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AMENDMENT FIFTEEN
Contract Number 102897 O4

Service Contract

Between
The State of Nebraska Department of Health and Human Services
And
Molina Healthcare of Nebraska

THIS AMENDMENT is entered into by and between the State of Nebraska Department of Health and Human Services (“DHHS”) and Molina Healthcare of Nebraska (“Molina”).

WHEREAS, the DHHS has a contract with Molina identified as 102897 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 Molina and the 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:

Item 1:

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

A. Section V.E.33.f.
f. In the event that a member transitions between MCOs during an inpatient stay the MCO must cover the stay in alignment with 482 NAC.

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

A. Attachment 2 – Nebraska Counties by Urban, Rural, Frontier Status
B. Attachment 6 - QPPs
C. Attachment 13 – Reporting Requirements

D. Glossary of Terms
Serious Mental Illness: is as defined in 42 CFR 483.102.

E. Section V.B.6.b.
b. After the initial ninety (90) calendar day period, Medicaid members will be locked in their MCO selection until the next annual open enrollment period. The annual open enrollment period will take place October 15th through December 7th each year of the contract.

F. Section V.B.8.e
e. The MCO must submit disenrollment requests to the enrollment broker that must 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 the 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 2-004.04(A).

G. Section V.F.2.k.iii.
iii. The MCO must maintain an average hold time of three (3) minutes or less. Hold time is defined as the amount of time a customer service representative places a caller on hold.

H. Section V.F.9.b.

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. 99% of all member ID cards must be mailed within ten (10) business days. The MCO must reissue the MCO ID card 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.

I. Section V.J.6.a.iv.

iv. Provide a quarterly Nebraska Medicaid specific newsletter that includes articles covering topics of interest for all provider types. This newsletter must be posted to the MCOs website.

J. Section V.L.14.a.iv.h)

h) Lab work for common health conditions e.g., blood pressure, diabetes, mental health conditions, Hepatitis C, and HIV. The review of lab work is not for the purpose of interpretations of the results but to aid with the development of the comprehensive assessment.

K. Section V.L.14.b.

b. MCOs must provide coverage for screening and diagnostic services in the thirty (30) calendar days prior to release (or within one week or as soon as practicable post-release) and offer targeted case management thirty (30) calendar days prior to release and for at least thirty (30) calendar days post-release.

L. Section V.L.14.d.

d. In the thirty (30) days prior to release (or not later than one week, or as soon as practicable after release from the public institution), and in coordination with the public institution, MCOs must provide coverage for any screenings and diagnostic services which meet reasonable standards of medical and dental practice, as determined by the state, or as otherwise indicated as medically necessary, and for youth under the age of 21, in accordance with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, including a behavioral health screening or diagnostic service.

M. Section V.N.17.a-g

17. Service Authorization

a. Service authorization includes, but is not limited to, prior authorization.
b. The MCO UM Program policies and procedures must include service authorization policies and procedures consistent with 42 CFR §438.210, 438.905, 438.910, and state laws and regulations for initial and continuing authorization of services that include, but are not limited to, the following:
    i. Written policies and procedures for processing requests for initial and continuing authorizations of services, where a provider does not request a service in a timely manner or refuses a service; and
    ii. Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate.
c. Health care professionals who have appropriate clinical expertise in treating the member's condition or disease are required to make any decision to deny a service authorization request or to authorize service in an amount, duration, or scope that is less than requested.
d. The MCO must provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process must be included in its member manual and incorporated in the grievance procedures.
e. The MCO's service authorization system must provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers.
f. The MCO's service authorization system must have capacity to electronically store and report all service authorization requests, decisions made by the MCO

regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.

g. The MCO must not deny continuation of higher level services for failure to meet medical necessity unless the MCO can provide the service through an in-network or out-of-network provider at a lower level of care.

J. Section V.N.18.a.-d.

18. Timing of Service Authorization Decisions

a. Standard Service Authorization

i. The MCO must make eighty percent (80%) of standard service authorization determinations within seven (7) business days of obtaining appropriate information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations must be made no later than fourteen (14) calendar days following receipt of the request for service unless an extension is requested. The MCO must maintain a documentation system to report to MLTC on a monthly basis all service authorizations provided in the format specified by MLTC.

ii. An extension may be granted for an additional fourteen (14) calendar days if the member or the provider or authorized representative requests an extension or if the MCO justifies to MLTC a need for additional information and the extension is in the member's best interest. In no instance must any determination of standard service authorization be made later than twenty-eight (28) calendar days from receipt of the request.

b. Expedited Service Authorization

In the event a provider indicates, or the MCO determines, that following the standard service authorization 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, but no later than seventy-two (72) hours after receipt of the request for service.

c. Post Authorization

i. The MCO may extend the seventy-two (72) hour expedited service authorization decision period by up to fourteen (14) calendar days if the member or if the MCO justifies to MLTC a need for additional information and how the extension is in the member's best interest.

ii. The MCO must make retrospective review determinations within thirty (30) calendar days of obtaining the results of any appropriate dental or medical information that may be required, but in no instance later than one hundred and eighty (180) calendar days from the date of service.

iii. The MCO must not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.

d. Timing of Notice

i. Approval

a) For service authorization approval for a non-emergency admission, procedure or service, the MCO must notify the provider as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and must provide documented confirmation of such notification to the provider within two (2) business days of making the initial determination.

b) For service authorization approval for extended stay or additional services, the MCO must notify the provider rendering the service, whether a healthcare professional or facility or both, and the member receiving the service within one (1) business day of the service authorization approval.

ii. Adverse Action

a) The MCO must notify the member, in writing using language that is easily understood, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in this RFP. The notice of action to members must be consistent with requirements in 42 CFR §438.10(c) and (d), 42 CFR §438.404(c), and 42 CFR §438.210(b)(c)(d) and in this RFP for member written materials.

b) The MCO must notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested.

iii. Informal Reconsideration

As part of the MCO appeal procedures, the MCO must include an Informal Reconsideration process that allows the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.

a) In a case involving an initial determination, the MCO must provide the treating provider an opportunity to send in new clinical information to be reviewed (informal reconsideration process) and to discuss (peer-to-peer process) the decision with the physician or dentist or clinical peer making the adverse determination, however this is not considered part of the formal appeal process.

b) Such processes should occur as soon as possible after the initial adverse determination is made. The informal reconsideration and peer-to-peer processes will no way extend the thirty (30) calendar day requirement timeframe for a Notice of Appeal Resolution.

iv. Exceptions to Requirements

a) The MCO must not require service authorization for emergency services as described in this section whether provided by an in-network or out-of-network provider.
b) The MCO must not require service authorization or referral for EPSDT screening services.
c) The MCO must not require service authorization for the continuation of covered services of a new member transitioning into the MCO, regardless of whether such services are provided by an in-network or out-of-network provider, however, the MCO may require prior authorization of services beyond thirty (30) calendar days.

K. Section V.P.14.
14. MLTC has established a High-Cost Drug Pool Risk Corridor. The purpose of this pool is to develop a mechanism that will retrospectively re-allocate funding between MCOs and MLTC should there be a disproportionate share and volume of high-cost drug experience for any MCO(s). This mechanism is in effect for all populations, with the exception of dual-eligible and HIPP members, effective starting CY24.

L. Section V.Q.16. Effective Date of Payment for New Members
16. 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, for any month the member is enrolled with the MCO.

Item 2:

COMPLIANCE WITH PRESIDENTIAL EXECUTIVE ORDERS 14151 AND 14173

Executive Order 14151, issued by President Donald Trump on January 20, 2025, and Executive Order 14173, issued by President Donald Trump on January 21, 2025, prohibit discriminatory "diversity, equity, and inclusion" (DEI) programs and "diversity, equity, inclusion, and accessibility" (DEIA) mandates, policies, programs, preferences, and activities in the federal government. If the Contract involves federal funds, Contractor shall not use contract funds for any DEI program or for any DEIA mandate, policy, program, or preference. Contractor shall assure its compliance and the compliance of any subcontractors with all requirements of Executive orders 14151 and 14173.

Attachments:

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

1. AMENDED Attachment 2- Nebraska Counties Classified by Urban Rural Frontier Status (Effective Date January 1, 2026)
2. AMENDED Attachment 6- QPPS (Effective Date January 1, 2026 – December 31, 2026)
3. AMENDED Attachment 13- Reporting Requirements (Effective Date January 1, 2026)

IN WITNESS WHEREOF, this amendment is entered into as of the last signature date below (the "Effective Date").

FOR DHHS:

By: Drew Gonshorowski

Name: Drew Gonshorowski

Title: Director, Division of Medicaid and Long-Term Care

Date: 4/1/2026 | 09:04:06 CDT

FOR VENDOR:

By: Francis Clepper

Name: Frank Clepper

Title: President & CEO

Date: 4/16/2026 | 12:22:34 CDT

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ATTACHMENT 2 - Nebraska Counties Classified by Urban Rural Frontier Status

Effective January 1, 2026 (AMENDED 3/1/2026)

		Population					
Classification	**County**	**2020**	**2021**	**2022**	**2023**	**2024**	**Note**
Frontier	McPherson County, Nebraska	396	380	374	377	376	
Frontier	Arthur County, Nebraska	432	435	427	416	423	
Frontier	Blaine County, Nebraska	428	463	448	431	454	
Frontier	Grant County, Nebraska	616	580	587	567	573	
Frontier	Loup County, Nebraska	605	600	597	587	582	
Frontier	Thomas County, Nebraska	674	679	667	675	634	
Frontier	Banner County, Nebraska	678	689	656	671	665	
Frontier	Logan County, Nebraska	718	688	691	661	694	
Frontier	Hooker County, Nebraska	707	735	680	677	698	
Frontier	Wheeler County, Nebraska	775	785	784	787	808	
Frontier	Keya Paha County, Nebraska	760	797	801	804	819	
Frontier	Hayes County, Nebraska	849	843	864	840	846	
Frontier	Sioux County, Nebraska	1,141	1,147	1,129	1,151	1,099	
Frontier	Rock County, Nebraska	1,265	1,276	1,234	1,259	1,241	
Frontier	Dundy County, Nebraska	1,651	1,629	1,601	1,565	1,581	
Frontier	Boyd County, Nebraska	1,803	1,782	1,737	1,739	1,700	
Frontier	Garfield County, Nebraska	1,805	1,830	1,783	1,758	1,707	
Frontier	Garden County, Nebraska	1,889	1,841	1,837	1,804	1,804	
Frontier	Gosper County, Nebraska	1,895	1,828	1,831	1,837	1,808	
Frontier	Deuel County, Nebraska	1,833	1,849	1,900	1,879	1,892	
Frontier	Greeley County, Nebraska	2,179	2,180	2,237	2,218	2,197	
Frontier	Hitchcock County, Nebraska	2,621	2,602	2,611	2,550	2,460	
Frontier	Pawnee County, Nebraska	2,541	2,542	2,536	2,511	2,521	**Formerly Rural**
Frontier	Frontier County, Nebraska	2,503	2,547	2,624	2,598	2,536	
Frontier	Perkins County, Nebraska	2,861	2,821	2,844	2,802	2,779	
Frontier	Franklin County, Nebraska	2,890	2,879	2,834	2,812	2,817	
Frontier	Brown County, Nebraska	2,903	2,922	2,894	2,877	2,877	
Frontier	Sherman County, Nebraska	2,953	2,964	3,000	2,970	2,949	
Frontier	Harlan County, Nebraska	3,054	3,095	3,023	3,046	3,018	**Formerly Rural**
Frontier	Nance County, Nebraska	3,394	3,380	3,323	3,261	3,262	**Formerly Rural**
Frontier	Kimball County, Nebraska	3,408	3,408	3,344	3,316	3,305	
Frontier	Webster County, Nebraska	3,392	3,404	3,334	3,344	3,326	**Formerly Rural**
Frontier	Chase County, Nebraska	3,889	3,827	3,768	3,761	3,764	
Frontier	Valley County, Nebraska	4,058	4,065	4,064	4,029	4,032	**Formerly Rural**
Frontier	Nuckolls County, Nebraska	4,091	4,071	4,076	4,103	4,094	**Formerly Rural**
Frontier	Furnas County, Nebraska	4,632	4,613	4,573	4,555	4,468	**Formerly Rural**
Frontier	Morrill County, Nebraska	4,558	4,570	4,528	4,531	4,485	
Frontier	Thayer County, Nebraska	5,024	4,892	4,866	4,855	4,870	**Formerly Rural**
Frontier	Sheridan County, Nebraska	5,104	5,091	5,015	4,932	4,927	
Rural	Johnson County, Nebraska	5,295	5,314	5,264	5,215	5,219	
Rural	Polk County, Nebraska	5,218	5,193	5,234	5,212	5,269	
Rural	Boone County, Nebraska	5,357	5,381	5,366	5,320	5,354	
Rural	Fillmore County, Nebraska	5,569	5,554	5,529	5,539	5,512	
Rural	Dixon County, Nebraska	5,585	5,561	5,522	5,530	5,526	
Rural	Cherry County, Nebraska	5,457	5,453	5,495	5,527	5,558	
Rural	Stanton County, Nebraska	5,822	5,830	5,748	5,825	5,756	
Rural	Clay County, Nebraska	6,110	6,046	6,070	6,144	6,103	
Rural	Antelope County, Nebraska	6,279	6,296	6,299	6,291	6,358	
Rural	Howard County, Nebraska	6,486	6,525	6,521	6,564	6,572	
Rural	Thurston County, Nebraska	6,759	6,627	6,549	6,562	6,637	
Rural	Burt County, Nebraska	6,724	6,716	6,790	6,730	6,727	
Rural	Kearney County, Nebraska	6,692	6,689	6,708	6,727	6,749	

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Rural	Nemaha County, Nebraska	7,085	7,008	7,028	7,064	7,046	
Rural	Jefferson County, Nebraska	7,260	7,160	7,151	7,097	7,136	
Rural	Pierce County, Nebraska	7,344	7,316	7,326	7,304	7,334	
Rural	Richardson County, Nebraska	7,860	7,785	7,736	7,708	7,666	
Rural	Merrick County, Nebraska	7,660	7,666	7,709	7,746	7,837	
Rural	Dawes County, Nebraska	8,155	8,147	8,250	8,145	8,003	
Rural	Keith County, Nebraska	8,326	8,259	8,205	8,155	8,148	
Rural	Cedar County, Nebraska	8,373	8,331	8,366	8,244	8,262	
Rural	Knox County, Nebraska	8,392	8,414	8,356	8,341	8,306	
Rural	Butler County, Nebraska	8,356	8,452	8,432	8,442	8,439	
Rural	Cuming County, Nebraska	9,011	8,993	8,970	8,951	8,952	
Rural	Phelps County, Nebraska	8,977	8,922	9,007	9,099	9,042	
Rural	Hamilton County, Nebraska	9,402	9,388	9,439	9,528	9,564	
Rural	Cheyenne County, Nebraska	9,486	9,504	9,524	9,549	9,602	
Rural	Wayne County, Nebraska	9,702	9,870	9,898	9,882	9,870	
Rural	Holt County, Nebraska	10,105	10,063	10,069	10,152	10,120	
Rural	Red Willow County, Nebraska	10,684	10,621	10,557	10,512	10,409	
Rural	Custer County, Nebraska	10,492	10,495	10,503	10,612	10,487	
Rural	Box Butte County, Nebraska	10,819	10,658	10,685	10,705	10,703	
Rural	Colfax County, Nebraska	10,556	10,480	10,645	10,696	10,826	
Rural	York County, Nebraska	14,105	14,245	14,319	14,386	14,375	
Rural	Saline County, Nebraska	14,715	14,522	14,621	14,651	14,740	
Rural	Otoe County, Nebraska	15,903	16,022	16,243	16,448	16,591	
Rural	Seward County, Nebraska	17,610	17,555	17,623	17,646	17,769	
Urban	**Washington County, Nebraska**	**20,926**	**20,991**	**21,175**	**21,182**	**21,254**	**Formerly Rural**
Urban	Dakota County, Nebraska	21,556	21,287	21,253	21,340	21,335	
Urban	Gage County, Nebraska	21,652	21,629	21,542	21,637	21,687	
Urban	**Saunders County, Nebraska**	**22,370**	**22,832**	**23,159**	**23,471**	**23,406**	**Formerly Rural**
Urban	Dawson County, Nebraska	24,082	23,935	24,048	24,393	24,554	
Urban	**Cass County, Nebraska**	**26,608**	**27,079**	**27,169**	**27,458**	**27,492**	**Formerly Rural**
Urban	Adams County, Nebraska	31,176	30,974	31,023	30,892	31,196	
Urban	Lincoln County, Nebraska	34,535	34,079	33,619	33,457	33,319	
Urban	Platte County, Nebraska	34,291	34,305	34,452	35,034	35,499	
Urban	Madison County, Nebraska	35,530	35,397	35,427	35,727	35,579	
Urban	Scotts Bluff County, Nebraska	36,051	35,909	35,798	35,721	35,734	
Urban	Dodge County, Nebraska	37,121	37,141	37,130	37,477	37,884	
Urban	Buffalo County, Nebraska	50,204	50,310	50,528	50,696	51,156	
Urban	Hall County, Nebraska	62,776	62,085	62,292	62,658	62,869	
Urban	Sarpy County, Nebraska	191,181	193,853	196,606	200,477	204,828	
Urban	Lancaster County, Nebraska	323,171	323,407	325,252	328,794	332,857	
Urban	Douglas County, Nebraska	585,451	585,534	587,894	593,645	601,158	

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Attachment 6

Quality Performance Program Measures – Contract Year Three

Effective January 1, 2026 through December 31, 2026 (AMENDED 3/1/2026)

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, dental, and behavioral health 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	5%
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%	5%
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	5%
Grievance Resolution Timeliness: MCO must resolve each grievance and provide notice, as expeditiously as the member's health condition requires, within 90 calendar days from the day the MCO receives the grievance.	N/A	95% within 60 calendar days	5%
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	30.7%	34.14%	9%

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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: 86.37% Postpartum Care: 82.48%	Timeliness of Prenatal Care: 88.56% Postpartum Care: 83.94%	4% 4%
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	3.5% 3.5%
Initiation and Engagement of Substance Use Disorder Treatment (IET): The percentage of new substance use disorder (SUD) episodes in individuals aged 18-64 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	Initiation of SUD Treatment: 37.54% Engagement of SUD Treatment: 10.45%	Initiation of SUD Treatment: 41% Engagement of SUD Treatment: 11.87%	4% 4%

engagement within 34 days of initiation.			
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.	58.55%	61.4%	7%
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: • The percentage of discharges for which the individual received follow-up within 30 days after discharge. (Total) • The percentage of discharges for which the individual received follow-up within 7 days after discharge. (Total)	30 days Total: 67.4% 7 days Total: 45.08%	30 days Total: 70.59% 7 days Total: 48.65%	3.5% 3.5%
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: • The percentage of ED visits for which the individual received follow-up within 30 days of the ED visit (31 total days). (Total) • 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: 57.13% 7 days Total: 41.52%	30 days Total: 62.41% 7 days Total: 46.71%	3.5% 3.5%
Follow-Up After Emergency Department Visit for Substance Use (FUA): The percentage of emergency department (ED) visits among individuals 18 years of age and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported: • The percentage of ED visits for which the individual received	30 days Total: 39.03%	30 days Total: 43.12%	3.5%

follow-up within 30 days of the ED visit (31 total days). (Total) • The percentage of ED visits for which the individual received follow-up within 7 days of the ED visit (8 total days). (Total)	7 days Total: 27.04%	7 days Total: 30.43%	3.5%
Oral Evaluation, Dental Services - (OEV-CH): Percentage of enrolled children under age 21 years who received a comprehensive or periodic oral evaluation within the reporting year	3% increase from previous year	5% increase from previous year	5%
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey: Child and Adult • Getting Care Quickly (Usually + Always) (Child) • Rating of Health Plan (9 + 10)	Getting Care Quickly (Usually + Always) (Child): 86.69% (50th) Rating of Health Plan (9 + 10) (Child): 75.57% (75th) Rating of Health Plan (9 + 10) (Adult): 62.18 (50th)	Getting Care Quickly (Usually + Always) (Child): 89.48 (75th) Rating of Health Plan (9 + 10) (Child): 78.8% (90th) Rating of Health Plan (9 + 10) (Adult): 64.32 (66th)	5% 5% 5%
Oral Evaluation During Pregnancy - (OEV-P): Percentage of enrolled persons aged 15 through 44 years with live-birth deliveries in the reporting year who received a comprehensive or periodic oral evaluation during pregnancy • Age 15 through 20 • Age 21 through 44	Monitoring Only	Monitoring Only	N/A
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey: Child and Adult • Getting Care Quickly (Usually + Always) (Adult) • Getting Needed Care (Usually + Always) • Customer Service (Usually + Always) • Rating of All Health Care (9 + 10)	Monitoring Only	Monitoring Only	N/A
Child and Adolescent Well-Care Visits (WCV) The percentage of adolescents 18-21 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.	Monitoring Only	Monitoring Only	N/A

Attachment 13 – Reporting Requirements 102897 04
Effective January 1, 2026 (AMENDED 3/1/2026)

Bi-Weekly	**B1** submission reporting period – **1st-15th**. **B2** submission reporting period – **16th- last day of the month.** Submissions are due three (3) business days after the reporting period.
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	Bi-weekly tips report: identifies patterns of data mining outliers, audit concerns, critical incidents, hotline calls, or other internal and external tips with potential implications about provider billing anomalies and the safety of Nebraska Medicaid members. **Reporting 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.	**B1** submission reporting period – **1st-15th**; **B2** submission reporting period – **16th- last day of the month.** Submissions are due three (3) business days after the reporting period.
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 Report	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 IServe.	Monthly; No later than the 15th

Executive Dashboard	Summary operations, communications, financial, claims, and care management data for leadership meetings.	Monthly

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
Care Management Log	Data of member assessment and their care management.	Monthly; No later than the 15th
Grievance Log	Data regarding the grievances received by the MCOs.	Monthly; No later than the 15th
Appeals Log	Data regarding the appeals received by the MCOs.	Monthly; No later than the 15th
State Fair Hearing Log	Data regarding the state fair hearings.	Monthly; No later than the 15th
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
Language Availability Report	Summary data and metrics on language availability access as determined by MLTC.	Quarterly
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. The Provider Appointment Availability Access report will remain quarterly. Our expectation is that the MCOs will meet the entire sample size on an annual basis rather than on a quarterly basis.	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
Annual Deliverables	**Description**	**Due Date**
Adult Core Measures	Adult Core Measures results.	Annually; August 15th
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
Annual Systems Refresh Plan	Plan must outline how IS within the MCO's control will be systematically assessed to determine the need to modify, upgrade, or replace application	Annually; No later than December 31st

	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. Section V.R.4.	
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; August 15th
Clinical Advisory Committee Plan	Plan describing the development of the Clinical Advisory Committee	Annually; No later than January 15th
Clinical Practice Guidelines	Using information acquired through its Quality Assurance and Process Improvement (QAPI) and UM activities, the MCO must submit to MLTC annually the implementation of the clinical practice guidelines, including compliance and outcomes measures and a process to integrate these practice guidelines into care and case management and UR activities.	Annually; No later than February 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 October 31st , State initiates the request
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
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

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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 & 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 V.I – Provider Network Requirements.	Annually. No later than November 1st
Ownership Disclosure	Federal law requires full disclosure of ownership, management, and control of an MCO (42 CFR § 455.100-455.106). This information must be provided during the readiness review, annually thereafter for each contract year, and within 30 (thirty) calendar days of any change in the MCO's management, ownership or control. Section V.T.2.	Annually; No later than March 1st and when changes are made.
Prior Authorization Report	Data summarizing prior authorizations for MCPAR report (CMS)	Annually; No later than May 1st
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.	Annually; No later than Feb 15th
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.	Annually; No later than Feb 15th
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

Attachment 13 – Reporting Requirements
Effective January 1, 2026

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
Department of Insurance Financial Report	Copy of annual audited financial statement	Annually; No later than June 1 and 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 MLTC

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Certificate Of Completion

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Drew Gonshorowski drew.gonshorowski@nebraska.gov Director of Medicaid and Long-term Care Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Accepted: 4/1/2026 9:03:58 AM ID: 6979be92-426f-4316-b83b-ed868e6a49cc	Drew Gonshorowski Signature Adoption: Pre-selected Style Using IP Address: 164.119.5.154	Sent: 3/30/2026 10:18:12 AM Viewed: 4/1/2026 9:03:58 AM Signed: 4/1/2026 9:04:06 AM
Francis Clepper Francis.clepper@molinahealthcare.com President & CEO Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Accepted: 4/16/2026 12:22:17 PM ID: fbe26813-0e63-47bc-b3dc-e5ad9d874b76	Francis Clepper Signature Adoption: Pre-selected Style Using IP Address: 72.206.115.12 Signed using mobile	Sent: 4/1/2026 9:04:07 AM Resent: 4/2/2026 9:04:37 AM Resent: 4/14/2026 3:20:31 PM Resent: 4/15/2026 11:37:34 AM Viewed: 4/16/2026 12:22:17 PM Signed: 4/16/2026 12:22:34 PM

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Bradley Murphy Bradley.Murphy@nebraska.gov Procurement Contracts Officer DHHS Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Not Offered via Docusign	COPIED	Sent: 4/16/2026 12:22:35 PM
Kendra Wiebe Kendra.Wiebe@nebraska.gov Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Not Offered via Docusign	COPIED	Sent: 4/16/2026 12:22:35 PM

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Certified Delivered	Security Checked	4/16/2026 12:22:17 PM
Signing Complete	Security Checked	4/16/2026 12:22:34 PM
Completed	Security Checked	4/16/2026 12:22:35 PM

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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

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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

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