AMENDMENT

STATE OF NEBRASKA – DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Nebraska Department of Health and Human Services ("DHHS") and Molina Healthcare of Nebraska, have entered into this Amendment, amending the following Service Contract(s):

EXISTING AGREEMENT NUMBER	AMENDMENT NUMBER
102897-O4	**AMD 5**

AMENDMENTS

I. Additions: The Parties hereto agree to add the following sections:

A. Glossary of Terms

Critical Incident: An actual event or situation that causes serious harm to the health or welfare of a person or negatively impacts the physical and/or mental health of a person or creates a situation of significant risk for serious harm.

Indian Health Care Provider (IHCP): A health care program operated by the IHS or by an I/T/U as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). [42 CFR 438.14(a)].

B. Section C.20.a-c - Dual Special Needs Plans

a. All current HIDE SNPs will adhere to a threshold of 90% coverage for all dual eligibles in the state of Nebraska effective January 1, 2024.

b. All new HIDE SNPs will be required to maintain the 90% threshold beginning in their second year of operation.

C. Section V.E.9.b.ii.14.

14. Crisis Services for Foster Care Youth

D. Section V.H.2.e.

e. Medicaid beneficiaries may now also appeal a denied or untimely prior authorization decision as if it were a denied claim.

E. Section V.L.2.d. – Care and Case Management Services

d. Include members in an Assisted Living Facility as a targeted population for holistic case management.

F. Section V.N.7.d. – Retrospective Utilization Review

d. The MCO must comply with any MLTC requested audits of network provider's clinical utilization to assure compliance with Medicaid requirements.

II. Modifications: The Parties hereto agree to modify the following sections:

A. Glossary of Terms

Grievance: A written or verbal expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee. Or failure to respect the enrollee's rights

regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO to make an authorization decision {42 CFR 438.400(b)].

B. Section V.B.4.c.ii. – Change in Status

ii. The MCO must notify MLTC via ACCESSNebraska, of any other known changes in status, including but not limited to, death, entry into involuntary custody, or incarceration, in a manner and format required by MLTC.

C. Section V.H.3.c.v. – Standard Service Authorization Denial (Effective January 1, 2025)

v. For a standard determination, as expeditiously as a beneficiary's health condition requires, but in no case later than 7 calendar days after receiving the request, unless a shorter minimum timeframe is established under State law. The timeframe for standard authorization decisions can be extended by up to 14 calendar days if the beneficiary or provider requests an extension, or if the State agency determines that additional information from the provider is needed to make a decision. 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.

D. Section M.14.b.-c. – Medical and Behavioral Health Provider Satisfaction Surveys

b. The MCO must work with MLTC and any other MCO to develop the provider satisfaction survey tool and methodology that will be used by all participating MCOs and submit to MLTC for review and approval annually by July 1. 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 should be avoided). The MCO must utilize measures that are based on current scientific knowledge and clinical experience.

c. The MCO must submit an annual medical and behavioral health provider satisfaction survey report that summarizes the survey methods and findings and provides an analysis of opportunities for improvement and action plans derived from surveys results. This report is due forty-five (45) calendar days after the end of each calendar year.

E. Section M.15.a.-b. – Dental Provider Satisfaction Surveys

a. The MCO must conduct an annual provider survey to assess satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing, claims reimbursement, and utilization management processes. The MCO must work with MLTC and any other MCO to develop the Dental Provider Satisfaction survey tool and methodology that will be used by all participating MCOs and submit to MLTC for review and approval annually by July 1.

b. The MCO must submit an annual dental 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 forty-five (45) calendar days after the end of each calendar year.

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STATE OF NEBRASKA – DEPARTMENT OF HEALTH AND HUMAN SERVICES

F. Section V.O.4.a.iv.(b)
b). When the MCO identifies a relationship with a debarred or excluded individual or entity, the MCO must initiate efforts to sever the relationship with the debarred or excluded individual or entity immediately and report to NMPI immediately (as described in section 1902(kk)(8) of the Act.)

G. Attachment 6 – QPPs

H. Attachment 13 – Reporting Requirements

III. Deletions: The Parties hereto agree to delete the following sections:

A. ACRONYM AND INITIALISM LIST

RMAP - Refugee Medical Assistance Program

B. Section V.A.2.j.
j. Members eligible for the Refugee Medical Assistance Program (RMAP)

C. Section P.2.d.xx.
xx. Refugee Medical

D. Section S.2.g.i.
i. MLTC will provide the current published edits to the MCO.

E. Section S.9.a.
a. On a quarterly basis, the MCO must submit payment accuracy reports to MLTC in a format determined by MLTC.

ATTACHMENTS

The following attachments, as amended (if applicable), are attached hereto and hereby incorporated into this Amendment:

1. Attachment 6 – QPPs
2. Attachment 13 – Reporting Requirements

All other terms and conditions remain in full force and effect.

SIGNATURES

IN WITNESS HEREOF, the parties hereto have duly executed this Amendment, and each individual signing below certifies that he or she has the authority to legally bind the party to this Amendment. Each party acknowledges the receipt of a duly executed copy of this Amendment.

AMENDMENT

STATE OF NEBRASKA – DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR DHHS	FOR
Matthew Ahern Interim Medicaid Director DocuSigned by: Matthew Ahern 0C7F86BE38C149A... **DATE:** 10/15/2024 | 06:20:15 PDT	Francis Clepper President & CEO Signed by: Francis Clepper 0B2997CCB120447... **DATE:** 10/15/2024 | 06:19:15 PDT

Attachment 6
Quality Performance Program Measures – Contract Year One
Molina

Base Performance Requirement	Full 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	20%
Encounter Acceptance Rate: Submitted encounters must be accepted 95% or greater by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	98%	20%
Average Hold Time: Calls to Member/Provider lines must be maintain an average hold time of three (3) minutes or less. Hold time includes both: a) 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. b) The amount of time a customer service representative places a caller on hold.	Member Avg Hold Time: Less than 2 minutes Provider Avg Hold Time: Less than 2 minutes	5% 5%
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.	Member Abandonment Rate: Less than 3% Provider Abandonment Rate: Less than 3%	5% 5%
Appeal Resolution Timeliness: The MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 30 calendar days from the day the MCO receives the appeal.	95% within 20 days	7.5%

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	7.5%
PDL Compliance: The MCO must dispense medications in PDL categories compliant with Nebraska State PDL Preferred Status at least 92% of the time each quarter.	95%	5%
Authorizations Turn Around Time: The MCO must adjudicate service authorizations within State-established timeframes not to exceed 14 calendar days from the day the MCO receives the authorization request.	95% within 8 days	20%

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 13 – 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
Vetting Report	Form, template, and field definitions used to respond to NMPI or MFPAU requests for provider history and detailed claims information.	Ad Hoc (5 Business Days to respond)
Bi-Weekly Deliverables	**Description**	**Due Date**
Bi-Weekly Tips	Pursuant to V.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**
Third Party Resource – Health Coverage	Data on instances of MCO identified TPR	Monthly; No later than the 15th
Member-Provider Call Center	Pursuant to Section V.F, data summarizing relevant call center operations.	Monthly; No later than the 15th
Death Notifications	Data reporting MCO notification of member deaths to AccessNE.	Monthly; No later than the 15th
EVV KPI – Home Health	Summary key performance indicators for home health claims and visits for electronic visit verification, as required by the 21st Century Cures Act.	Monthly; No later than the 15th
Executive Dashboard	Summary operations, communications, financial, claims, and care management data for leadership meetings.	Monthly; No later than 3 business days prior to

		Leadership meeting

Monthly Claims Report	Segmented data on all non-pharmacy claims volume, adjudication status, and payment timeliness.	Monthly; No later than the 15th
Monthly FWA Detection Effort Report	Summary of the MCO's fraud prevention efforts as described in Section V.O - Program Integrity.	Monthly; No later than the 15th
Monthly FWA Report	Summary of investigations as described in Section V.O – Program Integrity.	Monthly; No later than the 15th
Pharmacy Claims Report	Data on Pharmacy claims volume, adjudication status, and payment timeliness	Monthly; No later than the 15th
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; No later than the 15th
Provider Network Changes	Data and metrics summarizing any change to the MCO's network.	Monthly; No later than the 15th
Supplemental Member Care Report	Contains supplemental information related to member care and case management and member outreach.	Monthly; No later than the 15th
MLTC Reporting Database: Care Management Log	Data of member assessment and their care management.	Monthly; No later than the 15th
MLTC Reporting Database: Grievance Log	Data regarding the grievances received by the MCOs.	Monthly; No later than the 15th
MLTC Reporting Database: Appeals Log	Data regarding the appeals received by the MCOs.	Monthly; No later than the 15th
MLTC Reporting Database: State Fair Hearing Log	Data regarding the state fair hearings.	Monthly; No later than the 15th
MLTC Reporting Database: Out of Network Referrals	Data regarding out of network provider authorization requests.	Monthly; No later than the 15th
Quarterly Deliverables	**Description**	**Due Date**
Geographic Access Standards	Details of the MCO's network, including GeoAccess reports, as described in Section V.I – Provider Network Requirements and Attachment 14 – Access Standards.	Quarterly

SUD IMD Stays Report	SUD-related inpatient residential stays for Medicaid beneficiaries ages 21-64 in IMDs (over 16 beds primarily engaged in behavioral health treatment) from 07/01/2019 to the end of the reporting period.	Quarterly; due 10 calendar days after the end of the reporting period.
Insure Kids Now (IKN) Report	MCO must submit a file (or multiple files) to the federal government that contains information, specified in Attachment 5 – Insure Kids Now, about the Medicaid and CHIP providers in the state that provide dental care to children.	Quarterly; The MCO must submit these no later than:Feb 4th (FFY Q1 (Oct-Dec)); May 4th (FFY Q2 (Jan-Mar)); Aug 4th (FFY Q3 (Apr-Jun); Nov 4th (FFY Q4 (July-Sept))
Insure Kids Now (IKN) – MLTC Notification	MCOs must provide MLTC the **"Data File Submission and Validation Receipt", with Examination Results of "Accepted" or "Accepted with rejected rows."** If IKN does not accept it, then the MCO must work with IKN technical team for technical revisions until it is accepted by IKN. MLTC will reject the receipt and direct the MCO to revise and resubmit both the report to IKN and subsequent receipt with IKN approval to MLTC. Report accuracy and timeliness for this reporting deliverable reflect MCO contractual compliance.	Quarterly; Feb 15th; May 15th; August 15th; Nov 15th
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; Due 45 days after the most recent 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. Summary of value added services (paid as claims and outside of claims payment systems) as agreed upon by the MCO and MLTC.	Quarterly; Due 45 calendar days after the end of the reported period.
NEMT Quarterly Report	Data regarding non-emergency transportation.	Quarterly

NF Skilled Stay Authorizations	Report the NF skilled stays authorized by the MCO. The report must include accurate information for the following: Provider Name, Provider NPI, Provider Medicaid ID, authorized date, start date for the skilled stay, last date paid for the skilled stay (in MMIS this is known as the end date for the stay), Member Medicaid ID, and Member first and last name. In addition, provide the determination/completion date for the most current PASRR completed as of the start date for the skilled stay. Also, provide the type of PASRR (Level I, Level II, or one of the following categorical exemptions: 7 day emergency, 30 day hospital exempt, 30 day respite, serious medical, dementia categorical for individuals with intellectual disability or related condition, or 60 day convalescent).	Quarterly
Pharmacy Call Center Report	Data summarizing relevant pharmacy call center operations.	Quarterly
Pharmacy DUR Report	DUR statistics to support preparation of MLTC's annual CMS DUR report.	Quarterly
Provider Appointment Availability Access	Summary data and metrics on provider network appointment access as determined by MLTC and described in Attachment 14 – Access Standards.	Quarterly
Psychotropic Medication 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
Service Verification	Service verification summary as described in Section V.O – Program Integrity, Section V.S – Claims Management, and Section V. T – Reporting and Deliverables.	Quarterly
Dental QAPI Committee Report	Narrative of the activities of the MCO's Dental QAPI Committee as described in Section V.M.8.g. – Dental QAPI Committee Responsibilities.	Quarterly
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 V.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**

Attachment 13 – Reporting Requirements

Adult Core Measures	Adult Core Measures results.	Annually by September 30
Annual Program Integrity Confirmation	Signed form acknowledging responsibilities related to the receipt of State and federal funds as described in Section V.O - Program Integrity.	Annually; No later than December 31st
CAP – MCO Providers	Results and status of all corrective action plans by provider type.	Annually; No later than Jan 31st
Child Core Measures	Child Core Measures results.	Annually by September 30
Clinical Advisory Committee Plan	Plan describing the development of the Clinical Advisory Committee	Annually; No later than January 15th
Direct Medical Education/Indirect Medical Education Verification – In accordance with 471 NAC	For the state fiscal year, financial information on direct and indirect medical education costs as required by MLTC in accordance with 471 NAC.	Annually; No later than March 31th, State initiates therequest
Electronic Attestation Acknowledgement	42 CFR 438.606; The MCO must submit certification (attestation) concurrently with the certified data and documents.	Annually, No later than Feb 1st
Fraud, Waste, Abuse, and Erroneous Payments Annual Plan	Compliance plan addressing requirements outlined in Section V.O - Program Integrity and 42 CFR 438.608	Annually; No later than Feb 15th
HEDIS Report	HEDIS results.	Annually by June 30th
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 July 5th A
MLTC Reporting Database: CAHPS -- Adult	Data regarding the annual member satisfaction survey for the listed population and supplement.	Annually; No later than September 30th
MLTC Reporting Database: CAHPS – Child with CCC	Data regarding the annual member satisfaction survey for the listed population and supplement.	Annually; No later than September 30th
MLTC Reporting Database: CAHPS – CHIP with CCC	Data regarding the annual member satisfaction survey for the listed population and supplement.	Annually; No later than September 30th
MLTC Reporting Database: CAHPS – AdDental Survey	Data regarding the annual member satisfaction survey for the listed population and supplement.	Annually; No later than September 30th
MLTC Reporting Database: Child Dental Survey	Data regarding the annual member satisfaction survey for the listed population and supplement	Annually; No later than September 30th
Marketing Plan	Plan detailing the marketing activities it will undertake and materials it will create during the contract period.	Annually; Must submit a minimum of one hundred and fifty (150) calendar days

		before intended implementation of the marketing activity
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. Summary of value added services (paid as claims and outside of claims payment systems) as agreed upon by the MCO and MLTC.	Annually; Due 45 calendar days after the end of the reported period.
Member Advisory Committee Plan	Plan describing the draft goals and planned schedule for the Member Advisory Committee	Annually; No later than January 15th
Mental Health & Substance Use Disorder Parity Report	Pursuant to Section V.E.3.h. The MCO will report on the design and application of managed care practices such as prior authorization, reimbursement rate setting, and network design.	Annually; No later than July 1st
Network Development Management Plan & NetworkDevelopment 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 V.I – Provider Network Requirements.	Annually. No later than November 1st
PIP Report	Annual report of all PIPs.	Annually; No later than April 30th
Provider Satisfaction Survey - Medical and Behavioral Health Providers	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.	45 calendar days after the end of each calendar year.
Provider Satisfaction Survey – Dental Providers	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.	45 calendar days after the end of each calendar year.
QAPI Program Description and Work Plan	Discussion of the MCO's QAPI goals, objectives and accountabilities, including definition of the scope of the program; work plan to include timeline for the coming year and all planned QAPI activities. All as described in Section V.M – Quality Management.	Annually; No later than Feb 15th
QAPI Program Evaluation	Statistical analysis of the data a descriptive summary of findings from the annual QAPI Work Plan. All as described in Section IV.M – Quality Management.	Annually; No later than April 30th
Dental QAPI Program Description and Work Plan	Discussion of the MCO's Dental QAPI goals, objectives and accountabilities, including definition of the scope of the program; work plan to include timeline for the coming year and all planned QAPI activities. All as described in Section V.M – Quality Management.	Annually; No later than Feb 15th

Attachment 13 – Reporting Requirements

Dental QAPI Program Evaluation	Statistical analysis of the data a descriptive summary of findings from the annual Dental QAPI Work Plan. All as described in Section IV.M – Quality Management.	Annually; No later than April 30th
UM Program Description	Outlines UM structure and accountability mechanisms per contract section V.N.2.	Annually; No later than Feb. 15th
Department of Insurance Financial Report	Copy of annual audited financial statement	Annually; No later than June 1; Upon request of MLTC;
SOC 1 Audit Reports and Bridge Letters	SOC 1 Audit reports (and applicable Bridge Letters) for IT and business process controls. Applicable to MCOs and any subcontractors, such as PBMs processing claims.	Annually for each state fiscal year, upon request from the department

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Certificate Of Completion

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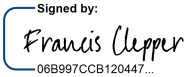
Signer Events	Signature	Timestamp
Francis Clepper Francis.clepper@molinahealthcare.com President & CEO Security Level: Email, Account Authentication (None)	Signed by:  06B997CCB120447... Signature Adoption: Pre-selected Style Using IP Address: 134.238.164.150	Sent: 10/8/2024 1:15:01 PM Viewed: 10/9/2024 12:08:55 PM Signed: 10/15/2024 8:19:15 AM
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Matthew Ahern Matthew.Ahern@nebraska.gov Interim Medicaid Director Security Level: Email, Account Authentication (None)	DocuSigned by:  0CCF86BE38C149A... Signature Adoption: Pre-selected Style Using IP Address: 164.119.5.85	Sent: 10/15/2024 8:19:16 AM Viewed: 10/15/2024 8:19:47 AM Signed: 10/15/2024 8:20:15 AM
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Envelope Summary Events	Status	Timestamps
Envelope Sent	Hashed/Encrypted	10/8/2024 1:15:00 PM
Certified Delivered	Security Checked	10/15/2024 8:19:47 AM
Signing Complete	Security Checked	10/15/2024 8:20:15 AM
Completed	Security Checked	10/15/2024 8:20:15 AM

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 withdraw your consent with Nebraska Department of Health & Human Services

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