Amendment Seven
Contract Number 102894 O4

Service Contract

Between
The State of Nebraska
And
Nebraska Total Care Inc

THIS AMENDMENT is entered into by and between the State of Nebraska Department of Health and Human Services ("DHHS") and Nebraska Total Care Inc ("NTC").

WHEREAS, the DHHS has a contract with NTC identified as 102894 O4 for use by state agencies and other entities.

WHEREAS, the terms of the contract specifically state that the contract may be amended when mutually agreeable to NTC and DHHS.

WHEREAS, 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.

NOW, THEREFORE, it is agreed by the parties to amend the contract as follows:

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

A. **Glossary of Terms**
Targeted Case Management: Case management services furnished without regard to the requirements of CFR 431.50(b) (related to statewide provision of services) and CFR 440.240 (related to comparability.) Targeted case management services may be offered to individuals in any defined location of the State or to individuals within targeted groups specified in the State plan.

B. **Acronyms**
PPP - Prenatal Plus Program

C. **Section V.E.34 - Prenatal Plus Program**

34. The purpose of the Prenatal Plus Program (PPP) is to reduce the incidence of low birth weight, pre-term birth, and adverse birth outcomes while also addressing other lifestyle, behavioral, and nonmedical aspects of an at-risk pregnant individual's life that may affect the health and well-being of the individual or the child**.** The program is effective January 1, 2025 through June 30, 2028.

a. MCOs must ensure that network providers who request to be a part of the PPP are educated about PPP and its services, which include targeted case management, nutrition counseling, psychosocial counseling and support, general patient education and health promotion, and breastfeeding support. MCOs must encourage utilization of the PPP and facilitate access for its members.
b. MCO Nurse Case Manager must be willing to collaborate with the designated provider Targeted Case Managers (care coordinators) and support coordination of service delivery for the clinical and non-clinical needs of the member.
c. MCOs must monitor the utilization of code H1002 and report any anomalies to MLTC.

D. **Section V.J.5.h.**
h. MCOs must provide targeted education for contracted providers being audited. This includes informing providers of the audit, any relevant policies and regulations, the MCOs expectations, and the MCOs responsibilities.

E. Section V.J.5.i.i-vi

i. The MCO must provide initial and ongoing education to its network providers on the Prenatal Plus Program (PPP) as needed. The education program must include, but is not limited to, the following components:

i. **Identification and enrollment of members**: MCO must ensure providers are trained on how to identify and enroll eligible members in the PPP**.**

ii. **Provision of Prenatal Plus Program Services**: Providers must be educated on expectations of specific services and applicable forms/documents outlined within the PPP. Must outline documentation requirements for the member's medical record.

iii. **Initial Comprehensive and Periodic Assessment**: MCO must provide education on access to the case management nurse assigned to the member for the PPP Care Coordinator to connect with or collaborate with during the course of pregnancy for close monitoring and follow-up. MCO must provide guidance on the requirements for conducting both the initial comprehensive assessment and periodic reassessments of the pregnant mother's needs.

iv. **Referrals and Linkages to Services**: MCOs must provide guidance on processes for making appropriate referrals and linking members both clinical and non-clinical services necessary for comprehensive care.

v. **Billing and Reimbursement Procedures**: Providers must be trained on the billing and reimbursement processes specific to the PPP.

vi. Ongoing education must be provided to address any updates or changes to the program, with plans responsible for ensuring that all relevant providers remain informed and ensure adherence to performance standards.

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

A. Section V.E.11 – Eye Care and Vision Services

11. 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 state licensed ophthalmologist or optometrist, conforming to accepted methods of screening, diagnosis, and treatment. If the MCO or its VBM operates a separate call center, it will be subject to the same call performance standards, per Section V.F.2.k. – Member Services Call Center and must be included in the Call Center monthly report (Attachment 13.)

B. Section V.E.29.g.v. – NEMT Customer Service Call Center

v. Call performance standards, per Section V.F.2.k. – Member Services Call Center, apply to the MCOs broker and must be included in the Call Center monthly report (Attachment 13.)

C. Section V.F.2.a.

a. The MCO must operate a member call center with a toll-free telephone line to respond to questions, concerns, and complaints from members, their families, and providers on behalf of the member. The call center and call center employees must be located in the United States.

D. Section V.F.2.d.

d. The MCO must ensure the call center is staffed adequately to respond to member's questions, at a minimum from 8am to 5pm, Central Time, Monday through Friday. The MCO must follow the MLTC holiday schedule for appropriate call center closures.

E. Section V.F.2.i.

i. The MCO must measure and monitor the accuracy of responses and telephone etiquette on at least two percent (2%) of calls answered in a month and take corrective action as necessary to ensure that members are being given correct information in a helpful and polite manner.

F. Section V.F.2.k.i

i. The MCO must answer ninety percent (90%) of calls within thirty (30) seconds measured from the time a caller is placed in the queue until an agent picks up the call.

G. Section V.F.2.k.iii.

iii. The MCO must maintain an average hold time of two (2) minutes or less. Hold time is defined as the amount of time a customer service representative places a caller on hold.

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H. Section V.F.2.k. iv.

iv. The MCO must maintain an abandonment rate of calls of not more than five percent (5%). Abandonment rate should be measured from the moment the caller is placed in the queue to speak with a customer service representative.

I. Section V.F.9.a.i-vi – Member ID Cards

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; and
vi. The MCO's toll-free number(s) for Member Services, filing a grievance, and reporting suspected fraud.

J. Section V.F.9.b. – Member ID Cards

b. 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.
The MCO must reissue the MCO ID care to a member within ten (10) calendar days of notice that a member has lost their card had a name change, or for any other reason that requires a change to the information on the current ID card.

K. Section V.F.9.f. – Dental Related ID Card Requirements

f. Include DBM contact information (including after-hours number if it is different.)

L. Section V.J.1.a.

a. Be available Monday through Friday from 7am to 6pm (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. The MCO must follow the MLTC holiday schedule.

M. Section V.J.2.c.

c. The MCO's call center system must have the capability to track provider call management metrics. Call performance standards, per Section V.F.2.k. – Member Services Call Center apply and must be included in the Call Center monthly report (Attachment 13).

N. Section V.N.2. – UM Program Description

2. The MCO must have a written UM Program description and work plan that outlines its structure and accountability mechanisms. The description must be submitted to MLTC for written approval annually by February 15th and include at a minimum:

O. Section V.N.2.o.

o. A description of the MCO's annual evaluation of their UM program. The evaluation must be submitted to MLTC annually, no later than April 30th.

P. Section V.N.5.e.

e. The MCO must maintain an electronic automated process, a toll-free telephone number, and a fax line for providers to submit requests for prior authorization of drugs that are non-preferred or subject to clinical edits. If the MCO or its PBM operates a separate call center for prior authorizations, it will be subject to the same call center performance standards per Section V.F.2.k – Member Services Call Center and must be included in the Call Center monthly report (Attachment 13.)

Q. Section V.Y.9.

9. The MCO must 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 or for the first 60 days, whichever comes first. (NAC 482 Ch. 2 004.05)

R. **Attachment 6 – Quality Performance Program Measures - Effective January 1, 2025**
S. **Attachment 13 – Reporting Requirements – Effective January 1, 2025**

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

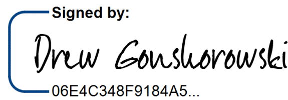
A. **Section V.F.9.f. – Dental Related ID Card Requirements**
f. The card may be issued without the Dental Home information if no Dental Home selection has been made as of the date of the card's mailing. Once the Dental Home selection has been made by the member or through auto-assignment, the MCO must reissue the card within ten (10) business days of the selection of auto-assignment. As part of the mailing of the reissued cared, 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.

Attachments:

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

1. Attachment 6 – (AMENDED 2/13/2025) Quality Performance Program Measures – Contract Year Two Nebraska Total Care, Effective January 1, 2025 – December 31, 2025
2. Attachment 13 –Reporting Requirements_021125.pdf (AMENDED 2/13/2025) Effective January 1, 2025

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

FOR DHHS:		FOR CONTRACTOR:	
By:		By:	
Name:	Drew Gonshorowski	Name:	Adam Proctor
Title:	Director, Division of MLTC	Title:	CEO
Date:	2/21/2025	08:40:16 CST	Date:	2/21/2025	09:15:13 CST

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Attachment 6
Quality Performance Program Measures – Contract Year Two
Nebraska Total Care and UnitedHealthcare
Effective January 1, 2025 through December 31, 2025

Base Performance Requirement	40% Payment Threshold	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.	**N/A**	**95% within 10 business days**	**6%**
Encounter Acceptance Rate: Submitted encounters must be accepted 95% or greater by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	**N/A**	**98%**	**6%**
Appeal Resolution Timeliness: 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.	**N/A**	**95% within 20 calendar days**	**6%**
Immunizations for Adolescents (IMA-E): The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. • Combination 2	31.39%	34.3%	**9%**

Docusign Envelope ID: 00EBCE58-5840-41A5-8DE3-0172EA9D6B00

Prenatal and Postpartum Care (PPC): **Timeliness of Prenatal Care:** The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in Medicaid/CHIP. **Postpartum Care:** The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery.	Timeliness of Prenatal Care: 84.55% Postpartum Care: 80.23%	Timeliness of Prenatal Care: 86.89% Postpartum Care: 82.48%	**5%** **5%**
Chlamydia Screening in Women (CHL): The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. • 16 – 20 years of age • 21 – 24 years of age	16 – 20 years of age: 5% increase from previous year 21 – 24 years of age: 5% increase from previous year	16 – 20 years of age: 10% increase from previous year 21 – 24 years of age: 10% increase from previous year	**3%** **3%**
Initiation and Engagement of Substance Use Disorder Treatment (IET): The percentage of new substance use disorder (SUD) episodes in individuals aged 18 and older (combining age groups 18-64 and 65+) that result in treatment initiation and engagement. • **Initiation of SUD Treatment**. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days. • **Engagement of SUD Treatment**. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.	Initiation of SUD Treatment: 36.71% Engagement of SUD Treatment: 10.51%	Initiation of SUD Treatment: 40.04% Engagement of SUD Treatment: 14.39%	**3%** **3%**

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Child and Adolescent Well-Care Visits (WCV) The percentage of adolescents 12-17 years of age who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement year.	56.22%	58.92%	**9%**
Follow-Up After Hospitalization for Mental Illness (FUH): The percentage of discharges for individuals 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: 1. The percentage of discharges for which the individual received follow-up within 30 days after discharge. (Total) 2. The percentage of discharges for which the individual received follow-up within 7 days after discharge. (Total)	30 days Total: 65.62% 7 days Total: 42.86%	30 days Total: 68.56% 7 days Total: 46.99%	**5%** **5%**
Follow-Up After Emergency Department Visit for Mental Illness (FUM): The percentage of emergency department (ED) visits for individuals 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported: 1. The percentage of ED visits for which the individual received follow-up within 30 days of the ED visit (31 total days). (Total) 2. The percentage of ED visits for which the individual received follow-up within 7 days of the ED visit (8 total days) (Total)	30 days Total: 59.65% 7 days Total: 38.62%	30 days Total: 63.06% 7 days Total: 44.33%	**5%** **5%**
Follow-Up After Emergency Department Visit for Substance Use (FUA): The percentage of emergency department (ED) visits among individuals 13 years of age and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported: 1. The percentage of ED visits for which the individual received follow-up within 30 days of the ED visit (31 total days). (Total) 2. The percentage of ED visits for which the individual received follow-up within 7 days of the ED visit (8 total days). (Total)	30 days Total: 39.35% 7 days Total: 24%	30 days Total: 41.86% 7 days Total: 27.62%	**5%** **5%**

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Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey: Child and Adult • Getting Care Quickly (Usually + Always) (Child Only) • Rating of Health Plan (9 + 10)	Getting Care Quickly (Usually + Always) (Child Only): 87.22% Rating of Health Plan (9 + 10) (Child): 71.65% Rating of Health Plan (9 + 10) (Adult): 65.52%	Getting Care Quickly (Usually + Always) (Child Only): 89.35% Rating of Health Plan (9 + 10) (Child): 73.76% Rating of Health Plan (9 + 10) (Adult): 68.54%	**4%** **4%** **4%**
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey: Child and Adult • Getting Care Quickly (Usually + Always) (Adult Only) • Getting Needed Care (Usually + Always) • Customer Service (Usually + Always) • Rating of All Health Care (9 + 10)	NA - Monitoring Only	NA - Monitoring Only	NA - Monitoring Only
Oral Evaluation, Dental Services (OEV-CH): The percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the measurement year.	NA - Monitoring Only	NA - Monitoring Only	NA - Monitoring Only

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.

Docusign Envelope ID: 00EBCE58-5840-41A5-8DE3-0172EA9D6B00

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). MCO must report Critical Incidents: actual events or situations that cause 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.	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
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

Docusign Envelope ID: 00EBCE58-5840-41A5-8DE3-0172EA9D6B00

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

Docusign Envelope ID: 00EBCE58-5840-41A5-8DE3-0172EA9D6B00

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**
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

Docusign Envelope ID: 00EBCE58-5840-41A5-8DE3-0172EA9D6B00

		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
CAHPS --Adult	Data regarding the annual member satisfaction survey for the listed population and supplement.	Annually; No later than September 30th
CAHPS –Child with CCC	Data regarding the annual member satisfaction survey for the listed population and supplement.	Annually; No later than September 30th
CAHPS – CHIP with CCC	Data regarding the annual member satisfaction survey for the listed population and supplement.	Annually; No later than September 30th
CAHPS –Dental Survey (Adult)	Data regarding the annual member satisfaction survey for the listed population and supplement.	Annually; No later than September 30th
Dental Survey (Child)	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

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 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 V.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
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 V.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
UM Program Evaluation	Statistical analysis of the data and descriptive summary of findings from the annual UM Program description. All as described in Section V.N.2. UM Program Description.	Annually; No later than April 30th

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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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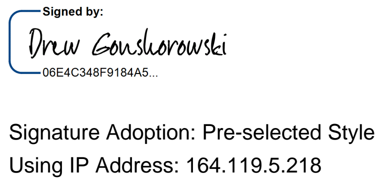
Drew Gonshorowski drew.gonshorowski@nebraska.gov Director of Medicaid and Long-term Care Security Level: Email, Account Authentication (None)	 Signature Adoption: Pre-selected Style Using IP Address: 164.119.5.218	Sent: 2/18/2025 10:36:13 AM Resent: 2/19/2025 2:11:29 PM Viewed: 2/21/2025 8:39:42 AM Signed: 2/21/2025 8:40:16 AM

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