STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	06/23/17
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

VENDOR NUMBER: 2266837

VENDOR ADDRESS:

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

CONTRACT NUMBER
71165 O4

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2022

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for a five (5) year period from date of award. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

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

(djo 04/12/16)

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

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

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 1	392,451,761.0000	$	1.0000	392,451,761.00
2	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 2	409,151,871.0000	$	1.0000	409,151,871.00
3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

DHHS Division Director

7/3/17 Michelle Thompson 7.3.17
BUYER

7/6/17
MATERIEL ADMINISTRATOR

R43500|NISH0003|NISH0003 20150901

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MT 7.3.17
BUYER INITIALS

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

The State of Nebraska and Nebraska Total Care Inc make this Amendment (the Amendment") to Contract 71165 O4 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. MODIFICATIONS: The Parties hereto modify the following sections upon execution of this Amendment:

A. Glossary of Terms

Adverse Benefit Determination (formerly referred to as "Action"):
(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
(2) The reduction, suspension, or termination of a previously authorized service.
(3) The denial, in whole or in part, of payment for a service.
(4) The failure to provide services in a timely manner, as defined by the State.
(5) The failure of the MCO to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
(6) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments and other enrollee financial liabilities.

B. Section IV.B.7.c.iv

If the member's request for disenrollment is denied, the member can file a grievance to the enrollment broker or appeal the decision through the State's fair hearing process.

C. Section IV.E. – Covered Services and Benefits

8. Core Benefits and Services

<u>The following services represent a minimum benefit package that the MCO must provide to its members:</u>

a. Physical Health Services

i. Inpatient hospital services, including transitional hospital services and transplant services.
ii. Outpatient hospital services.

iii. Ambulatory surgical center (ASC) services.
iv. Physician services, including services provided by nurse practitioners, certified nurse midwives, and physician assistants, and clinic-administered injections/medications, and anesthesia services including those provided by a certified registered nurse anesthetist.
v. Services provided in federally-qualified health centers (FQHCs) and rural health clinics (RHCs).
vi. Services provided in Indian Health Service (IHS) facilities.
vii. Clinical and anatomical laboratory services, including the administration of blood draws completed in the physician's office or an outpatient clinic for a behavioral health diagnosis.
viii. Radiology services.
ix. Health Check (EPSDT) services.
x. Home health services.
xi. Private duty nursing services.
xii. Therapy services (physical therapy, occupational therapy, and speech pathology and audiology).
xiii. Durable medical equipment and medical supplies, including hearing aids, orthotics, prosthetics, and nutritional supplements.
xiv. Podiatry services.
xv. Chiropractic services.
xvi. Vision services.
xvii. Free standing birth center services.
xviii. Hospice services, except when provided in a nursing facility.
xix. Skilled/rehabilitative and transitional nursing facility services.
xx. Ambulance services.
xxi. Non-emergency ambulance transportation.
xxii. Transplant services.
xxiii. Pharmacy services.
xxiv. Nutrition Services

b. Behavioral Health Services

<u>Services for individuals age 20 and under, unless otherwise indicated:</u>

i. Crisis stabilization services (includes treatment crisis intervention).

ii. Inpatient psychiatric hospital (acute and sub-acute).

iii. Psychiatric residential treatment facility (age 19 and under).

iv. Outpatient assessment and treatment:

a) Partial hospitalization.
b) Day treatment.
c) Intensive outpatient.
d) Medication management.
e) Outpatient therapy (individual, family, or group).
f) Injectable psychotropic medications.
g) Substance use disorder treatment.
h) Psychological evaluation and testing.
i) Initial diagnostic interviews.
j) Sex offender risk assessment.
k) Community treatment aide (CTA) services.
l) Comprehensive child and adolescent assessment (CCAA).
m) CCAA addendum.
n) Hospital observation room services (up to 23 hours and 59 minutes in duration).
o) Parent child interaction therapy.
p) Child-parent psychotherapy.
q) Applied behavioral analysis.
r) Multi-systemic therapy.
s) Functional family therapy.
t) Peer support.

v. Rehabilitation services

a) Day treatment/intensive outpatient.
b) CTA services.
c) Professional resource family care.
d) Therapeutic group home.

Services for adults age 21 and over:

i. Crisis stabilization services (includes treatment crisis intervention).

ii. Inpatient psychiatric hospital services (acute and sub-acute).

iii. Outpatient assessment and treatment:

a) Partial hospitalization.
b) Social detoxification.
c) Day treatment.
d) Intensive outpatient.
e) Medication management.
f) Outpatient therapy (individual, family, or group).

g) Injectable psychotropic medications.
h) Substance use disorder treatment.
i) Psychological evaluation and testing.
j) Electroconvulsive therapy.
k) Initial diagnostic interviews.
~~l) Ambulatory detoxification.~~
l) In-home psychiatric nursing.
m) Peer Support

iv. Rehabilitation services

a) Dual-disorder residential.
b) Intermediate residential (SUD).
c) Short-term residential.
d) Halfway house.
e) Therapeutic community (SUD only).
f) Community support.
g) Psychiatric residential rehabilitation.
h) Secure residential rehabilitation.
i) Assertive community treatment (ACT) and Alternative (Alt) ACT.
j) Community support.
k) Day rehabilitation.

11. Pharmacy Services

c. Nebraska Medicaid Preferred Drug List

i. The MCO must follow the Nebraska Medicaid PDL. Preferred drugs must be adjudicated as payable without prior authorization, unless they are subject to clinical or utilization edits, as defined by MLTC. The PDL is subject to change on an ongoing basis. Refer to the following link for additional information: http://dhhs.ne.gov/medicaid/Pages/med_pharm.aspx
ii. The MLTC PDL vendor will provide to the MCO a weekly national drug code (NDC) file delegating the preferred or non-preferred status of each NDC.
iii. The MCO must begin updating the pharmacy claim system within twenty-four (24) hours of file receipt of the PDL file and loading must be complete within five (5) business days.
iv. The MCO must, at the direction of MLTC, begin to perform off-cycle PDL file updates within twenty-four (24) hours of file receipt of the PDL file and loading must be complete within five (5) business days.
v. The MCO must implement Pharmacy and Therapeutics Committee-reviewed PDL changes posted to the MLTC PDL website on the first day after the 30 calendar day public notice posting of such changes.
vi. The MCO is not authorized to and must not negotiate rebates with manufacturers for pharmaceutical products listed on the PDL. MLTC or its

designee will negotiate rebate agreements. Regardless if the MCO or its PBM has an existing rebate agreement with a manufacturer, all Nebraska Medicaid outpatient drug claims, including provider-administered drugs, must be rebateable exclusively to Nebraska Medicaid.

vii. The MCO must nominate a non-voting member to attend the Nebraska Pharmaceutical and Therapeutics Committee's biannual meetings during the term of this contract. Written final approval of nominees is made by MLTC.

D. Section IV.H. – Grievances and Appeals

4. Appeal Process

b. Following receipt of a notification of an adverse benefit determination by the MCO, the member has sixty (60) calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the MCO.

e. The MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within thirty (30) calendar days from the day the MCO receives the appeal. The MCO may extend the timeframes by up to 14 calendar days if the member requests the extension or the MCO shows that there is need for additional information and the reason(s) why the delay is in the member's interest. For any extension not requested by the member, the MCO must:

I. Make reasonable efforts to give the member prompt verbal notice of the delay.

II. Within two (2) calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if s/he or she disagrees with that decision.

III. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date on which the extension expires.

6. Continuation of Benefits

a. The MCO must continue a member's benefits if all of the following occur:

i. The member files the request for an appeal timely;

ii. The appeal involves the termination, suspension, or reduction of previously authorized services;

iii. The services were ordered by an authorized provider;

iv. The period covered by the original authorization has not expired; and

v. The member timely files for continuation of benefits, timely files means on or before the later of the following:

i. Within ten (10) calendar days of the MCO sending the notice of adverse benefit determination.

ii. The intended effective date of the MCO's proposed adverse benefit determination.

b. If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

vi. The member withdraws the appeal or request for state fair hearing.
vii. The member fails to request a state fair and continuation of benefits within 10 calendar days after the MCO send the notice of an adverse resolution to the member's appeal.
viii. The state fair hearing office issues a hearing decision adverse to the member.
ix. The authorization expires or authorization service limits are met.

c. The MCO may recover the cost of the continuation of services furnished to the member while the appeal was pending if the final resolution of the appeal upholds the MCO action to the extent that the services were furnished solely because of the requirements of this section.

7. Access to State Fair Hearings

c. The member or the member's representative (if any) may request a state fair hearing no later than 120 calendar days from the date of the MCO's notice of resolution.

E. Section IV.P. – MCO Reimbursement

5. Supplemental Delivery Payments

l. The MCO must not bill for a supplemental maternity payment until the delivery is paid by the MCO. The MCO must submit encounter data evidence of the delivery to be eligible to receive a supplemental delivery payment.

16. Medicare Crossover Methodology

a. The MCO must use the methodology for reconciling Medicare crossover claim experience for the period of July 1, 2017, through December 31, 2017, as set forth in Attachment 41 – Medicare Crossover Methodology.

F. Section IV.Q. – Provider Reimbursement

4. Indian Health Protections

a. Per Section 5006(d) of the American Recovery and Reinvestment Act of 2009, Public Law 111-5, the MCO must:
   i. Provide I/T/U providers, whether participating in the network or not, payment for covered services provided to Indian members who are eligible to receive services from these providers either:

i. At the all-inclusive encounter rate that the Unites States Department of Health and Human Services establishes.

ii. Make prompt payment to all I/T/U providers in its network in compliance with Federal regulations regarding payments to practitioners in individual or group practices, per 42 CFR 447.45 and 447.46.

b. Additional required Indian health protections are included in Section IV.F Member Services and Education.

G. Section IV.S. – Claims Management

4. Drug Claims Processing

j. The MCO will send its pharmacy encounter claims to Magellan via the FTP process. The MCO will send the encounter claims in the current State of Nebraska proprietary format and must send files from the preceding month no later than the eighth (8^{th}) day of the following month.

H. Attachment 8 – PBM Claims Processing Edits for the Nebraska Medicaid Psychotropic Drugs and Youth Initiative

The MCO must utilize prior authorization and additional edits for psychotropic drugs prescribed to youth, at a minimum, following the current DHHS guidelines.

I. Attachment 14 – Quality Performance Program Measures – Contract Year One

The updated Attachment 14 is attached hereto and made a part hereof.

J. Attachment 38 – Revised Reporting Requirements

The reporting requirements and templates have been changed. The updated requirements and report titles are set forth in the amended Attachment 38 attached hereto and made a part hereof.

K. Attachment 11 – Rates

The capitation rates for the Contractor have been adjusted for the time period of July 1, 2017, through December 31, 2017, and are set forth in the amended Attachment 11 attached hereto and made a part hereof.

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

State of Nebraska

By: Douglas Wilken

Name: ~~Bo Botelho~~ Doug Wilken

Title: Materiel Administrator

Date: 6 July 17

Nebraska Total Care Inc

By: Ryan R Sadler, CEO

Name: Ryan R Sadler

Title: CEO

Date: 6/15/17

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

By:

Name: Thomas W Thompson

Title: Interim Director

Date: 6/29/2017

ATTACHMENT 11 - RATES Effective July 1, 2017			
CATEGORY OF AID	NON-UNMC PORTION OF THE RATE	UNMC PASS-THROUGH	PAYMENT RATE
AABD 00-20 M&F	$ 1,216.27	$ 21.85	$ 1,238.12
AABD 21+M&F	$ 1,763.79	$ 24.33	$ 1,788.12
AABD 21+M&F-WWC	$ 3,076.40	$ 70.82	$ 3,147.22
CHIP M&F	$ 179.27	$ 1.33	$ 180.60
Family Under 1 M&F	$ 710.56	$ 20.25	$ 730.81
Family 01-05 M&F	$ 158.35	$ 1.73	$ 160.08
Family 06-20 F	$ 174.79	$ 1.40	$ 176.19
Family 06-20 M	$ 191.75	$ 1.10	$ 192.85
Family 21+ M&F	$ 417.76	$ 4.96	$ 422.72
Foster Care M&F	$ 513.33	$ 5.55	$ 518.88
Healthy Dual	$ 257.06	$ 6.40	$ 263.46
Dual LTC	$ 221.47	$ 4.43	$ 225.90
Non-Dual LTC	$ 3,419.62	$ 72.91	$ 3,492.53
Dual Waiver	$ 265.57	$ 5.65	$ 271.22
Non-Dual Waiver	$ 1,689.23	$ 41.37	$ 1,730.60
Katie Beckett 00-18 M&F	$ 13,552.65	$ 35.65	$ 13,588.30
599 CHIP - Cohort	$ 385.19	$ 16.05	$ 401.24
599 CHIP - Supplemental	$ 5,012.09	$ 134.95	$ 5,147.04
Maternity	$ 8,093.98	$ 212.79	$ 8,306.77

Rating Region 2			
CATEGORY OF AID	NON-UNMC PORTION OF THE RATE	UNMC PASS-THROUGH	PAYMENT RATE
AABD 00-20 M&F	$ 1,198.92	$ 13.91	$ 1,212.83
AABD 21+ M&F	$ 1,827.85	$ 8.79	$ 1,836.64
AABD 21+ M&F-WWC	$ 3,884.51	$ 4.26	$ 3,888.77
CHIP M&F	$ 177.43	$ 0.88	$ 178.31
Family Under 1 M&F	$ 651.15	$ 18.64	$ 669.79
Family 01-05 M&F	$ 155.09	$ 0.68	$ 155.77
Familly 06-20 F	$ 179.88	$ 0.60	$ 180.48
Family 06-20 M	$ 212.55	$ 0.80	$ 213.35
Family 21+ M&F	$ 487.61	$ 1.49	$ 489.10
Foster Care M&F	$ 515.25	$ 3.46	$ 518.71
Healthy Dual	$ 213.38	$ 2.35	$ 215.73
Dual LTC	$ 186.89	$ 1.37	$ 188.26
Non-Dual LTC	$ 2,212.90	$ 24.75	$ 2,237.65
Dual Waiver	$ 231.96	$ 2.77	$ 234.73
Non-Dual Waiver	$ 1,574.71	$ 22.56	$ 1,597.27
Katie Beckett 00-18 M&F	$ 13,552.65	$ 35.65	$ 13,588.30
599 CHIP - Cohort	$ 385.19	$ 16.05	$ 401.24
599 CHIP - Supplemental	$ 5,012.09	$ 134.95	$ 5,147.04
Maternity	$ 8,139.57	$ 35.34	$ 8,174.91

Attachment 14
Quality Performance Program Measures – Contract Year One

Base Performance Requirement	Payment Threshold	% of Payment Pool
Claims Processing Timeliness - 15 Days: Process and pay or deny, as appropriate, at least 90% of all clean claims for medical services provided to members within 15 business days of the date of receipt. The date of receipt is the date the MCO receives the clean claim.	95% within 15 business days	20%
Pharmacy Claims Processing Timeliness - 7 Days: Process and pay or deny, as appropriate, at least 90% of all clean claims from pharmacy providers for covered services within seven calendar days of receipt. The date of receipt is the date the MCO receives the claim.	95% within 7 calendar days	10%
Encounter Acceptance Rate: 95% of encounters submitted must be accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	98%	20%
Call Abandonment Rate: Less than 5% of calls that reach the Member/Provider 800 lines and are placed in queue but are not answered because the caller hangs up before a representative answers the call. Measured using annual system-generated reports.	<3%	10%
Average Speed to Answer: Calls to Member/Provider lines must be answered on average within 30 seconds. Measured using annual system-generated reports.	30 seconds	10%
Appeal Resolution Timeliness: The MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 45 calendar days from the day the MCO receives the appeal.	95% within 30 days	10%
Grievance Resolution Timeliness: The MCO must dispose of each grievance and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes not to exceed 90 calendar days from the day the MCO receives the grievance.	95% within 60 days	10%
PDL Compliance: The MCO shall dispense medications in PDL categories compliant with Nebraska State PDL Preferred Status at least 92% of the time each quarter.	95%	10%

Attachment 38 – Revised Reporting Requirements

Bi-Weekly	Due the 1st and 15th of the month.
Monthly Deliverables	Due on the 15th day of the following calendar month unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Quarterly Deliverables	Due 45 calendar days after the end of the most recent quarter unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Semi-Annual Deliverables	Due as specified in this attachment.
Annual Deliverables	Reports, files, and other deliverables due annually must be submitted within 30 calendar days following the 12th month of the contract year, except those reports that are specifically exempted from the 30-calendar day deadline by this RFP or by written agreement between MLTC and the MCO.
Ad Hoc Deliverables	Ad hoc reports must be submitted within five business days from the date of request, unless otherwise specified by MLTC.

- **If a due date falls on a weekend or State-recognized holiday, the deliverable is due the next business day.**
- **All reports must be submitted in an MLTC provided template or in a format approved by MLTC.**

Ad Hoc Deliverables	**Description**	**Due Date**
Criminal Report	Pursuant to IV.T.6, the MCO will report any criminal findings of a provider. The findings should include the provider identifying information (name/NPI/Taxonomy/complete address) and nature of criminal offence.	Ad Hoc
Standard Financial Reports	MLTC will request this with adequate notice given to the MCO.	Ad Hoc
Bi-Weekly Deliverables	**Description**	**Due Date**
Bi-Weekly Tips	Pursuant to IV.O, The MCO must notify MLTC if it identifies patterns of provider billing anomalies and/or the safety of Nebraska Medicaid members (42 CFR 455.15).	Bi-Weekly
Monthly Deliverables	**Description**	**Due Date**
Behavioral Health Wait and Wards in Residential Treatment	Summary data, by member, of the number of days before a member is accepted into a program and, by member, the number of days before the member is admitted to the program.	Monthly
Claims Payment Accuracy	Claims payment accuracy percentages as described in Section IV.S - Claims Management.	Monthly
Eligible and Number of BH Services Recipients	Summary data documenting by cohort the number of members eligible for and receiving behavioral health services.	Monthly
Hospice Monthly Report	Data summarizing hospice authorizations, admissions, and discharges.	Monthly

Member-Provider Call Center	Pursuant to Section IV.F, data summarizing relevant call center operations.	Monthly
MLTC Reporting Database: Grievance System Log table	Pursuant to Section IV.H, data regarding the grievance and appeal systems.	15th day of the following calendar month for each of the first 6 months, then Quarterly
MLTC Reporting Database: Out of State Placement Table	Summary data on admissions and discharges of members placed in out of state residential treatment.	Monthly
Monthly Claims Report	Summary data on claims system.	Monthly
Monthly FWA Detection Effort Report	Summary of the MCO's fraud prevention efforts as described in Section IV.O - Program Integrity.	Monthly
Monthly FWA Report	Summary of investigations as described in Section IV.O – Program Integrity.	Monthly
PDL Load Report	Data documenting that the MCO received and loaded the PDL file per contract requirements.	Monthly
Pharmacy Call Center Report	Data summarizing relevant pharmacy call center operations.	Monthly
Pharmacy Claims Report	Summary data on pharmacy claims system.	Monthly
Pharmacy Prior Authorization Report	Summary of prior authorizations, peer review, and peer-to-peer consultation statistics; also includes special categories of drug prior authorizations.	Monthly
Provider Call Center Quality	MCO's report of its measurement and monitoring of the accuracy of responses by the provider call center staff.	Monthly
Provider Network Changes	Data and metrics summarizing any change to the MCO's network.	Monthly
Psychotropic Medications for Youth Report	Summary of prior authorization and utilization relating to clinical edits.	Monthly
Restricted Services Report	Summary data related to members on restricted services.	Monthly
Third Party Resource	Summary data of all instances in which an MCO identified a TPR.	Monthly
Quarterly Deliverables	**Description**	**Due Date**
BH Residential Beds and Critical Incident	Summary data on the number of behavioral health-related residential beds available statewide and the number of critical incident reports by behavioral health facility and location.	Quarterly
GEO Access	Details of the MCO's network, including GeoAccess reports, as described in Section IV.I – Provider Network Requirements.	Quarterly
IHS Pharmacy Report	Summary data related to IHS pharmacy services.	Quarterly

Attachment 38 – Revised Reporting Requirements

LB1063_68-2004 Children's Health and Treatment Act	Data related to youth Medicaid mental health authorization requests for all children ages 0-19	Quarterly: reports submitted to the Nebraska Legislature are due Jan. 1, Apr. 1, July 1, and Oct. 1. The MCO must submit these reports to MLTC December 15, March 15, June 15 and September 15 for the previous calendar quarter.
MCO Financial Report	Financial Reporting Template that allows the state to measure all financial key performance indicators related to Heritage Health Managed Care, to include but not limited to costs, utilization, enrollment and revenue.	Quarterly and Annually; Due 45 calendar days after the end of the reported period.
MLTC Reporting Database: 30 Day Behavioral Health ER Visits	Summary data of ER visits with a behavioral health diagnosis subsequent to an inpatient behavioral health discharge.	Quarterly
MLTC Reporting Database: 30 Day Inpatient Re-Admits	Summary data of inpatient re-admissions.	Quarterly
MLTC Reporting Database: Admit and Re-Admit to Psych Inpatient	Summary data of inpatient or residential admissions and re-admissions.	Quarterly
MLTC Reporting Database: Care Management Log	Summary data of member assessment and their care management.	Quarterly
MLTC Reporting Database: Grievance System Log table	Pursuant to Section IV.H, data regarding the grievance and appeal systems.	Quarterly, after the first 6 months of the contract. Monthly for the first 6 months of the contract.
MLTC Reporting Database: Out of Network Referrals	Data and analysis summarizing out of network provider authorizations.	Quarterly
MLTC Reporting Database: Restraint and Seclusion	Data summarized, by behavioral health provider, on the number of incidents of restraint or seclusion by program type and location.	Quarterly
Network Adequacy and Cultural Competency Report	Summary data and metrics demonstrating network adequacy as determined by MLTC and described in Attachment 2 - Access Standards; including data and metrics on cultural competency access as determined by MLTC.	Quarterly
PDL Compliance Report	Data documenting accuracy in dispensing medications in PDL categories.	Quarterly
Pharmacy Prospective DUR Report	DUR statistics to support preparation of MLTC's annual CMS DUR report.	Quarterly
Pharmacy Retro-DUR Education Intervention Report	Project update in a format approved by MLTC.	Quarterly

Pharmacy Utilization Management Report	Data summarizing pharmacy utilization management categories including, but not limited to: quantity limits, prior authorization, step therapy, dose optimization, MAC, top 100 drugs, and top 50 drug categories listed by expenditures and claim count.	Quarterly
Provider Network and PCP Access	Summary data and metrics on network access as determined by MLTC and described in Attachment 2 - Access Standards.	Quarterly
Quality Oversight Committee Report	Committee activity summary as described in Section IV.M - Quality Management.	Quarterly
Quarterly FWA Trending Reports	Summary data and narrative regarding FWA trends.	Quarterly
Quarterly IHS Tracking	Data and metrics summarizing Indian Health Service delivery.	Quarterly
Quarterly Value-Added	Summary of value added services as agreed upon by the MCO and MLTC.	Quarterly; Due 45 days after the most recent calendar quarter
Service Verification	Service verification summary as described in Section IV.O – Program Integrity, Section IV.S – Claims Management, and Section IV. T – Reporting and Deliverables.	Quarterly
Subrogation	Data summarizing new and ongoing instances of subrogation.	Quarterly
Semi-Annual Deliverables	**Description**	**Due Date**
Claims Auditing Reporting Requirements	A report on error rate measurement data processing, medical necessity, and provider documentation audit of a statistically valid random sample of paid claims. The MCO must prepare an error rate measurement audit plan and submit it to MLTC for review and approval a minimum of 45 calendar days prior to the audit's planned completion date. The findings of the audit plan must be submitted to NMPI when completed. MLTC may require a corrective action plan based on the audit results.	June 30 and December 31
Member Advisory Committee Report	Narrative of the activities of the MCO's Member Advisory Committee as described in Section IV.M - Quality Management.	June 30 and December 31
Annual Deliverables	**Description**	**Due Date**
Adult Core Measures	Adult Core Measures results.	Annually
Annual Program Integrity Confirmation	Signed form acknowledging responsibilities related to the receipt of State and federal funds as described in Section IV.O - Program Integrity.	Annually
CAP	Results and status of all corrective action plans by provider type.	Annually
Child Core Measures	CHIPRA performance measure results.	Annually

Attachment 38 – Revised Reporting Requirements

Direct Medical Education/Indirect Medical Education Verification – In accordance with 471 NAC	For the state fiscal year, financial information on direct and indirect medical costs as required by MLTC in accordance with 471 NAC.	Annually; No later than March 31, State initiates the request
Fraud, Waste, Abuse, and Erroneous Payments Annual Plan	Compliance plan addressing requirements outlined in Section IV.O - Program Integrity.	Annually
HEDIS Report	HEDIS results.	Annually
Medication Therapy Management Report	Data and analysis that summarizes MTM program activities, the effectiveness of the program over the reporting period, and the objectives and implementation plan for the next reporting period.	Annually
MLTC Reporting Database: CAHPS -- Adult	Data and analysis summarizing results of the annual member satisfaction survey.	Annually
MLTC Reporting Database: CAHPS – Child/CHIP with CCC	Data and analysis summarizing results of the annual member satisfaction survey.	Annually
MLTC Reporting Database: CAHPS – Child/CHIP without CCC	Data and analysis summarizing results of the annual member satisfaction survey.	Annually
MLTC Reporting Database: Provider and Facility Survey	Data and analysis summarizing results of the annual provider and facility satisfaction surveys. The provider satisfaction survey tool and methodology must be submitted to MLTC for approval at least 90 days prior to its administration.	Annually
Network Development Plan & Network Development Plan Template	Details of the MCO's network adequacy, including attestation, GeoAccess reports, and a discussion of any provider network gaps and the MCO's remediation plans, as described in Section IV.I – Provider Network Requirements.	Annually
PIP Report	Annual report of all PIPs.	Annually
Quality Management Work Plan and Program Evaluation	Discussion of the MCO's quality goals, initiatives and work plan; as well as data and analysis summarizing the results of the annual quality work plan. All as described in Section IV.M – Quality Management.	Annually
Utilization Management	Data and analysis summarizing the MCO's annual evaluation of its UM program.	Annually
Department of Insurance Financial Report	Copy of annual audited financial statement	**Annually; Upon request of MLTC, no later than June 1**
IRS Form 8963	Copy of form	**Annually; By Sept. 5**

Attachment 41 --
Medicare Crossover Methodology

The State of Nebraska is implementing a change in its methodology for reimbursing providers for crossover claims, effective July 1, 2017. The new approach will consist of Medicaid being responsible for the lesser of the Medicaid allowed amount, and the Medicare cost-sharing remaining to be paid for each claim. For example, if the Medicare allowed amount for a claim is $100, the Medicaid allowed amount is $75, and Medicare has already paid $80 (assuming 20% coinsurance), then Medicaid would pay $0. If the Medicaid allowed amount were instead $85, then Medicaid would pay $5 ($85 Medicaid allowed - $80 Medicare paid).

Due to the significant impact this adjustment has on the dually eligible populations, the State and MCOs have agreed to the conduct a risk corridor surrounding crossover claim payments for the July – December 2017 period, which provides protection against misestimating, but still provides limited risk transfer between the parties.

The process for the risk corridor reconciliation will consist of a comparison of the actual PMPM experienced for crossover claims during the July – December 2017 contract period, and the assumed crossover PMPM within the capitation rates. The initial calculation will be done by MCO, Rating Region (1 and 2), and Dual COA (Healthy Dual, Dual LTC, and Dual Waiver). However, after calculating the comparison at the detailed level, the aggregate difference between the assumed and actual PMPM amounts for an individual MCO (across all Rating Regions and COAs) will be subject to the reconciliation.

The reconciliation process will be handled as a +/- 3% risk corridor, with no transfer of funds between 97-103% of the assumed PMPM amount, and 100% reconciliation outside of that threshold. In other words, this will be handled in a manner such that experience within 3% of the assumed crossover claims PMPM within the capitation rate (converted to dollars based on actual contract period membership) for an MCO will be at full risk (no payments or recoupments from the State). Any difference in excess of +/-3% will be fully reconciled. For example, if an MCO experiences $95 in claims, and the crossover claim amount assumed within the rates was $100, the State would recoup $2 from the MCO, and vice versa if the actual experience were higher than $103. If the MCO experiences between $97-$103, no recoupments or payments will be necessary. These thresholds mirror the percentages currently in place for the Heritage Health program-wide risk corridor.

The calculation will occur with six months of claims run out (paid through June 30, 2018), with an estimate for IBNR.

Given that the State has other risk-mitigation strategies in place for the Heritage Health program, which must be conducted within nine months of the end of CY17, the outcome of the crossover claims risk corridor will be incorporated as an adjustment to MCO revenue, prior to the calculation of the program-wide risk corridor and MLR.