

**Amendment 11**  
**Contract Number 102894 O4**

**Service Contract**

**Between**  
**The State of Nebraska Department of Health and Human Services**  
**And**  
**Nebraska Total Care Inc**

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

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

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

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

**A. ACRONYM AND INITIALISM LIST**

JIY – Justice Involved Youth

**B. Section V.A.2.o.**

- o.** Youth transitioning from incarceration including youth under 21 years old who are eligible for Medicaid; youth under 19 years old who are eligible for CHIP; and youth and young adults formerly in foster care.

**C. Section V.D.7.a.i-viii. - JIY MCO Case Management Staff Training Requirements**

- a.** The MCO case management staff competencies must include, and is not limited to, training in the following areas:
  - i.** Trauma-informed care
  - ii.** Person-centered care planning
  - iii.** Cultural competency
  - iv.** Culturally and Linguistically Appropriate Services (CLAS)
  - v.** Basic concepts in Behavioral health and SUD
  - vi.** Caring for people with intellectual and developmental disabilities
  - vii.** Health disparity and social inequities
  - viii.** Unique needs of the justice-involved population

**D. Section V.E.36.a-d. – Justice Involved Youth (JIY)**

- a. Effective October 19, 2025, Justice Involved Youth (JIY), through the Medicaid program, will begin receiving both pre- and post-release services to support incarcerated youth transition into the community. In the 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, the state must provide 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, in accordance with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, including a behavioral health screening or diagnostic service.
- b. In the 30 days prior to release and for at least 30 days following release, the MCO must provide targeted case management services, including referrals to appropriate care and services available in the geographic region of the home or residence of the eligible juvenile, where feasible, under the Medicaid state plan (or waiver of such plan).
- c. The MCO shall be responsible for coverage of both pre- and post-release JIY services as described above. JIY under this program will either have suspended Medicaid coverage upon their entrance into a carceral facility, or they will be found Medicaid eligible before their release. In either case, these JIY will be able to access targeted case management, screening and diagnostic services as stated.
- d. For the purposes of MCO coverage assignment, Medicaid will utilize a similar algorithm that it currently utilizes to assign Medicaid-eligible members to an MCO. MLTC will notify the MCO regarding JIY who are newly Medicaid eligible that the MCO will be responsible for providing applicable coverage, including for which period the coverage applies. MLTC will establish and provide the MCO with a finite list of service codes which will be eligible for the pre- and post-release service set payment.

**E. Section V.L.14.a-e. - Care and Case Management for Medicaid-eligible Individuals Transitioning from Public Institutions and Re-entering the Community**

- a. The CAA (Consolidated Appropriations Act, 2023) requires pre-release case management within thirty (30) calendar days of the date on which the juvenile is scheduled to be released from a public institution. MCO case and case management functions must include, and are not limited to the following based on the availability of medical records:
  - i. Attempt contact with the individual and/or legal guardian within two (2) business days of being notified of the individual's assignment to the MCO.
  - ii. Establish contact with the individual and foster a relationship characterized by respect, dignity, and trust.
  - iii. Assess the individual comprehensively, by acquiring and synthesizing information from various sources which may include information available from the discharging Public Institution, medical records, IEP, interviews with the individual or legal guardian, and state agencies, regarding their needs.
  - iv. The comprehensive assessment must include and is not limited to:
    - a) Current and past history on medical, vision, hearing, maternal health, behavioral health, dental health, intellectual / developmental disabilities, substance use disorder, HIV/AIDS, and other healthcare needs.
    - b) Clinical consultations with specialists.
    - c) Medication(s).
    - d) Behavioral health assessments i.e., age-appropriate Child and Adolescent Needs and Strengths (CANS) Assessment; and Adolescent-to-Adult transition assessment.
    - e) Foster care status.

- f) Preventive health screenings, HEALTH CHECK examination(s), and immunizations.
  - g) Screenings as appropriate for depression, anxiety, suicide risk and SUD/AUD/OD risks.
  - h) Lab work for common health conditions e.g., blood pressure, diabetes, mental health conditions, Hepatitis C, and HIV. Also review lab work.
  - i) Diagnostic testing and services.
  - j) DME.
  - k) Need for family planning services and supplies for both men and women.
  - l) Need for therapy post release e.g., physical therapy, occupational therapy, psychotherapy.
  - m) Need for MAT and accompanying counseling post-release.
  - n) Health-related social needs (HRSN).
  - o) Family and community supports.
- v. Develop an individualized person-centered care plan, based on the assessment(s), to address and meet the individual's needs, engaging the individual and their authorized supports in the decision-making process.
  - vi. Facilitate access to meet the individual's HRSN needs such as nutritious food, affordable and accessible housing, convenient and efficient transportation, safe neighborhoods, strong social and familial connections, quality education, opportunities for meaningful employment or skill building.
  - vii. Offer information to the individual in an easy to understand and actionable person-centered care plan.
  - viii. Provide education to the individual on Medicaid benefits and value-added services.
  - ix. Obtain the individual's contact information for use post-release.
  - x. Assist the individual with referrals and applications for Waiver or LTSS services as applicable.
  - xi. Assist the individual with establishing a medical home, behavioral health care, and a dental home as needed.
  - xii. Assist the individual with obtaining pertinent medical documentation and consents.
  - xiii. Assist with identification of and making the linkages, referrals, scheduling, and coordination of appointments needed with post-release community-based providers.
  - xiv. Coordinate the closure of age-appropriate preventive health care gaps based on USPSTF and EPSDT recommendations.
  - xv. MCO will be responsible for ensuring members are referred to applicable providers for on-going medication management post-release. At minimum, a 30-day supply of medication(s) as clinically appropriate post-release. If the discharging public institution does not provide the patient with a 30-day supply of medication as clinically appropriate post release, the MCO must do so.
  - xvi. Promote access to MAT and medication adherence.
  - xvii. Provide access to peer support services as described in the NE Medicaid Service Definition.
  - xviii. Identify and mitigate barriers to care, including HRSN.
  - xix. Facilitate a warm hand-off to post-release Care & Case manager(s) if different, that includes a meeting between the individual and both pre-release and post-release Care & Case managers, to ensure timely access to services and seamless transition of the patient-centered care plan implementation.
  - xx. Monitor ongoing implementation of the patient-centered care plan to ensure continuity of care and services as frequently as necessary.

- xxi. Participate in multidisciplinary patient care team meetings as needed.
  - xxii. Facilitate appropriate communication and exchange of information between the individual's Public Institution, community-based providers, school and DHHS divisions as needed.
  - xxiii. Ensure follow-up on receipt of services post-release.
  - xxiv. Conduct periodic assessment of the individual's needs to ensure ongoing monitoring of the patient-centered care plan and achievement of goals.
  - xxv. Update the patient-centered care plan, as necessary and implement the actions needed to meet the individual's needs.
- b. MCOs must provide 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.
  - c. MCOs can use in-person, telephonic, or telehealth modalities to provide case management, screening, and diagnostic services.
  - 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 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.
  - e. In the 30 days prior to release and for at least 30 days following release, MCOs must provide no less than six (6) hours of targeted case management services, including referrals to appropriate care and case management services, including referrals to appropriate care and services available in the geographic region of the home or residence of the eligible youth, where feasible, under the Medicaid state plan (or waiver of such plan.)

**F. Section V.N.18.iii.a) – Informal Reconsideration**

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

**G. Section V.P.17.a-c – MCO Reimbursement for JIY Services**

- a. The MCO will provide claim payment to the service provider for the defined covered services within each pre and post release category and will use the Nebraska Medicaid fee schedule as the basis for establishing an allowable payment rate. Providers must be enrolled in Nebraska Medicaid and contracted with the MCO.
- b. The MCO can invoice MLTC for all pre-release JIY services, and targeted case management for post release services for Medicaid eligible beneficiaries. Screening and diagnostic services paid for by the MCO for Medicaid eligible JIY are not invoiced separately and are included in at risk capitation.
- c. The MCO will invoice MLTC on a quarterly basis for eligible claims reimbursed on behalf of JIY member. At this time, the JIY limited benefit, with the exception of post release screening and diagnostics, will be excluded from capitation rates. The MCO will utilize the file layout provided by MLTC for payment invoicing. All invoices for reimbursement under this section must be submitted no later than 12 months from the date of service and include details sufficient to support Medicaid allowability.

**H. Section V.P.18.****18. Certified Community Behavioral Health Clinic (CCBHC) Specific Risk Corridor**

MLTC has established a Certified Community Behavioral Health Clinic (CCBHC) Risk Corridor beginning for CY26, which reflects the first year in which the CCBHC program is implemented. The purpose of this corridor is to provide upside and downside protection to the MCOs, and MLTC should the experience in the contract period be significantly different than the amounts projected within the Heritage Health capitation rates. Projected CCBHC PMPM targets will be developed for each rating cohort, region, and MCO prior to the start of the contract period. The CCBHC PMPM targets will reflect the proportion of the Heritage Health capitation rates that are attributed to PPS-reimbursed CCBHC services and will exclude the non-benefit loading portion of the rates. Upon completion of the contract period, the following will occur with claims data and/or supplemental MCO reporting, with at least 4 months of runout beyond the contract period:

- a. Each MCO's member months for the contract period will be identified and multiplied by the CCBHC PMPM targets noted above, to arrive at a state-wide CCBHC total expenditure MCO target for the contract period.
- b. Actual claims-based utilization of Prospective Payment System (PPS)-reimbursed CCBHC visits and associated costs will be identified for each MCO for the contract period, which will result in a calculation of actual experience.
- c. Separate for each MCO, the actual experience in #2 will be compared to the MCO target in #1. The differences between the actual and target amounts will be compared to the risk corridor bands, and a calculation will be conducted to determine any applicable dollar transfer necessary under this risk corridor.

This risk corridor applies to all Heritage Health members, except for the HIPP cohorts. The results of the CCBHC risk corridor reconciliation will be incorporated into the program-wide risk corridor and MLR calculation.

**I. Section V.Q.24 Member Reimbursement by Providers**

**24.** MCOs must reimburse a provider for appropriate covered services and that provider must reimburse a member for any payments made by the member. [NAC 2-003.10]

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

**A.** All references in this contract to the term "behavioral health" are hereby replaced with the term "mental health and substance abuse disorder".

**B. Attachment 13 – Reporting Requirements****C. Section V.I.6.a.iv.**

iv. Provide a Nebraska specific quarterly newsletter that includes articles covering topics of interest for all provider types. The newsletter must be posted on the MCO's website.

**D. Section V.P.14****14. High-Cost Drug Pool Risk Corridor**

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, except for dual-eligible, HIPP members, and expansion members, effective starting CY24.

**E. Section V.P.16. – HIPP Specific Risk Corridor****16. HIPP Specific Risk Corridor**

This risk corridor will be an MLR-based risk corridor applicable only to the HIPP population. This corridor is developed such that the target MLR will be calculated as one hundred percent (100%) minus the rating administrative load (exclusive of margin for profit/risk/contingency.) Since the HIPP population comprises multiple different rating cohorts with differing NML amounts built into the capitation rates, a blended MLR target will be determined. Based on each MCO's enrollment distribution between the applicable HIPP cohorts, an aggregate MLR target will be determined for each MCO. Once the aggregate MLR target is determined based on actual enrollment experience, the risk corridor recoupments/payouts will be calculated based on an adjustment revenue.

The numerator for the MLR calculation for the HIPP risk corridor will consist of medical expenditures only and will not include additional expenditures related to HIPP premiums. The denominator will exclude revenue taxes, non-operating income, and any forfeited hold-back recoupments under the HIPP-specific risk corridor will be incorporated into the MCO revenue prior to the calculation of the program-wide risk corridor and MLR.

**III. Deletions:** The Parties hereto agree to delete the following sections:**A. Section V.P.15.****15. Expansion Adult - MLR-Based Risk Corridor**

MLTC may implement an Expansion Adult specific risk corridor. This risk corridor will be an MLR-based risk corridor applicable only to the Expansion Adult population, including any HIPP HHA enrollees, such that the target MLR will be calculated as one hundred percent (100%) minus the rating administrative load (exclusive of margin for profit/risk/contingency). Specifically, this would result in a target of one hundred percent (100%) - ten and one quarter of one percent (10.25%), or eighty-nine and three quarters of one percent (89.75%). The risk corridor recoupments/payouts will be calculated based on an adjustment to revenue, similar to the method used for the current Heritage Health MLR calculations. This means the calculation will be conducted in a way that the Medical PMPM experience relative to the adjusted revenue (after risk corridor payments/recoupments) will be no more than ninety-one and three quarters of one percent (91.75%), and no less than eighty-seven and three quarters of one percent (87.75%).

The numerator for the MLR calculation for the HHA risk corridor will consist of medical expenditures only and will not include the additional expenditures allowable within the federal MLR guidelines (such as Quality Improvement expenditures). Any payouts or recoupments under the HHA-specific risk corridor will be incorporated into the MCO revenue prior to the calculation of the program-wide risk corridor and MLR.

**B. Section V.Q.20.g.**

- g. The MCO must provide a MAC file to the MLTC PDL contractor a minimum of quarterly. The file format will be defined by MLTC before the Contract Start Date.

**Attachments:**

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

- 1. Attachment 13 Reporting Requirements – Contract 102894 O4\_ AMENDED 10-1-2025\_ 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:

Signed by:  
 By: Drew Gonshorowski  
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Signed by:  
 By: Adam Proctor  
AC913FACE283442...

Name: Drew Gonshorowski

Name: Adam Proctor

Title: Director, Division of MLTC

Title: CEO

Date: 11/5/2025 | 10:30:15 CST

Date: 10/27/2025 | 09:18:57 CDT

**Attachment 13 – Reporting Requirements [Amended 10/01/2025]  
Effective January 1, 2025**

<b>Bi-Weekly</b>	<b>B1</b> submission reporting period – <b>1<sup>st</sup>-15<sup>th</sup></b> . <b>B2</b> submission reporting period – <b>16<sup>th</sup>- last day of the month</b> . Submissions are due three (3) business days after the reporting period.	
<b>Monthly Deliverables</b>	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.	
<b>Quarterly Deliverables</b>	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.	
<b>Semi-Annual Deliverables</b>	Due as specified in this attachment.	
<b>Annual Deliverables</b>	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.	
<b>Ad Hoc Deliverables</b>	Ad hoc reports must be submitted within five business days from the date of request, unless otherwise specified by MLTC.	
<ul style="list-style-type: none"> <li>• <b>If a due date falls on a weekend or State-recognized holiday, the deliverable is due the next business day.</b></li> <li>• <b>All reports must be submitted in an MLTC provided template or in a format approved by MLTC.</b></li> </ul>		
<b>Ad Hoc Deliverables</b>	<b>Description</b>	<b>Due Date</b>
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)
<b>Bi-Weekly Deliverables</b>	<b>Description</b>	<b>Due Date</b>
Bi-Weekly Tips	<p><b>Bi-weekly tips:</b> 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.</p> <p><b>Reporting Critical Incidents:</b> 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.</p>	<b>B1</b> submission reporting period – <b>1<sup>st</sup>-15<sup>th</sup></b> ; <b>B2</b> submission reporting period – <b>16<sup>th</sup>- last day of the month</b> . Submissions are due three (3) business days after the reporting period.
<b>Monthly Deliverables</b>	<b>Description</b>	<b>Due Date</b>
Third Party Resource – Health Coverage	Data on instances of MCO identified TPR	Monthly; No later than the 15 <sup>th</sup>
Call Center Report	Pursuant to Section V.F, data summarizing relevant call center operations.	Monthly; No later than the 15 <sup>th</sup>
Death Notifications	Data reporting MCO notification of member deaths to IServe.	Monthly; No later than the 15 <sup>th</sup>

**Attachment 13 – Reporting Requirements [Amended 10/01/2025]  
Effective January 1, 2025**

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 15 <sup>th</sup>
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 15 <sup>th</sup>
Monthly FWA Report	Summary of investigations as described in Section V.O – Program Integrity.	Monthly; No later than the 15 <sup>th</sup>
Pharmacy Claims Report	Data on Pharmacy claims volume, adjudication status, and payment timeliness	Monthly; No later than the 15 <sup>th</sup>
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 15 <sup>th</sup>
Provider Network Changes	Data and metrics summarizing any change to the MCO’s network.	Monthly; No later than the 15 <sup>th</sup>
Supplemental Member Care Report	Contains supplemental information related to member care and case management and member outreach.	Monthly; No later than the 15 <sup>th</sup>
Care Management Log	Data of member assessment and their care management.	Monthly; No later than the 15 <sup>th</sup>
Grievance Log	Data regarding the grievances received by the MCOs.	Monthly; No later than the 15 <sup>th</sup>
Appeals Log	Data regarding the appeals received by the MCOs.	Monthly; No later than the 15 <sup>th</sup>
State Fair Hearing Log	Data regarding the state fair hearings.	Monthly; No later than the 15 <sup>th</sup>
Out of Network Referrals	Data regarding out of network provider authorization requests.	Monthly; No later than the 15 <sup>th</sup>
<b>Quarterly Deliverables</b>	<b>Description</b>	<b>Due Date</b>
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.

Attachment 13 – Reporting Requirements [Amended 10/01/2025]  
Effective January 1, 2025

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 4 <sup>th</sup> (FFY Q1 (Oct-Dec)); May 4 <sup>th</sup> (FFY Q2 (Jan-Mar)); Aug 4 <sup>th</sup> (FFY Q3 (Apr-Jun)); Nov 4 <sup>th</sup> (FFY Q4 (July-Sept))
Insure Kids Now (IKN) – MLTC Notification	MCOs must provide MLTC the “ <b>Data File Submission and Validation Receipt</b> ”, with Examination Results of “ <b>Accepted</b> ” or “ <b>Accepted with rejected rows.</b> ” 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

**Attachment 13 – Reporting Requirements [Amended 10/01/2025]  
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Provider Appointment Availability Access	Summary data and metrics on provider network appointment access as determined by MLTC and described in Attachment 14 – Access Standards.	Quarterly
Psychotropic Medication for Youth Report	Summary of prior authorization and utilization relating to clinical edits.	Quarterly
Quarterly FWA Trending Reports	Summary data and narrative regarding FWA trends.	Quarterly
Service Verification	Service verification summary as described in Section V.O – Program Integrity, Section V.S – Claims Management, and Section V. T – Reporting and Deliverables.	Quarterly
Dental QAPI Committee Report	Narrative of the activities of the MCO’s Dental QAPI Committee as described in Section V.M.8.g. – Dental QAPI Committee Responsibilities.	Quarterly
<b>Semi-Annual Deliverables</b>	<b>Description</b>	<b>Due Date</b>
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
<b>Annual Deliverables</b>	<b>Description</b>	<b>Due Date</b>
Adult Core Measures	Adult Core Measures results.	Annually by June 30 <sup>th</sup>
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 31 <sup>st</sup>
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 31 <sup>st</sup>
	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 31 <sup>st</sup>
Child Core Measures	Child Core Measures results.	Annually by June 30 <sup>th</sup>
Clinical Advisory Committee Plan	Plan describing the development of the Clinical Advisory Committee	Annually; No later than January 15 <sup>th</sup>
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 15 <sup>th</sup>

**Attachment 13 – Reporting Requirements [Amended 10/01/2025]  
Effective January 1, 2025**

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 31 <sup>st</sup> , 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 1 <sup>st</sup>
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 15 <sup>th</sup>
HEDIS Report	HEDIS results.	Annually by June 30 <sup>th</sup>
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 5 <sup>th</sup>
CAHPS --Adult	Data regarding the annual member satisfaction survey for the listed population and supplement.	Annually; No later than September 30 <sup>th</sup>
CAHPS –Child with CCC	Data regarding the annual member satisfaction survey for the listed population and supplement.	Annually; No later than September 30 <sup>th</sup>
CAHPS – CHIP with CCC	Data regarding the annual member satisfaction survey for the listed population and supplement.	Annually; No later than September 30 <sup>th</sup>
CAHPS –Dental Survey (Adult)	Data regarding the annual member satisfaction survey for the listed population and supplement.	Annually; No later than September 30 <sup>th</sup>
Dental Survey (Child)	Data regarding the annual member satisfaction survey for the listed population and supplement	Annually; No later than September 30 <sup>th</sup>
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 15 <sup>th</sup>

**Attachment 13 – Reporting Requirements [Amended 10/01/2025]  
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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 1 <sup>st</sup>
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 1 <sup>st</sup>
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 1 <sup>st</sup> and when changes are made.
Prior Authorization Report	Data summarizing prior authorizations for MCPAR report (CMS)	Annually; No later than May 1 <sup>st</sup>
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 15 <sup>th</sup>
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 15 <sup>th</sup>
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 15 <sup>th</sup>
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 30 <sup>th</sup>
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 15 <sup>th</sup>
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 30 <sup>th</sup>

Attachment 13 – Reporting Requirements [Amended 10/01/2025]  
 Effective January 1, 2025

UM Program Description	Outlines UM structure and accountability mechanisms per contract section V.N.2.	Annually; No later than Feb. 15 <sup>th</sup>
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 30 <sup>th</sup>
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

## Certificate Of Completion

Envelope Id: 2054A8E5-10B5-4807-AEEF-726A8892B071	Status: Completed
Subject: Complete with Docusign: 102894-O4 Nebraska Total Care Inc Amendment 11 CLMS 2260.pdf	
Envelope Type: Contract	
Envelope Name: 102894-O4 Nebraska Total Care Inc Amendment 11 CLMS 2260	
Divison:	
DHHS Sender: DHHS.Procurement@nebraska.gov	
DHHS Sharepoint ID:	
FFATA Reporting Required:	
Source Envelope:	
Document Pages: 14	Signatures: 2
Certificate Pages: 5	Initials: 0
AutoNav: Enabled	Envelope Originator:
Envelopeld Stamping: Enabled	Procurement Shared
Time Zone: (UTC-06:00) Central Time (US & Canada)	301 Centennial Mall S
	Lincoln, NE 68508-2529
	dhhs.procurement@nebraska.gov
	IP Address: 164.119.5.70

## Record Tracking

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10/23/2025 3:29:29 PM	dhhs.procurement@nebraska.gov	
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## Signer Events

Adam Proctor  
 Adam.Proctor@NebraskaTotalCare.com  
 CEO  
 Security Level: Email, Account Authentication (None)

## Signature

Signed by:  
  
 AC913FACE283442...  
 Signature Adoption: Pre-selected Style  
 Using IP Address: 165.225.57.251

## Timestamp

Sent: 10/23/2025 3:32:24 PM  
 Resent: 10/24/2025 9:09:28 AM  
 Viewed: 10/24/2025 9:57:06 AM  
 Signed: 10/27/2025 9:18:57 AM

## Electronic Record and Signature Disclosure:

Accepted: 10/24/2025 9:05:45 AM  
 ID: 004eb5d0-dca7-403c-879e-0742ad374b3c

Drew Gonshorowski  
 drew.gonshorowski@nebraska.gov  
 Director of Medicaid and Long-term Care  
 Security Level: Email, Account Authentication (None)

Signed by:  
  
 06E4C348F9184A5...  
 Signature Adoption: Pre-selected Style  
 Using IP Address: 164.119.5.218

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 Resent: 11/3/2025 1:54:31 PM  
 Resent: 11/4/2025 8:38:39 AM  
 Resent: 11/4/2025 8:39:39 AM  
 Resent: 11/5/2025 8:00:38 AM  
 Viewed: 11/5/2025 10:30:05 AM  
 Signed: 11/5/2025 10:30:15 AM

## Electronic Record and Signature Disclosure:

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 ID: 5c232428-a9c0-405e-92e6-967fc9250a5e

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 Kristine.Radke@nebraska.gov Security Level: Email, Account Authentication (None) <b>Electronic Record and Signature Disclosure:</b> Accepted: 6/24/2025 8:26:55 AM ID: 18af51c9-148a-404a-9568-30e6e254dad8	COPIED	Sent: 10/23/2025 3:32:24 PM

Kendra Wiebe Kendra.Wiebe@nebraska.gov Security Level: Email, Account Authentication (None) <b>Electronic Record and Signature Disclosure:</b> Not Offered via DocuSign	COPIED	Sent: 10/27/2025 9:18:58 AM
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Witness Events	Signature	Timestamp
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Notary Events	Signature	Timestamp
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Envelope Summary Events	Status	Timestamps
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Certified Delivered	Security Checked	11/5/2025 10:30:05 AM
Signing Complete	Security Checked	11/5/2025 10:30:15 AM
Completed	Security Checked	11/5/2025 10:30:15 AM

Payment Events	Status	Timestamps
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Electronic Record and Signature Disclosure
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### **Consequences of changing your mind**

If you elect to receive required notices and disclosures only in paper format, it will slow the speed at which we can complete certain steps in transactions with you and delivering services to you because we will need first to send the required notices or disclosures to you in paper format, and then wait until we receive back from you your acknowledgment of your receipt of such paper notices or disclosures. To indicate to us that you are changing your mind, you must withdraw your consent using the DocuSign 'Withdraw Consent' form on the signing page of a DocuSign envelope instead of signing it. This will indicate to us that you have withdrawn your consent to receive required notices and disclosures electronically from us and you will no longer be able to use the DocuSign system to receive required notices and consents electronically from us or to sign electronically documents from us.

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**How to contact Nebraska Department of Health & Human Services:**

You may contact us to let us know of your changes as to how we may contact you electronically, to request paper copies of certain information from us, and to withdraw your prior consent to receive notices and disclosures electronically as follows:

To contact us by email send messages to: [john.canfield@nebraska.gov](mailto:john.canfield@nebraska.gov)

**To advise Nebraska Department of Health & Human Services of your new e-mail address**

To let us know of a change in your e-mail address where we should send notices and disclosures electronically to you, you must send an email message to us at [john.canfield@nebraska.gov](mailto:john.canfield@nebraska.gov) and in the body of such request you must state: your previous e-mail address, your new e-mail address. We do not require any other information from you to change your email address..

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To inform us that you no longer want to receive future notices and disclosures in electronic format you may:

- i. decline to sign a document from within your DocuSign session, and on the subsequent page, select the check-box indicating you wish to withdraw your consent, or you may;
- ii. send us an e-mail to [john.canfield@nebraska.gov](mailto:john.canfield@nebraska.gov) and in the body of such request you must state your e-mail, full name, US Postal Address, and telephone number. We do not need any other information from you to withdraw consent.. The consequences of your withdrawing consent for online documents will be that transactions may take a longer time to process..

**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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\*\* These minimum requirements are subject to change. If these requirements change, you will be asked to re-accept the disclosure. Pre-release (e.g. beta) versions of operating systems and browsers are not supported.

**Acknowledging your access and consent to receive materials electronically**

To confirm to us that you can access this information electronically, which will be similar to other electronic notices and disclosures that we will provide to you, please verify that you were able to read this electronic disclosure and that you also were able to print on paper or electronically save this page for your future reference and access or that you were able to e-mail this disclosure and consent to an address where you will be able to print on paper or save it for your future reference and access. Further, if you consent to receiving notices and disclosures exclusively in electronic format on the terms and conditions described above, please let us know by clicking the 'I agree' button below.

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- Until or unless I notify Nebraska Department of Health & Human Services as described above, I consent to receive from exclusively through electronic means all notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to me by Nebraska Department of Health & Human Services during the course of my relationship with you.