**Amendment Nine**
**Contract Number 102897 O4**

**Service Contract**

**Between**
**The State of Nebraska**
**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 the Vendor and the State of Nebraska.

**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. Section V.F.1.d.**

d. MCOs must send an annual notice of nondiscrimination to their members. MCO must submit notice to MLTC for review and approval prior to its use.

**B. Section V.F.6.c.**

c. Homeless Members: MCO must make an attempt to contact the member (via telephone and electronically) to determine if there is an alternate address member materials can be sent to. This attempt must be documented in the MCO customer service system.

**C. Section V.M.10.g.**

g. MCO must validate CMS Adult Core Set and CMS Child Core Set measure data.

**D. Section V.N.18.i-ii.**

i. 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:

ii. 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.

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

**A. Section V.E.29.i.ix. – NEMT Provider Service Requirements**

ix. The provider must wait 15 minutes following the scheduled pick-up time before departing without the member.

**B. Section V.I.15.b.**

b. The MCO must completely process credentialing applications from all required provider types within 60 (sixty) calendar days of receipt of a completed credentialing application.

**C. Section V.M.4.d.i.**

i. All committees must have a representative from the Health Disparity Committee.

**D. Section V.M.4.i.f)**

f) Health Disparity Committee: The Health Disparity Committee must identify areas of disparity and collaborate with members, providers, and communities to develop policy and care strategies that proactively promote the elimination of health disparities.

**E. Section V.M.5.**

5. **Health Disparity Committee**

**F. Section V.M.5.a.**

a. The MCO must participate in the MLTC's efforts to reduce health disparities and address social risk factors.

**G. Section V.M.5.c.**

c. The MCO must ensure the delivery of services in a culturally competent and effective manner to all members by promoting cultural competency at all levels of the MCO and with network providers.

**H. Section V.M.5.l.**

l. The Health Disparity Committee must include MCO leadership, care managers, members representing the geographic, cultural, and racial diversity of the MCO's membership, community leaders, provider network manager, and the QAPI Program manager.

**I. Section V.M.5.m.**

m. The Health Disparity Committee must meet a minimum of quarterly, and the MCO must keep written minutes of the meetings. The MCO must pay travel costs for committee members who are members or their representatives.

**J. Section V.N.17.a.i. - ii.**

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

**K. Section V.N.17.d.iii.b) - c)**

b) In a case involving an initial determination, the MCO must provide the member or a provider acting on behalf of the member and with the member's written consent an opportunity to request informal reconsideration of an adverse determination by the physician or dentist or clinical peer making the adverse determination.

c) The informal reconsideration should occur within one (1) business day of the receipt of the request and should be conducted between the provider rendering the service and the MCO's physician or dentist authorized to make adverse determinations, or a clinical peer designated by the Medical or Dental Director if the physician or dentist who made the adverse determination cannot be available within one (1) business day. The Informal Reconsideration will in no way extend the thirty (30) calendar day required timeframe for a Notice of Appeal Resolution.

**L. Section V.N.17.d.iv.a) – b)**

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.

**M. Section V.Q.7.b.**

b. By the end of the first year of the contract and annually thereafter, the MCO must submit to MLTC for its review and approval its plan for implementing value-based purchasing (VBP) agreements. MCO's shall include in their VBP plans strategies for localizing care management, addressing SDOH gaps, and addressing health disparities for the Medicaid population. MCO's must include plans for VBP for Medical and Behavioral health services and providers. MLTC reserves the right to establish benchmarks for the percentage of covered lives and paid dollars included in VBP arrangements.

**O. Attachment 6 – QPPs**
**P. Attachment 13 – Reporting Requirements**

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

**A. Glossary of Terms**
**Health Equity Committee:** A diversity, equity and inclusion committee is a task force of diverse staff members who are responsible for helping bring the cultural, and possibly ethical, changes necessary for MCO business

**Attachments:**

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

1. Attachment 6 - QPPs Molina AMENDED 5-8-2025 - Effective 1-1-2025
2. Attachment 13 - Reporting Requirements_ AMENDED 5-8-2025 - EFFECTIVE 1-1-2025

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

| FOR DHHS: | | FOR CONTRACTOR: | |
|---|---|---|---|
| By: | Signed by: Drew Gonshorowski 06E4C348F9184A5... | By: | Signed by: Francis Clepper 06B997CCB120447... |
| Name: | Drew Gonshorowski | Name: | Francis Clepper |
| Title: | Director, Division of Medicaid and Long-Term Care | Title: | President & CEO |
| Date: | 6/5/2025 \| 08:22:18 CDT | Date: | 5/30/2025 \| 13:22:10 PDT |

# Attachment 6 (AMENDED 5/8/2025)
# Quality Performance Program Measures – Contract Year Two
# Molina Healthcare of Nebraska
# Effective January 1, 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, 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** | **20%** |
| **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%** | **20%** |
| **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. | **N/A** | **95% within 20 calendar days** | **10%** |
| **Grievance Resolution Timeliness:** The MCO must dispose of each grievance and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes not to exceed 90 calendar days from the day the MCO receives the grievance. | **N/A** | **95% within 60 calendar days** | **10%** |
| **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. | **N/A** | **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. | **N/A** | **95% within 8 calendar days** | **15%** |

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| **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.<br>• Combination 2 | 31.39% | 34.3% | **5%** |
| **Prenatal and Postpartum Care (PPC):**<br><br>**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.<br><br>**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:<br>84.55%<br><br>Postpartum Care:<br>80.23% | Timeliness of Prenatal Care:<br>86.89%<br><br>Postpartum Care:<br>82.48% | **2.5%**<br><br>**2.5%** |
| **Child and Adolescent Well-Care Visits (WCV)**<br>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% | **5%** |
| **Follow-Up After Hospitalization for Mental Illness (FUH):**<br>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:<br>1. The percentage of discharges for which the individual received follow-up within 30 days after discharge. (Total)<br>2. The percentage of discharges for which the individual received follow-up within 7 days after discharge. (Total) | 30 days Total:<br>65.62%<br><br>7 days Total:<br>42.86% | 30 days Total:<br>68.56%<br><br>7 days Total:<br>46.99% | **2.5%**<br><br>**2.5%** |

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| **Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey: (Child and Adult)**<br>• Getting Care Quickly (Usually + Always)<br>• Getting Needed Care (Usually + Always)<br>• Customer Service (Usually + Always)<br>• Rating of All Health Care (9 + 10)<br>• Rating of Health Plan (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.

# Attachment 13 – Reporting Requirements (AMENDED 5/8/2025)
## Effective January 1, 2025

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| **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 |
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| 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).<br><br>**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 AccessNE. | Monthly; No later than the 15th |

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| 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 |

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| 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** |
| Dental Record Reviews | The MCO must report the results of all record reviews to MLTC quarterly. Sec. V.N.15.g. | Quarterly |
| 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 |

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| 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 |

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| 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<br>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 |
| **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 |
| 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 |

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| | 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 by September 30 |
| 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 |

Attachment 13 – Reporting Requirements (AMENDED 5/8/2025)
Effective January 1, 2025

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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 ; When changes are made. |
| 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 |

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| 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 |

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| 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; 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 |

## Certificate Of Completion

Envelope Id: 566EF566-F3E8-4267-801D-EF8700868F35
Status: Completed
Subject: Complete with Docusign: 102897-O4 Molina Healthcare of NE Amendment 9 CLMS 2261.pdf
Envelope Type: Contract
Envelope Name: 102897-O4 Molina Healthcare of NE Amendment 9 CLMS 2261
Divison:
DHHS Sender: DHHS.Procurement@nebraska.gov
DHHS Sharepoint ID:
FFATA Reporting Required:
Source Envelope:

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| Document Pages: 14 | Signatures: 2 | Envelope Originator: |
| Certificate Pages: 5 | Initials: 0 | Procurement Shared |
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| EnvelopeId Stamping: Enabled | | Lincoln, NE 68508-2529 |
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## Record Tracking

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| Signer Events | Signature | Timestamp |
|---|---|---|
| Francis Clepper<br>Francis.clepper@molinahealthcare.com<br>President & CEO<br>Security Level: Email, Account Authentication (None) | Signed by:<br>Francis Clepper<br>06B997CCB120447...<br>Signature Adoption: Pre-selected Style<br>Using IP Address: 174.228.36.102<br>Signed using mobile | Sent: 5/19/2025 1:04:44 PM<br>Viewed: 5/30/2025 3:21:54 PM<br>Signed: 5/30/2025 3:22:10 PM |
| **Electronic Record and Signature Disclosure:**<br>Accepted: 5/30/2025 3:21:54 PM<br>ID: 6b024230-7b5d-4dad-9a27-5cba574f9b20 | | |
| Drew Gonshorowski<br>drew.gonshorowski@nebraska.gov<br>Director of Medicaid and Long-term Care<br>Security Level: Email, Account Authentication (None) | Signed by:<br>Drew Gonshorowski<br>06E4C348F9184A5...<br>Signature Adoption: Pre-selected Style<br>Using IP Address: 164.119.5.218 | Sent: 5/30/2025 3:22:12 PM<br>Viewed: 6/5/2025 8:21:57 AM<br>Signed: 6/5/2025 8:22:18 AM |
| **Electronic Record and Signature Disclosure:**<br>Accepted: 6/5/2025 8:21:57 AM<br>ID: 278cc12c-b1ce-4450-9d0e-f8fbc20bcfe2 | | |

| In Person Signer Events | Signature | Timestamp |
|---|---|---|

| Editor Delivery Events | Status | Timestamp |
|---|---|---|

| Agent Delivery Events | Status | Timestamp |
|---|---|---|

| Intermediary Delivery Events | Status | Timestamp |
|---|---|---|

| Certified Delivery Events | Status | Timestamp |
|---|---|---|

| Carbon Copy Events | Status | Timestamp |
|---|---|---|
| Kristine Radke<br>Kristine.Radke@nebraska.gov<br>Security Level: Email, Account Authentication (None)<br>**Electronic Record and Signature Disclosure:**<br>Accepted: 5/12/2025 12:46:35 PM<br>ID: f78362dd-f9dc-4037-86a1-2a1926c06b61 | COPIED | Sent: 5/19/2025 1:04:44 PM<br>Viewed: 5/19/2025 1:06:56 PM |
| Kendra Wiebe<br>Kendra.Wiebe@nebraska.gov<br>Security Level: Email, Account Authentication (None)<br>**Electronic Record and Signature Disclosure:**<br>Not Offered via Docusign | COPIED | Sent: 5/30/2025 3:22:11 PM |

| Witness Events | Signature | Timestamp |
|---|---|---|

| Notary Events | Signature | Timestamp |
|---|---|---|

| Envelope Summary Events | Status | Timestamps |
|---|---|---|
| Envelope Sent | Hashed/Encrypted | 5/19/2025 1:04:44 PM |
| Certified Delivered | Security Checked | 6/5/2025 8:21:57 AM |
| Signing Complete | Security Checked | 6/5/2025 8:22:18 AM |
| Completed | Security Checked | 6/5/2025 8:22:18 AM |

| Payment Events | Status | Timestamps |
|---|---|---|

| Electronic Record and Signature Disclosure |
|---|

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| | |
|---|---|
| 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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