produce and get state approval for all member materials, consistent with NE Contract	3/15/2016	1/1/2017		Marketing / Communications
Assure compliance with DHHS' Cultural and Linguistically Appropriate Service guidelines	3/15/2016	1/1/2017		Marketing / Communications
Produce and get state approval for provider directory (45 days prior to contract start)	3/15/2016	10/1/2016		Marketing / Communications
Develop NE policy regarding media contacts with MLTC approval / referral	3/15/2016	1/1/2017		Marketing / Communications
Develop Community Outreach Plan	3/15/2016	1/1/2017		Marketing / Communications
Network Development / Credentialing / Provider Relations				
Network Development				
Customize Policy & Procedures for NE Requirements including non-discrimination and mainstreaming of NE Medicaid members	3/15/2016	6/1/2016		Network Contracting
Hire, train local contracting staff / mobilize business development contracting resources	1/1/2016	3/15/2016		Network Contracting
Obtain current NE provider list from MLTC / purchase lists, as needed	Now	3/15/2016		Network Contracting
Meetings / Relationships with Key Provider Associations/community agencies/advocacy groups	Now	Ongoing		Network Contracting

Develop N. Development Plan & Strategy specific to NE Requirement (key providers, expertise & commitmer principles, adequacy requirements)	Now	6/1/2016		Network Contracting
Primary Care Provider / Specialist strategy (include direct access for members with SHCN criteria)	Now	6/1/2016		Network Contracting
Behavior health providers	Now	6/1/2016		Network Contracting
Hospital / Facility strategy	Now	6/1/2016		Network Contracting
FQHC / RHC strategy (notify MLTC if contract cannot be reached)	Now	6/1/2016		Network Contracting
ACO / Health System strategy	Now	6/1/2016		Network Contracting
PCMH strategy and requirements (submit PCMH implementation within 90 days)	Now	6/1/2016		Network Contracting
Methods to improve ability of BH provider s to meet all health needs / integrated care	Now	6/1/2016		Network Contracting
Pharmacy network (Medicaid network in good standing with MLTC)	Now	6/1/2016		Network Contracting
Specialty pharmacy (MLTC review and written approval 45 days of designated specialty drugs)	Now	6/1/2016		Network Contracting
Establish value based contracting strategy (30% by 3rd year)	Now	Ongoing		Network Contracting
Develop network tracking and reporting (CRMP system)	1/1/2016	3/15/2016		Network Contracting
Implement Contract Processing System and Resources	1/1/2016	3/15/2016		Network Contracting
Set-up systems / Geos to track adequacy (Attachment 2 - Access standards); Submit exception requests to MLTC, if needed	1/1/2016	1/1/2017		Network Contracting
Provider Contracting Adequacy Completed	1/1/2016	10/1/2016		Network Contracting
Draft Contract packet approved by MLTC (standard documents, contract, credentialing, FAQ)	1/1/2016	4/1/2016		Network Contracting
Provider Contracts developed / approved with all State requirements	1/1/2016	3/15/2016		Network Contracting
Implement Contracting Strategy (mailing, telephonic, face to face, key provider)	3/15/2016	1/1/2017		Network Contracting
Monitor and Track Progress / Adjust Resources and Methodology, as needed	3/15/2016	1/1/2017		Network Contracting
Develop and Implement special contracting for behavioral health requirements and commitment	3/15/2016	1/1/2017		Network Contracting
Develop and Implement National Contracting Strategy (state specific contract amendments)	3/15/2016	1/1/2017		Network Contracting
Develop and Implement Subcontractor strategy including contracting and oversight--Vision, Lab (CLIA), Radiology	3/15/2016	1/1/2017		Network Contracting
Develop transportation strategy	3/15/2016	6/1/2016		Network Contracting
Develop chiropractic strategy	3/15/2016	1/1/2017		Network Contracting
Develop P4P Incentive Program	3/15/2016	1/1/2017		Network Contracting
Network Adequacy Provider file to MLTC via provider enrollment file minimum of 90 calendar days prior to start	3/15/2016	1/1/2017		Network Contracting
Audit Find a Provider (FAP)	9/1/2016	Ongoing		Network Contracting
Credentialing/ Provider Data Mgmt. (PDM)				
Customize Credentialing Policy & Procedures (30 calendar days to complete, include subcontractor) - submit to MLTS for approval	1/1/2016	4/1/2016		Provider Data Mgmt. (PDM)
Assure all providers enrolled with MLTC	1/1/2016	Ongoing		
Hire and train new staff	3/15/2016	10/1/2016		Provider Data Mgmt. (PDM)
Set up Emptoris (contract management system)	3/15/2016	5/1/2016		Provider Data Mgmt. (PDM)
Create credentialing NE packet (State specific and non-standard requirements / state validation sources)	1/1/2016	4/1/2016		Provider Data Mgmt. (PDM)
Set up Portico (provider management system / hierarchy & business unit set-up)	3/1/2015	5/1/2016		Provider Data Mgmt. (PDM)
Load Provider information into Portico with required information (evaluate loading state data provided, as contracts received)	3/15/2016	1/1/2017		Provider Data Mgmt. (PDM)
Audit Provider Load Information	8/1/2016	Ongoing		Provider Data Mgmt. (PDM)
Portico to Amisys interface configuration complete	5/1/2016	10/1/2016		Provider Data Mgmt. (PDM)
Conduct Credentialing Committee meetings (increased frequency as needed)	5/1/2016	Ongoing		Provider Data Mgmt. (PDM)
Provider Relations				
Customize Policy & Procedures for NE Requirements (including appointment availability and referral access)	3/15/2016	6/1/2016		Provider Relations
Hire and Train Provider Relations Staff (available 7 am - 8 pm for PR; 8 to 8 for clinical RX, anytime for non-routine/ emergent)	5/1/2016	10/1/2016		Provider Relations
Define Provider Engagement / Relations Strategy (including BH integration)	3/15/2016	7/1/2016		Provider Relations
Set-up provider call center, separate RX line or menu option	3/15/2016	1/1/2017		
Identify key providers and associations (collaborate with contracting)	3/15/2016	5/1/2016		Provider Relations
Develop Provider Training and Outreach Plan (includes website)	5/1/2016	7/1/2016		Provider Relations
Develop Provider Handbook with all requirements, MLTC approval calendar days prior , post to website	6/1/2016	10/1/2016		Provider Relations
Provider Billing Manual updated	6/1/2016	11/1/2016		Claims/Config
Develop additional provider training materials, State review / approval	6/1/2016	1/1/2017		Provider Relations
Turn on online provider directory and print directory	10/1/2016	10/1/2016		Provider Relations
Conduct Provider "town halls" provider forums	9/1/2016	1/1/2017		Provider Relations
Conduct Provider Orientations within 30 days of contracting(welcome packet / orientation materials)	9/1/2016	1/1/2017		Provider Relations
Conduct provider " Open Mic " calls and/or other implementation provider outreach, as needed	9/1/2016	2/1/2017		Provider Relations
Establish Provider Advisory Committee (RX, BH providers included)	3/15/2016	1/1/2017		Provider Relations
Establish monthly provider newsletter	8/1/2016	Ongoing		Provider Relations
Provide encryption software on request to provider to allow exchange of member data via email	9/1/2016	1/1/2017		Provider Relations
Establish provider complaint system (submit to MLTC 45 days prior)	6/1/2016	10/1/2016		Provider Relations
Integrated Care Management (Care Management, Utilization Management, Transition Care Coordination)				
Hire and Train Staff (Section IV.D Staffing Requirements)	3/15/2016	1/1/2017		Medical Management

Customize & Procedures for patient centered approach to integrated medical and behavioral health & NE Req .nts	3/15/2016	6/1/2016		Medical Management
Risk stratification and identification of low, medium and high risk members w/ appropriate interventions or outreach	3/15/2016	1/1/2017		Medical Management
Comprehensive and integrated PH / BH case management program (guided by BH principles of care, advocacy, communication, problem-solving, collaboration and empowerment)	3/15/2016	1/1/2017		Medical Management
Ensure that "active treatment" is being provided to appropriate members with individual plans of care	3/15/2016	1/1/2017		Medical Management
Submit CM program description to MLTC 60 days prior to contract	3/15/2016	9/1/2016		Medical Management
Annual review of CM program with input, approval of Clinical Advisory Committee (CAC); MLTC approval 60 calendar days prior to implementation	3/15/2016	9/1/2016		Medical Management
Develop and implement health risk screening	3/15/2016	1/1/2017		Medical Management
Coordination with providers and other CM programs for specific members such as ABD, dual, HCBS, WIC, transition plans for discharge from State psychiatric hospitals	3/15/2016	1/1/2017		Medical Management
Revise policies and processes for special considerations for pregnant members including DHHS Set Aside, WIC, patient engagement, etc.	3/15/2016	1/1/2017		Medical Management
Develop policy and procedure specific to coordination with HCBS case managers (MLTC submission 60 days prior)	3/15/2016	9/1/2016		Medical Management
Develop policy and procedures, tribal liaison and other methods of coordinate with HIS, 638 providers, Urban Indian Centers and other involved agencies; submit to MLTC 60 days prior	3/15/2016	9/1/2016		Medical Management
Develop policy and procedures for collaboration with DCFS for children in foster care	3/15/2016	1/1/2017		Medical Management
Develop pre-augh list and obtain approval	3/15/2016	9/1/2016		Medical Management
Identify / Implement Clinical Programs Consistent with Contract Requirements / NE Contract Response	3/15/2016	1/1/2017		Medical Management
Establish UM policies, program description and practice guidelines; Establish UM Committee	3/15/2016	1/1/2017		Medical Management
Establish and submit for approval clinical criteria for pharmacy PA	3/15/2016	1/1/2017		Medical Management
Establish Medication Therapy Management (MTM) program and submit annual report to MLTC	3/15/2016	1/1/2017		Medical Management
Establish Drug Utilization Review (DUR) program	3/15/2016	1/1/2017		Medical Management
Define Transition of Care and Inpatient Strategy	3/15/2016	1/1/2017		Medical Management
Establish special health care needs (SHCN), EPSDT services and other special services identified in NE Contract	3/15/2016	1/1/2017		Medical Management
Develop Case Mgmt. /Utilization Mgmt. Programs specific to PH MCO Requirements	3/15/2016	1/1/2017		Medical Management
Develop EPSDT tracking process	3/15/2016	1/1/2017		Medical Management
Develop Lock-In Process	3/15/2016	1/1/2017		Medical Management
Develop Telehealth and telemonitoring services	3/15/2016	1/1/2017		Medical Management
Develop Pharmacy Contract Deliverables (NE PDL, NE rebates, OTC listed in Medicaid State plan and NE Contract requirements)	3/15/2016	1/1/2017		Medical Management
Set up Systems (TruCare, ECM, CRM, Centelligence)	3/15/2016	1/1/2017		Medical Management
Quality				
Update Policies and Procedures and QM deliverables for NE Requirements (Attachment 5 and 6); Submit to MLTC for approval 60 days prior	3/15/2016	9/1/2016		Quality
Hire and Train Staff	3/15/2016	1/1/2017		Quality
NCQA accreditation within 18 months of award	3/15/2016	1/1/2018		Quality
Methodology for evaluating provider participation and health outcomes achieved - work with MLTC for common evaluation methodology; report in annual quality report	3/15/2016	1/1/2017		Quality
Develop HEDIS process	3/15/2016	1/1/2017		Quality
Develop QAPI program and committees, work plan and evaluation	3/15/2016	1/1/2017		Quality
Establish and Convene Quality Improvement Committees (clinical advisory, corporate compliance, provider advisory, UM required)	3/15/2016	1/1/2017		Quality
Conduct minimum of 2 clinical and 1 non-clinical PIPs (1 joint with other MCOS)	3/15/2016	1/1/2017		Quality
Set-up member satisfaction surveys (CAHPS vendor)	3/15/2016	1/1/2017		Quality
Set-up annual provider satisfaction survey - submit tool and methodology to MLTC 90 days prior	3/15/2016	1/1/2017		Quality
Attend MLTC Quality Management Committee	3/15/2016	1/1/2017		Quality
Establish Member Advisory Committee	3/15/2016	1/1/2017		Quality
Establish Clinical Advisory Committee	3/15/2016	1/1/2017		Quality
Participate and support EQR reviews	3/15/2016	1/1/2017		Quality
Eligibility and Enrollment				
Customize Policy & Procedures for NE Requirements including work with ACCESSNebraska & enrollment broker	3/15/2016	6/1/2016		Eligibility & Enrollment
Hire and Train Eligibility Staff	5/1/2016	10/1/2016		Eligibility & Enrollment
Setup Eligibility FTP Site	7/1/2016	10/1/2016		Eligibility & Enrollment
Establish Core Eligibility Processing (initial auto-assignment / ongoing)	7/1/2016	10/1/2016		Eligibility & Enrollment
PCP selection and auto assignment process consistent with State NE Contract requirements	7/1/2016	1/1/2017		Eligibility & Enrollment
Load Initial Production File	7/1/2016	1/1/2017		Eligibility & Enrollment
834 test file from state (including retro effective date / Heritage Health contract effective dates)	7/1/2016	8/1/2016		Eligibility & Enrollment
Full 834 Eligibility File	10/1/2016	1/1/2017		Eligibility & Enrollment

Process file stent with initial 90 day enrollment / disenrollment defined in NE Contract	10/1/2016	1/1/2017		Eligibility & Enrollment
Load initial production file, daily updates, weekly reconciliation process	7/1/2016	1/1/2017		Eligibility & Enrollment
Notify change in status through ACCESSNebraska / disenrollment's through enrollment broker	7/1/2016	1/1/2017		Eligibility & Enrollment
Newborn eligibility consistent with NE requirements (hospital notification within 24 hours)	7/1/2016	1/1/2017		Eligibility & Enrollment
Contract & Benefit Configuration / Claims				
Customize Policy & Procedures for NE Requirements	3/15/2016	6/1/2016		Claims/Config
Assure behavioral health parity (compliance with Mental Health Parity and Addiction Equity Act MHPAEA)	3/15/2016	6/1/2016		Claims/Config
Determine any value added benefits, provide MLTC description with approval and any changes 45 days prior	3/15/2016	10/1/2016		Claims/Config
Telehealth and telemonitoring services	3/15/2016	1/1/2017		Claims/Config
Support claim audit requirements defined by MLTC	3/15/2016	1/1/2017		Claims/Config
Hire and Train Claims Staff	5/1/2016	1/1/2017		Claims/Config
Contracts loaded in config tracker	3/15/2016	1/1/2017		Claims/Config
Members and Providers in DEV and TEST	3/15/2016	1/1/2017		Claims/Config
Identify and Configure Benefits defined in NE Contract	3/15/2016	1/1/2017		Claims/Config
Identify and Setup Claims Supporting Processes(COB/TPL, Fraud & Abuse, EDI Clearinghouse)	3/15/2016	1/1/2017		Claims/Config
Setup Provider pay Classes - standard, derivatives, special arrangements	3/15/2016	1/1/2017		Claims/Config
Configure ARQs - TruCare Medical Management System	3/15/2016	1/1/2017		Claims/Config
Configure pay classes	3/15/2016	1/1/2017		Claims/Config
Configure Provider Contracts	3/15/2016	1/1/2017		Claims/Config
Configure TPL process, insure reporting requirements are completed	3/15/2016	1/1/2017		Claims/Config
Identify and Implement Pre-Adjudication Rules	3/15/2016	1/1/2017		Claims/Config
Claims Process Ready and First Check Run Scheduled	12/1/2016	12/30/2016		Claims/Config
First Claims Check Run	1/1/2017	1/7/2017		Claims/Config
Encounters				
Set up Encounters	5/1/2016	1/1/2017		Encounters
Customize Encounter Scorecard and measure KPI	5/1/2016	1/1/2017		Encounters
Create Encounter File	5/1/2016	1/1/2017		Encounters
Setup and Test Vendor Files including subcontractors	5/1/2016	1/1/2017		Encounters
Develop and Test Encounter Response File	5/1/2016	1/1/2017		Encounters
Develop Work Plan for Correcting Errors and Related Resubmissions	5/1/2016	1/1/2017		Encounters
IT				
Kickoff IT Portion of Project & assure compliance with Nebraska Technology Access Standards	3/15/2016	8/1/2016		IT
Update Policies and Procedures and Compliance/360 for NE requirements	3/15/2016	6/1/2016		IT
Meet federal and NE expectations and standards for data exchange, service orientation & interoperability	3/15/2016	1/1/2017		IT
Enter into agreement wit Nebraska Health Information Initiative (NeHII)	3/15/2016	1/1/2017		IT
Recruit, Hire and Train Nebraska Total Care IT Staff	5/1/2016	1/1/2017		IT
Document, validate, and vet Business and Technical Requirements using ITIL and Agile approach	3/15/2016	1/1/2017		IT
Set-up standard HIPAA files and code sets	3/15/2016	1/1/2017		IT
Access to systems help desk for MCO, MLTC and other state agency staff who have access to MCO systems	3/15/2016	1/1/2017		IT
Onboard and Certify New Trading partners	3/15/2016	1/1/2017		IT
Configure, deploy, test: Security Infrastructure	3/15/2016	1/1/2017		IT
Configure, deploy, test: Member Database for Eligibility and Enrollment	3/15/2016	1/1/2017		IT
Configure, deploy, test: Provider Data Management System	3/15/2016	1/1/2017		IT
Configure, deploy, test: Medical Management System (Trucare)	3/15/2016	1/1/2017		IT
Configure, deploy, test: Claims Processing	3/15/2016	1/1/2017		IT
Configure, deploy, test: Encounter Processing	3/15/2016	1/1/2017		IT
Configure, deploy, test: Call Center Telephony and Service Systems	3/15/2016	1/1/2017		IT
Configure, deploy, test: Centelligence EDW, and configure MicroStrategy Reports	3/15/2016	1/1/2017		IT
Configure, deploy, test: Websites, Member & Provider Portals, and Member Mobile Applications	3/15/2016	1/1/2017		IT
Configure, deploy, test: Infrastructure (Network and Field Office hardware, software, LAN, and services)	3/15/2016	1/1/2017		IT
Integration Testing for Member, Provider, Authorizations, Claim, Claim NE payment, Encounters, Portals	3/15/2016	1/1/2017		IT
Train NE Health and Wellness (NTC) user staff on the MIS	3/15/2016	1/1/2017		IT
Provide MLTC annual systems refresh plan	10/1/2016	1/1/2017		IT
Finance				
Update Policies and Procedures for NE Requirements/Insure contract requirements completed	3/15/2016	6/1/2016		Finance
Hire and Train Staff	5/1/2016	1/1/2017		Finance
Complete Bank Account Setup	6/1/2016	1/1/2017		Finance
Setup Test FTP Site	6/1/2016	1/1/2017		Finance
Determine and Configure Remittance EDI Processing	6/1/2016	1/1/2017		Finance
Complete and Submit Form D Submission	3/15/2016	5/1/2016		Finance

Set up data [illegible]ouse tools	6/1/2016	1/1/2017		Finance
Establish process for supplemental delivery payments	6/1/2016	1/1/2017		Finance
Set-up process for payment adjustments	6/1/2016	1/1/2017		Finance
Set-up process for health insurance providers fee	6/1/2016	1/1/2017		Finance
Set-up processes to monitor results of Quality Performance Program (QPP)	6/1/2016	1/1/2017		Finance
Establish process for reinvestment accounts	6/1/2016	1/1/2017		Finance
Reinsurance set-up	6/1/2016	1/1/2017		Finance
Set-up risk adjustment processes for year 2 and beyond of contract	6/1/2016	1/1/2017		Finance
Post Implementation Milestones				
Conduct Daily Go Live Meetings (adjust frequency based on need)	12/15/2016	2/1/2017		Business Implementation
Capture Daily Operations Metrics (adjust frequency / content based on need)	12/15/2016	2/1/2017		Business Implementation
Conduct Lessons Learned Meeting	2/1/2017	2/15/2017		Business Implementation
Ongoing Monitoring and Adjustments for Staffing & Training		Ongoing		Human Resources
Transition Responsibilities from Transition team to Nebraska Total Care health plan staff	10/1/2016	4/1/2017		All
Green= On Schedule				
Red = At Risk				
Blue=Completed				

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IV.Z FFS Claims Management & Processing

IV.Z FFS Claims Management and Processing

(page limit N/A)

117. Provide a detailed description of the MCO's approach to implementing the necessary functionality to support FFS claims processing.

Enterprise Scale Medicaid Claims Processing Experience and Assets

Nebraska Total Care (NTC), through its parent company, Centene Corporation (Centene), has over 30 years' experience receiving, processing, paying, and reporting adjudicated claims data to Medicaid state agencies. Centene's Management Information System (MIS) includes integrated capabilities to process both physical and behavioral health (BH) claims and serves over 4.8 million Americans in publicly-funded managed care plans across 23 states. Across all our affiliate health plans, Centene maintains an average claim auto-adjudication rate of over 80%, with approximately 95% of clean claims paid within 14 calendar days.

Our MIS processes approximately 60 million physical and behavioral health Medicaid claims per year, including over 1.5 million "claims broker services" (non-risk) claims per year. Our affiliated subcontractor US Script, processes over 42 Million pharmacy per year.

Ready to Support MLTC. We have reviewed the RFP, its Attachments and Addenda, including in particular Sections IV.D, E, F, J, N, Q, S and Z, as well as Addendum 6 (Question 38), Addendum 7 (Question 278), Addendum 9 (Questions 51, and 83 through 87), Addendum 10 (page 1), and Attachment 33. As a result of our review, we affirm that we have the operational "claims broker service" (CBS) experience and technological capabilities in place today to implement and we will meet or exceed all MLTC CBS requirements.

CBS Implementation Plan for Start-Up Activities. As one result of our detailed RFP analysis, we have formulated a draft Microsoft Project plan with approximately 200 activities and tasks. See ***Attachment 122: DRAFT CBS Project Plan***. Attachment 122 details CBS start-up activities (prior to CBS production operations) and is informed by comprehensive experience implementing similar claims processing functionality in the service of Medicaid and Long Term Services and Supports (LTSS) programs, for non-risk (e.g. "FFS") as well as risk-based (e.g. Heritage Health type) programs. In Attachment 122, NTC and Centene have budgeted a series of tasks using multi-disciplinary and coordinated teams to work closely with MLTC and the enrollment broker for a flawless deployment of CBS. Attachment 122 spans a ten month period, which we consider a prudent length of time, given our experience in similar claims processing start-ups. Please see Section 122 for more information on our proposed implementation activities, including a summary timeline version of Attachment 122.

Membership Volume is not the Critical Consideration in Project Complexity. We realize that MLTC anticipates a limited number of members in the FFS Medicaid program by the time claims broker services are implemented (for example, per RFP Attachment 33). However, it is the combination of program-specific claims processing and provider participation rules, in conjunction with program specific data interface needs and specialized requirements for reporting, that drives start-up and day-to-day operation complexity. Membership volume is only a secondary factor in claim processing complexity.

Implementing Operational Support for CBS. The discussion that follows provides a detailed description of our approach to implementing necessary functionality, once CBS contract operations begin, to support FFS claims processing and meet MLTC's CBS requirements, including the characteristics of our MIS that implements day to day claims broker services functionality, our claim-to-payment adjudication process, our commitment to timely payment for providers through our system capabilities, and ongoing provider outreach and education.

Claims Processing Architecture and Organization to Ensure CBS Accuracy and Availability

Claim System Redundancy. A focus on systems integration and availability is the basis for our continued ability to process claims accurately, reliably, and in a timely fashion. Our MIS incorporates claims software components that are best-of-breed and functionally rich, yet *integrated* where needed. We engineer system *availability* and *reliability* in all of our MIS components, through supporting hardware technologies such as blade servers, virtualization, database clustering, storage area networks, and hardware, software and networking *redundancy*. In addition, Centene owns and operates two enterprise scale, redundant datacenters, with either datacenter capable of taking on NTC FFS Medicaid claim processing should either datacenter be incapacitated. We regularly test our *Business Continuity Plans (BCP)* to help ensure claims timeliness standards are not materially disrupted due to staffing, weather problems or other unforeseen events.

Claims Operational Redundancy. We support claims operations from Centene owned processing centers (Claims Centers) in Missouri, Montana, Arkansas, and Texas. The Claim Centers are securely networked for voice and data connectivity with both datacenters, as well as NTC offices, and two Regional Service Centers (RSCs) that can take over FFS member and provider service calls if necessary (e.g. local power outages). Our automated claims workflow system can instantly route NTC claims workload amongst the Claim Centers as needed, with staff to handle NTC claims, including FFS Medicaid claims. As we do for all our affiliated health plans, we will maintain cross-trained claims staff who can process NTC claims if needed in the event of a site-disabling outage, or if there is an abnormally high level of claims volume for either FFS Medicaid or managed care (Heritage Health) claims. In addition, all of our Claims Centers have a program for quickly training additional staff if needed to process NTC FFS Medicaid claims.

Since 1/1/2012, we have implemented claims payment operations for publicly funded health programs successfully, and on time, in nine new Centene states.

NTC's FFS Medicaid pharmacy claims will be processed by US Script, NTC's affiliate and Prescription Benefit Manager (PBM). US Script's PBM1 claims system is housed in the same two datacenters as NTC's claims systems, and capitalizes on the same contingency planning infrastructure.

System Configuration. CBS FFS Medicaid claim requirements will be configured within our AMISYS Advance (AMISYS) claims processing system, separate and distinct from our Heritage Health claims processing configuration, but with both configurations managed by one claims configuration team. Our claims processing system houses benefit coverage information as well as authorization requirements and pricing for quick systems configuration and update via table driven utilities. Our claims processing system adjudicates claims through a combination of inter-related algorithms employing HIPAA compliant diagnosis and procedure codesets, and uses National Provider Indicator (NPI), Tax ID numbers, and state specific identifiers (e.g. Nebraska 11-digit provider ID), along with contracts driven by specialty, program participation, affiliation, and place of service for provider payment.

Experienced Claims Professionals. Centene consolidates core Medicaid claims operations in its four Claim Centers to realize efficiencies for fast processing turnaround times (TAT), ensure training consistency, and develop a critical mass of specialized Medicaid and LTSS claims processing expertise. The staff in our claims operations division have an average of 12+ years of claims experience per processor, including extensive readiness and implementation experience. Our centralized approach also allows us to continually improve, and adapt to changing federal mandates by applying consistent best practices and lessons learned from all of our health plan affiliates, from both FFS and managed care programs.

Training. We will ensure that all staff processing Nebraska FFS claims are current with their training, which will include topics for specific Nebraska FFS Medicaid needs. Our claims training curriculum

covers all aspects of processing, with specialized staff receiving up to 14 weeks of classroom and hands-on training. Along with claims processors assigned to NTC, NTC's Claims Administrator, Claims Analysts, Contract Implementation Manager, and Provider Claims Educator will undergo FFS Medicaid claims training appropriate to their respective job functions.

NTC FFS Medicaid Staff. Our centralized claims processing staff will support NTC's Claims Team, including the NTC Claims Administrator, who will be trained in FFS Medicaid specific rules for claims processing and claim data reporting. NTC's Claims Administrator and her supporting staff will serve as the primary coordinator of claims activities between NTC and the primary NTC FFS Medicaid Claim Center, and provide feedback on claim system configuration and claim data reporting. In addition, the NTC Claims Administrator and her team, will support the NTC Director of Provider Engagement and his team of Provider Engagement Specialists as well as our Provider Claims Educator. These professionals will receive training on FFS Medicaid claims processing, commensurate with their job responsibilities of supporting all providers (not just NTC's Heritage Health network providers) participating in the FFS Medicaid program. Our Provider Engagement Team, inclusive of our Provider Claims Educator, will conduct a variety of tasks to supplement our centralized processing such as one-on-one provider trainings on submission requirements and targeted claims audits following implementation of major FFS Medicaid changes (e.g. if MLTC decides to make a change in FFS covered populations) or major state reimbursement rate changes to ensure complete compliance with MLTC requirements.

Functionality for Claims Submission, Processing, and Payment

System and Process Components we will implement for FFS Processing. Our MIS employs systematic data edits to ensure processing accuracy for a high claim auto-adjudication rate and processed claims data quality (*please note*: we refer to "processed claims data" in this Section 117 as the FFS equivalent of managed care encounter data as defined in the RFP's Glossary of Terms). Please refer to ***Figure Q117.A: Claim Submission, Processing and Payment*** below for the following discussion on how we will implement day-to-day functionality to process provider FFS claims in compliance with MLTC, and Nebraska and Federal regulations.

Item 1 in Figure Q117.A: Inbound Claims.

Multiple FFS Claim Submission Alternatives for Providers. As is the case with our affiliates, Nebraska Medicaid providers (both FFS and managed care) will be able to submit FFS and/or managed care claims to NTC via direct HIPAA 837 EDI file upload to our Provider Portal, or through any of 80 claims clearinghouses. Providers participating in either FFS and/or NTC's Heritage Health managed care program will also be able to enter claims online via the HIPAA compliant Direct Data Entry (DDE) functionality in our secure, web-based Provider Portal. Our DDE claim entry function also has features expressly designed for Long Term Service and Support (LTSS) providers and the unique needs and nuances LTSS claim entry demands, with efficiency benefits for both providers and LTSS programs. For example, our affiliate in Florida operates a large scale LTSS program and cut the LTSS claim processing turnaround time approximately in half, in large part due to the rollout of the LTSS online claims "wizard": an important factor should MLTC require their CBS vendor to support LTSS claims processing (per RFP Addendum 9, Question 51).

Providers may also submit claims on CMS standard paper forms via regular mail or secure fax. Paper and fax claims are converted to data and we apply the same edits and validation routines to these claims (see discussion further below).

Ensuring HIPAA Transaction Compliance. The EDI subsystem of our MIS uses EDIFECS software to verify HIPAA format compliance in real-time, validating inbound data against ANSI Accredited Standards Committee (ASC) X12N Companion Guides' rules for syntax and data structure, then triggering notification to trading partners accordingly, using the ANSI TA1/999 Functional Acknowledgements. Item 1 also includes our integrated Centene Document Management System

(CDMS) which uses high performance Optical Character Recognition technology to convert paper and fax submissions to claim data, which we also validate for HIPAA and companion guide compliance.

Item 2: Pre-adjudication Edits. Our Service Oriented Architecture (SOA) middleware maps, translates, and validates EDI and paper claims data against data in the Member Data Management and Provider Data Management components of our MIS prior to adjudication, ensuring common edits, such as member and billing and rendering provider identifier validation. If a claim transaction is rejected at this "item 2 stage", our middleware systematically issues an ANSI 277 Unsolicited ("277U") notification citing the specific MLTC-approved reason(s) responsible. In the event a paper claim fails pre-adjudication edits, our middleware automatically generates and sends a letter to the submitting provider, rejecting the claim and citing the specific edit(s) responsible.

Item 3: Claims Processing System.

Claim Data Load. Once claims pass pre-adjudication edits, claims are loaded into our claims processing system, AMISYS Advance (AMISYS), which assigns each claim a unique control number incorporating the Julian time stamp we affix to all claims upon receipt. This "date stamp" is part of the control number used to identify each unique claim, allowing us to link together all available information surrounding a claim and to track our adherence to claims processing timeliness standards. AMISYS' audit trails retain snapshots of all transactions for current and historic activity. This audit function includes date span logic, historical claims tracking, and operator ID stamping as well as accommodates the setting of different audit parameters for any number of management controls. Our adjudication process for FFS will be the same for all FFS participating providers (not just NTC Heritage Health contracted providers). AMISYS uses Member ID and date(s) of service on the claim to determine which set of adjudication rules and edits (e.g. FFS or managed care) to apply to the claim.

Claim Adjudication. Our adjudication process is comprised of six primary steps that a claim must pass in logical succession to reach a "finalized" (paid or denied) status or internally pended status including:

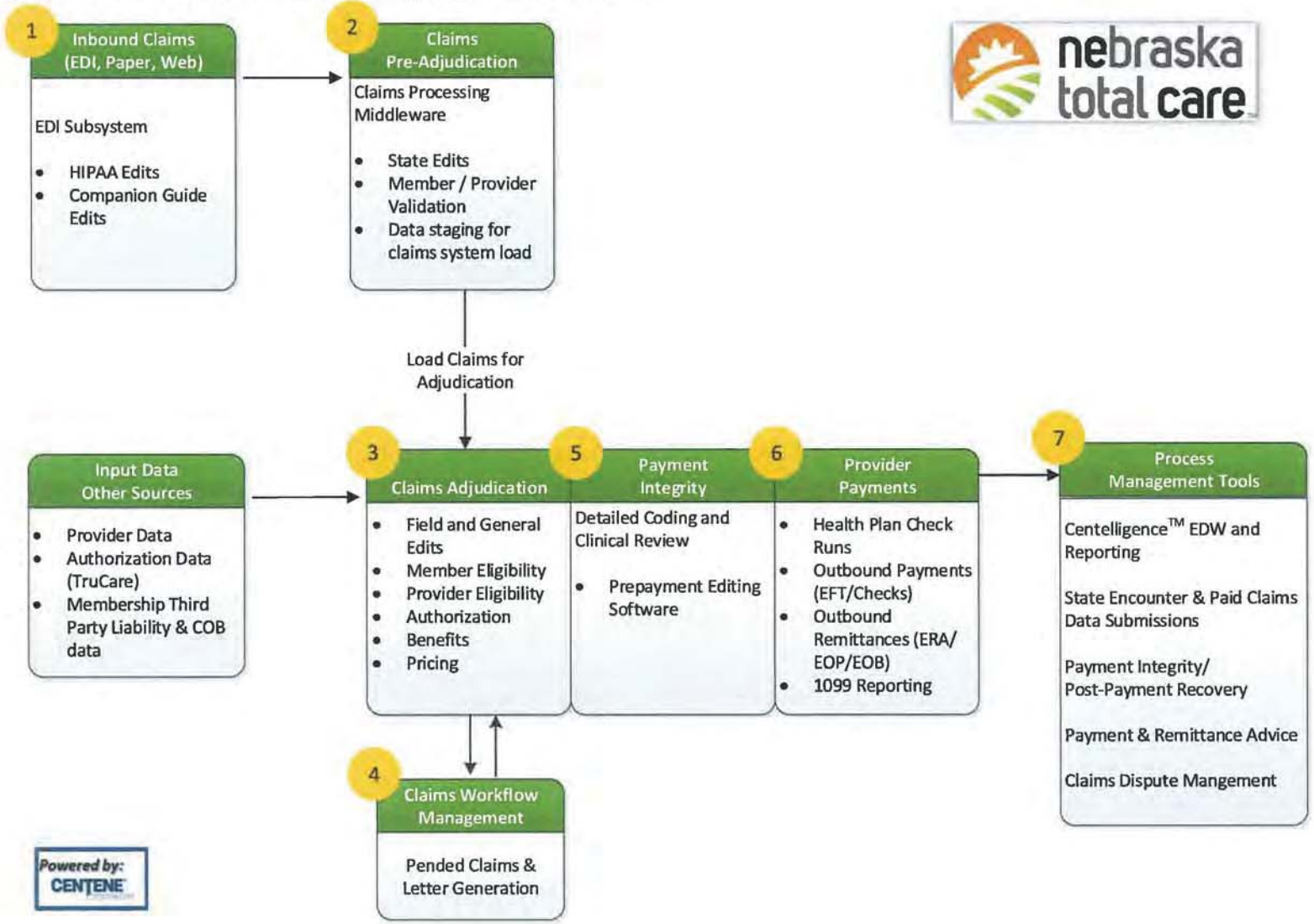
1. Field and general edits
2. Member data edits (e.g. eligibility for services)
3. Provider data edits (e.g. participating eligibility and status)
4. Prior-authorization validation when required
5. Validation that services claimed are covered
6. Pricing: including the application of Third Party Liability (TPL) and/or Coordination of Benefits (COB), provider agreements, and applicable reimbursement and timely filing rules, all specific to FFS Medicaid rules.

Instant Verification through Real Time Editing and Pricing (RTEP). We will offer all providers (those participating in either the FFS and/or the managed care program) our new real time claim pricing capability. Through our Provider Portal, the RTEP tool is an enhanced version of our existing DDE online claim entry "wizard" which allows providers to enter professional claims online with interactive assistance (e.g. look up and validation assists for codes, validation of member and provider data, and online help). The RTEP module enhancement to our DDE online claim entry function *instantly* applies adjudication logic validating member and provider eligibility for dates of service, matching authorizations to services on the claim, applying TPL/COB amounts, determining if benefits apply, enforcing edits, and pricing the claim – all during a single online session. An estimated paid amount is provided subject to adjustment after Fraud, Waste and Abuse (FWA) checks. This results in instant feedback on any claims submission issue, promoting clean claim entry, and thereby helping NTC facilitate timely, accurate, and complete encounter data (for the managed care program) and

In December, 2015, Centene's Information Management Security System and Program (inclusive of our claims security controls) received International Standards Organization (ISO 270001) certification, recognizing our adherence to security best practices and demonstrating that we have successfully adopted the globally recognized information security framework.

processed FFS claims data (for the FFS program) to MLTC. We will also offer providers payment within two days for all professional claims entered directly online via our Provider Portal, for both our FFS and managed care programs, further incenting providers to submit claims soon after services were rendered and to submit these claims completely and accurately, with the ultimate benefit of more timely and accurate FFS claims data (as well as managed care encounter data) to MLTC.

Figure Q117.A: Claims Submission, Processing, Payment, and Review



Item 4: Claims Workflow Management. Our claims workflow software, integrated with AMISYS, manages the workflow of any pended claim in real time. If a claim pends, an electronic work item is immediately routed to a claims processing analyst, skilled in the type of pend for that claim, for resolution and re-adjudication using the six-step process above. When necessary, we can route specific pend codes to our licensed clinical staff for research and determination when the pend is related to prior authorizations or medical policies.

Item 5: Payment Integrity. *ClaimsXten™ (CXT).* Claims passing adjudication are further analyzed by our CXT software, to determine clinical claim coding appropriateness and potentially fraudulent billing practices. CXT contains a comprehensive set of rules based on nationally-recognized coding guidelines that address coding inaccuracies such as unbundling, fragmentation, upcoding, duplication, over-utilization standards, invalid codes, and mutually exclusive procedures. CXT offers a recommendation that is applied to the claim when a provider's coding pattern is unsupported by a coding principle. CXT's flexible configuration tools allow us to customize edits for FFS benefit criteria and provider coding/reimbursement policies. In conjunction with AMISYS and CXT, we use Verisk's *HealthCare Insight™ (HCI)* service for the monitoring, detection, and denial of physician claims for provider preventable conditions (RFP Section IV.Q.12).

Item 6: Provider Claims Payment. Once claims successfully pass all claim edits, claims are finalized with a status of paid or denied on the next claims payable cycle. For payment, we offer providers Electronic Remittance Advices (ERA) directly to our providers, or through a clearinghouse, or through the *PaySpan* service (free to providers). We also offer providers the option of EFT electronic payment via PaySpan (also free to providers). PaySpan subscribers may also view ERAs online. Of course we also offer paper check and paper Explanations of Payment (EOP) for providers not interested in these electronic transactions. The EOP or ERA will clearly outline for the provider the MLTC approved reason(s) for any denials of services listed on the FFS claim, along with instructions for correction and resubmission, if applicable.

Item 7: Other Process Management Tools to be employed for FFS Claim Implementation.
Centelligence™ Data Warehousing, Analytics and Reporting. Centelligence™ is a comprehensive family of integrated data warehousing, decision support and health care reporting solutions. The Centelligence™ enterprise platform integrates data from multiple sources, including our AMISYS claims processing system and all of our core production systems. NTC will use Centelligence™ to provide operational insight, to inform, adjust, and continuously improve each step in the FFS claims process, in the same manner we and our affiliates use Centelligence™ to continually monitor the claims processing aspects of all our programs, both risk-based and FFS. See ***Figure Q117.B: Sample Claims Dashboard Report*** for an example of a drill-down report produced by Centelligence™. We will enable access for MLTC to these interactive dashboards, along with access to our claims system, via our deployment of a secure MLTC Client Portal (MLTC Portal – see discussion further below).

Figure Q117.B: Sample Claims Dashboard Report

State Encounter and Paid Claims Data Submissions. NTC benefits from Centene's more than 30 years' experience in successfully supporting encounter and processed claims data requirements for Medicaid health care programs. Today, Centene submits over nine million encounter transactions per month and over 96 million encounter records per year. NTC will submit accurate and timely processed FFS claim data to MLTC and the NTC Chief Financial Officer (CFO), or designee, will attest to the truthfulness, accuracy, and completeness of all such data we submit to MLTC per RFP requirements. We use an industry leading encounter workflow system, Encounter Data Manager (EDM) to prepare processed claims data for requirements such as RFP Section IV.Z.16. Fully integrated with our MIS, EDM is configurable to meet FFS program requirements as defined by MLTC. For every clean claim, our processed claims data includes the same line item detail as received on the FFS claim, regardless of claim type, and disposition (e.g. paid, denied, adjusted, voided), and we include diagnosis, DRGs as appropriate, and will implement MLTC standards regarding the definition and treatment of certain data elements captured on claims, counting methods, units, etc. We provide all rendered services, rendering provider's identification numbers, and billed amounts, as well as an indication whether the claim is original, adjusted, voided, denied, or a replacement.

Please see Section 112 for more information on our process and organizational resources for producing encounter data for risk-based programs, which is essentially the same process and organizational approach we take for producing and submitting processed claims data for FFS programs.

Post-Payment Recovery and Payment Integrity. Centene's Special Investigations Unit (SIU) utilizes the above applications to track and systematically identify billing irregularities based on industry standards

(e.g., providing unapproved procedures at an ambulatory surgery center, excessive services provided in one day based on CPT time guidelines, upcoding, or excessive utilization). Our tools analyze paid claims data and employs hundreds of edits to identify outliers that may indicate Fraud, Waste, and Abuse (FWA). Centene also conducts routine validation of claims data upon receipt, which includes checks for all applicable claims data fields. We also validate processed claims data (known as "encounter data" for managed care programs) through focus studies, annual provider medical record reviews, provider profiling, reconciliation of processed claim data detail with claim payments, and targeted utilization review of specific provider claims. Centene partners with various vendors to assist with FWA identification efforts. These vendors, who we will use for the FFS program, include:
Health Management Systems, Inc. (HMS), which works to ensure claims are paid correctly, control costs associated with fraudulent claims, and reduce overall payment discrepancies, adjudication, and reimbursement expenditures. HMS helps identify and recover overpayments, detect and prevent fraud, coordination of benefits, and ensure compliance with regulations.
AIM Healthcare Services, Inc. (AIM), which provides claims cost management services, including credit balance recoveries, retrospective FWA analysis and coordination of benefits.
iHealth, which is an Inpatient Diagnosis Related Group (DRG) and Inappropriate Setting (aka Observation Audit) claim audit review process which Centene implemented in an effort to improve medical claims payment accuracy using a method that is acceptable and understandable to providers.
Payment and Remittance Advice. NTC will make payments for all FFS claims to providers, and through our Centelligence™ platform, we will submit to MLTC a reconciliation report of all FFS funds expended and received with remaining balance to be reimbursed to MLTC for FFS payments. NTC will submit a funding request on a weekly basis to MLTC to cover the cost of FFS claims payments, and this report will be submitted by NTC with each funding request to justify the request.

Centene's claims processing operations and supporting MIS undergo annual SSAE16 Type II SOC and Sarbanes-Oxley (SOX) Section 404 audits, both external assurances of the integrity of our claims, systems, and financial controls.

In addition, our MLTC Portal (see description further below) will provide secure inquiry access to our online systems for MLTC and will feature (among other functions) an online, actionable claim payment status board, allowing authorized MLTC users to securely view at a summary and (via drill down click actions) at a detailed claim level, all NTC planned FFS claim payments for review. MLTC users will be able to flag online any FFS claim payment batch or individual FFS claim payments for hold and follow/up actions by NTC and Centene claims professionals, while allowing MLTC to release other claim payments in a batch for payment release, all driven by configurable, event driven workflow. This automated claims payment release approach offers both administrative efficiencies for MLTC, while retaining all workflow actions for full auditability and transparency.
Claims Dispute Process. NTC's Provider Manual will include written policies and procedures supporting an established, internal claims dispute process whereby FFS providers may appeal denied claims. Our MIS supports integrated document workflow required for processing claim disputes. All paper or fax claim dispute related documents are stored in our integrated Centene Document Management System (CDMS) and indexed to the appropriate provider records in our Provider Data Management system before being electronically assigned for follow up. We use our claims workflow management system to track and manage the claim dispute throughout the process, including State Fair Hearing procedures. The integrated combination of CDMS, and our claims workflow management system allows us to support MLTC in claims disputes by providing all required documentation and subject matter representation in the manner specified by MLTC. Our NTC Claims Administrator and her staff, and Medical Management Department will work with NTC support staff in Centene's Claims Center to assist providers seeking (1) reconsideration of any claim, or (2) to dispute our response to such a request. We will follow all Claim

Dispute requirements per RFP Section IV.S.8, and IV.Z.14, including a review of our Claim Dispute policies and procedures with MLTC at least 60 calendar days prior to the start of CBS operations for FFS processing.

Inquiry Access for MLTC. NTC will give MLTC inquiry access to our FFS claims processing system to view claims and all information related to FFS claims processing, and we will provide system user training to MLTC staff who support this scope of work. We will provide a number of online tools, for inquiry and information access to MLTC via an integrated, secure web portal system: our MLTC Client Portal.

MLTC Client Portal. Several of our affiliates support (or are planning to support in 2016) their state Medicaid Agencies with a secure Client Portal expressly for access by authorized state personnel, for a variety of inquiry, reporting and collaborative applications. We will configure a Client Portal for MLTC (MLTC Portal) to support functions to enhance MLTC's ability for oversight and compliance monitoring, document library functionality and collaborative workflow support with NTC. The MLTC Portal will offer access for qualified MLTC (and other Nebraska State Agency staff as necessary) to these resources:

- Online inquiry access to our claims processing system (per RFP Section IV.Z.4).
- Updated Library Systems Documentation (per RFP Section IV.R.1b), Systems Design & Management Manuals, User Manuals, and Quick Reference Guides, with content and update frequency prescribed in RFP Section IV.R.3. If an update or change to our MIS is needed that pertains to material in our documentation, we will forward the relevant updated documentation to MLTC 45 calendar days prior to our intended implementation, and we will post approved MLTC updated documentation on the MLTC Portal and have printed revisions ready within ten business days of the change.
- Updates on any System Unavailability events and related problem resolution activities. Note that this does not limit MLTC in any way from contacting our Systems Help Desk, and NTC will proactively contact an MLTC designate for system issue communications as prescribed in RFP Section IV.R.10.
- Other applications, such as online access to reports and data to be defined in detail with MLTC.

In addition to above, NTC will facilitate access to all of our live systems for MLTC at any time, and this is a request that many of our affiliates satisfy for their state Medicaid Agency clients.

Drug Claim Processing. As will be the case with Heritage Health managed care, NTC's pharmacy benefits manager (PBM) subcontractor, and NTC affiliate, US Script, will perform drug claim processing for the FFS Medicaid program, and will pay FFS drug claims in accordance with the same requirements for managed care pharmacy claims in the RFP. US Script's system, PBM1, is an integrated pharmacy claims, prior authorization and prescriber and pharmacy service system configurable for the specific needs of individual programs such as Nebraska's FFS program. In addition, US Script shares the same data center facilities as does NTC, leveraging the same enterprise datacenter services including physical security, systems management, data backup, business continuity, and redundant networking. Among other advantages, this means NTC, US Script, and supporting Centene Claims Center staff share a common communications platform, enabling them to detect when a colleague is online, whether on e-mail, or available for instant messaging or phone conference, or logged into our Customer Relationship Management (CRM) system - fostering quicker communication, multi-disciplinary teamwork, and rapid, coordinated response to issues or requests demanding immediate attention.

Drug Rebates. Because US Script electronically sends processed drug claims data to our Centelligence™ data warehouse, NTC can and will provide pharmacy claims information to MLTC so the State may perform all drug rebate activities (including disputed drug rebates) for FFS drug claims. We will work with MLTC to finalize the state's pharmacy claims information needs, and can support both HIPAA NCPDP and proprietary drug claims formats for MLTC.

PBM Oversight. NTC's Joint Operating Committee (JOC) will monitor US Script PBM operations for the FFS program through the JOC's Vendor Oversight Program (VOP). The NTC Director of Compliance will be responsible for monitoring and documenting subcontractor adherence to FFS drug claim processing and reporting requirements. The VOP encompasses the following key elements: execution of FFS contract terms and agreements, FFS delegation audits, FFS performance monitoring, administration of any necessary Corrective Action Plans, enforcement of contractual penalties, coordination of day-to-day business operations, and quarterly Joint Operating Committee meetings. US Script will enter into a written agreement which includes, but is not limited to, responsibilities of the NTC and the US Script, specific delegated activities, including business and regulatory reporting requirements, performance standards and reports for oversight of delegated activities, and explicit statement of consequences and corrective action process if the subcontractor fails to meet the agreement terms, up to and including revocation of the delegation agreement. NTC staff will hold monthly operational meetings with US Script, which will include regular reviews of FFS drug claim reporting and performance accountability.

FFS Program Third Party Liability

Centene and our 20 Medicaid health plan affiliates have a successful history of maximizing cost avoidance, as well as recovering payments made for our members who were subsequently found to have Third Party Resources (also known as "Other Insurance") all in compliance to federal and state requirements. We structure our cost avoidance and TPL practices around a "Medicaid as a payer of last resort" principle.

Capturing TPL and Related Information. We will capture all known COB/TPL and Third Party Resource information (e.g. based on data from our cost recovery vendor Health Management Services (HMS), from prior claims submissions, etc.) at the member level within the member's eligibility record in our MIS. During the claims adjudication process, our AMISYS claims processing system checks for TPL/COB information in the member record and will pend or deny the claim based on the information contained within the record if there is no evidence of primary payer adjudication of the claim, and in compliance with MLTC policies and applicable Nebraska and federal law. When we become aware of Third Party Resources or other insurance a member has, we will update the member's record in our MIS. We will employ several processes to collect TPL/COB information:

Accident and Trauma Related Diagnosis Code Edits. We load accident and trauma related ICD-10 diagnosis code edits into our AMISYS claims processing system, creating another way NTC will intercept claims that may be the liability of a third party. If a claim is received without documentation to support the liability or non-liability of a third party, and the claim contains an accident- or injury- related diagnosis code, and/or trauma indicator of "Y", we will pay the claim and request that the provider submit accident-related documentation or payment information from the third party. We send this information to HMS, our partner for post-payment recovery services, for further investigation

Data Mining. NTC and Centene's claim department will regularly identify TPL and COB cases by data mining through our Centelligence™ informatics platform and using diagnosis and trauma edits, in addition to member outreach, to confirm the presence of TPL based on these edits. We also validate TPL whenever we receive a first time claim with an EOB attached, or an adjustment request from the provider. Both of these situations are detected systematically through Centelligence™, and our web-based reporting and management dashboards capability.

Claims Oversight. NTC's Claims Administrator and her staff will be responsible for regularly reviewing standard claims operations reports focused on first time claims with EOB attachments and claim adjustments. The Claims Administrator or her delegate will route this information (members contact information, plus other information from the EOB or adjustment request) to the TPL/COB team in NTC's primary Claims Center to verify enrollment with either the third party and/or the member to ensure we are coordinating benefits appropriately.

Health Management Systems (HMS). HMS is an established leader in TPL/COB identification and post-payment recovery in the public sector. Each month, as our affiliates do today, we will securely send FFS member demographic data to HMS. This information will be matched to HMS' database of national insurance eligibility information, which is updated regularly to identify other available coverage. HMS reviews access coverage information from government healthcare programs, such as Medicare. HMS' database is regularly updated and contains over 1.2 billion unique current and historical segments of eligibility from various sources, including insurance carriers, Third Party Administrators, Pharmacy Benefit Managers, and unions used for identification of potential TPL. When a match is found, HMS verifies coverage directly with the carrier through a combination of online tools and telephone contact, and sends the resulting data back to NTC. We then load this member level TPL/COB and updated carrier information into our Member Data Management system and from there the data automatically, and electronically, feeds our claims processing system.

Provider Training. Through TPL/COB provisions in our provider contracts (for NTC contracted providers), regular provider orientations, ongoing training meetings, and our online provider manual, NTC will educate all FFS and NTC Heritage Health providers on the importance of identifying COB/TPL information at the time the member receives services. We inform and educate providers about the importance and process for submitting denial notices from third parties, accident details, and medical records corroborating no other liable parties, or EOB or payment information from a third party where member liability exists in the TPL/COB and other payer segments of their HIPAA 837 EDI claim submissions, or their paper claim submissions.

Notification from NTC Staff. NTC staff may also become aware of TPL/COB during member and provider interactions, chart reviews, etc. When staff learn about TPL/COB not already included in the member's eligibility record, it will be verified by the Claims Administrator or her designate, and the member record will be updated to ensure accurate handling of future claim submissions.

Secure Provider Portal. NTC's secure web-based Provider Portal will allow authorized FFS and/or managed care provider users to see any current TPL information we have on record for a member, affording them a means to check for TPL as part of their routine member eligibility verification process prior to claim creation and submittal. The Provider Portal will also allow providers to submit TPL documentation by uploading images, PDFs, Microsoft Word documents, or other digitally formatted TPL related documents. This information is accessible to our claims processors to expedite finalizing claims with TPL. In addition, a provider may enter a claim directly via our HIPAA compliant Direct Data Entry (DDE) online claim entry facility available through our Provider Portal. Our online claim entry application has logical field checks so that, for example, if a provider indicates that the member has other insurance, but no entry is made concerning third party payments, the application alerts the user to the missing information they are entering the claim.

Coordination of Benefits Agreement (COBA). NTC will execute a COBA with the CMS Benefits Coordination & Recovery Center (BCRC) and participate in the automated crossover process for dual eligible individuals enrolled in FFS and Heritage Health programs. Our MIS currently supports the COBA based claims crossover process for several of our affiliates. Please see Section 113 for information on how we can and will adjudicate Medicare crossover claims – a process that we will employ for FFS Medicaid administration as well as for Heritage Health.

Configuring COB/TPL Rules for FFS Claims. Our claims configuration team will use AMISYS' table driven parameters to configure the system to coordinate benefits in accordance with MLTC FFS claim processing rules. In those cases where the member has received services that were paid by a third party, but the member has coinsurance, deductibles, co-payments, or other cost-sharing expenses, we will pay those expenses on behalf of the member, not to exceed the lowest allowable amount by the primary payer. For example, for claims where the TPL allowable amount is less than the Medicaid allowable amount and there is member liability, we will pay up to member liability, not to exceed the primary's allowed amount.

NTC will provide coverage for services excluded by another carrier should the service be an allowed benefit under the state's FFS Medicaid program. Authorization processes, approvals, or denials made by another carrier (such as the primary carrier) will not drive NTC FFS authorization or adjudication processes. NTC processes are directed in accordance within the requirements of MLTC and not affected by other carrier coverage decisions.

Pay and Chase and Subrogation. NTC will leverage post payment recovery services from HMS. HMS provides recoupment when TPL/COB is not known at the time we pay the claim, and for subrogation to parties with TPL/COB. On a weekly basis, we will provide HMS with a claims detail report of claims processed the previous week. If HMS determines that a claim is related to TPL/COB for a member with commercial insurance, HMS will initiate steps to recover the overpaid TPL/COB dollars from the insurance carrier, on behalf of NTC and request reimbursement to NTC for the amount of payment. Any recoveries we make we will immediately return to MLTC in full.

Reporting TPL Coverage to MLTC. Through our Centelligence reporting platform, which is integrated with both our Member Data Management and AMISYS claims processing system, we can and will produce a weekly file of TPL information for MLTC, as well as a monthly file of member Third Party Resource information, per MLTC specifications.

Claims Operations Regularly Audited

Centene claim operations and process controls are audited regularly, including two major external audits performed annually. Each year our claims processing operations and supporting data center operations undergo an SSAE16 Type II SOC audit, and in our most recent audit (2014), Centene received an unqualified opinion from our external auditors, indicating controls operated effectively with no significant deficiencies identified. In addition, Centene management annually conducts evaluations of the effectiveness of internal controls over financial reporting according to Sarbanes-Oxley Section 404 (SOX) regulations and we test the design and operating effectiveness of Centene's internal controls over financial reporting, many of which relate to claims processing. Our external auditor expressed an unqualified opinion on the effectiveness of internal controls over financial reporting for the period ending December 31, 2014, indicating that no significant deficiencies or material weaknesses were identified.

Meeting Applicable Section IV.Z Requirements

In ***Table Q117***, we summarize our discussion above, and in Sections 118 through 122 of our proposal, with requirements from Section Z of the RFP that relate to implementing FFS claims processing.

Table Q117

RFP Section	Requirement	How NTC Meets Requirement
IV.Z.1	***Claims Broker Service.*** 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.	**NTC acknowledges and will comply with all requirements in IV.Z.1.** Through our integrated MIS, which includes our Centelligence™ reporting platform, we can and will supply MLTC with detailed reports for validation of FFS payments and recoveries.
	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	Using our enterprise Compliance/360 governance, risk and compliance management system, we will claims handling and payment policies specific to

RFP Section	Requirement	How NTC Meets Requirement
	Initiative (NCCI) guidelines and Medicaid service limits. The claims broker must ensure accurate collection, processing, payment, and reporting of all FFS claims.	FFS processing. As described above in this Section 117 as well as Section 119 of our proposal, our integrated MIS and supporting processes will ensure accurate collection, processing, payment, and reporting of all FFS claims.
IV.Z.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.	**NTC acknowledges and will comply with all requirements in IV.Z.2.** Our integrated MIS and Centelligence reporting platform enables us to satisfy reconciliation reporting requirements. In addition, we will provide the MLTC Portal as described above, with online tools allowing authorized MLTC staff to monitor our FFS claims and payments.
IV.Z.3	***Implementation Timeline***	**Please see Section 122 of our proposal for our response to this requirement.** Working with MLTC, we will implement FFS claims processing in a ten month implementation timeline.
IV.Z.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.	**NTC acknowledges and will comply with all requirements in IV.Z.4.** Our configurable MIS allows us to implement the MLTC's FFS program with specific edits, and payment, member eligibility, provider participation, and reporting rules specific to FFS claims processing parameters. In addition to discussion in this section, please also see Section 119 for more information.
	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.	Through our best-practices approach to Agile based change management, we can and will support operational changes mandated by MLTC. Please also see Section 118 of our proposal for information on how we address system change requirements.
	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.	Our MIS, including the AMISYS claims processing component of our MIS, allows us to configure specific reimbursement methodologies for MLTC's FFS program.
	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.	Using a secure web portal (MLTC Portal), we will provide MLTC inquiry access. Please see discussion above in this Section 117 as well as Section 118 of our proposal for information on how we will grant inquiry access for MLTC to our claims

RFP Section	Requirement	How NTC Meets Requirement
		system.
IV.Z.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	**NTC acknowledges and will comply with all requirements in IV.Z.5.** Our MIS, including the AMISYS claims processing component of our MIS, allows us to configure specific reimbursement methodologies for MLTC's FFS program. We often configure new benefit plans using an existing benefit plan as the basis, and we will thus set/up FFS claims processing rules to "inherit" those characteristics of managed care claims processing that are common to both. Please see Section 119 of our proposal for additional discussion.
IV.Z.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.	**NTC acknowledges and will comply with all requirements in IV.Z.6.** NTC, with the support of its affiliate and PBM subcontractor, US Script, can and will comply with these requirements. See our discussion above for more information.
IV.Z.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.	**NTC acknowledges and will comply with all requirements in IV.Z.7.** Our TruCare care coordination and prior authorization system is integrated with AMISYS, and we can and will configure TruCare and AMISYS with prior authorization rules specific to FFS claims processing in accordance with FFS authorization policies. Please see Section 119 of our proposal for more information.
IV.Z.8	***Payments to Providers.*** The claims broker must pay FFS claims at a fee schedule rates set by MLTC.	**NTC acknowledges and will comply with all requirements in IV.Z.8.** Our Provider Data Management (PDM) system is integrated with AMISYS, and we associate fee schedules in AMISYS to applicable benefit plans and provider contractual affiliations, allowing AMISYS to apply the appropriate fee schedule to the benefit plan of the member for the date(s) of service on a FFS claim. In addition, we recognize that MLTC may require changes in FFS fee schedule rates, and can apply these changes in MLTC mandated timeframes. See Section 118 of our proposal for more information.
IV.Z.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	**NTC acknowledges and will comply with all requirements in IV.Z.9.** Centene and our affiliates support

RFP Section	Requirement	How NTC Meets Requirement
	Section IV.S Claims Management of this RFP.	requirements similar to those in Section IV.S today for our Medicaid plans in 20 states. We offer several complementary methods for providers to receive remittance advice notices from us, including via our Provider Portal, and/or HIPAA 835 transaction, and/or via the free Payspan service, and/or via paper Explanation of Payment notice included with paper check payments.
IV.Z.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.	**NTC acknowledges and will comply with all requirements in IV.Z.10.** Please see our detailed discussion on our TPL, COB, and Third Party Resource and other insurance identification processes, and cost avoidance and cost recovery procedures, which we will implement in support of MLTC requirements for the FFS program.
IV.Z.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	**NTC acknowledges and will comply with all requirements in IV.Z.11.** NTC will have a Member and Provider Service unit dedicated to the FFS Medicaid program with a separate 1/800 phone line for FFS Medicaid service. Please see Section 120 and Section 28 of our proposal for additional information.
IV.Z.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.	**NTC acknowledges and will comply with all requirements in IV.Z.12.** NTC will have a Member and Provider Service unit dedicated to the FFS Medicaid program, with a separate 1/800 phone line for FFS Medicaid service. We will also provide the same level of support for providers for the FFS Medicaid program as the risk-based program, including FFS program support for providers who do not participate in NTC's Heritage Health program. We will make all required FFS materials available on our website for all providers participating in the FFS program. Please see Sections 120, 48,49, 50 and 101

RFP Section	Requirement	How NTC Meets Requirement
		of our proposal for more information.
IV.Z.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.	**NTC acknowledges and will comply with all requirements in IV.Z.13.** As described in Section 109 of our proposal for Heritage Health, NTC and our Claims Department will administer RFP mandated Paid Claims Sampling in the *same manner* for the FFS Medicaid as for the risk-based (Heritage Health) program.
IV.Z.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.	**NTC acknowledges and will comply with all requirements in IV.Z.14.** As described above, NTC and our Claims Department will administer RFP mandated Claims Dispute Management processes in the same manner for FFS Medicaid as for the risk-based program.
IV.Z.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.	**NTC acknowledges and will comply with all requirements in IV.Z.15.** As described in Section 108 of our proposal, NTC and our Claims Department will maintain the same processes to assure Claim Payment Accuracy in the same manner for FFS Medicaid as for the risk-based program. Our sampling and audit processes are segregated by program, allowing us to measure accuracy by program.
IV.Z.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.	**NTC acknowledges and will comply with all requirements in IV.Z.16.** NTC and our Encounter Business Operations (EBO) unit (see Section 112 of our proposal) will prepare this claims data. Our MIS can support all HIPAA formats (including the HIPAA 837 processed claim data format), and we can include FFS and account code identifiers on the FFS program claim data we send to MLTC.
IV.Z.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.	**NTC acknowledges and will comply with all requirements in IV.Z.17.** NTC, with the support of its affiliate and PBM subcontractor, US Script, can and will comply with this requirements. See our discussion above for more information.
IV.Z.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.	**NTC acknowledges and will comply with all requirements in IV.Z.18.** We will comply with this requirement in the same manner as for Heritage Health (see Section 108 of our proposal).

(page limit N/A)
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.

Processes and System Oriented to Program and Policy Changes

For Claims Broker Services (CBS), Nebraska Total Care (NTC) will use an enterprise scale, interoperable and configurable Management Information System (MIS) operated by our parent company, Centene Corporation (Centene). NTC and supporting Centene CBS staff, as well as our MIS, are equipped to support program and policy changes of operating health programs (whether for Managed Medicaid or direct "FFS" Medicaid) accurately and efficiently. Our experience in supporting program and policy changes allows us to affirm that we will make system or operational changes for FFS claims processing within 60 calendar days of notification by MLTC. We will also correct all processing errors identified by MLTC immediately on notification, and we recognize that recoupment of erroneous payments made to providers is the sole responsibility of NTC as MLTC's CBS vendor. Furthermore, we recognize that MLTC will not reimburse NTC for uncollected recoupments for FFS claims paid in error.

Centene's interoperable MIS supports over 4.8 Million Americans participating in government sponsored health plans across 23 states. Our staff and MIS necessarily and successfully supports the frequent program and policy changes endemic to Medicaid and other state programs.

Level of Effort for Changes to Covered Services. In general, changes to covered services are not at all uncommon to us, and require *nominal effort* on our part to implement. Although we historically do not see more than one change in covered services per program in any given year, we can certainly accommodate changes of a greater frequency if this is what MLTC foresees in the FFS Medicaid program. We process changes to covered services through configuration changes to the benefit plan grid configured for the program (e.g. FFS Medicaid) in the AMISYS Advance (AMISYS) claims processing component of our MIS. Once we have confirmed the change in writing with our state client (in this case, MLTC), we document the requested change as a Change Request (CR) in our ServiceNow change management workflow system, so that we can quickly track the configuration change, along with MLTC and NTC signoffs. The CR will be assigned to an NTC Configuration Analyst to configure and test the change, along with our claims configuration test team, following our standard, Agile based change management approach (see Section 101 for more on our change management procedures).

Level of Effort for Changes to Prior Authorization Requirements. In the case of Prior Authorization (PA) changes (e.g. PA coverage period, number of units per PA, etc.), we configure changes in the TruCare utilization management component of our MIS. Once we have confirmed the change in writing with MLTC, we again file a CR in ServiceNow, and our TruCare configuration team implement the PA change. If the PA change is of a nature that changes whether a particular service *requires* a PA or not (for example a situation where a covered service now requires a PA where before the change the service did not require a PA), then we will make that change in the benefit plan grid in AMISYS. This latter scenario does not occur often, but (as above) the level of effort is certainly manageable and we routinely handle PA change requests successfully and on time, given sufficient notice (e.g. within 60 calendar days of effective date).

Level of Effort for Additional Populations. We include additional populations in a program (e.g. FFS Medicaid, or Managed Medicaid programs) through the Member Data Management (MDM) component of our MIS. Generally we work with our state clients to identify and test new member group related values in the inbound 834 enrollment and eligibility file. We define new member record load processing rules so that members of an additional population are assigned to the correct member group (e.g. FFS

Medicaid). There is usually little (if any) change needed in AMISYS (claims processing component) for inclusion of an additional population in a benefit plan. Note that our MIS components (including MDM and AMISYS) can process member records and claims according to different retroactivity rules, depending on MLTC's claims retrospective processing requirements when introducing additional populations.

Level of Effort for Changes to Pricing Schedules. We support changes to Fee Schedules for our state clients, and these generally occur annually, quarterly, or on an ad-hoc basis. We can and do implement Fee Schedule changes with nominal effort through our AMISYS Configuration Team. The most important consideration in implementing Fee Schedule changes is having adequate lead time, but we can implement these changes well within 60 days of notice. We also support electronic fee schedule updates from state clients. For example, our Medicaid state agency client in Indiana sends us via FTP updates to the Medicaid Fee Schedule, and we monitor and load those changes into AMISYS directly. Particularly in this latter "electronic update" scenario, we do not experience a major level of effort to apply changes to Medicaid Fee Schedules.

Level of Effort for Changes to Pharmacy Information. NTC's pharmacy benefits manager (PBM) and affiliate subcontractor is US Script, which supports the PBM requirements of our Centene affiliates nationwide for Medicaid and other government sponsored health plans. As such, US Script necessarily must accommodate frequent changes mandated by states to Preferred Drug Lists (PDLs) and formularies, as well as continual updates to pharmacy drug costs (e.g. Maximum Allowable Cost (MAC) schedules), NDC codesets, and more. US Script's integrated MIS (known as PBM1) is a proprietary system developed by US Script with efficient configuration change capabilities in mind, and US Script can and will accommodate pharmacy drug related changes to FFS Medicaid policy and program alterations from MLTC.

Monitoring Changes. In addition to complying with all Audit Requirements in the RFP in Section IV.S. 13, we will give MLTC inquiry access to our FFS claims processing system to view claims and all information related to FFS claims processing and we will provide system user training to MLTC staff who support the CBS scope of work. This inquiry access to our MIS will give MLTC additional transparency into our CBS operations, and allow MLTC to confirm requested changes have been made appropriately. Please see Sections 117 and 122 for more information on our MLTC Portal to enable this access.

(page limit N/A)
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.

Separation of FFS and managed care Processing Rules

Nebraska Total Care (NTC) will use an enterprise scale, standards based Management Information System (MIS) operated by our parent company, Centene Corporation (Centene) that successfully distinguishes unique FFS and managed care processing rules on behalf of our affiliates today administering government funded health programs in 23 states, including Medicaid programs in 20 states. We have the HIPAA compliant controls, data segmentation, configuration structures, and Role Based Access Controls (RBAC) to maintain complete distinction between FFS and managed care processing rules, claims transactions, providers, members and prior authorizations within our system.

Centene's scalable MIS successfully processes approximately 60 Million physical and behavioral health Medicaid claims a year for Medicaid programs across 20 states, distinguishing each claim per individual program.

Architected to Process Health Programs Separately yet Efficiently. Our MIS is comprised of modular system components (claims, eligibility, care management, etc.) that are integrated via a Service Oriented Architecture (SOA) design, and employs a Master Data Management approach to data governance and segregation informed by CMS' Medicaid Information Technology Architecture (MITA). NTC will maintain distinction between FFS and managed care processing rules by defining each program (FFS and managed care) as independent benefit plans for purposes of plan administration, using member group and benefit plan configuration tables, which allow not only for data segmentation, but enable workflows adapted to meet the needs of each program, and fully compliant with State and Federal security and privacy mandates. In addition, we can and will associate provider contract affiliations with FFS and/or managed care, to distinguish which program (or both programs) the provider participates in as an NTC managed care network provider and/or a provider with active Nebraska Medicaid ID able to see patients under Nebraska Medicaid.

Maintaining Distinction. In the discussion that follows, we use the phrase "NTC managed care" to refer to the Heritage Health Managed Medicaid program that NTC will administer for MLTC as an MCO, and we refer to "FFS" as the "direct FFS Medicaid" program NTC would support with Claim Broker Services (CBS) per RFP Section Z. NTC will:

- ***Configure our Core Processing Systems.*** Our modular MIS components allow us to customize and configure business processing rules according to FFS or NTC managed care programs. For example, we configure our eligibility loads for specific benefit plans (FFS or NTC managed care) set/up in our claims processing system. We also configure each provider as participating in either FFS or NTC managed care – or both.
- ***Systematically Translate and Route Data for FFS or MCO Processing: Driven by Member Identification.*** NTC will use our integrated EDI subsystem to handle automated file exchanges (transmission and receipt) with MLTC. Upon receipt of membership data, the Centelligence™ Data Service Bus (our SOA middleware) will identify member records as participants in the appropriate program (FFS or NTC managed care) and electronically route the data to and from our integrated *Core Processing System Components* where configured business rules will use the member records (identified for the appropriate program participation) for applicable processing. Identifying data receipt to its defined program (FFS vs. NTC managed care) at the point of eligibility record receipt maximizes data integration for downstream workflows, mitigating against mismatching and any need for reconciliation. Similarly, when we receive inbound claims (whether as EDI, entered online via our Provider Portal, or on paper or fax), our MIS validates the member against our Member Data

Management system (see below), and processes the claim according to the benefit plan (e.g. FFS or NTC managed care) of the member for the dates of service on the claim.

- ***Define and Employ Access Security Rules.*** We implement Role-Based Access Controls (RBAC) for all applications that process electronic protected health information. We will define separate RBAC profiles for NTC and Centene staff administering FFS or NTC managed care claims and related functional support (e.g. utilization management). RBAC addresses security risks by defining employee access rights based on the employee's job responsibilities, including whether that employee has access rights to update information or view only. Individual security change requests are recorded through a documented security authorization and implementation process.
- ***Provide Segregation of Duties.*** NTC will enforce strict control over global application and systems access via coordinated and complementary technical and administrative controls. For all core business applications, the individuals responsible for provisioning application access are not themselves members of roles that have rights to perform transactions within those applications. Furthermore, our monitoring regimen mitigates the risk of security personnel modifying their own roles, or provisioning new roles for themselves, by logging changes to access, issuing privileged access reports for periodic review by application owners, and by notifying oversight personnel when there are any changes to highly privileged administrative roles.
- ***Follow HIPAA Minimum Necessary Requirements.*** Through a coordinated blend of administrative, technical, and physical controls, our HIPAA Security Program helps assure that all access to our systems and information is appropriate for their role and responsibility, and follows the HIPAA Minimum Necessary Requirement for information accessibility. Our HIPAA compliance plan and highly available IT architecture will help us ensure that we maintain the highest possible level of information availability so that all authorized users of our MIS can access (depending on their job function) information related to FFS or NTC managed care claims, member eligibility, and reporting data.
- ***Maintain Separate Policies & Procedures.*** NTC will track and maintain policies and procedures specific to each MLTC program (FFS or NTC managed care) independently, meaning that each policy and procedure will undergo separate review and approval cycles to ensure operations are tailored to meet the needs of the FFS and managed care programs, respectively. NTC will use Compliance 360 (C360), a leading Governance, Risk Management and Compliance (GRC) system, to incorporate State contract requirements and regulations by "line of business" (FFS or NTC managed care), and to store our policies, procedures and systematically track compliance activities, (with auditable records of management approval). C360 will effectively help NTC administer and monitor our internal governance, as well as our contractual and regulatory oversight responsibilities, for the FFS and NTC managed care programs – independently of each other. However, NTC's Director of Compliance will ensure that both sets of policies are consistent where they need to have common policy and process stipulations.

In December of 2015, Centene's Information Management Security System and Program received International Standards Organization (ISO 27001) certification, recognizing our adherence to security best practices and demonstrating that we have successfully adopted the globally recognized information security framework.

Master Data Management facilitates FFS Processing Distinction. One critical way our MIS supports *multiple* program contracts is through the maintenance of a single "source of truth" repository for member and provider data. We leverage master data management principles, where every data element is stored

logically once, and any linkages to this data (e.g. member or provider record identifiers) are by reference. Thus, when any such data element is updated, this update propagates to the core processing components of our MIS and our subcontractors without the possibility of a duplicate value. The member and provider identifiers provide a reference key to all downstream systems indicating, for the dates in question (e.g. member eligibility spans, provider managed care contract or Nebraska Medicaid certification period) what business unit (FFS or NTC managed care) the member's or provider's record pertains, and therefore what configured business rules to apply.

Member Data Management (MDM) Component. Similar in design to a Master Patient Index application, the Member Data Management (MDM) component of our MIS will provide the single "source of truth" for all member information. In addition to eligibility and enrollment, MDM will support all informational aspects of the member's relationship with NTC and MLTC (including whether the member is a FFS or NTC managed care member for any particular eligibility date span), and store member attributes such as member identifiers, address and contact information, confirmed or potential family linkages, and special needs. One rule MDM will enforce is that, given any particular date, a member can be an active participant in the FFS program or the NTC managed care program but *not* both programs for that particular date.

Our MITA informed design provides an effective means to collect, aggregate, match, and segregate MLTC member data throughout our organization to ensure consistency and control in the ongoing maintenance of member data. Once in MDM, based on the benefit plan (FFS or NTC managed care) information in the member record, the member data is electronically promulgated to all systems requiring that data, where core processing systems will only use configured business rules of the program (FFS or NTC managed care) that applies for that member record. For example, our AMISYS claims processing system, will adjudicate a claim using the FFS benefit plan, based on the fact that the member denoted on the claim, for the dates of service on the claim, fits within the FFS eligibility date span with the member's record in MDM.

Unified Member View. Through Centene's experience, we frequently see individuals move across different Centene affiliate health programs within and across states, and we have come to appreciate the need to employ an MIS that is capable of centering on a person rather than on separate current and historical "member eligibility date spans". Transitions through multiple programs and associated member and provider activity, are all invaluable information that helps us better manage the member's care from aspects of care coordination as well as care transition. To accommodate this "total member perspective", MDM has a function we refer to as Unified Member View (UMV). UMV will ensure a system-wide, holistic view of a member's history and her enrollment spans across FFS or NTC managed care programs (or other Centene affiliate participation history). In other words, if a member moves between FFS or NTC managed care programs, we will be readily equipped to support that member and all transactional processing (FFS or NTC managed care) related to the member, including claims, authorizations, member service calls, grievances and/or appeals, etc.

Provider Data Management (PDM) Component. Similar to MDM, PRM provides a single "source of truth" for all of MLTC's core provider functions, including provider program (e.g. FFS and/or NTC managed care) enrollment, data management, financial affiliation configuration, and provider directory management. Our Provider Data Management Department enters and updates provider data in PDM, ensuring that all provider data comes from one source. PDM stores multiple provider identifiers, including Tax ID, state Medicaid IDs (e.g. the 11 digit Nebraska Medicaid ID), the HIPAA National Provider ID (NPI), provider's language information, locations, office hours, etc. Because our provider records indicate which programs the participates in, our core systems can apply appropriate business rules. For example, AMISYS will determine the appropriate benefit plan to apply for a member based on member ID and benefit plan ("member group") as denoted in our records for the claim date of service. AMISYS will then validate the provider's participation in the program (FFS or NTC managed care) that

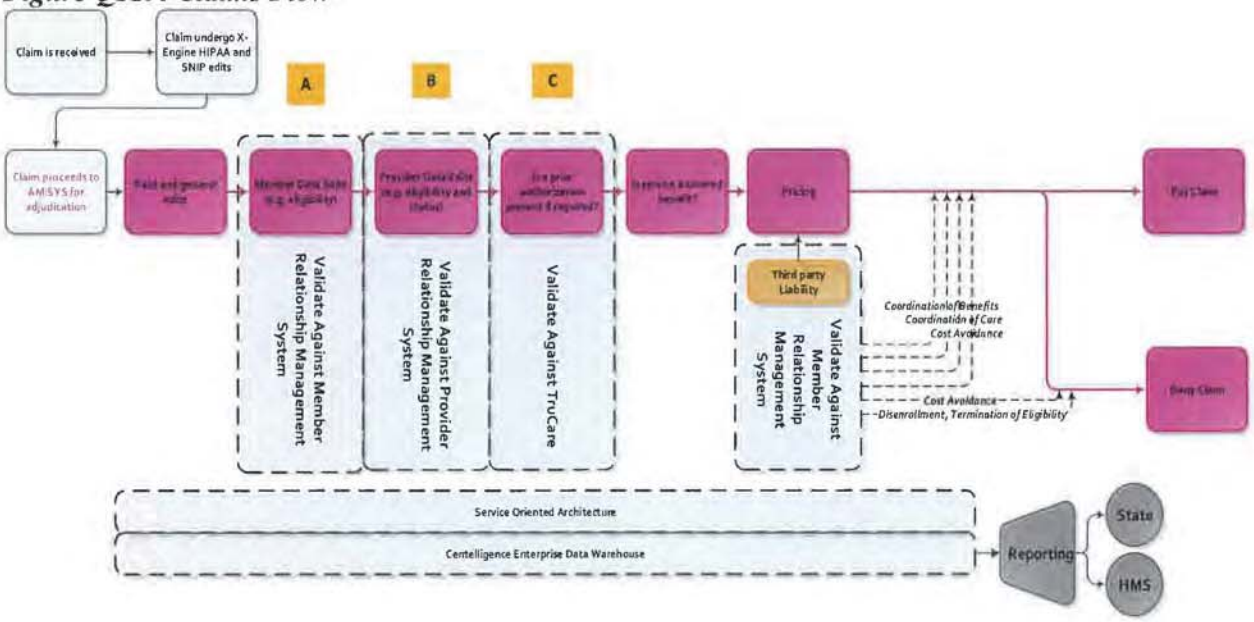
the member participates in - and apply appropriate fee schedule (FFS or NTC managed care) when pricing a claim.

Authorizations Linked to Member Eligibility Records. Member eligibility is electronically promulgated from MDM to TruCare, our care management platform where authorized NTC staff will perform care management and utilization management activities, as well as the Provider Portal, where providers will have access to authorization submission and status lookup. Authorization requests submitted in either platform are tied directly to the member eligibility record, and therefore directly linked to the business unit (FFS or NTC managed care) to which that authorization applies (FFS or NTC managed care), and authorizations follow the rules (as configured in TruCare) for that specific program (FFS or NTC managed care).

Claims Processing and Payment Flow. The NTC Contract Implementation Manager will create separate payment guides which will specify the configuration of the payment arrangements in AMISYS for FFS and NTC managed care programs. During claims adjudication, claims are loaded into the AMISYS claims processing system component of our MIS. We perform six primary steps of adjudication that are specific to a particular benefit plan (FFS or NTC managed care) - including general edits, member eligibility, provider eligibility, prior authorization, covered services, and pricing; that a claim must pass in logical succession to reach a "finalized" (paid or denied) or internally pended status. Please refer to ***Figure Q119: Claims Flow*** below for the following discussion:

- ***Validation of Member Eligibility.*** (Item A in ***Figure Q119***) Through the MDM membership component of our MIS, AMISYS validates member data on the inbound claim against the member's record in MDM to check member data elements such as eligibility, enrollment, and program (FFS or managed care). This drives AMISYS to the correct benefit plan and covered service package for pricing and payment.
- ***Validation of Provider Eligibility.*** (Item B in ***Figure Q119***) Similarly, AMISYS validates provider data on the inbound claims against the provider's record in PDM to check provider data elements, including the participation status of the provider in the program (FFS or NTC managed care) the member is eligible for on the claim date(s) of service. This drives AMISYS to the correct provider pricing grid for payment.
- ***Prior Authorization.*** (Item C in ***Figure Q119***) Similarly, AMISYS validates against TruCare, our care management platform, for prior authorizations during its adjudication process. Prior authorizations created will be referenced to the member eligibility (and therefore to the appropriate program: FFS or NTC managed care).

Figure Q119: Claims Flow



Meeting RFP Requirements for Distinction between FFS and managed care.

In ***Table Q119***, we summarize key requirements from Section Z of the RFP that relate to our ability to successfully make the distinction between FFS and managed care processing rules, claims transactions, providers, members and prior authorizations within our MIS.

Table Q119

RFP Section	Requirement	How NTC Meets Requirement
IV.Z.4	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.	Our AMISYS system supports an expansive array of reimbursement methodologies from FFS to managed care to fully capitated arrangements. We configure AMISYS benefit plans (e.g. FFS or NTC managed care) and associate reimbursement schedules to each benefit plan. Members are associated to benefit plans, and providers are affiliated with contracts (FFS, or NTC managed care, or both). Thus, at the point of claim adjudication, AMISYS will determine the member's benefit plan (FFS or NTC managed care), and apply the right benefit plan, while also applying appropriate provider contract for reimbursement, according to the rules we configure for each program (FFS or NTC managed care).
IV.Z.5	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,	We will support the same claims processing standards for FFS and NTC managed care. Our Centelligence™ data reporting system uses paid claims data from AMISYS and we produce claims operational reports by

	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.	program (e.g. FFS and NTC managed care). Centelligence™ will enable us to ensure we maintain the same operational standards for both program. We often configure new benefit plans in our AMISYS claims system based on existing plans. For example, by building the FFS benefit plan by starting with the NTC managed care plan, we can keep the appropriate edits the same (as applicable) for both programs. We can and will post all applicable edits to denied FFS claims during a single processing cycle, and thanks to AMISYS' architecture, we process and distinguish denied claims by program (e.g. FFS vs. NTC managed care).
IV.Z.7	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.	Similar to AMISYS, TruCare allows us to configure authorization rules around a particular program (e.g. FFS or NTC managed care). TruCare feeds authorization data to AMISYS every 15 minutes and AMISYS applies authorizations against information on inbound claims, including the member ID. This means FFS authorizations are applied to appropriate services for FFS members and matched to inbound claims filed on behalf of that member. Our ability to configure TruCare and AMISYS for auth production and claim matching, means we will pay or deny claims in accordance with FFS authorization policies.
IV.Z.16	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.	We will readily meet this requirement. Our MIS segregates and stores all data relevant to claim adjudication and payment (including processed claims data) by program, and we will process and submit FFS claims data to MLTC distinctly and separately (per MLTC requirements) from NTC managed care encounter data, identifying claim data as FFS with appropriate account codes on our claim data record submissions to MLTC.
IV.Z.17	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.	Our affiliate subcontractor, US Script, is our Pharmacy Benefits Manager (PBM). Similar to NTC, US Script's MIS (known as PBM1) can process pharmacy claims distinctively for FFS and NTC managed care programs, because PBM1 stores and uses all record data elements we electronically issue to US Script, and PBM1 supports multiple benefit

		plans with distinctive processing rules per program. Similarly, PBM1 processes paid pharmacy claims data by program and will segregate FFS from NTC managed care pharmacy claims records so that NTC can supply that information to MLTC for drug rebate activities.
IV.Z.18	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.	We can and will support this requirement. Our MIS not only segregates the FFS and NTC managed care data (claims, member, provider, etc.) and rules, but our MIS also segregates data related to audit activities (e.g. randomized claim samples, audit reports by program, claim accuracy measures, claim turnaround time metrics, etc.). Similarly, thanks to our MIS architecture which separates processing rules, edits, and data by programs, we can provide MLTC with specific FFS claims payment explanations as required by MLTC.

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? (page limit N/A)

Business Operations to Address Specific Needs of FFS and Risk-Based Programs

Nebraska Total Care (NTC), in conjunction with our parent, Centene Corporation (Centene), will mobilize our specialized expertise and system resources to deliver efficient business operations support uniquely *attuned* for each MLTC program: the FFS volume (FFS Medicaid program) as well as the risk-based volume (managed care program). Our Management Information System (MIS), with its health program segregation capabilities, along with its ability to support specialized job profiles (known as Role Based Access Controls), gives NTC and Centene the latitude to organize business operation units around each program (FFS and risk-based) to offer the best possible service solution for both programs.

Our Centene MCO affiliates configure business operation units in a number of different arrangements to meet our state client needs, with over a dozen types of Medicaid and other government funded programs, ranging from Medicaid to LTSS to Medicare and more, and supported in 23 states for over 4.8 Million members.

Specialized Units within Business Operation Departments.

For those functions that directly face members and providers, NTC will support FFS and risk-based programs using separate, specialized business operation units, with these units integrated into our overall Operations and Medical Management departments. We will have a FFS unit within our Operations Department with staff trained and specialized for the FFS program, alongside a unit dedicated to the risk-based program, with both units reporting to our VP of Operations. Similarly, we will have separate FFS and risk-based program units to support care coordination and Utilization Management (UM) functions, with both reporting to our VP of Medical Management.

Grounding Our Approach in MLTC Requirements. We formulated this approach after careful analysis of the RFP, its Attachments and Addenda, including in particular Sections IV.F, J, N, S and Z, as well as Addendum 7 (Question 247), Addendum 9 (Question 51), Addendum 10 (page 1), and Attachment 33. We realize that MLTC anticipates a relatively limited number of FFS Medicaid members by the time Heritage Health launches on 1/1/2017, but we also fully recognize that there are key distinctions in both programs, calling for specialized support. Our approach delivers quick and accurate service responsiveness to members, providers, and MLTC for either program; ensures NTC organizational simplicity while identifying clear accountability for FFS and risk-based programs, leverages core administrative processes to maximum advantage for MLTC; and maintains full reporting and auditing transparency for both programs.

Separate Units to Support Member and Provider Services in each Program

FFS and Risk-based Programs Need Specialized Expertise. NTC's Customer Service Representatives (CSRs) will work in our Nebraska based member and provider call centers, and these call agents will need to be "expert" in the nuances of the FFS and risk-based programs for clear communications. This need for expert support is the primary reason we will operate separate units for FFS and risk-based programs in NTC's one Operations Department. There are not only differences between the two programs in provider networks, member benefits, prior authorization rules, etc., there may be (per RFP Addendum 9, Question #87) a need to administer Dental and Non-Emergency Medical Transport (NEMT) benefits under the FFS program, which will not be present under the risk-based Heritage Health program. There may also be a need for the FFS Medicaid program to support Long Term Services and Supports (LTSS) claims (per RFP Addendum 9, Question 51). We have direct access to firsthand experience on supporting specialized

units in these scenarios; for example: our affiliate in Florida successfully maintains separate business operating units for its Managed Medicaid plan and its Long Term Services & Supports (LTSS) programs.

Another reason we will deploy separate service units is that most provider calls to our CSRs today are either eligibility inquiry or claim status related. Both of these two areas are key in the distinction between MLTC's FFS and risk-based programs, so we will need CSRs to focus on either FFS or risk-based eligibility and claims specifics, a requirement best addressed through separate service units within our service department.

Simplicity in Operations for Members and Providers. In addition to separate service units, we will also keep as clear a distinction as possible between the FFS and risk-based programs in terms of the "caller experience", so that the caller clearly understands the program he is calling about. We will maintain two separate service phone numbers for the FFS and risk-based program to keep the distinction as clear as possible for the caller. If a member or provider calls our FFS Medicaid 1/800 telephone line, a Customer Services Representative (CSR), specifically trained for FFS calls, will service the call, and will answer with a greeting that clearly identifies us as representing Nebraska Medicaid (or other program name subject to MLTC approval). Calls into our FFS 1/800 telephone number will only be answered by our FFS specialized CSRs. Of course if a caller mistakenly uses the wrong number, our CSRs will be able to easily transfer the call to the correct CSR, using a warm transfer approach if necessary.

Training Program to Support Both Specialized Units. Our dedicated call center trainer will conduct and maintain curricula and training materials for both the FFS and risk-based programs, which, among other advantages, allows us to cross-train senior CSRs from our risk-based program to serve as back-up if needed for our smaller FFS service unit. No matter which separate service unit (FFS or risk-based) our CSRs are assigned, all CSRs will receive the same in-depth training for handling member and provider calls. FFS unit staff will also receive additional training specifically focused on the FFS program, and risk-based unit CSRs will receive additional training focused on the risk-based program. Our Texas affiliate, which administers a highly specialized state health program for children in Foster Care, with dramatically different service needs than their "mainstream" managed care program, has used this same "tiered training" approach for separate service units with great success since 2008, as has several of our other affiliates administering multiple programs.

Whether trained for FFS or risk-based programs, NTC's Customer Service Representatives, Care Coordinators, and Utilization Management staff will all be based in Nebraska, support only MLTC programs, and will have instant access to each other to support FFS or risk-based program needs.

Care Coordination and UM

Our approach for Care Coordination and UM mirrors our strategy for member and provider services, for much the same reason: to maintain simplicity for providers and members, while ensuring FFS and risk-based program separation and integrity. We will maintain separate units for our Nebraska based Care Coordination and UM FFS and risk-based staff to ensure deep staff expertise in the two programs, with potentially different providers, prior authorization rules, etc. The fact that there may be a need to administer LTSS, Dental and Non-Emergency Medical Transport (NEMT) benefits and claims under the FFS program, (as noted above) is even a more important reason for separate UM units than with member and provider services, due to different and expanded sets of medical necessity criteria, and (in the case of LTSS) very different assessment, service delivery models, and provider types. However, as with our service units, both our FFS and risk-based Care Coordination and UM units will both be part of one NTC Medical Management department, headed by our NTC VP of Medical Management. Our approach to Care Coordination and UM also is similar to our service approach in these ways:

- All staff in both units will undergo in-depth common training for NTC, with additional training specific to FFS and risk-based programs
- All staff in both units will be based in Nebraska, and dedicated exclusively to MLTC programs

Joint Units to Ensure Consistency and Efficiency

Grievance and Appeals (G&A). We will have one shared NTC unit for G&A, because the G&A process is essentially the same for both FFS and Heritage Health. Thanks to the flexibility of our Role Based Access Controls, our Nebraska based Grievance System Manager will have access to G&A related records for members in both the FFS as well as the risk-based program.

Joint Claims Processing and Adjudication Units. Although we will configure our MIS to handle FFS Medicaid and risk-based program claims separately per MLTC requirements (see Section 119), in terms of claim processing *staff*, we organize claims processors by specific claims functions across programs. This is because most of our claims today *automatically adjudicate*: approximately 80% of clean claims (paper and electronic) submitted to us this year to date (11/2015) have automatically adjudicated. Thus we organize claim processor expertise on handling specific claim pend types; an expertise that can be leveraged across both FFS and risk-based claims. Other claims functions, such as those related to mail room and scanning/indexing paper claims, are much more efficient and executed to higher quality levels when leveraged across programs, because increased automation is feasible at high volumes and there is no material difference in the process between MLTC's FFS and risk-based programs. In taking this approach, we can assure MLTC that we will adhere to the same requirements for FFS claims as for risk-based claims, including requirements related to claim audits, claim disputes, paid claims sampling, claims payment accuracy, remittance processing, claims data reporting, TPL/COB, and Fraud, Waste, and Abuse (FWA) mitigation and identification.

By leveraging core Medicaid claims processing across programs, we continue to attain the highest standards. For example, so far in 2015, we have paid 96% of clean claims sent to us electronically in 15 days, with an average turnaround time for these claims of less than 7 days.

Meeting Applicable Section IV.Z Requirements

Many of our Centene affiliate health plans administer multiple programs within their respective states and through their respective organizations. We customize our business operations approach depending on the differences in covered populations, benefit plans, administrative requirements, clinical policies, provider networks, and regulatory constraints amongst the programs our affiliates serve.

In ***Table Q120***, we summarize our discussion above with key requirements from Section Z of the RFP that relate business operations unit support.

Table Q120

RFP Section	Requirement	How NTC Meets Requirement
IV.Z.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	NTC will have a Member and Provider Service unit dedicated to the FFS Medicaid program. with a separate 1/800 phone line for FFS Medicaid service.
IV.Z.12	Provider Services. The claims broker must provide a provider toll-free telephone line to all providers who	NTC will have a Member and Provider Service unit dedicated to the FFS Medicaid

	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.	program, with a separate 1/800 phone line for FFS Medicaid service. We will also provide the same level of support for providers for the FFS Medicaid program as the risk-based program, including FFS program support for providers who do not participate in NTC's Heritage Health program. We will make all required FFS materials available on our website for all providers participating in the FFS program.
IV.Z.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.	As described above, NTC and our Claims Department will administer RFP mandated Paid Claims Sampling in the same manner for FFS Medicaid as for the risk-based program.
IV.Z.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.	As described above, NTC and our Claims Department will administer RFP mandated Claims Dispute Management processes in the same manner for FFS Medicaid as for the risk-based program.
IV.Z.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.	As described above, NTC and our Claims Department will maintain the same processes to assure Claim Payment Accuracy in the same manner for FFS Medicaid as for the risk-based program.
IV.Z.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.	NTC and our Encounter Business Operations (EBO) unit (see Section 112) will prepare this claims data. Our MIS can support all HIPAA formats (including the HIPAA 837 processed claim data format), and we can include FFS and account code identifiers on the FFS program claim data we send to MLTC.

(page limit N/A)
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.

Implementation Risks and Mitigation Strategies

Nebraska Total Care (NTC's) parent company, Centene Corporation (Centene), has implemented claims operations for both MCO and claim broker services, and based on over 30 years of this implementation and operational experience, we offer this discussion of significant risks associated with claim broker services, along with mitigation strategies we have found to be effective.

Implementation Risk: Change in Project Scope. We have noted MLTC's response to Question and Answer #87 in Addendum 9, issued 12.18.15, which states that the CBS vendor will be responsible for dental and Non-Emergency Medical Transport (NEMT) claims administration for members in the FFS Medicaid program, however MLTC notes that both dental and NEMT claims processing may be excluded from CBS operations dependent on MLTC plans over the next few years. Similarly, we have noted MLTC's response to Question and Answer #51 in Addendum 9, which states that the CBS vendor may *potentially* be responsible for Long Term Services and Supports (LTSS) claims for both FFS and managed care programs, dependent on CBS implementation date and other program decisions by MLTC regarding LTSS.

Mitigation Strategy. We have built into our timeline and draft project plan (see Section 122) an allowance for administration of both dental and NEMT claims. We can and do administer claims processing for both benefits today. We will maintain close communications with MLTC's designated contact through years one and two of the contract and be prepared to implement dental and NEMT FFS claims.

With respect to LTSS claims administration, Centene and our affiliates have some of the most extensive experience in Medicaid processing LTSS claims and supporting LTSS providers, supporting LTSS programs in seven states. We have online Provider Portal tools expressly designed for claims submission by LTSS providers, facilitating quick and accurate LTSS claim submission and can readily configure our claims system (AMISYS Advance) for Nebraska LTSS processing, enabling very timely LTSS claims turnaround time. For example, in our Florida affiliate, we have cut in half the average clean claim turnaround time of LTSS claims through the use of our web tools and AMISYS. As above, we will maintain close communications with MLTC's designated contact through years one and two of the contract and be prepared to implement LTSS claims processing if needed.

Implementation Risk: Lack of Test Data Representing Key Test Scenarios. We have learned that it is important to avoid viewing individual data interfaces as "silos" of isolated data exchanges. We have found that it is not enough to test individual exchanges (e.g. receipt of eligibility data, transmission of test paid claims data) with our clients and Trading Partners without progressing through an entire cycle of information processing that spans all the core functions served by enrollment, eligibility, provider, authorization request, claims, and encounter data in holistic "end to end" scenarios. Part of the challenge in performing this "end to end" or "full cycle" testing is to obtain higher quality test data (i.e., test data that more closely resembles production data) and test "scenarios". The risk of inadequate test data to exercise our configured systems can be an inadvertent exposure to a particular scenario(s) resulting in inaccurate or delayed claims payment.

For example, in our most successful implementations, we were able to work with our state client to get "full scenario" test data - e.g. test member data in the enrollment file linked to a particular PCP on the test provider file subsequently authorized for a covered service, with claims from that provider for that member processed in a specific paid claims data record encompassing the entire "cycle". This approach not only allowed us to validate each data exchange, it also allowed us to simulate the scenario throughout our member and provider inquiry services applications, our reporting applications, and our web portal

applications. "End to end" scenario testing such as this is, in our judgment, the most practical way to uncover implementation nuances and challenges that might not otherwise surface.

Mitigation Strategy. In the case of Nebraska Medicaid, the above risk is somewhat mitigated by the fact that the MCO serving as the CBS will have had almost a year's experiential MCO data through their administration of Heritage Health. We can allow for differences in processing rules between FFS and MCO claims processing and test using MCO data as a "back/up strategy", and we are also proposing a ten month CBS timeline (see Section 122) in part to allow for the construction of a thorough test bed of CBS FFS Medicaid data. We have also noted MLTC's response to Question and Answer #84, in Addendum 9, and look forward to discussing the topic of test data (as well as historical data for purposes of migration to CBS). As an additional mitigation strategy, with MLTC approval we will (if necessary) work with high volume FFS claim submitting providers to help formulate end-to-end test data.

Implementation Risk: Effective Communications with CBS Clients. A consistent point of contact between us and our clients is often a risk area. We occasionally experience staff turnover at our clients and/or on our end during claims implementations, and this, if not managed, can have a negative effect on project communications and project deliverables, which could lead to misunderstandings on requirements and missed deadlines.

Mitigation Strategy. We organize our implementation teams so that there is always a team member who can step into the key project liaison role with the state at any time, and we always have multiple team members present at any project meetings with our state clients. We also build in sufficient time at the beginning of our project timelines for Project Initiation, which includes the designation of points of contacts for both us and our state clients – with designated back/up contacts for both. We also focus on thorough yet clear project documentation, ongoing communications, and issues tracking and resolution using best practices including those from the Agile framework and the Information Technology Infrastructure Library (ITIL). Centene requires MIS management to obtain certification in ITIL v3 and incorporate these practices into all service areas, including implementation.

Implementation Risk: Provider Data Interface. Although there are challenges and important considerations with all interfaces we configure with our state clients when implementing claims processing, we have found that it is *provider data exchanges* which need to be treated as "first among equals" - particularly in terms of defining these interfaces with complete clarity early in the implementation. We believe there are several reasons why provider data exchanges have become relatively more problematic than other data interfaces:

Nature of Provider Interfaces. Unlike enrollment, eligibility, and encounter data - there is no HIPAA transaction standard, nor any other "de facto" convention, for the structure of provider file exchanges. Although the HIPAA transaction standards are not perfect, they certainly do provide a more mature standard for data usage and a common file structure for enrollment and eligibility (the HIPAA 834) and paid claims records (the HIPAA 837) than proprietary provider file interfaces. The result: it is painfully easy for two Trading Partners to *misunderstand* the exact meaning and use of provider data - in terms of definitional meaning and contextual use.

Nature of Provider Data Itself. As compared to membership or processed claims data, neither the state nor NTC and Centene have as much control over provider information attributes such as demographic, specialty, licensure, location and affiliation data. Provider information is more volatile, and changes stem from many different parties - not just the provider (e.g. board certification, affiliation arrangements). The result: the opportunity is much higher for an "out of data synch" condition between us, the state, and even the enrollment broker with provider data - than with membership or encounter information.

Mitigation Strategies. From an *implementation planning* perspective, we now emphasize with our clients the need to focus on provider data as "step one" in our data interface planning - even before eligibility and encounter analysis and configuration. We can (and do) support the import and export of daily, weekly and

monthly provider data, but of course we will need to know the exact nature and processing purpose of daily provider data feeds to our FFS Medicaid operation. We can and will support all Nebraska providers approved by MLTC including those not contracted with NTC for services administered under our MCO program, and this latter fact makes defining and testing the FFS provider data interface even more critical.

Implementation Risk: Lack of Clarity in Specifications. Looking back at the over 30 years of implementations we have performed alongside our state clients, their intermediaries, our subcontractors and providers (in other words: all our Trading Partners); we can synthesize another lesson: it is necessary, *but not sufficient*, to share clearly documented data interface specifications amongst Trading Partners. These interfaces must be rigorously vetted, discussed and paraphrased via both written formal documentation, and extended meetings with small working groups.

Mitigation Strategies. We build into our implementation plans approaches where (after review of all available documentation) we document detailed questions regarding enrollment, eligibility, provider and paid claims data interfaces for the full MIS implementation team (meaning the state, enrollment broker and other affected state agencies and intermediaries, as well as NTC and Centene) followed by meetings driven in part by discussion and documenting responses to those questions - with answers distributed to all parties. We *strongly encourage* this technique for our CBS project implementations - especially for this project, which will rely on other related initiatives such as the potentially new Medicaid Eligibility & Enrollment System, potentially new enrollment broker (per DHHS plans to issue an enrollment broker RFP), and the Data Management and Analytics (DMA) project. We have found that, in the past, all implementation participants (ourselves included) tend to *underestimate* the time and effort needed for arriving at a workable understanding of data interface and process requirements. The bottom line of this lesson regarding data interface requirements: when in doubt, **over-specify**.

To help our implementation efforts for meetings such as the above, when not in face-to-face meetings we make extended use of screen sharing over the web (via Adobe Connect). An even more powerful assist is the use of video teleconferencing, and we have recently implemented *Cisco Telepresence* equipment in our corporate offices. Should MLTC employ video conferencing equipment, we have found this "face to face" use for small meetings very effective.

To further align our "systems syntax" and technology framework with our clients, we have adopted a view of Medicaid Management Information Systems (MMIS) in line with CMS' Medicaid Information Technology Architecture (MITA). Thus, similar to MITA, our MIS adopts a Service Oriented Architecture (SOA) view of business and technical services applied to public sector healthcare; Master Data Management (MDM); and other architectural components and nomenclature as they pertain to MMIS design. One reason we are adopting a MITA view is in order to be better able to "talk a common technology" language with our clients, and execute smoother data interface implementations in support of eligibility, enrollment, provider data and paid claims data processes.

Operational Risk: Threats to Business Continuity outside our Span of Control. Like almost all service operations, we face a variety of local, regional and national threats to normal business operations from weather, utility outages, acts of terrorism, pandemic, etc. These external factors can have a serious impact on our ability to meet operational commitments.

Mitigation Strategy. We maintain and regularly test our annually audited HIPAA Compliant and integrated Business Continuity Plan (BCP) and Disaster Recovery Plan, including plans to address pandemics. NTC's affiliated Centene health plans have successfully implemented the BCP an average of 60 times a year since 2012 to address events such as winter storms, floods, and power outages. In each case, the BCP ensured employee safety and minimal impact on members, providers, and claims operations. Please see Section 106 for more information.

Operational Risk: Failure of System Components. A hardware, software, or data network failure could impact our daily CBS operation, including our ability to receive and send information to MLTC and providers.

Mitigation Strategy.

Redundant Infrastructure. Supporting our CBS operations, our voice and data information technology (IT) architecture is engineered for high availability and real time telephone system recovery. It is centered on two mutually redundant enterprise datacenter installations, both wholly owned and controlled by Centene, which operate in a "hot backup" contingency mode for critical business functions. Both facilities employ redundant environmental, power, and networking systems, and backup capability. A site-disabling event in our primary datacenter, in which the datacenter was destroyed or damaged, would immediately result in the redirection of critical voice and networking processes to the secondary datacenter. In addition, the systems of both of our two affiliated CBS subcontractors: US Script (pharmacy claims) and OptiCare (vision claims), are housed in the same two datacenters as Centene claims systems, and capitalizes on the same contingency planning infrastructure.

Management Information System (MIS) Engineered for Availability. The MIS supporting our CBS operations makes extensive use of redundant hardware, software, and networking technologies such as virtualized servers, database clustering, data and storage replication, network services from multiple, independent vendors, disk mirroring, backup power, and other controls. These safeguards prepare us for scenarios such as system outages that could compromise transaction and/or data integrity in a live or archival system as well as other interruptions not threatening to transaction or data integrity, but that could limit access to our MIS.

Operational Risk: Unforeseen Increase in Claims Volume. Although MLTC forecasts an ever diminishing number of members served by the FFS Medicaid program, any number of demographic, economic, or other external factors could lead to an unanticipated increase in claims volume, such as members not moving as fast as anticipated to Heritage Health MCO plans.

Mitigation Strategy. We always operate our MIS with a buffer of overcapacity, and we have enough capacity in place right now to handle an additional 500,000 members. In addition, we support claims processing out of Centene owned claims processing centers in Missouri, Montana, Arkansas, and Texas. The centers are securely networked for voice and data connectivity with both of our datacenters (described above), as well as NTC offices. Our automated claims workflow system can instantly route FFS Medicaid claims workload amongst these centers, with staff at each to handle claims. In addition, as part of our BCP, all four of our claims centers have a program for quickly training additional staff if needed to process FFS Medicaid claims.

(page limit N/A)
122. Provide a timeline for implementation of claims broker functionality, including the number of months that it will take to pay FFS claims.

Claims Broker Services Implementation Timeline Informed by Experience

Nebraska Total Care (NTC), in conjunction with our parent, Centene Corporation (Centene), proposes to implement Claims Broker Services (CBS) for MLTC according to a summary timeline as depicted in ***Figure Q122: Timeline*** below, fully realizing that there are a number of details, internal and external factors, and dependencies (e.g. see Section 121) which may impact the final Timeline.

The Timeline below depicts a ten month timeframe from Project Initiation (item A in the Timeline below) to FFS claims payment operations (item E in the Timeline below). This timeline is based on our understanding of the RFP and its associated documents, as well as our experience in successfully deploying similar claims broker service capabilities for our clients.

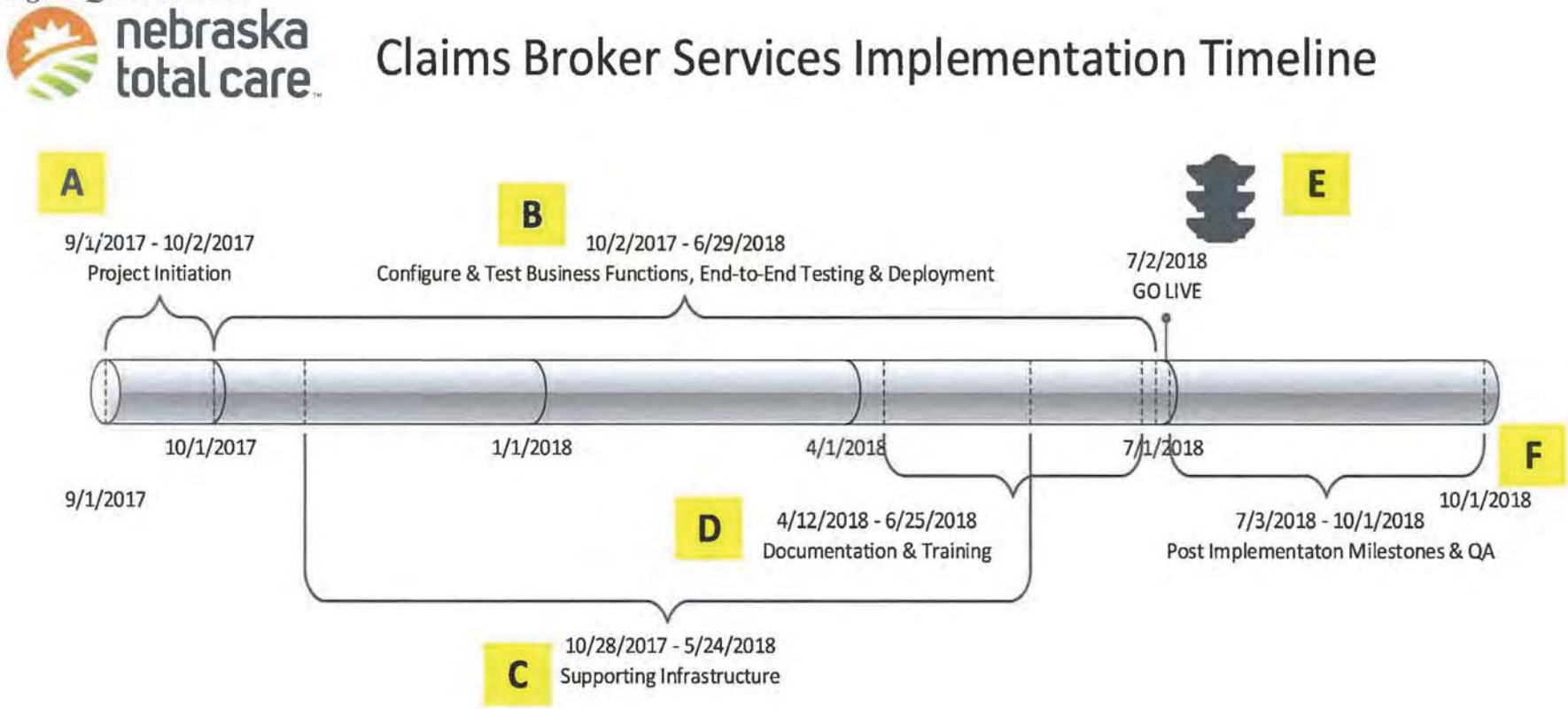
Since 1/1/2012, we have implemented claims payment operations for publicly funded health programs successfully, and on time, in nine new Centene states.

Timeline Overview. Our Timeline below is a graphical summary of our *draft project plan*, included as **Attachment 122**: ***DRAFT CBS Project Plan.*** Strictly for purposes of illustration, we have assumed a CBS "go-live" date of **7/2/18** (based on RFP Section IV.Z.3). In ***Figure Q122: Timeline*** we depict:

1. In A: Project Initiation activities, including (if necessary) finalization of Service Level Agreements, set/up of Project Administration and communications, the CBS Project Plan (a finalized version of Attachment 122 after review with MLTC), and a Project Kickoff.
2. B symbolizes the configuration of core functional systems, including enrollment and eligibility, provider data, member and provider services, claims, reporting (including claims data reporting per RFP Section IV.Z.16). Item B also includes testing of all components, as well as end-to-end testing (e.g. eligibility through authorizations through claims to reporting), signoffs and deployment to production.
3. C represents the configuration of incremental hardware/software (end-user workstations), and telephony software (e.g. call queues, phone rollover set/ups).
4. Item D symbolizes activities related to updating system and end user documentation as well as training – both for NTC CBS staff as well as MLTC staff (the latter for access by authorized MLTC staff to our system per RFP Section IV.Z.4).
5. Item E represents the start of CBS contract operations.
6. Item F represents our standard practice of close monitoring of operations by our implementation team until we are assured that CBS operations are functioning per MLTC requirements. Operations monitoring will continue after post monitoring by our NTC and Centene CBS operations staff.

Draft Project Plan. Please see ***Attachment 122: DRAFT CBS Project Plan*** for detail activities underlying Figure Q122: Timeline. Attachment 122 is informed by over 30 years' Centene implementation experience, and we look forward to discussing and refining our plans to meet MLTC's exact requirements.

Figure Q122: Timeline



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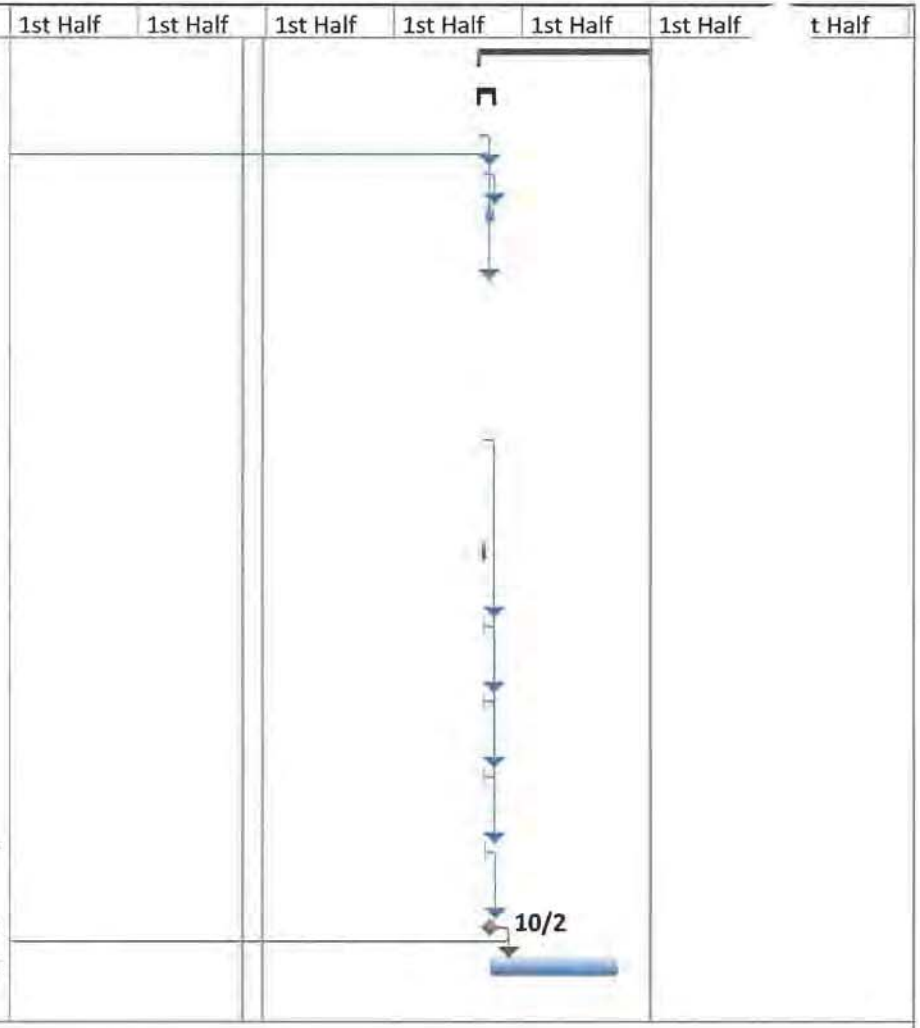
IV.Z ATTACHMENTS

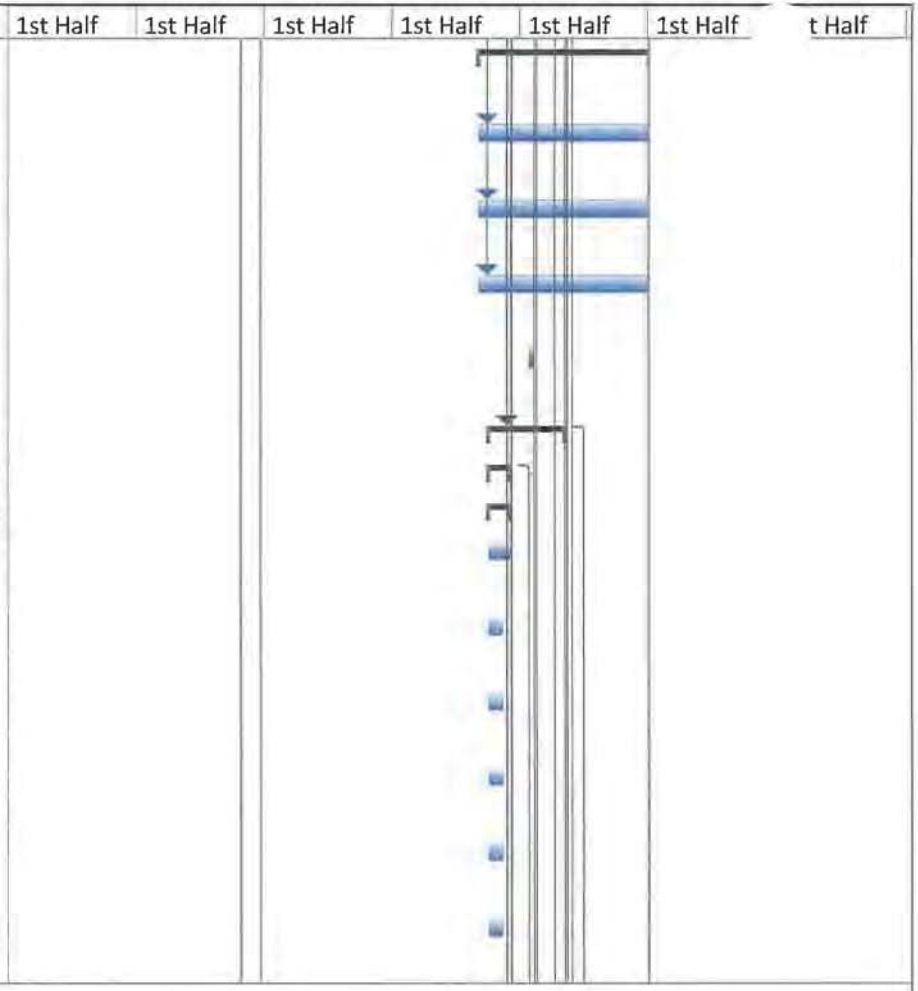
ID	Task Name	Start	Finish
1	**Project Management**	**Fri 9/1/17**	**Wed 1/2, ..**
2	**Initiate Project**	**Fri 9/1/17**	**Fri 10/13/17**
3	Launch CBS Implementation Planning i MLT	Fri 9/1/17	Fri 9/1/17
4	Finalize CBS Service Level Agreements	Mon 9/4/17	Fri 9/15/17
5	Build Contract Requirements/Deliverable Schedule in Compliance/360	Mon 9/18/17	Fri 10/13/17
6	Review Draft Project Plan with MLTC & Refine	Mon 9/4/17	Fri 9/22/17
7	Create SharePoint Site with Workgroup subfolders and Activity Logs	Fri 9/1/17	Thu 9/7/17
8	Finalize Workgroup leads & Schedule Regular Meetings to review Activity Logs & Establish Communications & Reporting	Fri 9/1/17	Thu 9/14/17
9	**Develop Implementation Structure and Workgroups**	**Fri 9/15/17**	**Fri 9/15/17**
10	Schedule Weekly Integrated Lead Meetings	Fri 9/15/17	Fri 9/15/17
11	Schedule Cross Functional Workgroups	Fri 9/15/17	Fri 9/15/17
12	Schedule Project Steering Committee	Fri 9/15/17	Fri 9/15/17
13	Project Plan finalized w/ Integrated leads assigned	Mon 9/18/17	Mon 9/18/17
14	CBS Project Kickoff	Mon 10/2/17	Mon 10/2/17
15	Ongoing Project Management, Status Reporting, Issue Resolution	Tue 10/3/17	Mon 10/1/18



Project: Att_122-A_CBS_Project_P
Date: Tue 12/22/15

Task	Inactive Task	Start-only	
Split	Inactive Milestone	Finish-only	
Milestone	Inactive Summary	Deadline	
Summary	Manual Task	Progress	
Project Summary	Duration-only	Manual Progress	
External Tasks	Manual Summary Rollup		
External Milestone	Manual Summary		

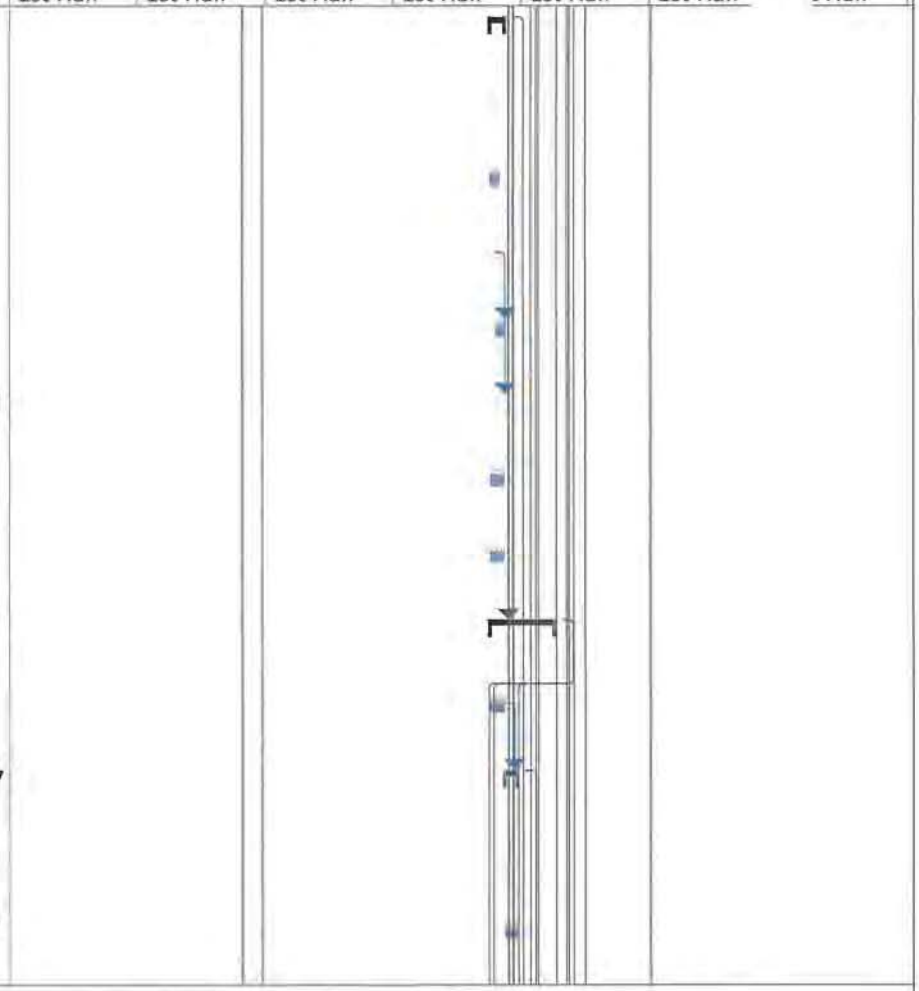
ID	Task Name	Start	Finish
16	**Coordinate with other MLTC Projects (Ongoing)**	**Mon 9/4/17**	**Wed 1/2, ..**
17	NE Medicaid Eligibility & Enrollment Project	Mon 9/4/17	Wed 1/2/19
18	NE Data Management & Analytics (DMA) Project	Mon 9/4/17	Wed 1/2/19
19	NE Independent Verification & Validation (IV&V) Project	Mon 9/4/17	Wed 1/2/19
20	MLTC Readiness Review	Thu 2/1/18	Mon 2/5/18
21	**Configure and Test Business Functions**	**Mon 10/2/17**	**Wed 5/9/18**
22	**Configure and Test Provider Data & Services**	**Tue 10/3/17**	**Mon 12/4/17**
23	**Configure Provider Touch Points**	**Tue 10/3/17**	**Mon 12/4/17**
24	Provider Website and Portal	Tue 10/3/17	Mon 12/4/17
25	Centene Document Mgt System Fax set/up & OCR registration	Tue 10/3/17	Mon 11/13/17
26	ACD Phone Queues and Auto Attendant Script and Rollover	Tue 10/3/17	Mon 11/13/17
27	**Provider Notifications, Bulletins, FAQs, Newsletters, et.al. (IV.Z.12)**	Tue 10/3/17	Mon 11/13/17
28	**Configure Provider Disputes in CRM (IV.Z.14)**	Tue 10/3/17	Mon 11/13/17
29	Provider Data Interface with MLTC	Tue 10/3/17	Mon 11/13/17



Project: Att_122-A_CBS_Project_P
Date: Tue 12/22/15

Task		Inactive Task		Start-only	
Split		Inactive Milestone		Finish-only	
Milestone		Inactive Summary		Deadline	
Summary		Manual Task		Progress	
Project Summary		Duration-only		Manual Progress	
External Tasks		Manual Summary Rollup			
External Milestone		Manual Summary			

ID	Task Name	Start	Finish
30	**. .ovider data integration with MLTC**	**Tue 10/3/17**	**Mon 11/13/17**
31	Provider data specifications received or defined	Tue 10/3/17	Mon 10/16/17
32	Test plan	Tue 10/3/17	Mon 10/30/17
33	MLTC first provider test files (full and incremental) to NTC	Tue 10/3/17	Mon 10/16/17
34	Provider data intake testing	Tue 10/17/17	Mon 11/13/17
35	Provider data load	Tue 10/17/17	Tue 10/17/17
36	Unit, Systems, and User Acceptance Test	Tue 10/3/17	Mon 11/13/17
37	Unit, Systems, and User Acceptance Test	Tue 10/3/17	Mon 11/13/17
38	**Configure and Test Service Authorization & Care Coordination**	**Tue 10/3/17**	**Wed 4/4/18**
39	**Specify and document FFS Authorization Procedures per NE Medicaid policy & IV.N**	Tue 10/3/17	Mon 11/13/17
40	**Develop PA list**	**Tue 11/14/17**	**Tue 12/19/17**
41	Code level review	Tue 11/14/17	Fri 12/1/17
42	Finalize PA suammry for provider notification	Tue 11/14/17	Tue 12/19/17



Project: Att_122-A_CBS_Project_P
Date: Tue 12/22/15

Task	Inactive Task	Start-only	
Split	Inactive Milestone	Finish-only	
Milestone	Inactive Summary	Deadline	
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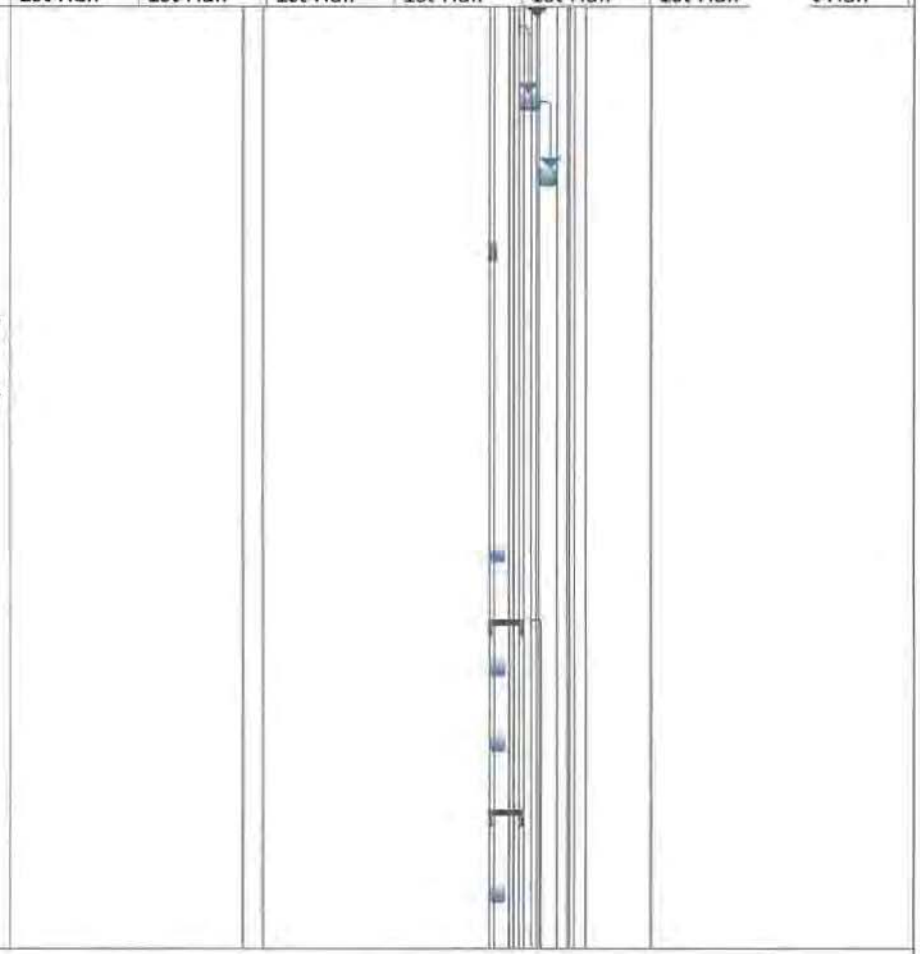
Project Summary	Duration-only	Manual Progress	
External Tasks	Manual Summary Rollup		
External Milestone	Manual Summary		

ID	Task Name	Start	Finish
43	Configure Auth Rules in TruCare	Wed 12/20/17	Wed 12/20/17
44	Authorization Data Integration	Thu 12/21/17	Wed 2/21/18
45	Implement TruCare configuration	Thu 2/22/18	Wed 4/4/18
46	**Transition of Current "In flight" UM Auths and Cases**	**Tue 10/3/17**	**Mon 10/16/17**
47	Define process to transition current UM cases	Tue 10/3/17	Tue 10/10/17
48	Define process for referrals	Tue 10/3/17	Tue 10/10/17
49	Set/up auth migration interface	Tue 10/3/17	Mon 10/16/17
50	Unit, Systems, and User Acceptance Test	Tue 10/3/17	Mon 11/13/17
51	**Configure and Test Member Data & Services**	**Mon 10/2/17**	**Mon 1/1/18**
52	Configure Member Website & Portal	Tue 10/3/17	Mon 11/13/17
53	Member Manual, Newsletters, Blog and Forms	Tue 10/3/17	Mon 11/13/17
54	**Eligibility Data Interface**	**Tue 10/3/17**	**Mon 1/1/18**
55	**Configure data interace with MLTC for FFS member eligibility (IV.Z.11)**	Tue 10/3/17	Mon 11/13/17



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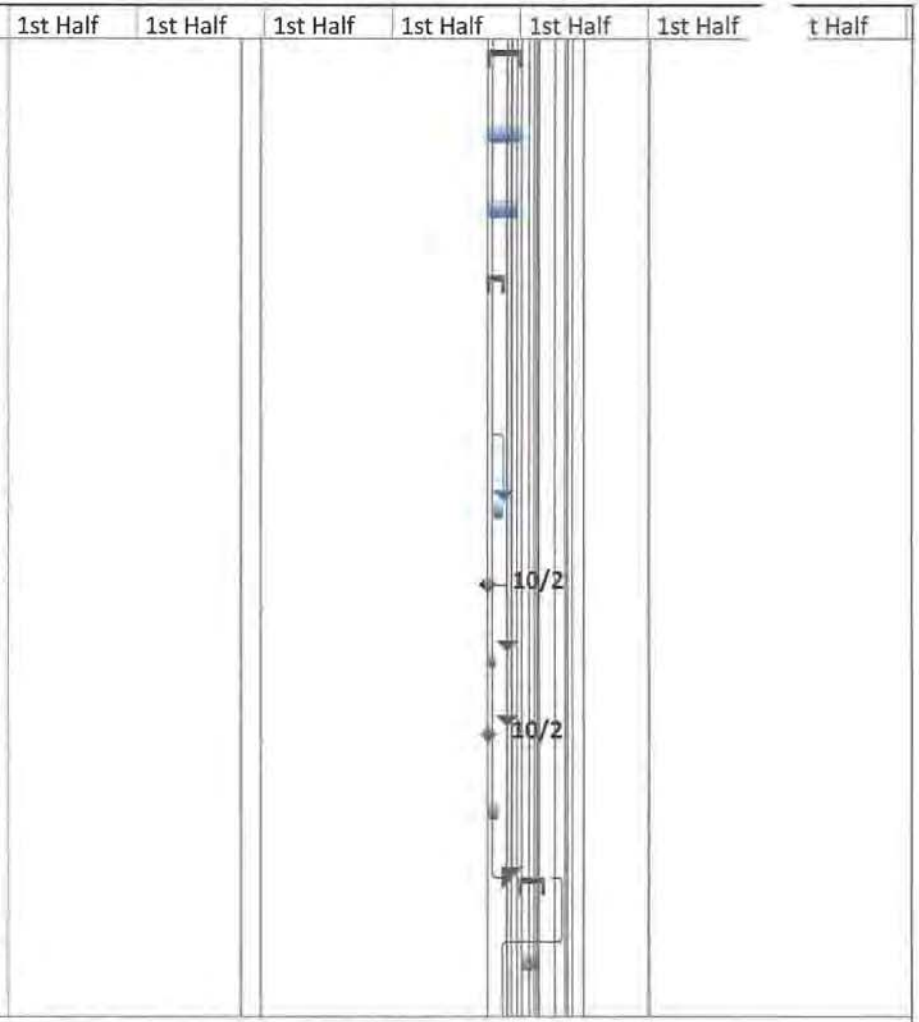
Project Summary	Duration-only	Manual Progress	
External Tasks	Manual Summary Rollup		
External Milestone	Manual Summary		

ID	Task Name	Start	Finish
56	**Submission and approval of any member materials**	**Tue 10/3/17**	**Mon 1/1, ..**
57	Submission of Materials to MLTC & Review	Tue 10/3/17	Mon 1/1/18
58	Final approval through MLTC	Tue 10/3/17	Mon 12/25/17
59	**Membership data integration (834)**	**Mon 10/2/17**	**Mon 11/13/17**
60	Member data specifications received or defined	Tue 10/3/17	Mon 10/16/17
61	First test file of membership data to NTC	Tue 10/3/17	Mon 10/16/17
62	Test plan	Tue 10/17/17	Mon 11/13/17
63	First membership test files to NTC	Mon 10/2/17	Mon 10/2/17
64	Membership intake testing	Tue 10/3/17	Mon 10/23/17
65	Member data production load	Mon 10/2/17	Mon 10/2/17
66	Unit, Systems, and User Acceptance Test	Tue 10/3/17	Mon 10/30/17
67	**Configure and Test Claims Data Capture (Claim Submission)**	**Thu 1/4/18**	**Thu 3/8/18**
68	Set/up EDIFECS with FFS Medicaid Companion Guide Rules	Thu 1/4/18	Wed 2/21/18



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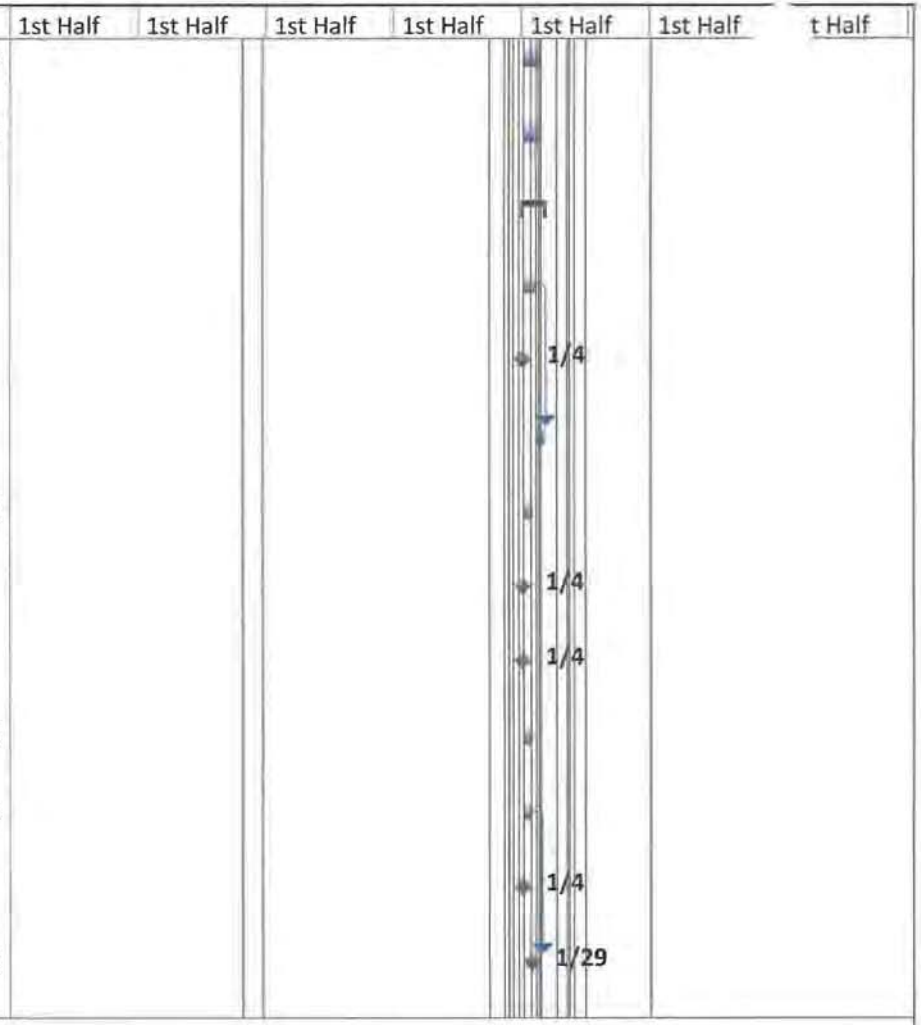
External Tasks		Manual Summary Rollup			
External Milestone		Manual Summary			

ID	Task Name	Start	Finish
69	Set/up RTEP with FFS Medicaid Rules and Edits	Thu 1/4/18	Wed 2/21/18
70	Set/up Clearinghouses for FFS Medicaid (e.g. Payer ID)	Thu 1/4/18	Wed 2/21/18
71	**Claims data integration (837 & NCPDP v4.2)**	**Thu 1/4/18**	**Thu 3/8/18**
72	EDI intake development	Thu 1/4/18	Thu 2/8/18
73	Claims data specifications received or defined	Thu 1/4/18	Thu 1/4/18
74	Medical claims test plan	Fri 2/9/18	Thu 3/8/18
75	Pharmacy claims test plan	Thu 1/4/18	Wed 1/31/18
76	MLTC APD test file for medical claims to NTC	Thu 1/4/18	Thu 1/4/18
77	First claims test files to NTC	Thu 1/4/18	Thu 1/4/18
78	Medical (837) claims intake testing	Thu 1/4/18	Mon 1/29/18
79	Pharmacy claims (NCPDP) intake testing	Thu 1/4/18	Mon 1/29/18
80	MLTC send claims history and associated provider and member data	Thu 1/4/18	Thu 1/4/18
81	Claims data production load	Mon 1/29/18	Mon 1/29/18



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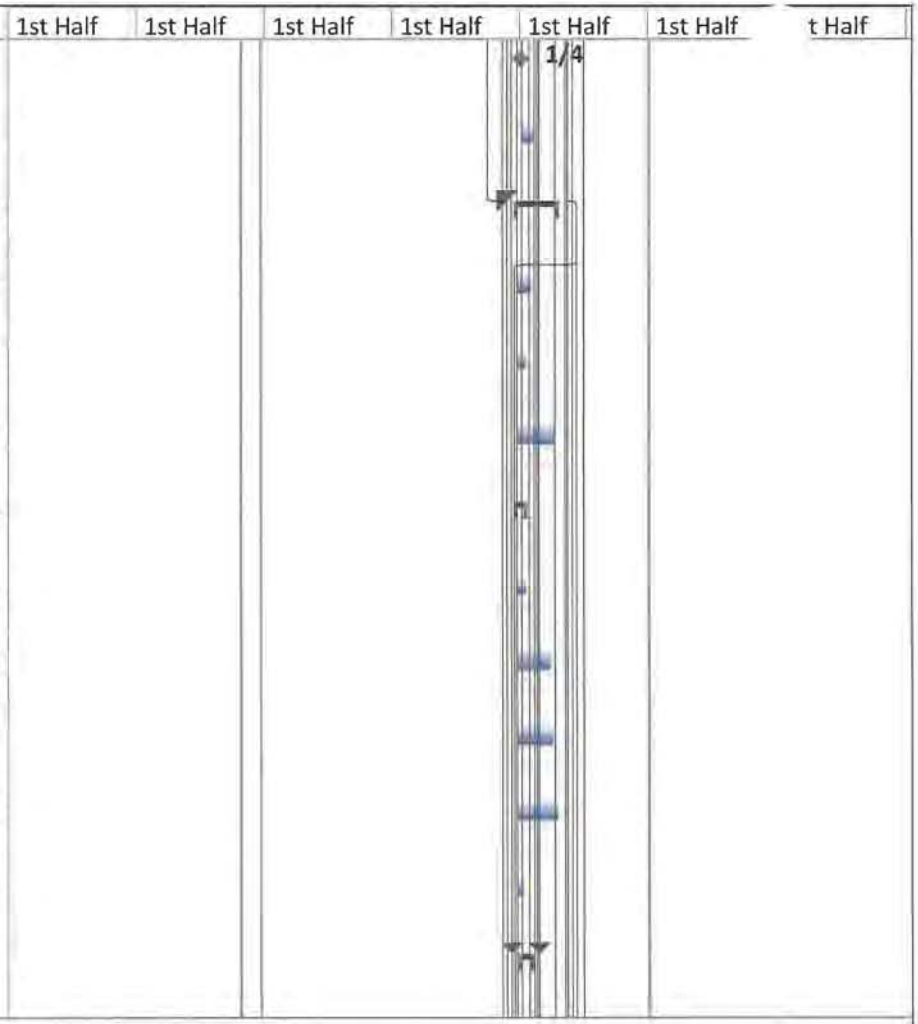
External Milestone		Manual Summary			

ID	Task Name	Start	Finish
82	Non-standard data for risk adjustment	Thu 1/4/18	Thu 1/4/18
83	Unit, Systems and User Acceptance Test	Thu 1/4/18	Wed 2/7/18
84	**Configure and Test Claim Adjudication**	**Thu 12/21/17**	**Wed 4/18/18**
85	**Develop Claims Handling & Payment Policies (IV.Z.1)**	Thu 12/21/17	Wed 1/31/18
86	Update config data for new business segments	Thu 12/21/17	Wed 1/17/18
87	Preadj creation and setup	Thu 12/21/17	Wed 4/11/18
88	**Configure Automated Work Distribution (AWD)**	**Thu 12/21/17**	**Wed 1/17/18**
89	AWD Unit, Systems, and User Acceptance Test	Thu 12/21/17	Wed 1/17/18
90	Configure TPL/COB Processing	Thu 12/21/17	Wed 3/28/18
91	TPL load creation and updates	Thu 12/21/17	Wed 4/4/18
92	Configure Provider Payment	Thu 12/21/17	Wed 4/18/18
93	User Acceptance Test (UAT) and signoff	Thu 12/21/17	Wed 1/10/18
94	**Configure Pharmacy Benefits Enrollment, Eligibility, Auth, and Claims System**	**Tue 1/2/18**	**Mon 2/5/18**



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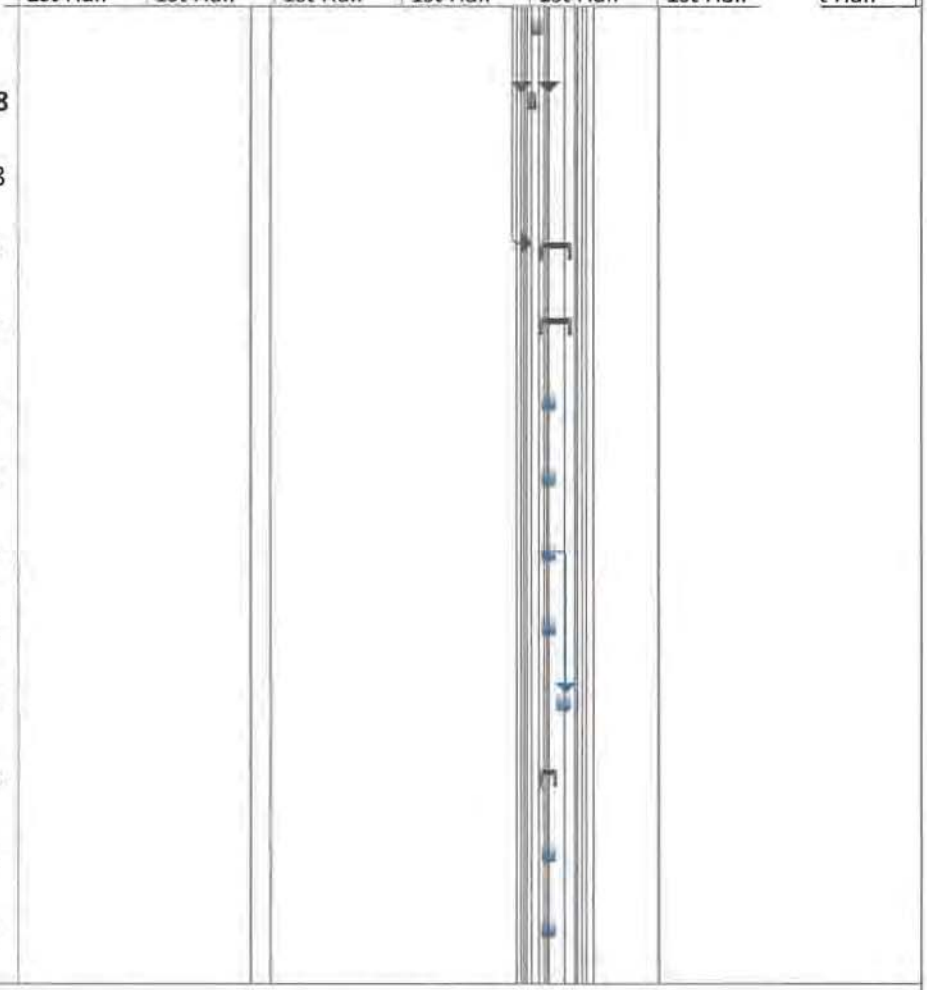
External Milestone	Manual Summary		

ID	Task Name	Start	Finish
95	...nit, Systems, and User Acceptance Test	Tue 1/2/18	Mon 2/5/...
96	**Configure Vision Benefits Enrollment, Eligibility, Auth, and Claims System**	**Tue 1/2/18**	**Mon 1/15/18**
97	Unit, Systems, and User Acceptance Test	Tue 1/2/18	Mon 1/15/18
98	**Configure Finance Processes**	**Fri 2/2/18**	**Thu 4/26/18**
99	**NTC Financial Set-up**	**Fri 2/2/18**	**Thu 4/26/18**
100	Complete Bank Setup	Fri 2/2/18	Thu 3/15/18
101	Setup NTC for State and Federal Tax	Fri 2/2/18	Thu 3/15/18
102	Setup Internal Operations / Payroll	Fri 2/2/18	Thu 3/15/18
103	Financial Reporting Established	Fri 2/2/18	Thu 3/15/18
104	Set up general ledger and accounts payable	Fri 3/16/18	Thu 4/26/18
105	**Determine Financial Processes with MLTC**	**Fri 2/2/18**	**Thu 3/15/18**
106	Monthly Payment	Fri 2/2/18	Thu 3/15/18
107	Incentive Payment	Fri 2/2/18	Thu 3/15/18



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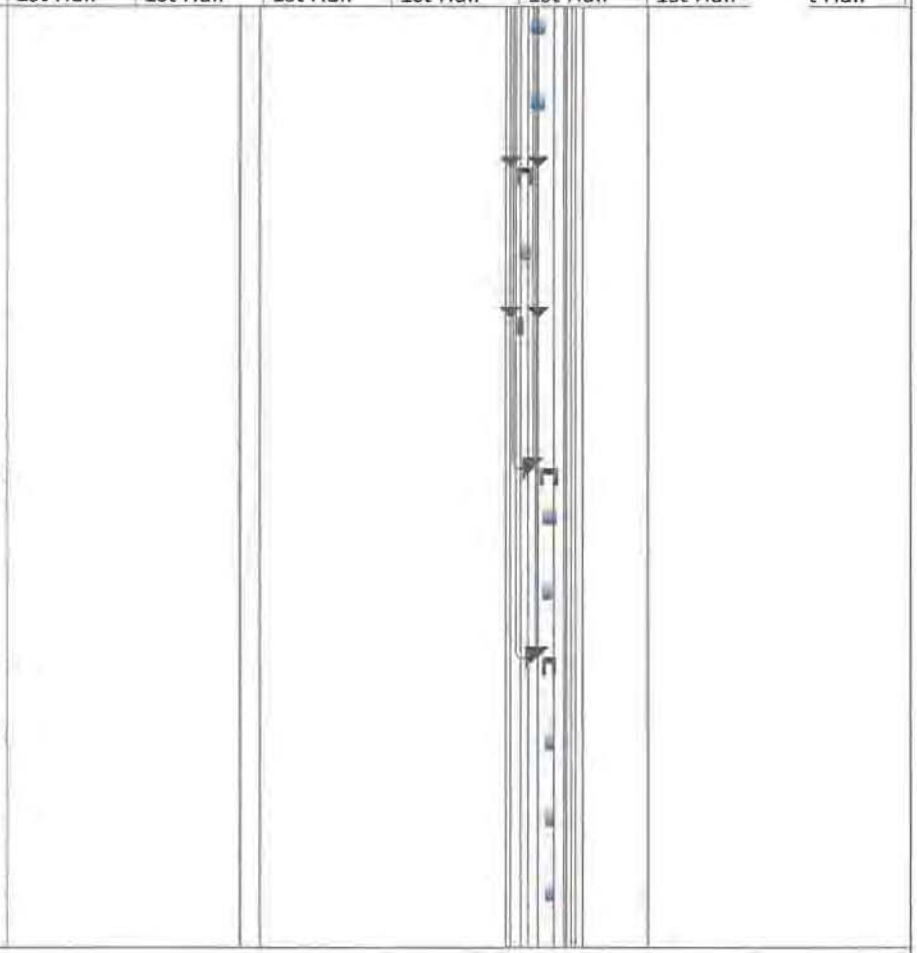
ID	Task Name	Start	Finish
108	Reconciliation Process	Fri 2/2/18	Thu 3/15/18
109	Reporting and Audit process	Fri 2/2/18	Thu 3/15/18
110	**TO BE CONFIRMED: Configure DENTAL Benefits Enrollment, Eligibility, Auth, and**	**Tue 1/2/18**	**Mon 2/5/18**
111	Unit, Systems, and User Acceptance Test	Tue 1/2/18	Mon 2/5/18
112	**TO BE CONFIRMED: Configure Transportation claims support in AMISYS**	**Tue 1/2/18**	**Mon 1/8/18**
113	Unit, Systems, and User Acceptance Test	Tue 1/2/18	Mon 1/8/18
114	**Configure Claims Data for MLTC**	**Thu 3/8/18**	**Wed 4/18/18**
115	**Specify, Configure & Test FFS Claims Data in HIPAA Format (IV.Z.16)**	Thu 3/8/18	Wed 4/18/18
116	Unit, Systems, and User Acceptance Test	Thu 3/8/18	Wed 4/4/18
117	**Grievance & Appeals**	**Thu 3/15/18**	**Wed 4/11/18**
118	Identify A&G Committees & NTC level of participation	Thu 3/15/18	Wed 4/11/18
119	Determine interface for A&G data receipt	Thu 3/15/18	Wed 4/11/18
120	State Fair Hearing and Additional Reviews	Thu 3/15/18	Wed 4/11/18



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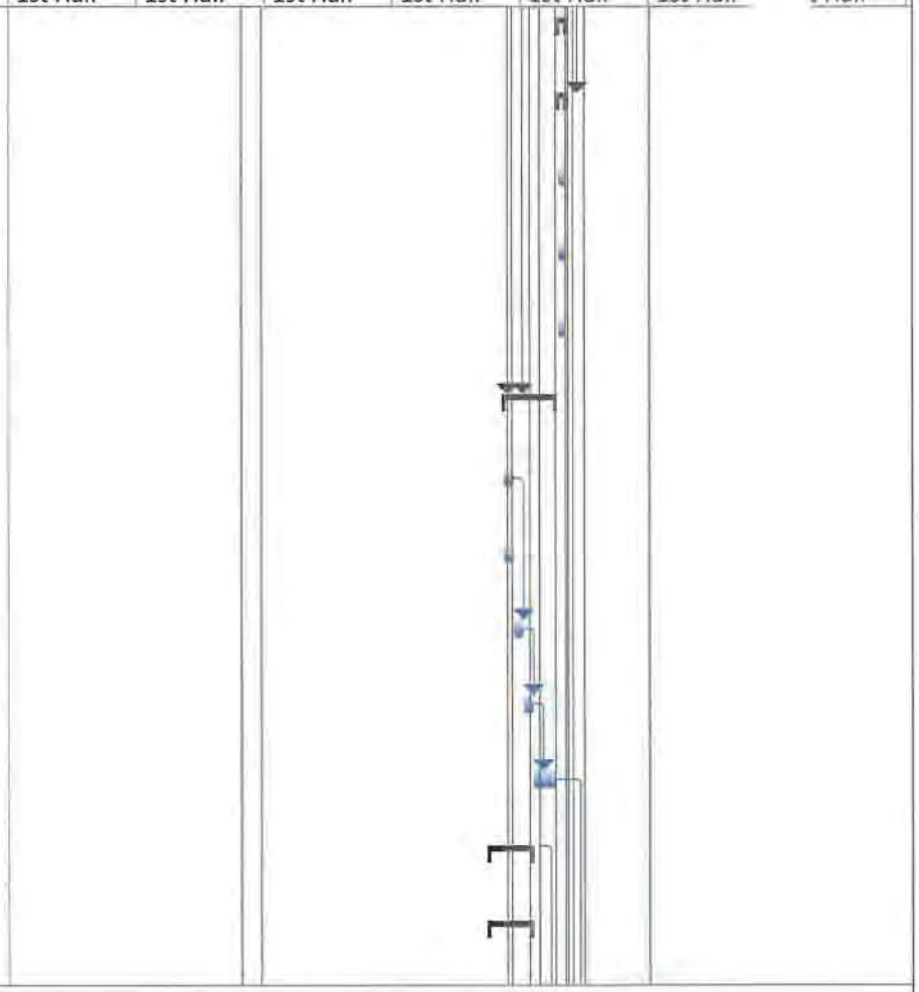
121	**Quality & Audit**	**Thu 4/19/18**	**Wed 5/9/18**
122	**Audit**	**Thu 4/19/18**	**Wed 5/9/18**
123	**Customize Audit Policies for FFS Medicaid (IV.Z.18)**	Thu 4/19/18	Wed 5/9/18
124	**Configure Sampling rules (IV.Z.13)**	Thu 4/19/18	Wed 5/9/18
125	**Configure audit policies for FFS Medicaid (IV.Z.15)**	Thu 4/19/18	Wed 5/9/18
126	**Configure CBS Client Portal for MLTC**	**Tue 11/14/17**	**Mon 4/9/18**
127	Client portal functions finalized with MLTC	Tue 11/14/17	Mon 12/11/17
128	Configure inquiry access to claims system (IV.Z.4)	Tue 11/14/17	Mon 12/11/17
129	Configure Client Portal	Tue 12/12/17	Mon 1/8/18
130	Unit, Systems and User Acceptance Test	Tue 1/9/18	Mon 2/5/18
131	MLTC system access (via MLTC Client Portal)	Tue 2/6/18	Mon 4/9/18
132	**Configure Data Integration, Analytics,Reports and Reports Scheduler**	**Mon 10/2/17**	**Fri 2/2/18**
133	**Configure Centelligence EDW**	**Mon 10/2/17**	**Fri 2/2/18**



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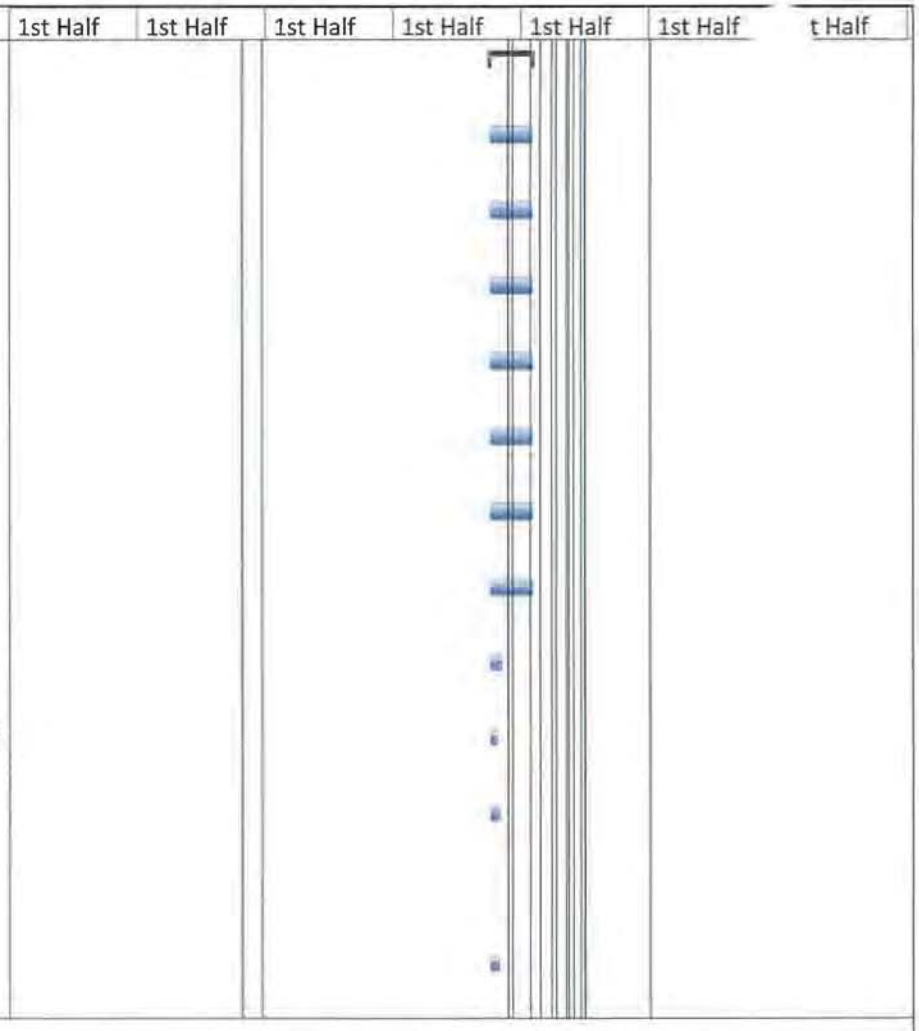
ID	Task Name	Start	Finish
134	**EDW Interfaces**	**Tue 10/3/17**	**Fri 2/2/18**
135	Pharmacy to EDW	Tue 10/3/17	Fri 2/2/18
136	Restricted person / Member 834 to UMV	Tue 10/3/17	Fri 2/2/18
137	TruCare BiDir EDW	Tue 10/3/17	Fri 2/2/18
138	QSI/RA BiDir EDW	Tue 10/3/17	Fri 2/2/18
139	Analytics tools (ImpactPro, IL) BiDir EDW	Tue 10/3/17	Fri 2/2/18
140	Centelligence/Reporting BiDir EDW	Tue 10/3/17	Fri 2/2/18
141	Centelligence/Reporting BiDir Client Secure Portal	Tue 10/3/17	Fri 2/2/18
142	EDW Member integration development	Tue 10/3/17	Tue 11/7/17
143	EDW Member data integration testing	Tue 10/3/17	Tue 10/24/17
144	EDW integration test plan	Tue 10/3/17	Mon 10/30/17
145	NTC load MLTC integrated test data to EDW Test	Tue 10/3/17	Thu 10/5/17
146	EDW Integration testing	Tue 10/3/17	Mon 10/30/17



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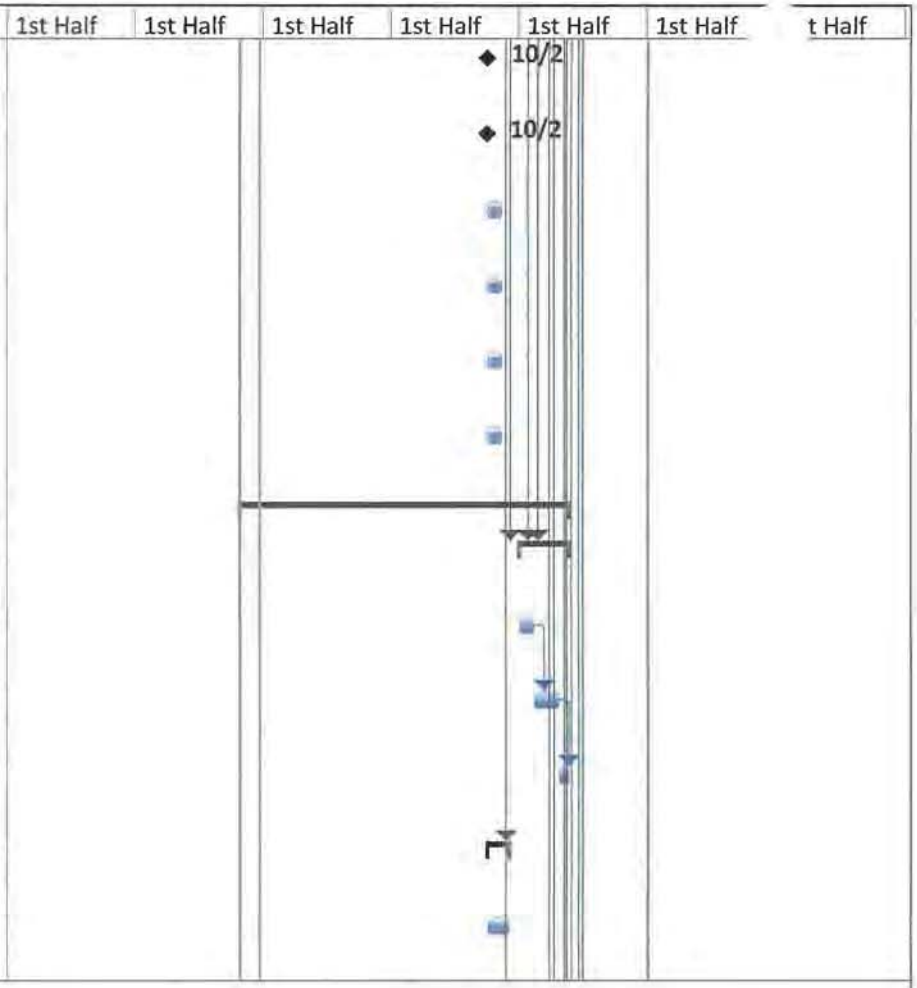
147	EDW ready in Test	Mon 10/2/17	Mon 10/2/17
148	EDW Prod ready	Mon 10/2/17	Mon 10/2/17
149	**Specify, Configure & Test FFS Claims Data in HIPAA Format (IV.Z.16)**	Tue 10/3/17	Mon 11/13/17
150	**Specify, Configure & Test FFS Pharmacy Claims Data (IV.Z.17)**	Tue 10/3/17	Mon 11/13/17
151	**Specify, Configure & Test FFS Payment and Recovery Reports for MLTC (IV.Z.1)**	Tue 10/3/17	Mon 11/13/17
152	**Specify, Configure & Test Reconciliation Reports for MLTC (IV.Z.1)**	Tue 10/3/17	Mon 11/13/17
153	**Implement Other Supporting Infrastructure**	**Wed 10/28/15**	**Thu 5/24/18**
154	**Telephony and IVR integration**	**Tue 1/2/18**	**Thu 5/24/18**
155	Agree upon process for inbound calls & faxes	Tue 1/2/18	Mon 2/12/18
156	Implement IVR logic and scripts	Tue 2/13/18	Mon 4/23/18
157	IVR & Fax setup/integration	Tue 4/24/18	Thu 5/24/18
158	**Infrastructure Assessment and Integration**	**Tue 10/3/17**	**Mon 12/4/17**
159	Equipment acquisition	Tue 10/3/17	Mon 12/4/17



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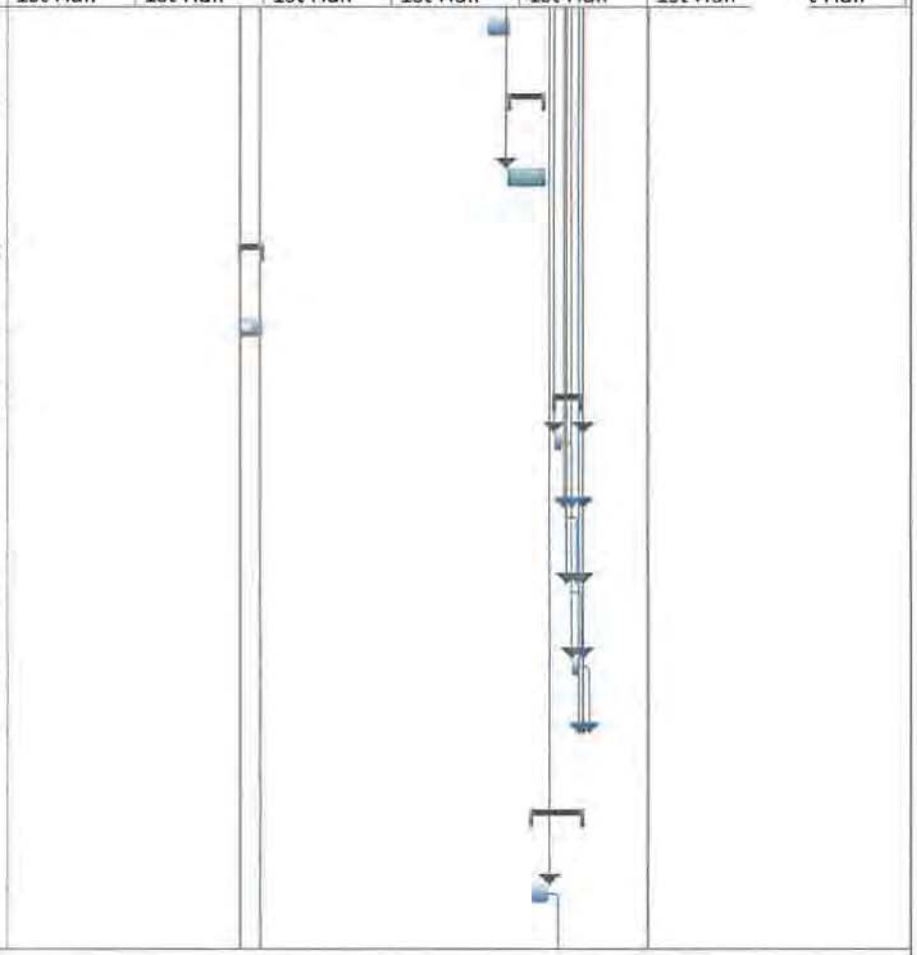
ID	Task Name	Start	Finish
160	Connectivity and equipment setup	Tue 10/3/17	Mon 12/4/17
161	**Finalize Project Claims Volume Range & Additional Staff Needed**	**Tue 12/5/17**	**Mon 3/12/18**
162	Hire and train ramp-up resources	Tue 12/5/17	Mon 3/12/18
163	**Establish data needs and file delivery schedule**	**Wed 10/28/15**	**Tue 12/29/15**
164	Test data / file transfer through STFP	Wed 10/28/15	Tue 12/29/15
165	**Training & Documentation**	**Thu 4/12/18**	**Mon 6/25/18**
166	Establish training schedule	Thu 4/12/18	Wed 5/2/18
167	Determine technical requirements	Thu 5/10/18	Wed 5/16/18
168	Update Training Material and Documentation	Thu 5/17/18	Wed 5/30/18
169	Conduct Training	Thu 5/31/18	Wed 6/20/18
170	Perform training for MLTC (IV.Z.4)	Thu 6/21/18	Mon 6/25/18
171	**End-to-End Testing (eligibility - auths- claims - reporting)**	**Mon 2/5/18**	**Fri 6/29/18**
172	Finalize End-to-end operational test plan & test & regression data	Mon 2/5/18	Fri 3/23/18



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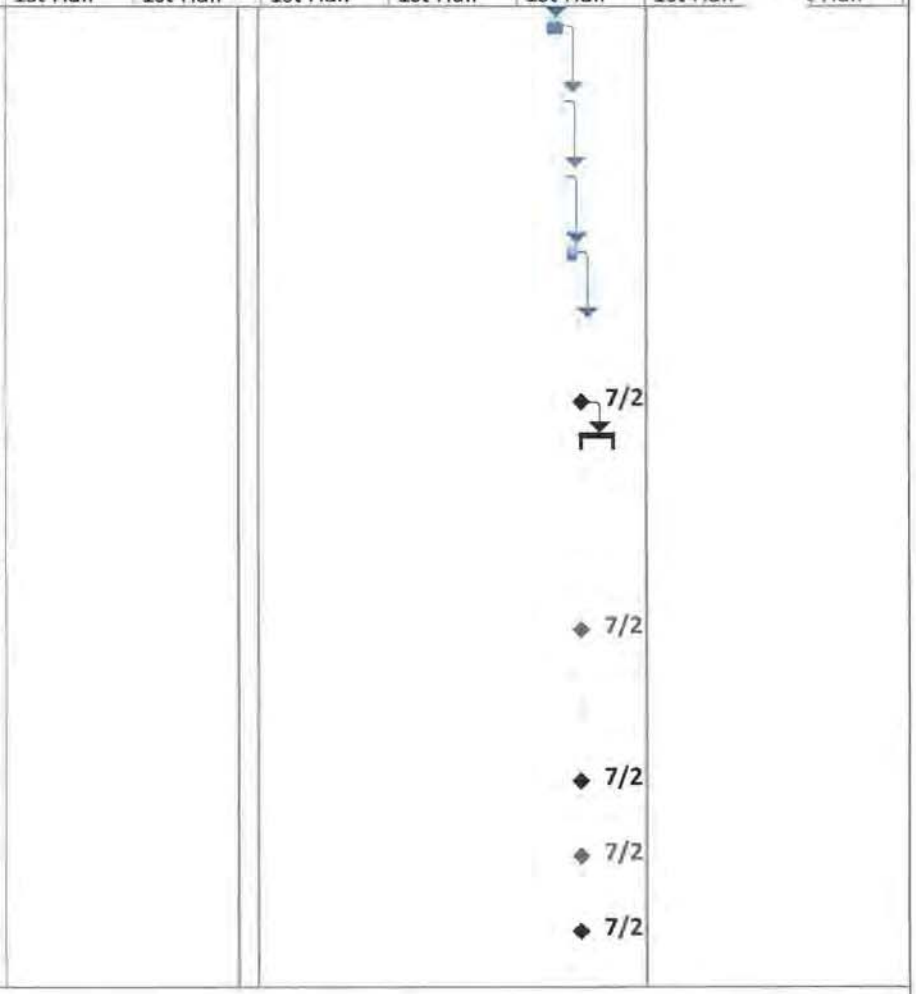
ID	Task Name	Start	Finish
173	End-to-end testing all operational systems	Mon 3/26/18	Fri 5/11/18
174	NTC signoff	Mon 5/14/18	Wed 5/16/18
175	MLTC signoff	Thu 5/17/18	Mon 5/21/18
176	Slack	Tue 5/22/18	Thu 6/21/18
177	Deploy to Production	Fri 6/22/18	Fri 6/29/18
178	**GO LIVE**	Mon 7/2/18	Mon 7/2/18
179	**Post Implementation Milestones**	**Mon 7/2/18**	**Mon 10/1/18**
180	Conduct Daily Go Live Meetings	Mon 7/2/18	Mon 7/16/18
181	Capture Daily Operations Metrics	Mon 7/2/18	Mon 7/16/18
182	First Claims Data Run	Mon 7/2/18	Mon 7/2/18
183	Conduct 30 Day Post Go-Live Review & Go Forward Adjustments if needed	Mon 7/2/18	Mon 7/2/18
184	Conduct 60 Day Post Go-Live Review & Go Forward Adjustments if needed.	Mon 7/2/18	Mon 7/2/18
185	Ongoing monitoring and adjustments for staffing and training	Mon 7/2/18	Mon 7/2/18
186	Conduct 90 Day Post Go-Live Review & Go Forward Adjustments if needed.	Mon 7/2/18	Mon 7/2/18



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ID	Task Name	Start	Finish	1st Half	1st Half	1st Half	1st Half	1st Half	1st Half	t Half
187	Implementation Close - 90 Day post Audit	Mon 7/2/18	Mon 7/2/18					7/2		
188	Ongoing Monitoring and Adjustments for Staffing & Training	Mon 7/2/18	Mon 10/1/18							

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Proposal deliverables as listed in Attachment 5 – Policies, Procedures & Plans

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ATTACHMENT 5

PROVIDER CONTRACT TEMPLATE

C. PROPOSAL DELIVERABLES AS LISTED IN ATTACHMENT 5 POLICIES, PROCEDURES, AND PLANS

Provider Contract Template

Submit provider contract template as described in Section IV.I - Provider Network.

Nebraska Total Care's Provider Contract template is included immediately following this page.

PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (together with all Attachments and amendments, this "Agreement") is made and entered by and between [BTV: Provider Name] ("Provider") and Nebraska Total Care, Inc. ("Health Plan") (each a "Party" and collectively the "Parties"). This Agreement is effective as of the date designated by Health Plan on the signature page of this Agreement ("Effective Date").

WHEREAS, Provider desires to provide certain health care services to individuals in products offered by or available from or through a Company or Payor (as hereafter defined), and Provider desires to participate in such products as a Participating Provider (as defined herein), all as hereinafter set forth.

WHEREAS, Health Plan desires for Provider to provide such health care services to individuals in such products, and Health Plan desires to have Provider participate in certain of such products as a Participating Provider, all as hereinafter set forth.

NOW, THEREFORE, in consideration of the recitals and mutual promises herein stated, the Parties hereby agree to the provisions set forth below.

ARTICLE I - DEFINITIONS

When appearing with initial capital letters in this Agreement (including an Attachment), the following quoted and underlined terms (and the plural thereof, when appropriate) have the meanings set forth below.

"Affiliate" means a person or entity directly or indirectly controlling, controlled by, or under common control with Health Plan.

"Attachment" means any document, including an addendum, schedule or exhibit, attached to this Agreement as of the Effective Date or that becomes attached pursuant to Section 2.2 or Section 8.7, all of which are incorporated herein by reference and may be amended from time to time as provided in this Agreement.

"Clean Claim" has, as to each particular Product, the meaning set forth in the applicable Product Attachment or, if no such definition exists, the Provider Manual.

"Company" means, as appropriate in the context, Health Plan and/or one or more of its Affiliates, except those specifically excluded by Health Plan.

"Compensation Schedule" means at any given time the then effective schedule(s) of maximum rates applicable to a particular Product under which Provider and Contracted Providers will be compensated for the provision of Covered Services to Covered Persons. Such Compensation Schedule(s) will be set forth or described in one or more Attachments to this Agreement, and may be included within a Product Attachment.

"Contracted Provider" means a physician, hospital, health care professional or any other provider of items or services that is employed by or has a contractual relationship with Provider. The term "Contracted Provider" includes Provider for those Covered Services provided by Provider.

"Coverage Agreement" means any agreement, program or certificate entered into, issued or agreed to by Company or Payor, under which Company or Payor furnishes administrative services or other services in support of a health care program for an individual or group of individuals, and which may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan.

"Covered Person" means any individual entitled to receive Covered Services pursuant to the terms of a Coverage Agreement.

"Covered Services" means those services and items for which benefits are available and payable under the applicable Coverage Agreement and which are determined, if applicable, to be Medically Necessary.

"Medically Necessary" or "Medical Necessity" shall have the meaning defined in the applicable Coverage Agreement or applicable Regulatory Requirements.

"Participating Provider" means, with respect to a particular Product, any physician, hospital, ancillary, or other health care provider that has contracted, directly or indirectly, with Health Plan to provide Covered Services to Covered Persons, that has been approved for participation by Company, and that is designated by Company as a "participating provider" in such Product.

"Payor" means the entity (including Company where applicable) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement and, if such entity is not Company, such entity contracts, directly or indirectly, with Company for the provision of certain administrative or other services with respect to such Coverage Agreement.

"Payor Contract" means the contract with a Payor, pursuant to which Company furnishes administrative services or other services in support of the Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan. The term "Payor Contract" includes Company's or other Payor's contract with a governmental authority (also referred to herein as a "Governmental Contract") under which Company or Payor arranges for the provision of Covered Services to Covered Persons.

"Product" means any program or health benefit arrangement designated as a "product" by Health Plan (e.g., Health Plan Product, Medicaid Product, PPO Product, Payor-specific Product, etc.) that is now or hereafter offered by or available from or through Company (and includes the Coverage Agreements that access, or are issued or entered into in connection with such product, except those excluded by Health Plan).

"Product Attachment" means an Attachment setting forth requirements, terms and conditions specific or applicable to one or more Products, including certain provisions that must be included in a provider agreement under the Regulatory Requirements, which may be alternatives to, or in addition to, the requirements, terms and conditions set forth in this Agreement or the Provider Manual.

"Provider Manual" means the provider manual and any billing manuals, adopted by Company or Payor which include, without limitation, requirements relating to utilization management, quality management, grievances and appeals, and Product-specific, Payor-specific and State-specific requirements, as may be amended from time to time by Company or Payor.

"Regulatory Requirements" means all applicable federal and state statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of Governmental Contracts and standards and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in a Product Attachment.

"State" is defined as the state identified in the applicable Attachment.

ARTICLE II – PRODUCTS AND SERVICES

2.1. Contracted Providers. Provider shall, and shall cause each Contracted Provider, to comply with and abide by the agreements, representations, warranties, acknowledgements, certifications, terms and conditions of this Agreement (including the provisions of Schedule A that are applicable to Provider, a Contracted Provider, or their services, and any other Attachments), and the Provider Manual, and fulfill all of the duties, responsibilities and obligations imposed on Provider and Contracted Providers under this Agreement (including each Attachment), and the Provider Manual.

2.2. Participation in Products. Subject to the other provisions of this Agreement, each Contracted Provider may be identified as a Participating Provider in each Product identified in a Product Attachment designated on Schedule B of this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

Provider shall, at all times during the term of this Agreement, require each of its Contracted Providers to, subject to Company's approval, participate as Participating Providers in each Product identified in a Product Attachment that is designated on Schedule B to this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

A Contracted Provider may only identify itself as a Participating Provider for those Products in which the Contracted Provider actually participates as provided in this Agreement. Provider acknowledges that Company or Payor may have, develop or contract to develop various Products or provider networks that have a variety of provider panels, program components and other requirements. No Company or Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Product.

Attached hereto as Schedule C is the initial list of the Contracted Providers as of the Effective Date. Provider shall provide Health Plan, from time to time or on a periodic basis as requested by Health Plan, with a complete and accurate list containing the names, office telephone numbers, addresses, tax identification numbers, hospital affiliations, specialties and board status (if applicable), State license number, and National Provider Identifier of Contracted Providers and such other information as mutually agreed upon by the Parties, and shall provide Health Plan with a list of modifications to such list at least thirty (30) days prior to the effective date of such changes, when possible. Provider shall provide such lists in a manner and format mutually acceptable to the Parties.

Provider may add new providers to this Agreement as Contracted Providers. In such case, Provider shall provide written notice to Health Plan of the prospective addition(s), and shall use best efforts to provide such notice at least sixty (60) days in advance of such addition. Provider shall maintain written agreements with each of its Contracted Providers (other than Provider) that require the Contracted

Providers to comply with the terms and conditions of this Agreement and that address and comply with the Regulatory Requirements.

If Company desires to add one or more Contracted Providers to an additional Product, Company or Payor, as applicable, will provide advance written notice (electronic or paper) thereof to Provider, along with the applicable Product Attachment and the new Compensation Schedule, if any. The applicable Contracted Providers will not be designated as Participating Providers in such additional Product if Provider opts out of such additional Product by giving Company or Payor, as applicable, written notice of its decision to opt-out within thirty (30) days of Company's or Payor's, as applicable, giving of written notice. If Provider timely provides such opt-out notice, the applicable Contracted Providers will not be considered Participating Providers in such Product. If Provider does not timely provide such opt-out notice, then each applicable Contracted Provider shall be a Participating Provider in such additional Product on the terms and conditions set forth in this Agreement and the applicable Product Attachment.

2.3. Covered Services. Each Contracted Provider shall provide Covered Services described or referenced in the applicable Product Attachment(s) to Covered Persons in those Products in which the Contracted Provider is a Participating Provider, in accordance with this Agreement. Each Contracted Provider shall provide Covered Services to Covered Persons with the same degree of care and skill as customarily provided to patients who are not Covered Persons, within the scope of the Contracted Provider's license and in accordance with generally accepted standards of the Contracted Provider's practice and business and in accordance with the provisions of this Agreement, the Provider Manual, and Regulatory Requirements.

2.4. Provider Manual; Policies and Procedures. Provider and Contracted Providers shall at all times cooperate and comply with the requirements, policies, programs and procedures ("Policies") of Company and Payor, which may be described in the Provider Manual and include, but are not limited to, the following: credentialing criteria and requirements; notification requirements; medical management programs; claims and billing, quality assessment and improvement, utilization review and management, disease management, case management, on-site reviews, referral and prior authorization, and grievance and appeal procedures; coordination of benefits and third party liability policies; carve-out and third party vendor programs; and data reporting requirements. The failure to comply with such Policies could result in a denial or reduction of payment to the Provider or Contracted Provider or a denial or reduction of the Covered Person's benefits. Such Policies do not in any way affect or remove the obligation of Contracted Providers to render care. Health Plan shall make the Provider Manual available to Provider and Contracted Providers via one or more designated websites or alternative means. Upon Provider's reasonable request, Health Plan shall provide Provider with a copy of the Provider Manual. In the event of a material change to the Provider Manual, Health Plan will use reasonable efforts to notify Provider in advance of such change. Such notice may be given by Health Plan through a periodic provider newsletter, an update to the on-line Provider Manual, or any other written method (electronic or paper).

2.5. Credentialing Criteria. Provider and each Contracted Provider shall complete Company's and/or Payor's credentialing and/or recredentialing process as required by Company's and/or Payor's credentialing Policies, and shall at all times during the term of this Agreement meet all of Company's and/or Payor's credentialing criteria. Provider and each Contracted Provider represents, warrants and agrees: (a) that it is currently, and for the duration of this Agreement shall remain: (i) in compliance with all applicable Regulatory Requirements, including licensing laws; (ii) if applicable, accredited by The Joint Commission or the American Osteopathic Association; and (iii) a Medicare participating provider under the federal Medicare program and a Medicaid participating provider under applicable federal and State laws; and (b) that all Contracted Providers and all employees and contractors thereof will perform their duties in accordance with all Regulatory Requirements, as well as applicable national, State and

local standards of professional ethics and practice. No Contracted Provider shall provide Covered Services to Covered Persons or identify itself as a Participating Provider unless and until the Contracted Provider has been notified, in writing, by Company that such Contracted Provider has successfully completed Company's credentialing process.

2.6. Eligibility Determinations. Provider or Contracted Provider shall timely verify whether an individual seeking Covered Services is a Covered Person. Company or Payor, as applicable, will make available to Provider and Contracted Providers a method, whereby Provider and Contracted Providers can obtain, in a timely manner, general information about eligibility and coverage. Company or Payor, as applicable, does not guarantee that persons identified as Covered Persons are eligible for benefits or that all services or supplies are Covered Services. If Company, Payor or its delegate determines that an individual was not a Covered Person at the time services were rendered, such services shall not be eligible for payment under this Agreement. In addition, Company will use reasonable efforts to include or contractually require Payors to clearly display Company's name, logo or mailing address (or other identifier(s) designated from time to time by Company) on each membership card.

2.7. Referral and Preauthorization Procedures. Provider and Contracted Providers shall comply with referral and preauthorization procedures adopted by Company and or Payor, as applicable, prior to referring a Covered Person to any individual, institutional or ancillary health care provider. Unless otherwise expressly authorized in writing by Company or Payor, Provider and Contracted Providers shall refer Covered Persons only to Participating Providers to provide the Covered Service for which the Covered Person is referred. Except as required by applicable law, failure of Provider and Contracted Providers to follow such procedures may result in denial of payment for unauthorized treatment.

2.8. Treatment Decisions. No Company or Payor is liable for, nor will it exercise control over, the manner or method by which a Contracted Provider provides items or services under this Agreement. Provider and Contracted Providers understand that determinations of Company or Payor that certain items or services are not Covered Services or have not been provided or billed in accordance with the requirements of this Agreement or the Provider Manual are administrative decisions only. Such decisions do not absolve the Contracted Provider of its responsibility to exercise independent judgment in treatment decisions relating to Covered Persons. Nothing in this Agreement (i) is intended to interfere with Contracted Provider's relationship with Covered Persons, or (ii) prohibits or restricts a Contracted Provider from disclosing to any Covered Person any information that the Contracted Provider deems appropriate regarding health care quality, medical treatment decisions or alternatives.

2.9. Carve-Out Vendors. Provider acknowledges that Company may, during the term of this Agreement, carve-out certain Covered Services from its general provider contracts, including this Agreement, for one or more Products as Company deems necessary or appropriate. Provider and Contracted Providers shall cooperate with and, when medically appropriate, utilize all third party vendors designated by Company for those Covered Services identified by Company from time to time for a particular Product.

2.10. Disparagement Prohibition. Provider, each Contracted Provider and the officers of Company shall not disparage the other during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Neither Provider nor Contracted Provider shall interfere with Company's direct or indirect contractual relationships including, but not limited to, those with Covered Persons or other Participating Providers. Nothing in this Agreement should be construed as limiting the ability of either Health Plan, Company, Provider or a Contracted Provider to inform Covered Persons that this Agreement has been terminated or otherwise expired or, with respect to Provider, to

promote Provider to the general public or to post information regarding other health plans consistent with Provider's usual procedures, provided that no such promotion or advertisement is specifically directed at one or more Covered Persons. In addition, nothing in this provision should be construed as limiting Company's ability to use and disclose information and data obtained from or about Provider or Contracted Provider, including this Agreement, to the extent determined reasonably necessary or appropriate by Company in connection with its efforts to comply with Regulatory Requirements and to communicate with regulatory authorities.

2.11. Nondiscrimination. Provider and each Contracted Provider will provide Covered Services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of Payor, source of payment (e.g., Medicaid generally or a State-specific health care program), physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991. Provider and Contracted Providers recognize that, as a governmental contractor, Company or Payor may be subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors, and Provider and each Contracted Provider agree to comply with such requirements as described in any applicable Attachment.

2.12. Notice of Certain Events. Provider shall give written notice to Health Plan of: (i) any event of which notice must be given to a licensing or accreditation agency or board; (ii) any change in the status of Provider's or a Contracted Provider's license; (iii) termination, suspension, exclusion or voluntary withdrawal of Provider or a Contracted Provider from any state or federal health care program, including but not limited to Medicaid; or (iv) any settlements or judgments in connection with a lawsuit or claim filed or asserted against Provider or a Contracted Provider alleging professional malpractice involving a Covered Person. In any instance described in subsection (i)-(iii) above, Provider must notify Health Plan or Payor in writing within ten (10) days, and in any instance described in subsection (iv) above, Provider must notify Health Plan or Payor in writing within thirty (30) days, from the date it first obtains knowledge of the pending of the same.

2.13. Use of Name. Provider and each Contracted Provider hereby authorizes each Company or Payor to use their respective names, telephone numbers, addresses, specialties, certifications, hospital affiliations (if any), and other descriptive characteristics of their facilities, practices and services for the purpose of identifying the Contracted Providers as "Participating Providers" in the applicable Products. Provider and Contracted Providers may only use the name of the applicable Company or Payor for purposes of identifying the Products in which they participate, and may not use the registered trademark or service mark of Company or Payor without prior written consent.

2.14. Compliance with Regulatory Requirements. Provider, each Contracted Provider and Company agree to carry out their respective obligations under this Agreement and the Provider Manual in accordance with all applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder. If, due to Provider's or Contracted Provider's noncompliance with applicable Regulatory Requirements or this Agreement, sanctions or penalties are imposed on Company, Company may, in its sole discretion, offset such amounts against any amounts due Provider or Contracted Providers from any Company or require Provider or the Contracted Provider to reimburse Company for such amounts.

2.15. Program Integrity Required Disclosures. Provider agrees to furnish to Health Plan complete and accurate information necessary to permit Company to comply with the collection of disclosures requirements specified in 42 C.F.R. Part 455 Subpart B or any other applicable State or federal

requirements, within such time period as is necessary to permit Company to comply with such requirements. Such requirements include but are not limited to: (i) 42 C.F.R. §455.105, relating to (a) the ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request and (b) any significant business transaction between Provider and any wholly owned supplier or subcontractor during the five (5) year period ending on the date of the request; (ii) 42 C.F.R. §455.104, relating to individuals or entities with an ownership or controlling interest in Provider; and (iii) 42 C.F.R. §455.106, relating to individuals with an ownership or controlling interest in Provider, or who are managing employees of Provider, who have been convicted of a crime.

ARTICLE III – CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

Claims or Encounter Data Submission. As provided in the Provider Manual and/or Policies, Contracted Providers shall submit to Payor or its delegate claims for payment for Covered Services rendered to Covered Persons. Contracted Provider shall submit encounter data to Payor or its delegate in a timely fashion, which must contain statistical and descriptive medical and patient data and identifying information, if and as required in the Provider Manual. Payor or its delegate reserves the right to deny payment to the Contracted Provider if the Contracted Provider fails to submit claims for payment or encounter data in accordance with the Provider Manual and/or Policies.

Compensation. The compensation for Covered Services provided to a Covered Person ("Compensation Amount") will be the appropriate amount under the applicable Compensation Schedule in effect on the date of service for the Product in which the Covered Person participates. Subject to the terms of this Agreement and the Provider Manual, Provider and Contracted Providers shall accept the Compensation Amount as payment in full for the provision of Covered Services. Subject to the terms of this Agreement, Payor shall pay or arrange for payment of each Clean Claim received from a Contracted Provider for Covered Services provided to a Covered Person in accordance with the applicable Compensation Amount less any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement.

Financial Incentives. The Parties acknowledge and agree that nothing in this Agreement shall be construed to create any financial incentive for Provider or a Contracted Provider to withhold Covered Services.

Hold Harmless. Provider and each Contracted Provider agree that in no event, including but not limited to non-payment by a Payor, a Payor's insolvency, or breach of this Agreement, shall Provider or a Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or person acting on the Covered Person's behalf, other than Payor, for Covered Services provided under this Agreement. This provision shall not prohibit collection of any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement. This provision survives termination or expiration of this Agreement for any reason, will be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between Provider or a Contracted Provider and a Covered Person.

Recovery Rights. Payor or its delegate shall have the right to immediately offset or recoup any and all amounts owed by Provider or a Contracted Provider to Payor or Company against amounts owed by the Payor or Company to the Provider or Contracted Provider. Provider and Contracted Providers agree that all recoupment and any offset rights under this Agreement will constitute rights of recoupment authorized under State or federal law and that such rights will not be subject to any requirement of prior or other

approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider or a Contracted Provider.

ARTICLE IV – RECORDS AND INSPECTIONS

Records. Each Contracted Provider shall maintain medical, financial and administrative records related to items or services provided to Covered Persons, including but not limited to a complete and accurate permanent medical record for each such Covered Person, in such form and detail as are required by applicable Regulatory Requirements and consistent with generally accepted medical standards.

Access. Provider and each Contracted Provider shall provide access to their respective books and records to each of the following, including any delegate or duly authorized agent thereof, subject to applicable Regulatory Requirements: (i) Company and Payor, during regular business hours and upon prior notice; (ii) appropriate State and federal authorities, to the extent such access is necessary to comply with Regulatory Requirements; and (iii) accreditation organizations. Provider and each Contracted Provider shall provide copies of such records at no expense to any of the foregoing that may make such request. Each Contracted Provider also shall obtain any authorization or consent that may be required from a Covered Person in order to release medical records and information to Company or Payor or any of their delegates. Provider and each Contracted Provider shall cooperate in and allow on-site inspections of its, his or her facilities and records by any Company, Payor, their delegates, any authorized government officials, and accreditation organizations. Provider and each Contracted Provider shall compile information necessary for the expeditious completion of such on-site inspection in a timely manner.

Record Transfer. Subject to applicable Regulatory Requirements, each Contracted Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider, at no charge and when required.

ARTICLE V – INSURANCE AND INDEMNIFICATION

Insurance. During the term of this Agreement and for any applicable continuation period as set forth in Section 7.3 of this Agreement, Provider and each Contracted Provider shall maintain policies of general and professional liability insurance and other insurance necessary to insure Provider and such Contracted Provider, respectively; their respective employees; and any other person providing services hereunder on behalf of Provider or such Contracted Provider, as applicable, against any claim(s) of personal injuries or death alleged to have been caused or caused by their performance under this Agreement. Such insurance shall include, but not be limited to, any "tail" or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier acceptable to Health Plan, and in a minimum amount of one million dollars ($1,000,000) per occurrence, and three million dollars ($3,000,000) in the aggregate unless a lesser amount is accepted by Health Plan or where State law mandates otherwise. Provider and each Contracted Provider will provide Health Plan with at least fifteen (15) days prior written notice of cancellation, non-renewal, lapse, or adverse material modification of such coverage. Upon Health Plan's request, Provider and each Contracted Provider will furnish Health Plan with evidence of such insurance.

Indemnification by Provider and Contracted Provider. Provider and each Contracted Provider shall indemnify and hold harmless (and at Health Plan's request defend) Company and Payor and all of their respective officers, directors, agents and employees from and against any and all third party claims for

any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) judgments or obligations arising from or relating to any negligence, wrongful act or omission, or breach of this Agreement by Provider, a Contracted Provider, or any of their respective officers, directors, agents or employees.

Indemnification by Health Plan. Health Plan agrees to indemnify and hold harmless (and at Provider's request defend) Provider, Contracted Providers, and their officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees), judgments, or obligations arising from or relating to any negligence, wrongful act or omission or breach of this Agreement by Company or its directors, officers, agents or employees.

ARTICLE VI – DISPUTE RESOLUTION

Informal Dispute Resolution. Any dispute between Provider and/or a Contracted Provider, as applicable (the "Provider Party"), and Health Plan and/or Company, as applicable (including any Company acting as Payor) (the "Administrator Party"), with respect to or involving the performance under, termination of, or interpretation of this Agreement, or any other claim or cause of action hereunder, whether sounding in tort, contract or under statute (a "Dispute") shall first be addressed by exhausting the applicable procedures in the Provider Manual pertaining to claims payment, credentialing, utilization management, or other programs. If, at the conclusion of these applicable procedures, the matter is not resolved to satisfaction of the Provider Party and the Administrator Party, or if there are no applicable procedures in the Provider Manual, then the Provider Party and the Administrator Party shall engage in a period of good faith negotiations between their designated representatives who have authority to settle the Dispute, which negotiations may be initiated by either the Provider Party or the Administrator Party upon written request to the other, provided such request takes place within one year of the date on which the requesting party first had, or reasonably should have had, knowledge of the event(s) giving rise to the Dispute. If the matter has not been resolved within sixty (60) days of such request, either the Provider Party or the Administrator Party may, as its sole and exclusive forum for the litigation of the Dispute or any part thereof, initiate arbitration pursuant to Section 6.2 below by providing written notice to the other party.

Arbitration. If either the Provider Party or the Administrator Party wishes to pursue the Dispute as provided in Section 6.1, such party shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"). In no event may any arbitration be initiated more than one (1) year following, as applicable, the end of the sixty (60) day negotiation period set forth in Section 6.1, or the date of notice of termination. Arbitration proceedings shall be conducted by an arbitrator chosen from the National Healthcare Panel at a mutually agreed upon location within the State. The arbitrator shall not award any punitive or exemplary damages of any kind, shall not vary or ignore the provisions of this Agreement, and shall be bound by controlling law. The Parties and the Contracted Providers, on behalf of themselves and those that they may now or hereafter represent, agree to and do hereby waive any right to pursue, on a class basis, any Dispute. Each of the Provider Party and the Administrator Party shall bear its own costs and attorneys' fees related to the arbitration except that the AAA's Administrative Fees, all Arbitrator Compensation and travel and other expenses, and all costs of any proof produced at the direct request of the arbitrator shall be borne equally by the applicable parties, and the arbitrator shall not have the authority to order otherwise. The existence of a Dispute or arbitration proceeding shall not in and of itself constitute cause for termination of this Agreement. Except as hereafter provided, during an arbitration proceeding, each of the Provider Party and the Administrator Party shall continue to perform its obligations under this Agreement pending the decision of the arbitrator. Nothing herein shall bar either the Provider Party or the Administrator Party from seeking emergency injunctive relief to preclude any actual or perceived breach of this Agreement, although such party shall be obligated to file and pursue arbitration at the earliest reasonable opportunity.

Judgment on the award rendered may be entered in any court having jurisdiction thereof. Nothing contained in this Article VI shall limit a Party's right to terminate this Agreement with or without cause in accordance with Section 7.2.

ARTICLE VII – TERM AND TERMINATION

Term. This Agreement is effective as of the Health Plan Effective Date, and will remain in effect for an initial term ("Initial Term") of three (3) year(s), after which it will automatically renew for successive terms of one (1) year each (each a "Renewal Term"), unless this Agreement is sooner terminated as provided in this Agreement or either Party gives the other Party written notice of non-renewal of this Agreement not less than one hundred eighty (180) days prior to the end of the then-current term. In addition, either Party may elect to not renew a Contracted Provider's participation as a Participating Provider in a particular Product for the next Renewal Term, by giving Provider written notice of such non-renewal not less than one hundred eighty (180) days prior to the, as applicable, last day of the Initial Term or applicable Renewal Term; in such event, Provider shall immediately notify the affected Contracted Provider of such non-renewal. Termination of any Contracted Provider's participation in a particular Product will not have the effect of terminating either this Agreement or the Contracted Provider's participation in any other Product in which the Contract Provider participates under this Agreement.

Termination. This Agreement, or the participation of Provider or a Contracted Provider as a Participating Provider in one or more Products, may be terminated or suspended as set forth below.

Upon Notice. This Agreement may be terminated by either Party giving the other Party at least one hundred eighty (180) days prior written notice of such termination. The participation of any Contracted Provider as a Participating Provider in a Product may be terminated by either Party giving the other Party at least one hundred eighty (180) days prior written notice of such termination; in such event, Provider shall immediately notify the affected Contracted Provider of such termination.

With Cause. This Agreement, or the participation of any Contracted Provider as a Participating Provider in one or more Products under this Agreement, may be terminated by either Party giving at least ninety (90) days prior written notice of termination to the other Party if such other Party (or the applicable Contracted Provider) is in breach of any material term or condition of this Agreement and such other Party (or the Contracted Provider) fails to cure the breach within the sixty (60) day period immediately following the giving of written notice of such breach. Any notice given pursuant to this Section 7.2.2 must describe the specific breach. In the case of a termination of a Contracted Provider, Provider shall immediately notify the affected Contracted Provider of such termination.

Suspension of Participation. Unless expressly prohibited by applicable Regulatory Requirements, Health Plan has the right to immediately suspend or terminate the participation of a Contracted Provider in any or all Products by giving written notice thereof to Provider when Health Plan determines that (i) based upon available information, the continued participation of the Contracted Provider appears to constitute an immediate threat or risk to the health, safety or welfare of Covered Persons, or (ii) the Contracted Provider's fraud, malfeasance or non-compliance with Regulatory Requirements is reasonably suspected. Provider shall immediately notify the affected Contracted Provider of such suspension. During such suspension, the Contracted Provider shall, as directed by Health Plan, discontinue the provision of all or a particular Covered Service to Covered Persons. During the term of any suspension, the Contracted Provider shall notify Covered Persons that his or her status as a Participating Provider has been suspended. Such suspension will continue until the Contracted Provider's participation is reinstated or terminated.

Insolvency. This Agreement may be terminated immediately by a Party giving written notice thereof to the other Party if the other Party is insolvent or has bankruptcy proceedings initiated against it.

Credentialing. The status of a Contracted Provider as a Participating Provider in one or more Products may be terminated immediately by Health Plan giving written notice thereof to Provider if the Contracted Provider fails to adhere to Company's or Payor's credentialing criteria, including, but not limited to, if the Contracted Provider (i) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (ii) fails to comply with the insurance requirements set forth in this Agreement; or (iii) is convicted of a criminal offense related to involvement in any state or federal health care program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program. Provider shall immediately notify the affected Contracted Provider of such termination.

Effect of Termination. After the effective date of termination of this Agreement or a Contracted Provider's participation in a Product, this Agreement shall remain in effect for purposes of those obligations and rights arising prior to the effective date of termination. Upon such a termination, each affected Contracted Provider (including Provider, if applicable) shall (i) continue to provide Covered Services to Covered Persons in the applicable Product(s) during the longer of the ninety (90) day period following the date of such termination or such other period as may be required under any Regulatory Requirements, and, if requested by Company, each affected Contracted Provider (including Provider, if applicable) shall continue to provide, as a Participating Provider, Covered Services to Covered Persons until such Covered Persons are assigned or transferred to another Participating Provider in the applicable Product(s), and (ii) continue to comply with and abide by all of the applicable terms and conditions of this Agreement, including, but not limited to, Section 3.4 (Hold Harmless) hereof, in connection with the provision of such Covered Services during such continuation period. During such continuation period, each affected Contracted Provider (including Provider, if applicable) will be compensated in accordance with this Agreement and shall accept such compensation as payment in full.

Survival of Obligations. All provisions hereof that by their nature are to be performed or complied with following the expiration or termination of this Agreement, including without limitation Sections 2.8, 2.10, 3.2, 3.4, 3.5, 4.2, 5.1, 5.2, 5.3, 6.2, 7.3, and 7.4 and Article VIII, survive the expiration or termination of this Agreement.

ARTICLE VIII - MISCELLANEOUS

Relationship of Parties. The relationship between or among Health Plan, Company, Provider, and any Contracted Provider hereunder is that of independent contractors. None of the provisions of this Agreement will be construed as creating any agency, partnership, joint venture, employee-employer, or other relationship. References herein to the rights and obligations of any Company under this Agreement are references to the rights and obligations of each Company individually and not collectively. A Company is only responsible for performing its respective obligations hereunder with respect to a particular Product, Coverage Agreement, Payor Contract, Covered Service or Covered Person. A breach or default by an individual Company shall not constitute a breach or default by any other Company, including but not limited to Health Plan.

Conflicts Between Certain Documents. If there is any conflict between this Agreement and the Provider Manual, this Agreement will control. In the event of any conflict between this Agreement and any Product Attachment, the Product Attachment will control as to such Product.

Assignment. This Agreement is intended to secure the services of and be personal to Provider and may not be assigned, sublet, delegated, subcontracted or transferred by Provider without Health Plan's prior written consent. Health Plan shall have the right, exercisable in its sole discretion, to assign or transfer all or any portion of its rights or to delegate all or any portion of its interests under this Agreement or any Attachment to an Affiliate, successor of Health Plan, or purchaser of the assets or stock of Health Plan, or the line of business or business unit primarily responsible for carrying out Health Plan's obligations under this Agreement.

Headings. The headings of the sections of this Agreement are inserted merely for the purpose of convenience and do not limit, define, or extend the specific terms of the section so designated.

Governing Law. The interpretation of this Agreement and the rights and obligations of Health Plan, Company, Provider and any Contracted Providers hereunder will be governed by and construed in accordance with applicable federal and State laws.

Third Party Beneficiary. This Agreement is entered into by the Parties signing it for their benefit, as well as, in the case of Health Plan, the benefit of Company, and in the case of Provider, the benefit of each Contracted Provider. Except as specifically provided in Section 3.4 hereof, no Covered Person or third party, other than Company, will be considered a third party beneficiary of this Agreement.

Amendment. Except as otherwise provided in this Agreement, this Agreement may be amended only by written agreement of duly authorized representatives of the Parties.

Health Plan may amend this Agreement by giving Provider written notice of the amendment to the extent such amendment is deemed necessary or appropriate by Health Plan to comply with any Regulatory Requirements. Any such amendment will be deemed accepted by Provider upon the giving of such notice.

Health Plan may amend this Agreement by giving Provider written notice (electronic or paper) of the proposed amendment. Unless Provider notifies Health Plan in writing of its objection to such amendment during the thirty (30) day period following the giving of such notice by Health Plan, Provider shall be deemed to have accepted the amendment. If Provider objects to any proposed amendment to either the base agreement or any Attachment, Health Plan may exclude one or more of the Contracted Providers from being Participating Providers in the applicable Product (or any component program of, or Coverage Agreement in connection with, such Product).

Entire Agreement. All prior or concurrent agreements, promises, negotiations or representations either oral or written, between Health Plan and Provider relating to a subject matter of this Agreement, which are not expressly set forth in this Agreement, are of no force or effect.

Severability. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other terms or provisions.

Waiver. The waiver by either Party of the violation of any provision or obligation of this Agreement will not constitute the waiver of any subsequent violation of the same or other provision or obligation.

Notices. Except as otherwise provided in this Agreement, any notice required or permitted to be given hereunder is deemed to have been given when such written notice has been personally delivered or

deposited in the United States mail, postage paid, or delivered by a service that provides written receipt of delivery, addressed as follows:

To Health Plan at:	To Provider at:
Attn: President	Attn:
_____	_____
_____	_____
_____	_____

or to such other address as such Party may designate in writing. Notwithstanding the previous paragraph, Health Plan may provide notices by electronic mail, through its provider newsletter or on its provider website.

Force Majeure. Neither Party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, strikes or other work stoppages by either Party's employees, or any other similar cause beyond the reasonable control of such Party.

Proprietary Information. Each Party is prohibited from, and shall prohibit its Affiliates and Contracted Providers from, disclosing to a third party the substance of this Agreement, or any information of a confidential nature acquired from the other Party (or Affiliate or Contracted Provider thereof) during the course of this Agreement, except to agents of such Party as necessary for such Party's performance under this Agreement, or as required by a Payor Contract or applicable Regulatory Requirements. Provider acknowledges and agrees that all information relating to Company's programs, policies, protocols and procedures is proprietary information and Provider shall not disclose such information to any person or entity without Health Plan's express written consent.

Authority. The individuals whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement. Provider represents and warrants that it has all legal authority to contract on behalf of and to bind all Contracted Providers to the terms of the Agreement with Health Plan. Provider and each Contracted Provider acknowledges that references herein to the rights and obligations of any "Company" or a "Payor" under this Agreement are references to the rights and obligations of each Company and each Payor individually and not of the Companies or Payors collectively. Notwithstanding anything herein to the contrary, all such rights and obligations are individual and specific to each such Company and each such Payor and the reference to Company or Payor herein in no way imposes any cross-guarantees or joint responsibility or liability by, between or among such individual Companies or Payors. A breach or default by an individual Company or Payor shall not constitute a breach or default by any other Company or Payor, including but not limited to Health Plan.

* * * * *

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement, including all Product Attachments noted on Schedule B, effective as of the date set forth beneath their respective signatures.

Health Plan: Provider:

(Legibly Print Name of Health Plan) (Legibly Print Name of Provider)

Authorized Signature: Authorized Signature:

Print Name: Print Name:

Title: Title:

Signature Date: Signature Date:

To be completed by Health Plan only: Tax Identification Number:

Effective Date:_____ State Medicaid Number:

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE A
CONTRACTED PROVIDER-SPECIFIC PROVISIONS

Provider and Contracted Providers shall comply with the applicable provisions of this Schedule A.

1 Hospitals. If Provider or a Contracted Provider is a hospital ("Hospital"), the following provisions apply.

1.1 24 Hour Coverage. Each Hospital shall be available to provide Covered Services to Covered Persons twenty-four (24) hours per day, seven (7) days per week.

1.2 Emergency Care. Each Hospital shall provide Emergency Care (as hereafter defined) in accordance with Regulatory Requirements. The Contracted Provider shall notify Company's medical management department of any emergency room admissions by electronic file sent within twenty-four (24) hours or by the next business day of such admission. "Emergency Care" (or derivative thereof) has, as to each particular Product, the meaning set forth in the applicable Coverage Agreement or Product Attachment. If there is no definition in such documents, "Emergency Care" means inpatient and/or outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition. "Emergency Medical Condition" means 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: (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; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

1.3 Staff Privileges. Each Hospital shall assist in granting staff privileges or other appropriate access to Company's Participating Providers who are qualified medical or osteopathic

physicians, provided they meet the reasonable standards of practice and credentialing standards established by the Hospital's medical staff and bylaws, rules, and regulations.

1.4 Discharge Planning. Each Hospital agrees to cooperate with Company's system for the coordinated discharge planning of Covered Persons, including the planning of any necessary continuing care.

1.5 Credentialing Criteria. Each Hospital shall (a) currently, and for the duration of this Agreement, remain accredited by the Joint Commission or American Osteopathic Association, as applicable; and (b) ensure that all employees of Hospital perform their duties in accordance with all applicable local, State and federal licensing requirements and standards of professional ethics and practice.

2 Practitioners. If Provider or Contracted Provider is a physician or other health care practitioner (including physician extenders) ("Practitioner"), the following provisions apply.

2.1 Contracted Professional Qualifications. At all times during the term of this Agreement, Practitioner shall, as applicable, maintain medical staff membership and admitting privileges with at least one hospital that is a Participating Provider ("Participating Hospital") with respect to each Product in which the Practitioner participates. Upon Company's request, Practitioner shall furnish evidence of the foregoing to Company. If Practitioner does not have such admitting privileges, Provider or the Practitioner shall provide Company with a written statement from another Participating Provider who has such admitting privileges, in good standing, certifying that such individual agrees to assume responsibility for providing inpatient Covered Services to Covered Persons who are patients of the applicable Practitioner.

2.2 Acceptance of New Patients. To the extent that Practitioner is accepting new patients, such Practitioner must also accept new patients who are Covered Persons with respect to the Products in which such Practitioner participates. Practitioner shall notify Company in writing forty-five (45) days prior to such Practitioner's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Practitioner be considered a new patient.

2.3 Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Practitioners shall use commercially reasonable efforts, when medically appropriate under the circumstances, to comply with formulary or preferred drug list when prescribing medications for Covered Persons.

3 Ancillary Providers. If Provider or Contracted Provider is an ancillary provider (including but not limited to a home health agency, durable medical equipment provider, sleep center, pharmacy, ambulatory surgery center, nursing facility, laboratory or urgent care center)("Ancillary Provider"), the following provisions apply.

3.1 Acceptance of New Patients. To the extent that Ancillary Provider is accepting new patients, such Ancillary Provider must also accept new patients who are Covered Persons with respect to the Products in which such Ancillary Provider participates. Ancillary Provider shall notify Company in writing forty-five (45) days prior to such Ancillary Provider's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Ancillary Provider be considered a new patient.

4 FQHC. If Provider or a Contracted Provider is a federally qualified health center ("FQHC"), the following provision applies.

4.1 FQHC Insurance. To the extent FQHC's employees are deemed to be federal employees qualified for protection under the Federal Tort Claims Act ("FTCA") and Health Plan has been provided with documentation of such status issued by the U.S. Department of Health and Human Services (such status to be referred to as "FTCA Coverage"), Section 5.1 of this Agreement will not apply to those Contracted Providers with FTCA Coverage. FQHC shall provide evidence of such FTCA Coverage to Health Plan at any time upon request. FQHC shall promptly notify Health Plan if, any time during the term of this Agreement, any Contracted Provider is no longer eligible for, or if FQHC becomes aware of any fact or circumstance that would jeopardize, FTCA Coverage. Section 5.1 of this Agreement will apply to a Contracted Provider immediately upon such Contracted Provider's loss of FTCA Coverage for any reason.

5 Long Term Services and Supports ("LTSS") Provider. If Provider or a Contracted Provider is a provider of LTSS services, the following provisions apply.

5.1 Acknowledgement. Health Plan acknowledges that Provider is a provider of LTSS services and is not necessarily a provider of medical or health care services. Nothing in this Agreement is intended to require Provider to provide medical or health care services that Provider does not routinely provide.

5.2 Notification Requirements. Provider or the applicable Contracted Provider shall provide the following notifications to Health Plan, via written notice or via telephone contact at a number to be provided by Health Plan, within the following time frames:

a) Provider or the applicable Contracted Provider shall notify Health Plan of a Covered Person's visit to the emergency department of any hospital, or of a Covered Person's hospitalization, within 24 hours of becoming aware of such visit or hospitalization.

b) Provider or the applicable Contracted Provider shall notify Health Plan of any change to a Covered Person's plan of care and/or service plan, within 24 hours of becoming aware of such change.

c) Provider or the applicable Contracted Provider shall notify Health Plan if a Covered Person misses an appointment with Provider, within 24 hours of becoming aware of such missed appointment.

d) Provider or the applicable Contracted Provider shall notify Health Plan of any change in a Covered Person's medical or behavioral health condition, within 24 hours of becoming aware of such change. (Examples of changes in condition are set forth in the Provider Manual.)

e) Provider or the applicable Contracted Provider shall notify Health Plan of any safety issue identified by Provider or Contracted Provider or its agent or subcontractor, within 24 hours of the identification of such safety issue. (Examples of safety issues are set forth in the Provider Manual.)

f) Provider or the applicable Contracted Provider shall notify Health Plan of any change in Provider's or Contracted Provider's key personnel, within 24 hours of such change.

5.3 Minimum Data Set. If Contracted Provider is a nursing facility, Provider or such Contracted Provider shall submit to Health Plan or its designee the Minimum Data Set as defined by CMS and required under federal law and Health Plan policy as it relates to all Covered Persons who are residents in

Contracted Provider's facility. Such submission shall be via electronic mail, facsimile transmission, or other manner and format reasonably requested by Health Plan.

5.4 Quality Improvement Plan. Each Contracted Provider shall participate in Health Plan's LTSS quality improvement plan. Each Contracted Provider shall permit Health Plan to access such Contracted Providers' assessment and quality data upon reasonable advance notice, which may be given by electronic mail.

5.5 Electronic Visit Verification. If Contracted Provider is a personal care aide, Contracted Provider shall comply with Health Plan's electronic visit verification system requirements where applicable.

5.6 Criminal Background Checks. Provider shall conduct a criminal background check on each Contracted Provider prior to the commencement of services under this Agreement and as requested by Health Plan thereafter. Provider shall provide the results of such background checks to Health Plan within a reasonable time period following the completion thereof. Provider agrees to immediately notify Health Plan of any criminal convictions of any Contracted Provider. Provider shall pay any costs associated with such criminal background checks.
PARTICIPATING PROVIDER AGREEMENT

SCHEDULE B
PRODUCT PARTICIPATION

Provider will be designated as a "Participating Provider" in the Product Attachments listed below as of the date of successful completion of credentialing in accordance with this Agreement.

List of Product Attachments:

Attachment A: Medicaid
Attachment B: [Reserved]
Attachment C: [Reserved]

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE C
CONTRACTED PROVIDERS

ENTITY/GROUP/CLINIC/FACILITY NAME TAX ID # NPI #

NOTE: This Schedule is intended to capture all groups, clinics and facilities participating under the Agreement (i.e., are Contracted Providers under this Agreement) as of the Effective Date.

Attachment A: Medicaid

MEDICAID PRODUCT ATTACHMENT

[TBD]

Attachment A: Medicaid

SCHEDULE A
GOVERNMENTAL CONTRACT REQUIREMENTS

[TBD]

Attachment A: Medicaid

SCHEDULE B
REGULATORY REQUIREMENTS

[TBD]

Attachment A: Medicaid

EXHIBIT __
COMPENSATION SCHEDULE

[?BTVProvider Name?]

[TBD]

nebraska total care™

ATTACHMENT 5

NETWORK DEVELOPMENT PLAN

Network Development Plan

Submit plan for developing an adequate provider network within the timeframe described in Section IV.I - Provider Network.

Overview

The following detailed work plan and corresponding narrative demonstrate NTC's strong capacity for developing an adequate provider network within the timeframes prescribed in Section IV.I of the RFP, as well as the proven methods NTC will employ on an ongoing basis to assess and ensure that MLTC's network standards are maintained and exceeded. NTC acknowledges and agrees that, from the date of contract award and then every two weeks until the contract effective date, NTC will be expected to provide updates about our network development activities to include, in detail, NTC's network status, corresponding Quest Analytics reports, descriptions of any provider network gaps, and NTC's remediation plans. Further, NTC acknowledges that future network development plans must be submitted by November 1st of each contract year, and that such documents serve as an assurance of the adequacy and sufficiency of NTC's provider network. NTC will also submit, as requested by MLTC, an updated plan when there has been a significant change in operations that would affect adequate capacity and services such as, but not limited to, changes in services, covered benefits, payments, or eligibility of a new population. NTC will include in such future network development plans all components set forth in Section I.16 Network Development Plan of the RFP.

In Nebraska we will prepare the Network Development Plan using the following materials to ensure compliance: MLTC contract templates, RFP requirements, Covered Services, and MLTC access standards. We will train all network staff to ensure competence and knowledge of all Nebraska requirements and continue our meetings with our key Nebraska partners such as ENHANCE Health Network, CHI, the Nebraska Hospital Associations, the Behavioral Health Regions, and FQHCs to understand practice and referral patterns, Provider needs/concerns and any population nuances throughout the state.

Tasks and Timeframes

The following table describes our network development plan to ensure that the NTC provider network satisfies MLTC, NCQA, and internal access and availability standards for Nebraska Medicaid members:

Task Name	Start Date	Finish Date	Status	Accountable Team
Network Development / Provider Credentialing / Provider Relations				
Network Development				
Customize Policy & Procedures for NE Requirements including non-discrimination and mainstreaming of NE Medicaid members	3/15/2016	6/1/2016	On Target	Network Contracting
Hire, train local contracting staff / mobilize business development contracting resources	1/1/2016	4/5/2016	On Target	Network Contracting
Obtain current NE provider list from MLTC / purchase lists, as needed	Current	3/1/2016	On Target	Network Contracting
Meetings / Relationships with Key Provider Associations/community agencies/advocacy groups	Current	Ongoing	On Target	Network Contracting
Develop Network Development Plan & Strategy specific to NE Requirement (key providers, expertise & commitment to BH principles, adequacy requirements)	Current	6/1/2016	On Target	Network Contracting
Primary Care Provider / Specialist strategy (include direct access for members with SHCN criteria)	Current	6/1/2016	On Target	Network Contracting
Behavioral health provider strategy	Current	6/1/2016	On Target	Network Contracting

Hospital / Facility strategy	Current	6/1/2016	On Target	Network Contracting
FQHC / RHC strategy (notify MLTC if contract cannot be reached)	Current	6/1/2016	On Target	Network Contracting
ACO / Health System strategy	Current	6/1/2016	On Target	Network Contracting
PCMH strategy and requirements (submit PCMH implementation within 90 days)	Current	6/1/2016	On Target	Network Contracting
Methods to improve ability of BH provider s to meet all health needs / integrated care	Current	6/1/2016	On Target	Network Contracting
Pharmacy network (Medicaid network in good standing with MLTC)	Current	6/1/2016	On Target	Network Contracting
Specialty pharmacy (MLTC review and written approval 45 days of designated specialty drugs)	Current	6/1/2016	On Target	Network Contracting
Establish value based contracting strategy (30% by 3rd year)	Current	Ongoing	On Target	Network Contracting
Develop network tracking and reporting (CRMP system)	11/1/2015	3/1/2016	On Target	Network Contracting
Implement Contract Processing System and Resources	1/1/2016	3/1/2016	On Target	Network Contracting
Configure systems / Geos to track adequacy (Attachment 2 - Access standards); Submit exception requests to MLTC, if needed	1/1/2016	1/1/2017	On Target	Network Contracting
Provider Contracting Adequacy Completed	1/1/2016	10/1/2016	On Target	Network Contracting
Draft Contract packet approved by MLTC (standard documents, contract, credentialing, FAQ)	1/1/2016	4/1/2016	On Target	Network Contracting
Provider Contracts developed / approved with all State requirements	1/1/2016	3/1/2016	On Target	Network Contracting
Implement Contracting Strategy (mailing, telephonic, face to face, key provider)	3/15/2016	1/1/2017	On Target	Network Contracting
Monitor and Track Progress / Adjust Resources and Methodology, as needed	3/15/2016	1/1/2017	On Target	Network Contracting
Develop and Implement special contracting for behavioral health requirements and commitment	3/15/2016	1/1/2017	On Target	Network Contracting
Develop and Implement National Contracting Strategy (state specific contract amendments)	3/15/2016	1/1/2017	On Target	Network Contracting
Develop and Implement Subcontractor strategy including contracting and oversight--Vision, Lab (CLIA), Radiology	3/15/2016	1/1/2017	On Target	Network Contracting
Develop transportation strategy	3/15/2016	6/1/2016	On Target	Network Contracting
Develop chiropractic strategy	3/15/2016	1/1/2017	On Target	Network Contracting
Develop P4P Incentive Program	3/15/2016	1/1/2017	On Target	Network Contracting
Network Adequacy Provider file to MLTC via provider enrollment file minimum of 90 calendar days prior to start	3/15/2016	1/1/2017	On Target	Network Contracting
Audit Find a Provider (FAP)	9/1/2016	Ongoing	On Target	Network Contracting

Customize Credentialing Policy & Procedures (30 calendar days to complete, include subcontractor) - submit to MLTS for approval	1/1/2016	4/1/2016	On Target	Provider Data Mgmt. (PDM)
Assure all providers enrolled with MLTC	1/1/2016	Ongoing	On Target	Network Contracting
Hire and train new staff	3/15/2016	10/1/2016	On Target	Provider Data Mgmt. (PDM)
Configure Emptoris (contract management system)	3/15/2016	5/1/2016	On Target	Provider Data Mgmt. (PDM)
Create credentialing NE packet (State specific and non-standard requirements / state validation sources)	1/1/2016	4/1/2016	On Target	Provider Data Mgmt. (PDM)
Configure Portico (provider management system / hierarchy & business unit configuration)	3/5/2016	5/1/2016	On Target	Provider Data Mgmt. (PDM)
Load Provider information into Portico with required information (evaluate loading state data provided, as contracts received)	3/15/2016	1/1/2017	On Target	Provider Data Mgmt. (PDM)
Audit Provider Load Information	8/1/2016	Ongoing	On Target	Provider Data Mgmt. (PDM)
Portico to Amisys interface configuration complete	5/1/2016	10/1/2016	On Target	Provider Data Mgmt. (PDM)
Conduct Credentialing Committee meetings (increased frequency as needed)	5/1/2016	Ongoing	On Target	Provider Data Mgmt. (PDM)
Provider Relations				
Customize Policy & Procedures for NE Requirements (including appointment availability and referral access)	3/15/2016	6/1/2016	On Target	Provider Relations
Hire and Train Provider Relations Staff (available 7 am - 8 pm for PR; 8 to 8 for clinical RX, anytime for non-routine/ emergent)	5/1/2016	10/1/2016	On Target	Provider Relations
Define Provider Engagement / Relations Strategy (including BH integration)	3/15/2016	7/1/2016	On Target	Provider Relations
Configuration of provider call center, separate RX line or menu option	3/15/2016	1/1/2017	On Target	Provider Relations
Identify key providers and associations (collaborate with contracting)	3/15/2016	5/1/2016	On Target	Provider Relations
Develop Provider Training and Outreach Plan (includes website)	5/1/2016	7/1/2016	On Target	Provider Relations
Develop Provider Handbook with all requirements, MLTC approval calendar days prior , post to website	6/1/2016	10/1/2016	On Target	Provider Relations
Provider Billing Manual updated	6/1/2016	11/1/2016	On Target	Claims/Config
Develop additional provider training materials, State review / approval	6/1/2016	1/1/2017	On Target	Provider Relations
Turn on online provider directory and print directory	10/1/2016	10/1/2016	On Target	Provider Relations
Conduct Provider "town halls" provider forums	9/1/2016	Ongoing	On Target	Provider Relations
Conduct Provider Orientations within 30 days of contracting(welcome packet / orientation materials)	9/1/2016	1/1/2017	On Target	Provider Relations
Conduct provider " Open Mic " calls and/or other implementation provider outreach, as needed	9/1/2016	Ongoing	On Target	Provider Relations
Establish Provider Advisory Committee (RX, BH providers included)	3/15/2016	1/1/2017	On Target	Provider Relations

Establish monthly provider newsletter	8/1/2016	Ongoing	On Target	Provider Relations
Provide encryption software on request to provider to allow exchange of member data via email	9/1/2016	1/1/2017	On Target	Provider Relations
Establish provider complaint system (submit to MLTC 45 days prior)	6/1/2016	10/1/2016	On Target	Provider Relations

Ensuring and Assessing Geographic Distance Access Standards. In accordance with the requirements set forth in "Attachment 2 – Access Standards", NTC shall ensure compliance with the geographic distance access standards set forth below. NTC acknowledges that the classification of counties as urban, rural and frontier is included in "Attachment 3 - Nebraska Counties Classified by Urban/Rural/Frontier Status", with classifications based upon data from the most recent U.S. Census.

Provider Type	Access Standard
Primary Care Physicians	Two or more contracted PCPs within 30 miles of the personal residences of members in urban counties; one or more contracted PCPs within 45 miles of the personal residences of members in rural counties; one or more contracted PCPs within 60 miles of the personal residences of members in frontier counties.
High-Volume Specialists (including cardiologists, neurologists, hematologists/oncologists, OB/GYNs, and orthopedic physicians)	One or more high-volume specialist within 90 miles of the personal residences of members
Retail Pharmacies	Through its fully integrated affiliate, NTC shall provide one or more network retail pharmacies within five miles of 90% of members' personal residences in urban counties; one or more network retail pharmacies within 15 miles of 70% of members' personal residences in rural counties; and one or more network retail pharmacies within 60 miles of 70% of members' personal residences in frontier counties.
Behavioral Health Inpatient and Residential Service Providers	NTC will 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. In the event MLTC determines that no inpatient providers are available within the access requirements, NTC will develop alternative plans for accessing comparable levels of care, instead of these services, subject to MLTC approval.
Behavioral Health Outpatient Assessment and Treatment Providers	NTC will provide adequate choice of behavioral health outpatient assessment and treatment providers within 30 miles of members' personal residences in urban areas; two or more providers within 45 miles of members' personal residences in rural counties; and two or more providers within 60 miles of members' personal residences in frontier counties. In the event rural or frontier county access requirements cannot be met due to lack of behavioral health providers, NTC will utilize telehealth options.

Measuring and Monitoring Compliance with Geographic Distance Access Standards. Using our best-in-class network access mapping tool, NTC will ensure compliance with geographic distance access standards primarily through regularly-scheduled network mapping exercises and ongoing monitoring activities. NTC's Network Leadership will generate Quest Analytics tables and maps to plot member and provider locations by zip code and analyze the information, considering the prevalent modes of transportation available to members against our distance standards and those developed by the State. Quest Analytics is a "best in class" network access mapping software that enables us to measure access using multiple variables and to quickly assess travel distance issues. Prior to the program start date, we will conduct access mapping on a weekly basis for the provider types most relevant to members. After implementation, we will conduct such network accessibility mapping at least monthly until six months after go-live or until travel distance standards are met. At that point, we will begin network access mapping every quarter (or per State requirements) as a component of our broader semi-annual Access and Availability Evaluation and to submit required network reports to the State. The Director of Provider Relations and Network Development will lead the scheduled departmental reviews of Quest Analytics tables and maps. The maps provide a visual, high-level view of any gaps. The tables use actual member residence data and allow us to identify at the zip code level any coverage gaps. The tables also will show the municipality and county in which each zip code is located. At a minimum, the provider specialties we will review include, but are not limited to:

- Allergy
- Cardiology
- Dermatology
- Endocrinology
- Family/General Practice
- Gastroenterology
- General Surgery
- Internal Medicine
- Neonatology
- Nephrology
- Urology
- Neurology
- Neurosurgery
- Obstetrics and Gynecology
- Occupational Therapy
- Oncology/ Hematology
- Ophthalmology
- Orthopedics
- Otolaryngology
- Pathology
- Pediatrics
- Physical Therapy
- Psychiatry (adult)
- Psychiatry (child and adolescent)
- Radiology
- Reconstructive Surgery
- Rheumatology
- Speech Therapy

Ensuring and Assessing Appointment Availability Access Standards. NTC will ensure compliance with appointment availability access standards in accordance with all requirements set forth in "Attachment 2 – Access Standards". As further described in our response to Question 41, NTC will audit compliance with appointment access and wait time standards, as well as physician 24-hour availability, through our formal quarterly audit program. We will conduct all audits in a non-punitive way, using primarily outside vendors with follow-up education and remediation conducted by NTC's Provider Relations (PR) staff. In addition, we will monitor compliance using other approaches such as through our Post Primary Care Physician (PCP) Appointment Survey Program; during onsite Provider Relations (PR) Representative Provider office visits; through the analysis of CAHPS member satisfaction (for both appointment availability and wait times) and Provider Satisfaction Survey, member and provider Complaint/Appeal, utilization management and other data; and from input received from our members and providers through call center inquiries and Advisory Committee feedback. A formal, comprehensive analysis of PCP service hours is performed annually, the results of which are reported to NTC's Quality Assessment and Performance Improvement Committee (QAPIC). Although an undesirable outcome, consistent failure to meet approved standards is grounds for dismissal from the NTC provider network.

Ensuring and Assessing Cultural Competency among Network Providers and Subcontractors. NTC will build upon the *experience* and *successes* of our parent company, Centene, whose health plans have provided culturally competent services to all members, including those with Limited English

Proficiency (LEP), those with disabilities, and those with diverse cultural and ethnic backgrounds for more than 30 years. NTC will meet State and federal requirements (per 42 CFR 438.206), but is also committed to fostering a culturally competent environment among our network providers and subcontractors. Building upon this foundation, NTC will support the delivery of services in a culturally competent manner, with the expectation that all members be treated with dignity and respect. These values are fostered through provider and subcontractor training to ensure a network that reflects the diversity of our membership.

NTC analyzes population data available through the U.S. Census, the FQHC Uniform Data System, and utilization of our free interpretive services and translation requests to ensure our network reflects the culture of our members. We recruit providers from within communities we know have a high prevalence of non-English speaking members. Although language is one measure of diversity, NTC recognizes the importance cultural competency has in engaging and retaining members in care and providing services that meet their needs.

Promoting Culturally-Appropriate Care through NTC's Provider Network. Culturally-appropriate care by its very nature is delivered by a provider who can relate to the member, beyond language, and provide services and support with ***sensitivity, understanding, and respect for the member's culture***. We have designed our care management and service delivery model and processes to identify and respond to what is important to each individual, including strengths, goals and cultural considerations, so each member understands how and why to access appropriate care, feels comfortable, and is empowered to do so. Our MemberConnections Representatives, staff hired from the communities we serve to provide on-the-ground member service, offer invaluable insights unmet community needs which may have the potential to be resolved at the provider level. When developing provider outreach and engagement strategies, we take into account all cultures. For example, NTC is committed to serving our Native American members through engagement with and inclusion of Tribal providers; we continue to communicate with each of the tribes headquartered in Nebraska to ensure their awareness of service availability. Additionally, we are aware of the Somalian and Micronesian refugee populations located in Lincoln, and that refugees are eligible to receive eight months of Medicaid coverage. We are committed to ensuring these members receive culturally-appropriate care through our provider network. In speaking with providers across the region, an FQHC in Omaha shared that its ZIP code, 68111, has a very high level of child poverty, a 26% unemployment rate, and that the significant migrant and refugee populations result in 25 different languages spoken among their patient base, 16% of which speak English as their 2nd language. The top notable languages outside of English that have been mentioned by providers across Nebraska include Spanish, Kurtish, Vietnamese, Sudanese, Somalian, Syrian and the Micronesian languages. NTC will create an environment of cultural awareness by implementing the NCQA Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards), as well as the Americans with Disabilities Act standards for the basis of programs and policies. Our policies and procedures, administration and service practices the value of providing culturally competent care, including honoring members' beliefs, sensitivity to cultural diversity, and fostering in providers and subcontractors attitudes and interpersonal communication styles which respect to members' cultural backgrounds. These policies and procedures are communicated to all providers and subcontractors to ensure we are creating an environment of cultural competency for the member. Implementing CLAS standards provides us clear direction to ensure that we provide culturally competent services to our members. We will implement and conduct continuous quality improvement for the CLAS standards, through implementation of our Cultural Competency Plan and provider and subcontractor training in collaboration with local advocacy and community groups. Adhering to the CLAS standards, we will work to minimize physical, mental, and cultural barriers to care and to preserve the dignity of our members. Additionally, we encourage our providers to assess their practice using CLAS standards and offer our provider network training resources on culturally competent health care such as the *Physician Toolkit and Curriculum: Resources to Implement Cross-Cultural Guidelines for Medicaid Practitioners* available at

https://www.thinkculturalhealth.hhs.gov/Content/ContinuingEd.asp. This will be located in the located in the Practice Improvement Resource Center on the Provider Portal. Building on best practices established in our affiliate health plans, NTC will establish a CLAS Task Force that will be responsible for the oversight and maintenance of our framework and commitment to ensure that members receive care and services that are delivered in a culturally and linguistically sensitive manner. Chaired by our Vice President of Compliance, the Task Force will include management staff from our Customer Services, Provider Services, Contracting and Network Development, Medical Management, and Quality Departments, as well as our Chief Medical Officer (CMO) and other senior leadership staff. The Task Force evaluates the effectiveness of our cultural competency strategies and initiatives, and reports results to our Quality Assessment and Performance Improvement (QAPI) Committee, which incorporates relevant data and information in our annual QAPI Work Plan and subsequent QAPI Evaluation. The CLAS Task Force will meet quarterly, and will annually update the Cultural Competency Plan and evaluate the effectiveness of cultural competency strategies, including interpreter services provider training.

Ensuring and Assessing After-Hours Provider Access Standards. NTC will ensure that members in all areas of the service region have access to providers who offer morning care before 8:00 AM, evening care after 5:00 PM and weekend hours, in addition to scheduled daytime hours. Our approach includes promoting physicians to become PCMH certified where extended hours are a requirement of that program.

NTC Encourages Providers to Expand Service Hours. During provider contracting and orientation, NTC staff will solicit information regarding available office hours. NTC will proactively support and monitor providers in their efforts to ensure or expand access through increased hours of operation. For our members' convenience, providers' morning, evening and weekend hours are noted in the Provider Directory and online via Find-A-Provider functionality. One of the best examples of an NTC affiliate engaging with providers to develop creative solutions for expanding service hours comes from Louisiana Healthcare Connections (LHCC). During regular meetings with closely engaged practices in LHCC's network, they brought up the concern of patients visiting the Emergency Room (ER) and Urgent Care (UC) clinics instead of calling or coming to their PCP's office/medical home. Some members simply used these alternatives because their PCP's office was closed after normal business hours. The practices expressed interest in remaining open for longer hours, but not being able to cover the cost of staffing to do so. The LHCC finance team worked with one of Centene's corporate actuaries to research usage of ER and UC amongst our members since 2014. In November 2015, a financial model was developed that determined if LHCC enhanced the reimbursement for after-hours CPT codes, the practices could choose to staff and remain open. Additionally, LHCC could keep members connected with their medical home after hours and reduce unnecessary costs (testing, inaccurate diagnoses, inaccurate prescriptions) attributed to care in the ER and UC's. Not only does this provide access to working families who cannot schedule routine appointments during normal office hours, it gives our providers and members the opportunity to increase access in the evenings, weekends and holidays in their medical home.

NTC Requires 24-Hour Accessibility And After-Hours Coverage. Regardless of whether PCPs offer morning care before 8:00 AM, evening care after 5:00 PM, or weekend hours, NTC requires that a PCP or designee must be available via an answering service, pager, or instructions that provide members with access to an on-call medical professional any time of day. NTC will arrange for members to receive transportation services to and from after-hours and weekend provider appointments. NTC will monitor compliance with accessibility and after-hours coverage standards by conducting regular "secret shopper" access surveys, the results of which are reported to NTC's QAPIC.

Ensuring Network Inclusion of PCPs. NTC shall consistently demonstrate that each member has an ongoing source of primary care appropriate to his or her needs and a person formally designated as

primarily responsible for coordinating the health care services furnished to the member. NTC's Primary Care Provider (PCP) program will include all of the traditional specialty options for the provision of primary care services (internal medicine, family practice, general practice, pediatrics and OB/GYN) plus the inclusion of additional physician specialties based upon the individual member's health status, chronic health conditions, and/or individual care plan. Thus, an individual member who might benefit by having a cardiologist, oncologist, pulmonologist, endocrinologist, psychiatrist or other specialist effectively serve as his or her primary medical provider can choose a specialist as their PCP that best understands and can meet their needs. Additionally, with the enactment of recent legislation, NTC is committed to expanding member access to primary care through the inclusion of nurse practitioners, with oversight from a PCP, in to our provider network.

Ensuring Network Inclusion of Behavioral Health Providers. NTC's behavioral health (BH) team has managed behavioral health services for numerous state Medicaid, CHIP and special needs populations for more than 20 years. To ensure network adequacy in anticipation of additional membership and varying groups of Medicaid enrollees in Nebraska, our BH team has developed partnerships with appropriately credentialed behavioral health providers to assure the availability of behavioral health services to both adults and children and to meet the access requirements as described in "Attachment 2 – Access Standards". Our BH team has secured agreements with regularly utilized BH provider groups including Boy's Town and each of the state's six BH regions, and is currently reaching out to all mental health authorities within Nebraska. Our Nebraska BH provider network will consist of:

- BH Outpatient Facilities
- BH Hospitals
- BH Outpatient Therapists and Prescribers
- FQHCs
- Substance Use Disorder (SUD) Facilities

The BH Outpatient therapists (groups and individuals) are comprised of MDs, ARNPs, Physician Assistants (PAs), PhD Level and Master's Level Psychologists, and Social Workers/Professional Counselors/Marriage and Family Therapists.

BH Telemedicine Services in Nebraska. Our BH team is developing innovative partnerships with Nebraska BH providers in collaboration with medical providers to address the needs of children in rural areas who have historically had limited access to both physical and behavioral health services. Specifically, NTC has been working with CHI Health's network of providers to make behavioral health services available to members in rural areas. NTC also will utilize telemedicine to serve both adult and pediatric populations effective January 1, 2017.

Ensuring Network Inclusion of High-Volume Specialists. NTC's specialist physicians will include a robust network of specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical and behavioral health needs of the Nebraska populations we will serve without imposing excessive travel requirements on our members.

Ensuring Network Inclusion of Federally Qualified Health Centers and Rural Health Clinics. Because NTC recognizes that each Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) throughout the state has different needs, NTC has individually met in-person on multiple occasions with and is working to formalize partnerships with all seven FQHCs in Nebraska, in addition to All Care, located in Council Bluffs, Iowa. The NTC team has also met with many RHCs located throughout Nebraska. In the event a contract cannot be reached between NTC and any FQHC or RHC, NTC will notify MLTC. Additionally, NTC has entered into a formal partnership with HCAN, Nebraska's Primary Care Association. NTC's partnership with HCAN will serve as the lynchpin of

efforts to facilitate collaboration and explore synergies between Nebraska's FQHCs. We will also seek to facilitate collaboration between the FQHC community and other partners such as the behavioral health regions. For example, we learned during a visit to Midtown Health Center in Norfolk that the Midtown would like to explore ways to better coordinate services and share data with Region 4 Behavioral Health and Faith Regional Health Services. NTC recognizes that as the common denominator in partnership with all three parties, it has a unique opportunity to broker communication and ongoing collaboration to support fully integrated care.

NTC is committed to working with all FQHCs to achieve and/or maintain the highest level of PCMH accreditation. Below are examples of the FQHC-specific programs and pilots NTC plans to support for each:

Charles Drew Health Center (Omaha)

- Assistance with funding a Healthy Homes Assessment Officer
- Assistance with interpretive services
- Support for additional transportation needs

Community Action Partnership of Western Nebraska Health Center (Gering)

- Support for a Chronic Disease Manager to help serve the Panhandle
- Strengthening their ED/Hospital relationship
- Provide more access to data, in addition to defining the results
- Effort toward innovative solutions to educate diabetics in the area, including group visits
- Support of diabetic education initiative specific to the Hispanic population in the Panhandle
- 1-on-1 behavioral health focus

Good Neighbor Community Health Center
East-Central District Health Department (Columbus)

- Support of their language line
- Funding for home monitoring pilot
- Nutrition courses/cooking lessons for diabetic/obese members (very high obesity rate among kindergarteners locally)
- Support of telemundo novella pilot

Heartland Health Center (Grand Island)

- Support for language services
- Support in reaching members who have incorrect phone numbers and addresses on file with DHHS

Midtown Health Center (Norfolk)

- Assistance with collaboration between Faith Hospital and Behavioral Health Region 4
- Provide more access to data, in addition to defining the results
- Coordinate introduction of Midtown to Avera Health to expand BH services

OneWorld Community Health Centers, Inc. (Omaha)

- More frequent Provider Relations/Engagement meetings
- Support with education and outreach surrounding the chlamydia crisis
- Provide more access to data, in addition to defining the results

People's Health Center (Lincoln)

- Support for a social worker/case manager on-site
- Assistance with language line

Ensuring Network Inclusion of Urgent Care Centers. NTC is committed to ensuring that members have access to services when they need them, and we believe that ensuring access to urgent care is critical. NTC recognizes its responsibility to do whatever it reasonably can to prevent an urgent health

care matter from becoming an emergency. Thus, we will utilize all available resources within our network, including CVS/pharmacy's seven Minute Clinics throughout Nebraska, to share information with our members about and facilitate access to urgent care services such as immunizations and extended office hours when our members need them. NTC will work with urgent care centers to administer immunizations as a way to expand access and share data through our provider portal.
While we encourage our primary care physicians (PCPs) to offer flexible and extended office hours, we know that many urgent health care conditions arise during after-hours or on weekends. Accordingly, we will use established utilization management guidelines in encouraging and evaluating the availability and utilization of urgent care services. We also encourage members to seek emergency services when they believe a medical emergency exists, and we will educate our members regarding the appropriate use of urgent care through the Member Handbook, articles in our Member Newsletter, and engagement with Customer Service Representatives.

Ensuring Network Inclusion of Retail Pharmacies. NTC's pharmacy program will integrate seamlessly with physical health, behavioral health and provider and member services through shared technology, clinically trained and experienced staff, and a network of pharmacies to meet member needs, providing coverage of all prescription and over-the-counter drugs as applicable to the Medicaid FFS pharmacy benefit. NTC will subcontract with our affiliate US Script, Inc.® as our pharmacy benefit manager (PBM). Established in 1999, US Script combines comprehensive drug management services with extensive Medicaid experience, functioning as the PBM for 15 Centene-affiliate Medicaid plans in 15 states, representing 4.5 million members. Populations include State Children's Health Insurance Program (CHIP), as well as Aged, Blind or Disabled (ABD), Foster Care, Intellectual and Developmental Disabilities (IDD) and Long Term Services and Supports (LTSS), in addition to other state-sponsored/hybrid programs and Medicare (Special Needs Plans). US Script contracts directly with chain and independent pharmacies as well as pharmacy services administration organizations (PSAO), and is currently contracted with more than 66,000 pharmacies nationwide and over 450 pharmacies in the state of Nebraska, including those pharmacies embedded in Nebraska's FQHCs. We are working in conjunction with the Nebraska Pharmacists Association to expand our current pharmacy network. NTC will keep an up-to-date pharmacy directory online for public access. US Script offers 24/7/365 Customer Service Support to our pharmacy network.

Ensuring Network Inclusion of Hospitals. NTC recognizes the importance of having quality hospital services available when our members need them. Accordingly, NTC will be entering into value-based contracts with Nebraska's two major hospital systems, CHI Health and ENHANCE Health Network, who serve the highest density population areas along with rural communities. In addition, NTC has distributed LOAs to all hospitals in Nebraska. Based upon LOAs returned thus far, we anticipate an extremely high hospital participation rate with NTC.

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ATTACHMENT 5

KEY STAFF RESUMES

Key Staff Resumes

As possible, submit resumes of proposed key staff as described in Section IV.X - Transition and Implementation.

Nebraska Total Care, Inc. has submitted resumes for our proposed key staff as part of the Corporate Overview Section I. Summary of Bidder's Proposed Personnel/Management Approach.

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PRELIMINARY IMPLEMENTATION PLAN

ATTACHMENT 5

PRELIMINARY IMPLEMENTATION PLAN

Preliminary Implementation Plan

Submit preliminary implementation plan as described in Section IV.X - Transition and Implementation.

Please see the Nebraska Total Care (NTC) Preliminary Implementation Plan in **Attachment 5. IV.X** which identifies the tasks, staff responsibilities and timelines NTC will use to ensure its network and operations are set up no later than three months before the implementation date of 1/1/17. Below, we discuss our experience with new health plan/product implementations and the project management methodology NTC will use to ensure *we will be ready*.

Implementation Experience

Across the nation and across all lines of business, Centene Corporation (Centene), NTC's parent company, has achieved an impeccable record of successful implementations that represent more than **2,850,000 new members** across 15 states. This includes new health plans, reprocurements/service area expansions, and product expansions. Our high touch, local approach to implementation and state-centered operating models are at the core of our business philosophy and ensure we will become an efficient and transparent partner with the Division of Medicaid and Long Term Care (MLTC). During the last five years alone, Centene has successfully implemented new managed care plans in highly penetrated managed care markets similar to what we will experience in Nebraska, in states as diverse as Washington and Missouri. We have also seamlessly implemented new health plans (network and operations) in multiple markets where the State transitioned from Medicaid Fee-for-Service (FFS) to managed care. Centene also has completed a number of significant program expansions including adding Aging, Blind and Disabled populations and services such as Behavioral Health and Long Term Services and Supports that required extensive network development and staff recruitment. Based on these experiences in implementing our flexible healthcare delivery model, we will tailor our approach to meet/exceed all MLTC requirements and expectations.

Centene's efforts in Nebraska are already well underway. Over the past several years our Business Development team has been on the ground in Nebraska creating strong partnerships across the state that will serve as a strong foundation for our implementation and our ongoing program operations. Immediately following the contract award, as we begin our actual implementation activities we will involve our Provider Engagement (PE) team to continue identifying opportunities to engage providers and community stakeholders to improve our knowledge of and programs in Nebraska. Also post contract award, the PE team will schedule provider trainings and town hall meetings to create a strong handoff, building on the trusted relationships we have established to create tremendous momentum within our implementation process.

Project Management Methodology.

Project Structure and Resources. Please see our ***Pre-Implementation Work Plan (Attachment 5. IV.X*** for details on ***Resource Allocation and Deployment.*** Immediately upon notice of contract award, NTC will deploy a dedicated Transition Leadership Team (TLT) who will work onsite in Nebraska and in collaboration with Centene's corporate ***Business Implementation and Integration Team (BIIT) – collectively the Team***. The Team will be comprised of veteran executive, management and technical staff who understand how to and have implemented Medicaid programs and have significant collective experience in health plan operations, network development, project management and new health plan implementations. The BIIT team has been on the ground in Nebraska creating partnerships with state and local entities preparing to manage the Work Plan, resources and schedules to help ensure timelines are met. The team is working to identify and manage risks; and manage cross-functional teams to achieve project goals addressing staffing, facilities, other operational issues, and all the elements necessary of the implementation as designated by MLTC:

- Member services
- Network development and management
- Quality management, including credentialing
- Care management

- Utilization management
- Transition and care coordination
- Information systems management
- Claims management
- Grievances and appeals

The TLT will be responsible for directing program and process design and overseeing development of policies and procedures related to the above essential program elements. The TLT will also oversee network provider contracting, new Provider training and credentialing, recruitment and training of all permanent health plan staff, and systems testing. The TLT will also work closely with newly hired health plan staff to prepare for and participate in the readiness review and collaborate with health plan staff to ensure the effective transition of health plan operations post Go-Live. The Transition Team will continue to be available to health plan staff as advisors for no less than six months post Go-Live. To ensure an on-time operational start date and effective implementation we will use a project management approach that consists of six key elements:

- A consistent project management lifecycle methodology with defined stages and activities that ensure progress toward implementing the health plan
- The deployment of dedicated, highly specialized professionals with defined levels of authority to implement contract requirements
- Systematic review of implementation progress, issue/risk identification/assessment, alternatives analysis and resolution
- Co-management of the project blending the market expertise of our TLT, and the implementation expertise of the BIIT and other Centene corporate resources
- A customized communications plan that ensures adequate and timely reporting to executive management and department personnel and ensures consistent communication between implementation participants
- A set of industry standard and proprietary tools to define accountability, track progress, and identify and mitigate risks to implementing the health plan

Our implementation model has standards for, and delivers excellence around, how projects are organized to support resource planning, fiscal responsibilities and risk management components that are critical to ensuring the overall success of our implementation. The Team will customize Centene's proprietary and proven implementation tools and processes to ensure we address all Heritage Health contract requirements. They also will develop a detailed Work Plan that outlines all necessary activities, resources, staffing, and key dependencies such as timeframes and completion dates. As part of the Work Plan development process, the Team will assess contractual "musts and shalls" to clearly understand each requirement, determine activities required to address each, and identify associated issues or risks.

For those areas requiring new or more detailed approaches or techniques, we will develop secondary Work Plans, which will be maintained and monitored by workgroups and overseen and incorporated into the overall Work Plan by the Team. These workgroups will report progress/barriers into Weekly Project Team meetings and Project Team leads and Senior Leadership will report progress to the Enterprise Implementation Steering Committee (Steering Committee), which will monitor the overall project Work Plan and direct/oversee course changes when and if necessary. Our consolidated team of BIIT and Transition Team resources, with oversight by the Steering Committee, will ensure integrity of the process and avoid any potential communication gap that could jeopardize our implementation success. Further, we will convene pre-implementation Provider and Community Advisory Groups and meet continuously with MLTC to obtain input into program, process and network design; work through start-up issues; ensure we meet all Contract requirements; and guarantee our ability to deliver service excellence members and Providers expect from the Heritage Health Program on Day One. In the area of child welfare, we have recognized a great need for training information and resources and therefore have conducted more than 40 trainings from December 2012 to the present. Attendees have totaled more than 1,691 persons, including Foster Care parents, Judges, Guardian ad Litems, Court Appointed Special Advocates (CASAs), case managers, and others.

Project Lifecycle Methodology. Centene's project lifecycle methodology provides a solid framework for managing key implementation activities according to a defined set of standards. This methodology provides the same framework as a typical "Project Office" in which resources and tools are deployed in a standardized manner. This approach, along with oversight by the Team, enables us to effectively meet tight timeframes, manage cross-functional activities, and establish clear expectations with all stakeholders and participants of the activities needed. With this approach we effectively meet MLTC timeframes, manage cross-functional activities, and establish clear expectations with all stakeholders and project participants.

This Lifecycle enables us to manage our implementation through the various phases of implementation including:

- Our initial needs assessment (based upon market and contract review), assignment of resources and development of a detailed project Work Plan with due dates clearly outlined
- Applying standards and metrics to each phase of the implementation/development life cycle
- Assigning functional owners who can make decisions and ensure project progress/success
- Assigning key milestones and deliverables to each phase with specific ownership
- Reporting weekly status to key stakeholders
- Continually assessing for risk and developing risk mitigation strategies to ensure resolution of every issue
- Clarifying escalation paths at the beginning of the project to facilitate timely response, priority, and resolution.

Risk Management: Issue Identification and Resolution. NTC's BIIT applies a project risk methodology to each project. Our goal is to avoid, reduce or mitigate exposure from any issues on a timely basis. As part of this process, Risk is defined as "an uncertain event or condition, if it occurs has a positive or negative effect on the objectives of the project". Risk consists of 3 components: 1) Probability of occurrence; 2) Impact on the program; and 3) Time frame of occurrence if the risk is not mitigated. Once these components are determined, a Risk Score is calculated and level of risk assigned to each issue as it occurs. A low risk results in little or no impact on the performance or project; a moderate risk may cause some increase in cost or disruption of the schedule; and a high risk is likely to cause a significant increase in cost or disruption to the overall schedule. Remediation plans are determined by risk level for each issue. Risks and challenges facing MCO's in Nebraska include technology and transportation access. Our teams have begun developing collaborations with providers and other stakeholders to address these issues especially in rural and frontier areas where they are particularly impactful upon health access.

As a component of our effort to mitigate these challenges, we will engage telehealth resources and practices such as those within the University of Nebraska Medical Center and other entities.

Our risk management processes align to the specific risk identified. For instance, normal management attention follows a low risk score whereas high-priority management attention results in an in-depth response plan for a high risk score. Detailed work plans with key milestones and deliverables are determined for each risk identified as moderate or high. Within our work plans we specifically address key Nebraska pain points and challenges with a fresh, local perspective creating effective communication channels to help shape and inform our engagement. Workgroups are formed and we report status to both the Executive Level Steering Committee as well as the TLT during regular check in meetings until the issues identified are resolved. We will continuously report risk identification and mitigation status to MLTC during our regular meetings, or verbally, or as soon as is necessary. With expertise in numerous program implementations, we know how to identify risks and work hand-in-hand with MLTC to resolve challenges in a collaborative partnership. We continually assess risks and repeat the process throughout the project and may result in updates, changes, and additions to the overall project work plan to resolve each issue identified.

Communications with and Reporting to MLTC. As part of our standard process, we will request regular recurring meetings between MLTC and NTC to ensure we provide MLTC regular updates and progress reports. Typically, these meetings are held weekly with agenda items developed in advance of the meetings. We take a team approach to these meetings by ensuring we include agenda items from the MLTC as well as NTC. Our goal will be to create an information sharing and problem solving forum in which we can communicate with MLTC at each stage of the implementation process. To foster effective communications we will create committees to focus on community engagement with stakeholders including county governments and others to ensure our program implementation considers all stakeholder concerns and mitigates risks from the outset prior to Go-Live. One such committee is the Native American Health Committee which will include participation from our **Native American Liaison**, Sheina Yellowhair, to ensure we understand, address, and provide solutions to Native American care access barriers. Through our many implementations, we have found these joint meetings to be extremely helpful for all parties. We welcome these ongoing meetings with MLTC as a way to develop a strong initial and ongoing relationship and communication flow with MLTC.

Overall Readiness. As we prepare for go-live, we will conduct a series of internal operational readiness reviews 90 and 30 days prior to go live, including an executive review with the TLT. We will conduct check-in meetings, from weekly to daily 2 weeks prior to go-live. During this time, we will conduct readiness assessments, identify barriers/issues, and report status to the TLT and Centene executives. As issues are identified, we will follow our risk stratification and mitigation processes outlined above. Centene executives approve Cutover when all tasks are complete and readiness is finalized. During this phase, key functions like claims, encounters, IT and Reporting are "tested" once again to ensure all processes and systems are running properly and milestones have been achieved. After Go Live, daily team meetings continue to occur employing the same issue identification/reporting process previously described until resolved.

Network Process Readiness. Centene has significant experience building networks and have already begun this process over the previous two years in Nebraska. The network implementation sub-group will be led by the VP, Network Development and a team of dedicated, experienced contractors on the ground throughout Nebraska. This team of twenty has built numerous statewide networks over the past five years and will continue to do so through the implementation process. To preserve and expand Member access, we will build the most comprehensive network possible, recruiting "any willing provider" interested in contracting with NTC, including physician extenders, and nurse-midwives. In Nebraska, we will prepare

the Network Development Plan using the following materials to ensure compliance: Heritage Health contract templates, RFP requirements, Covered Services, and MLTC access standards. We will download the State Provider network, if applicable into our Contract Relationship Management Prospecting (CRMP) tool and define our strategy/resource requirements and timelines. We will train all network staff to ensure competence and knowledge of all MLTC requirements and begin meeting with key Nebraska provider groups such as the Nebraska Hospital Association, the Health Care Association of Nebraska, and FQHCs to understand practice and referral patterns, Provider needs/concerns and any population nuances specific to rural, urban and frontier regions of Nebraska.
As a part of our Network Development, NTC has been working with ENHANCE Health Network, based in Lincoln. With ENHANCE we have developed a Strategic Network Alliance Agreement, which contains a value-based program tied to quality and network. ENHANCE Health Network consists of nine founding PHOs members (all Nebraska based health systems):

- Bryan Health
- Columbus Community Hospital
- Faith Regional
- Fremont
- Great Plains
- Mary Lanning
- Methodist
- Regional West
- University of Nebraska Medical Center (UNMC)

We have met with other key providers, including those in Behavioral Health and Long Term Care, to form effective collaborations across the health care spectrum. We will also engage large systems and practices and review competitor networks to ensure completeness of our targeted recruitment lists.

As an example, NTC is collaborating with **Vest Psychiatric Services** to expand telehealth services into the North Platte area. Through this pilot, NTC will provide grant funding for infrastructure development and enhanced Care Coordination services for those members engaged in telehealth services with Vest Psychiatric Services. Vest will provide psychiatric nurse practitioners and licensed clinical social workers (or other appropriately licensed BH professional) to help support primary care providers in the North Platte area and expand member choice for BH service providers. In working with Vest to develop this pilot, NTC identified that PCPs in this area have expressed reluctance to refer to telehealth, because they did not fully understand the service and the value of telehealth and the opportunity to connect members with this resource. Therefore, we will provide resources and support to all PCPs during provider orientation to educate providers about telehealth, and for those in North Platte this education will specifically focus on referral and participation in the Vest Psychiatric program.

Once we have completed the above steps, we will deploy local contracting teams that will address specific concerns and understand the nuances of individual urban, rural and frontier communities, patterns of care etc. We have already begun meeting with:

- large systems/academic medical centers/trauma centers/transplant facilities
- local hospitals
- Behavioral Health providers
- Primary Care/Pediatricians/OB-GYNs
- Specialists
- FQHCs/RHCs
- Dentists and orthodontists
- Other Providers—ambulance, long-term care, rehab etc.

We will continue to meet with these health care entities and do so through contract award and beyond. As we learn more, we will continuously refine our recruitment strategy. We will review and amend national contracts such as lab, pharmacy and DME to include the new market region and ensure adequacy

requirements. We also will review our subcontractor recruitment plans and incorporate status reporting into our regular Joint Operating Committee Meetings.

We and our subcontractors will generate frequent geo-access reports throughout the network contracting process and continuously re-prioritize our efforts. For example, we will continuously prioritize all underserved areas or those with identified deficiencies, such as specialties. We understand underserved areas can be in the middle of the most populous regions and not specific to frontier or rural communities. The TLT and the Enterprise Steering Committee will closely monitor all network development efforts and direct course directions as needed to ensure readiness by 3 months prior to 1/1/17.

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ATTACHMENT 5

DRAFT MEMBER HANDBOOK

Draft Member Handbook

Submit a draft copy of the member handbook as described in Section IV.F – Member Services and Education.

Please see the Attachment in Section IV.F - Member Services and Education, Question 29 for the Nebraska Total Care's Draft Member Handbook.

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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DOCUMENT SUMMARY 1

NEBRASKA MANAGED CARE CLIENT ELIGIBILITY DATA RECORD LAYOUT 2

H RECORD - CLIENT ELIGIBILITY HEADER RECORD 2
N, C, X, D RECORD - CLIENT ELIGIBILITY DETAIL RECORD 2
T RECORD - CLIENT ELIGIBILITY TRAILER RECORD 6

NOTES FOR HEALTH PLAN CLIENT ELIGIBILITY HEADER DATA RECORD - "H" RECORD 8

FIELD HHH NEBRASKA MANAGED CARE CLIENT ELIGIBILITY HEADER RECORD 8
FIELD H01 HEADER ACTION TYPE 8
FIELD H02 HEADER DATE/TIME STAMP 8

NOTES FOR HEALTH PLAN CLIENT ELIGIBILITY DETAIL DATA RECORD - "D" RECORD 9

FIELD DDD NEBRASKA MANAGED CARE CLIENT ELIGIBILITY DETAIL RECORD 9
FIELD D01 DETAIL ACTION TYPE 9
FIELD D02 CLIENT MEDICAID IDENTIFICATION NUMBER 9
FIELD D03 CLIENT SOCIAL SECURITY NUMBER 9
FIELD D04 CLIENT NAME 10
FIELD D05 MEDICAL PLAN NUMBER 10
FIELD D06 PROVIDER IDENTIFICATION NUMBER 10
FIELD D07 MEDICAL MEDICAID PROVIDER TERMINATED 10
FIELD D08 VENDOR PROVIDER NUMBER 10
FIELD D09 BEHAVIORAL HEALTH PLAN NUMBER 10
FIELD D10 CAP RATES 11
FIELD D11 DSS AGENCY CODE 11
FIELD D12 CLIENT LIVING ARRANGEMENT 11
FIELD D13 CLIENT NATIONALITY 13
FIELD D14 PREGNANCY RELATED SERVICES FEE INDICATOR 13
FIELD D15 NMC AUTOASSIGNMENT INDICATOR 13
FIELD D16 CLIENT CAP GENDER 13
FIELD D17 SPECIAL NEEDS CLIENT INDICATOR 13
FIELD D18 REASON FOR CLIENTS CASE CLOSING 13
FIELD D19 LOCK IN CODE 14
FIELD D20 LOCK IN PHARMACY NUMBER 14
FIELD D21 LOCK IN PRIMARY PRACTITIONER NUMBER 14
FIELD D22 LOCK IN LICENSE (PRESCRIBING PHYSICIAN NUMBER) 14
FIELD D23 LOCK IN HOSPITAL 14
FIELD D24 FETAL NUMBER 15
FIELD D25 MOTHERS NAME 15
FIELD D26 CARRIER NUMBER 15
FIELD D27 CARRIER NAME 15
FIELD D28 POLICY KEY 15
FIELD D29 SUBSCRIBER SOCIAL SECURITY NUMBER 15
FIELD D30 SUBSCRIBER NAME 15
FIELD D31 RELATION POLICY HOLDER 16
FIELD D32 COVERAGE CODE 16
FIELD D33 EFFECTIVE TPL STARTING DATE 17
FIELD D34 EFFECTIVE TPL ENDING DATE 17
FIELD D35 TPL TOTAL TIMES 17
FIELD D36 PREGNANCY INDICATOR 18
FIELD D37 EXPECTED DATE OF BIRTH 18
FIELD D38 TRANSFER REASON CODE 18
FIELD D39 PAE PROGRAM CODE 19
FIELD D40 RATE GROUP 20
FIELD D41 CLIENT COUNTY 20
FIELD D42 SPECIAL PROGRAM INDICATOR (SPI) CODES 21

FIELD D43 CO-PAY INDICATOR 22

NOTES FOR HEALTH PLAN CLIENT ELIGIBILITY TRAILER DATA RECORD - "T" RECORD 23

FIELD TTT NEBRASKA MANAGED CARE CLIENT ELIGIBILITY TRAILER RECORD 23
FIELD T01 TRAILER ACTION TYPE 23
FIELD T02 TRAILER DATE/TIME STAMP 23
FIELD T03 TOTAL DETAIL RECORDS 24
FIELD T04 TOTAL ENROLLED CLIENTS 24
FIELD T05 TOTAL DIS-ENROLLED CLIENTS 24
FIELD T06 TOTAL TRANSFERRED CLIENTS 24
FIELD T07 TOTAL CAPITATION AMOUNT 1 24
FIELD T08 TOTAL CAPITATION AMOUNT 2 24
FIELD T09 TOTAL CAPITATION AMOUNT 3 24
FIELD T10 TOTAL CAPITATION AMOUNT 4 25
FIELD T11 TOTAL CAPITATION AMOUNT 5 25
FIELD T12 TOTAL CAPITATION AMOUNT 6 25

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

No.	RFP Section	Statement/Question	Page Limit
	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

No.	RFP Section	Statement/Question	Page Limit
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

No.	RFP Section	Statement/Question	Page Limit
	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

No.	RFP Section	Statement/Question	Page Limit
		• 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

No.	RFP Section	Statement/Question	Page Limit
	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

*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-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

*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 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

*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 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

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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	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	$ -	-	-	$ -	$ -

*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	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**

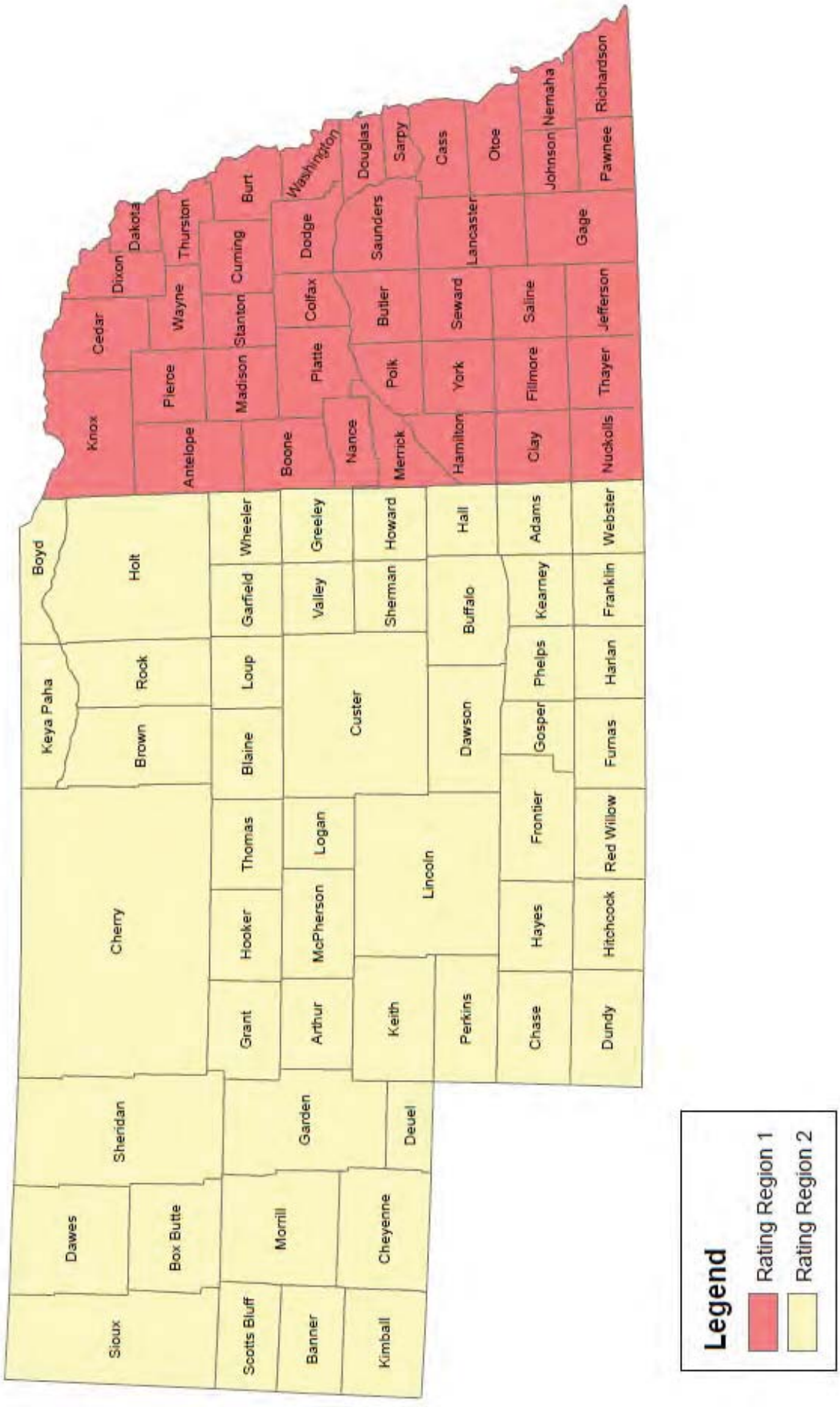
*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

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.

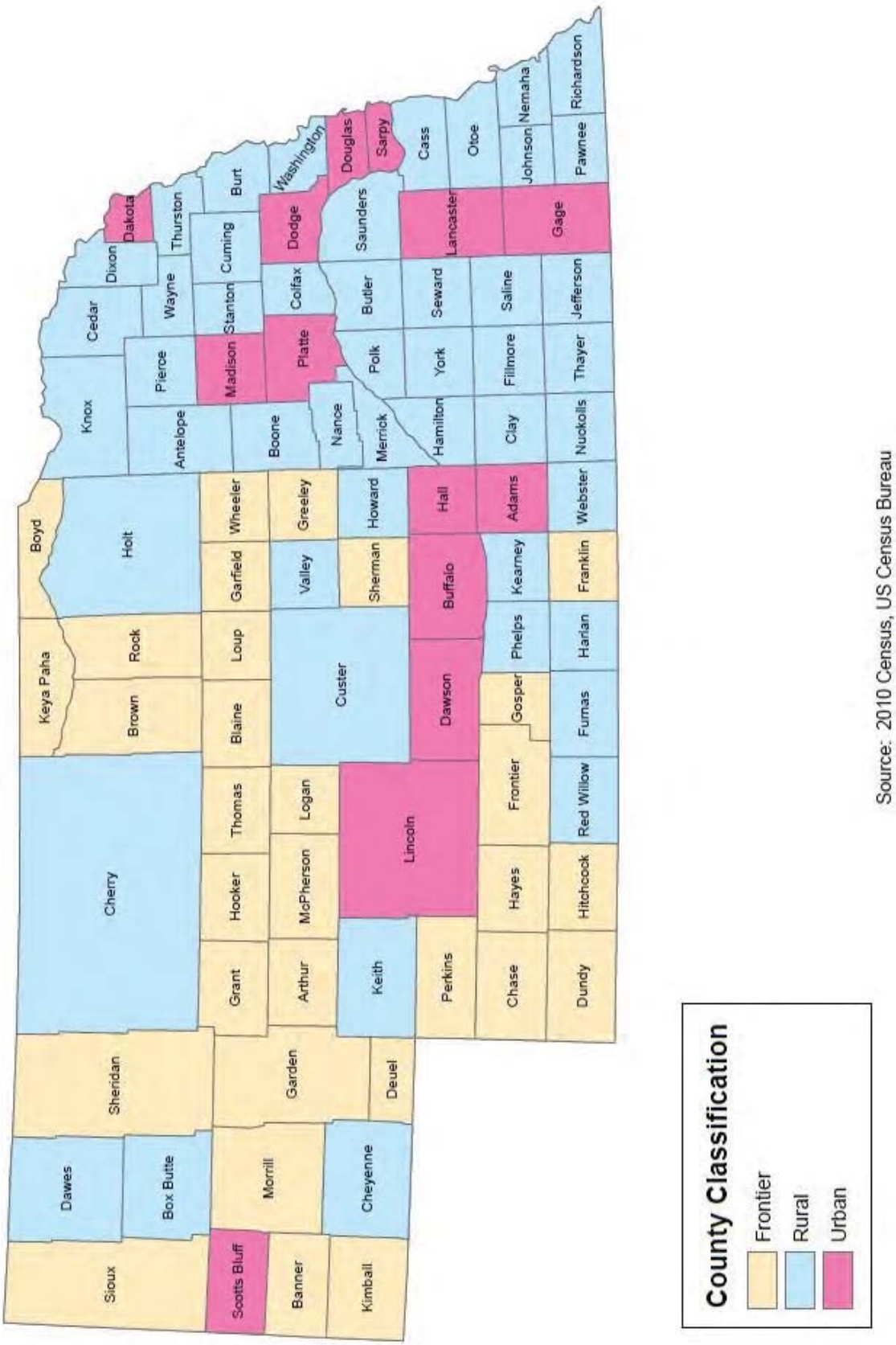
3. Practice develops an operational quality improvement plan for the practice with at least one focus area.

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: _____

TABLE OF CONTENTS

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM i

TABLE OF CONTENTS iii

GLOSSARY OF ACRONYMS 6

GLOSSARY OF TERMS 9

I. SCOPE OF THE REQUEST FOR PROPOSAL 1

A. SCHEDULE OF EVENTS 1

II. PROCUREMENT PROCEDURES 2

A. PROCURING OFFICE AND CONTACT PERSON 2
B. GENERAL INFORMATION 2
C. CUSTOMER SERVICE 2
D. COMMUNICATION WITH STATE STAFF AND EVALUATORS 2
E. WRITTEN QUESTIONS AND ANSWERS 3
F. PRE-PROPOSAL CONFERENCE 3
G. ORAL INTERVIEWS/PRESENTATIONS AND/OR DEMONSTRATIONS 3
H. SUBMISSION OF PROPOSALS 4
I. PROPOSAL OPENING 4
J. LATE PROPOSALS 4
K. REJECTION OF PROPOSALS 4
L. EVALUATION OF PROPOSALS 4
M. EVALUATION COMMITTEE 5
N. MANDATORY REQUIREMENTS 5
O. REFERENCE CHECKS 6
P. SECRETARY OF STATE/TAX COMMISSIONER REGISTRATION REQUIREMENTS 6
Q. VIOLATION OF TERMS AND CONDITIONS 6

III. TERMS AND CONDITIONS 7

A. GENERAL 7
B. AWARD 7
C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION 8
D. PERMITS, REGULATIONS, LAWS 8
E. OWNERSHIP OF INFORMATION AND DATA 8
F. INSURANCE REQUIREMENTS 9
G. COOPERATION WITH OTHER CONTRACTORS 11
H. INDEPENDENT CONTRACTOR 11
I. CONTRACTOR RESPONSIBILITY 11
J. CONTRACTOR PERSONNEL 12
K. STATE OF NEBRASKA PERSONNEL RECRUITMENT PROHIBITION 12
L. CONFLICT OF INTEREST 13
M. PROPOSAL PREPARATION COSTS 13
N. ERRORS AND OMISSIONS 13
O. BEGINNING OF WORK 13
P. ASSIGNMENT BY THE STATE 14
Q. ASSIGNMENT BY THE CONTRACTOR 14
R. DEVIATIONS FROM THE REQUEST FOR PROPOSAL 14
S. GOVERNING LAW 14
T. ATTORNEY'S FEES 15

U. ADVERTISING 15
V. STATE PROPERTY 15
W. SITE RULES AND REGULATIONS 15
X. NOTIFICATION 16
Y. EARLY TERMINATION 16
Z. FUNDING OUT CLAUSE OR LOSS OF APPROPRIATIONS 18
AA. BREACH BY CONTRACTOR 18
BB. ASSURANCES BEFORE BREACH 18
CC. ADMINISTRATION – CONTRACT TERMINATION 19
DD. PENALTY 19
EE. PERFORMANCE BOND 19
FF. FORCE MAJEURE 20
GG. PAYMENT 20
HH. RIGHT TO AUDIT 20
II. TAXES 21
JJ. INSPECTION AND APPROVAL 21
KK. CHANGES IN SCOPE/CHANGE ORDERS 22
LL. SEVERABILITY 22
MM. CONFIDENTIALITY 22
NN. PROPRIETARY INFORMATION 23
OO. CERTIFICATION OF INDEPENDENT PRICE DETERMINATION/COLLUSIVE BIDDING 23
PP. STATEMENT OF NON-COLLUSION 24
QQ. PRICES 24
RR. BEST AND FINAL OFFER 24
SS. ETHICS IN PUBLIC CONTRACTING 24
TT. INDEMNIFICATION 25
UU. NEBRASKA TECHNOLOGY ACCESS STANDARDS 26
VV. ANTITRUST 26
WW. DISASTER RECOVERY/BACK UP PLAN 26
XX. TIME IS OF THE ESSENCE 26
YY. RECYCLING 27
ZZ. POLICY 27
AAA. EMPLOYEE WORK ELIGIBILITY STATUS 27
BBB. CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND INELIGIBILITY 28
CCC. OFFICE OF PUBLIC COUNSEL 28
DDD. LONG-TERM CARE OMBUDSMAN 28
EEE. LICENSE/SERVICE OR OTHER AGREEMENTS 28

IV. PROJECT DESCRIPTION AND SCOPE OF WORK 30

A. PROGRAM DESCRIPTION 30
B. ELIGIBILITY AND ENROLLMENT 33
C. BUSINESS REQUIREMENTS 39
D. STAFFING REQUIREMENTS 44
E. COVERED SERVICES AND BENEFITS 52
F. MEMBER SERVICES AND EDUCATION 67
G. MEMBER MARKETING 82
H. GRIEVANCES AND APPEALS 87
I. PROVIDER NETWORK REQUIREMENTS 93
J. PROVIDER SERVICES 103
K. SUBCONTRACTING REQUIREMENTS 110
L. CARE MANAGEMENT 110
M. QUALITY MANAGEMENT 118

N. UTILIZATION MANAGEMENT 125
O. PROGRAM INTEGRITY 133
P. MCO REIMBURSEMENT 141
Q. PROVIDER REIMBURSEMENT 149
R. SYSTEMS AND TECHNICAL REQUIREMENTS 154
S. CLAIMS MANAGEMENT 161
T. REPORTING AND DELIVERABLES 176
U. CONTRACT MONITORING 180
V. CONTRACT NON-COMPLIANCE 181
W. INTERMEDIATE SANCTIONS 184
X. TRANSITION AND IMPLEMENTATION 187
Y. Termination of MCO Contract 190
Z. FFS CLAIMS MANAGEMENT AND PROCESSING 191

V. PROPOSAL INSTRUCTIONS 196

A. PROPOSAL SUBMISSION 196

Form A Bidder Contact Sheet 199

Form B Notification of Intent to Attend First Pre-Proposal Conference 200

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