STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
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PAGE	ORDER DATE
1 of 1	11/30/16
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

CONTRACT NUMBER
71165 O4

VENDOR NUMBER: 2266837

VENDOR ADDRESS:

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

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)

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

12/2/16 pk Michelle Thompson 12-1-16
BUYER

12/2/16
MATERIEL ADMINISTRATOR

AMENDMENT ONE
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.

This Amendment (the "Amendment") is made by the State of Nebraska and Nebraska Total Care, Inc. parties 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. **ADDITION:** The following section is hereby added upon execution by the parties hereto:

A. Section IV.B.4.e Retroactive Enrollment

i. For members who are enrolled with retroactive enrollment dates, the plan must establish processes for: appropriate payment of providers for services provided.
ii. Providers to request retroactive determination of medical necessity for services.
    a. Plans may only deny the retroactive request after consultation with the provider and if the plan determines that the service was not medically necessary.
iii. Reimbursement of out-of-network Medicaid providers for services provided prior to the plan selection.
iv. The plan must establish a method for waiving the claim timely filing limit if the provider submitted the claim within the State's established timely filing limit from the date of member plan selection.

B. Section IV.E.31 Continuity of Care Post Implementation

a. The plans must establish processes for continuity of care for members newly enrolled in the plan after the implementation period.

b. The plans must establish an automated process for sharing of previously approved authorizations and care management plans in which a member was enrolled. The previous plan, must respond to the request of the new plan for this information within three (3) business days.

c. The plans shall provide active assistance to members when transitioning to another Heritage Health MCO or to Medicaid FFS.

d. The receiving Heritage Health MCO shall be responsible for the provision of medically necessary services covered under the Contract that are required for the member during the transition period (i.e. prenatal care, acute care, etc.). During this transition period, the receiving MCO shall be responsible for, but not limited to, notification to the new PCP of member's selection, initiation of the request of transfer for the member's medical files, arrangement of medically necessary services (if applicable) and all other requirements for new members.

e. With the exception of transplants, for which all previous authorizations will be honored, plans will honor, regardless of provider participation network status, previous authorizations for the lesser of:

i. 30 days from the transition between Heritage Health Plans;

ii. The end date on the authorization from the previous entity; or

iii. A new decision by the plan with consultation from the provider is reached on the medical necessity of the service.

C. Section IV.N.11.e.v.
The MCO's must establish processes for identification of new and transferred members who have existing restricted services.

II. **REMOVAL:** The following sections are hereby removed upon execution by the parties hereto:

A. Section IV.B.2.d.
B. Section IV.P.11. State Performance Penalties

III. **MODIFICATIONS:** The following sections are hereby modified effective upon execution by the parties hereto:

A. Glossary of Terms.

Administrative cap: The upper limit a MCO may spend on non-quality improvement administrative expenses. The calculation of the administrative cap is conducted by dividing an MCO's administrative spend by the MCO's revenue. The revenue used for this calculation will be the original premium developed by the

MLTC actuary net of HIPF but gross of hold-back funds (i.e. HIPF load will be subtracted but the premium will include both earned and forfeited hold-back funds). The HIPF load is the only component removed from the premium when calculating the administrative cap.

Health care professional: A physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, licensed mental health practitioner or licensed independent mental health practitioner, physician's assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse(including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed and certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Risk Corridor payment: Payment made by MLTC to a MCO to compensate the MCO for losses greater than the contracted amount for year one, as determined by the risk corridor calculation.

State Fair Hearing: A request by a member or any provider to appeal a decision made by a MCO, addressed to the State.

B. Section IV.B.2. Member Enrollment/Assignment

a. The MCO must comply with all enrollment and disenrollment procedures described in this section of the RFP.

b. The MCO and all its staff and subcontractors must have an understanding of the Medicaid population and the enrollment process. The MCO must work cooperatively with MLTC to resolve issues relating to enrollee participation and the enrollment process.

c. The State maintains responsibility for the enrollment of members into MCOs through a contractual arrangement with its enrollment broker. The State or its enrollment broker provides enrollees with access to a member guidebook, plan matrix, and provider directory to assist each enrollee in choosing a MCO plan and a PCP. The enrollment broker provides impartial choice counseling to assist each enrollee in choosing an MCO.

d. The enrollment broker is the only entity, other than MLTC, authorized to assist a Medicaid enrollee in the selection of an MCO. The enrollment broker is responsible for notifying all managed care enrollees and MCO members of their enrollment and disenrollment rights and responsibilities within the timeframe specified in this section.

e. Potential enrollees determined mandatory for managed care will be immediately enrolled in a Heritage Health Plan, retroactive to the first day of the member's eligibility for Medicaid. Retroactive enrollment into a Heritage Health Plan will not exceed three (3) months prior to month of plan selection, but in no instance shall be prior to January 1, 2017.

f. The MCO must have the technological capability and resources to interface with the State's and the enrollment broker's systems as necessary to support all aspects of the enrollment and disenrollment processes.

g. The MCO's eligibility system must show the member's effective date with the MCO as the first day of the month in which the member is determined Medicaid eligible, not to exceed three (3) months prior to the month of plan selection, but in no instance shall be prior to January 1, 2017. For example, if the State's eligibility file indicates the member was determined eligible on March 15, 2017 with a retroactive eligibility date of January 1, 2017, the MCO's eligibility system must reflect an enrollment date of January 1, 2017.

h. For current Heritage Health members at the time of the effective date of this contract, the annual enrollment choice period will be aligned with the contract start date.

i. MLTC and it enrollment broker shall make every effort to ensure that Medicaid eligible individuals who are excluded from managed care are not enrolled in a MCO. To ensure that such individuals are not assigned to a MCO, the MCO must work with MLTC or its enrollment broker to identify these individuals. The MCO must also notify MLTC if it learns that a member is no longer Medicaid eligible.

j. The enrollment broker will automatically re-enroll a member who is disenrolled solely because he or she loses Medicaid eligibility, when the loss of eligibility does not exceed two (2) months, into the same MCO.

C. Section IV.B.4.b. ii.

Because individuals can be retroactively eligible for Medicaid, and the effective date of initial enrollment in a MCO is the effective date of eligibility, not to exceed

three (3) months, the effective date of enrollment may occur prior to the MCO being notified of the individual's enrollment.

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

If the member's request for disenrollment is denied, the member can make a grievance or appeal to the enrollment broker.

E. Section IV.C.2.a.

All contracts must comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding educational programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; Section 1557 of the Affordable Care Act; and the Americans with Disabilities Act. The MCO must comply with any other applicable Federal and State laws (such as Title VI of the Civil Rights Act of 1964, etc.) and 45 CFR parts 160 and 164 (the Health Insurance Portability and Accountability Act [HIPAA] privacy rule).

F. Section IV.E.25 Durable Medical Equipment

a. The MCO must provide coverage and be financially responsible for medically necessary durable medical equipment (DME), prosthetics, orthotics, medical supplies, and assistive devices including, but not limited to, hearing aids.
b. The MCO must, at a minimum, provide coverage for DME-related covered services as listed in Chapters 7 and 8 of Title 471 of the Nebraska Administrative Code.
c. For in-network and out-of network providers, air fluidized beds, non-standard wheelchairs and wheelchair accessories, options, and components, including power operated vehicles, and negative pressure wound therapy (wound VAC) will be reimbursed separately to the nursing facility or intermediate care facility for intellectual and developmental disabled according to the maximum allowable rate on the durable medical equipment and supplies fee schedule.

G. Section IV.L.6.e.

The MCO must educate staff members and providers of the DHHS Division of Behavioral Health Women's Set Aside program. The MCO must educate staff of the Priority Populations which include; pregnant and injecting drug users, pregnant substance abusers, injecting drug users, and women with dependent children. This may include collaboration with the Division of Behavioral Health (DBH) as appropriate.

H. Section IV.P.9. Risk Corridor

a. Annual MCO profits must not exceed 3% in the first contract year. Annual MCO profits must not exceed 2.5% in the second contract year, and annual MCO profits in subsequent contract years must not exceed 2%. MCO losses for the first contract year must not exceed 3%. In subsequent contract years, there is no limit on MCO losses.

b. Profits and losses are calculated by MLTC's actuary as a percentage of the aggregate of all qualifying revenue by the MCO and related parties, including parent and subsidy companies and risk bearing partners under this contract. The calculation ignores revenue taxes, non-operating income, and any forfeited hold-back.

c. This calculation must be completed within nine months of the end of the contract year. The risk corridor will be calculated first, and any payments/receipts under the risk corridor will be incorporated in the MLR calculation. This methodology is consistent with the Final Rule published by CMS.

d. If the calculation produces a profit above the indicated amount, the MCO must ensure that the surplus is deposited in the reinvestment account, as described in this section, within nine months of the end of each contract year.

e. The MCO must provide a full financial statement and additional data as requested to MLTC and its actuary to support the calculation. MLTC will reimburse the Federal share of the forfeited funds to CMS. The remaining State share of the forfeited funds will be returned to the MCO for deposit back into the reinvestment account.

f. If the calculation for the first contract year produces a loss of more than 3%, MLTC will make a payment to the MCO an amount equal to the loss above that amount.

g. There will be no payment under this calculation by either party for the first contract year if the calculation produces an amount between a 3% profit and a 3% loss. There will be no payment by the MCO under this calculation for the second contract year if the calculation produces an amount that does not exceed a 2.5% profit. There will be no payment by the MCO under this calculation

for any subsequent contract year if the calculation produces an amount that does not exceed a 2% profit.

I. Section IV.P.10.a

The MCO must participate in the MLTC quality performance program (QPP), effective as of contract start date. The MLTC QPP must be implemented in accordance with Neb. Rev. Stat. §71-831 and any successor statutes.

J. Section IV.P.10.d

The MCO must report its performance measures that affect the MCO's eligibility to earn holdback funds monthly, quarterly, annually, and upon the request of MLTC.

K. Section IV.P.12 Administrative Cap

a. Per Neb. Rev. Stat. §71-831, the MCO's administrative spending must not exceed 12%.

b. Administrative expenditures do not include profit.

c. With its quarterly financial report, the MCO must provide to MLTC an accounting of administrative expenses.

d. To ensure compliance with state law, MLTC will calculate the administrative expense rate within nine months of the end of each contract year.

e. Hold-back funds, both earned and forfeited, are factored into the administrative cap calculation.

L. Section IV.S.11.d

The MCO must ensure that its claims adjudication process only allows claims from providers with 340B Health Resources and Service Administration (HRSA) designation to carve-in Nebraska Medicaid. The MCO must have a system in place to properly identify at the claim level and transmit these claims to MLTC or its designee.

The MCO must ensure that its claims adjudication process recognizes and denies payment on 340B claims submitted by any contract pharmacy in addition to, any provider that does not have a HRSA designation carving-in Nebraska Medicaid.

M. Section IV.V.2.d. Network Performance Requirement

Between the contract award date and the contract start date, the MCO must have a contracted provider network in place, sufficient in size and composition to meet the service requirements of its members on the contract start date. The required sufficiency must be submitted to MLTC a minimum of forty-five (45) calendar days prior to contract start date. MLTC may assess a penalty of $1,000 per calendar day for each day that the provider network is not adequate to meet the service needs of its members.

N. Section IV.X.2 Transition Period

a. The transition period for the contract begins on contract award and ends 90 calendar days after the contract start date. During the transition period the MCO must implement the requirements of the contract and collaborate with MLTC to facilitate a seamless transition between MCOs, providers, and programs in order to prevent an interruption of services and to ensure continuity of care for members.

   With the exception of transplants, for which all previous authorizations will be honored, MCOs will honor regardless of provider participation network status previous authorizations for the lesser of:

   i. 90 days from implementation;

   ii. The end date on the authorization from the previous entity; or

   iii. A new decision by the plan with consultation from the provider is determined on the medical necessity of the service.

O. Attachment 11- Rates

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

This amendment becomes 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.

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

State of Nebraska
Administrative Services

By: _____

Name: Bo Botelho

Title: Materiel Administrator

Date: 12/5/16

Nebraska Total Care, Inc.

By: _____

Name: Ryan R Sadler

Title: CEO

Date: 11/2/16

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

By: _____

Name: Calder Lynch

Title: Director

Date: 11/30/16

Amended Attachment 11
Rates

Rating Region 1			
Category Of Aid	Non-UNMC Portion of the Rate	UNMC Supplemental	Payment Rate
AABD 00-20 M&F	$ 1,217.94	$ 28.18	$ 1,246.12
AABD 21+ M&F	$ 1,712.27	$ 31.43	$ 1,743.70
AABD 21+ M&F-WWC	$ 2,840.54	$ 113.34	$ 2,953.88
CHIP M&F	$ 189.25	$ 2.17	$ 191.42
Family Under 1 M&F	$ 703.82	$ 20.98	$ 724.80
Family 01-05 M&F	$ 155.03	$ 2.83	$ 157.86
Family 06-20 F	$ 180.20	$ 2.41	$ 182.61
Family 06-20 M	$ 197.24	$ 1.92	$ 199.16
Family 21+ M&F	$ 423.08	$ 5.84	$ 428.92
Foster Care M&F	$ 519.52	$ 7.91	$ 527.43
Katie Beckett 00-18 M&F	$ 13,208.51	$ 100.00	$ 13,308.51
599 CHIP - Cohort	$ 398.99	$ 23.12	$ 422.11
599 CHIP - Supplemental	$ 5,280.32	$ 169.84	$ 5,450.16
Maternity	$ 8,108.55	$ 201.41	$ 8,309.96
Healthy Dual	$ 333.60	$ 10.79	$ 344.39
Dual LTC	$ 275.65	$ 7.45	$ 283.10
Non-Dual LTC	$ 3,163.51	$ 72.77	$ 3,236.28
Dual Waiver	$ 324.04	$ 9.36	$ 333.40
Non-Dual Waiver	$ 1,637.27	$ 45.52	$ 1,682.79

Rating Region 2			
Category of Aid	Non-UNMC Portion of the Rate	UNMC Supplemental	Payment Rate
AABD 00-20 M&F	$ 1,251.17	$ 18.54	$ 1,269.71
AABD 21+ M&F	$ 1,820.84	$ 10.10	$ 1,830.94
AABD 21+ M&F-WWC	$ 3,280.01	$ 0.47	$ 3,280.48
CHIP M&F	$ 188.17	$ 1.16	$ 189.33
Family Under 1 M&F	$ 683.16	$ 16.73	$ 699.89
Family 01-05 M&F	$ 163.69	$ 0.88	$ 164.57
Family 06-20 F	$ 187.70	$ 0.92	$ 188.62
Family 06-20 M	$ 224.63	$ 1.02	$ 225.65
Family 21+ M&F	$ 512.11	$ 1.88	$ 513.99
Foster Care M&F	$ 535.16	$ 4.11	$ 539.27
Katie Beckett 00-18 M&F	$ 13,208.51	$ 100.00	$ 13,308.51
599 CHIP - Cohort	$ 398.99	$ 23.12	$ 422.11
599 CHIP - Supplemental	$ 5,280.32	$ 169.84	$ 5,450.16
Maternity	$ 8,164.11	$ 42.87	$ 8,206.98
Healthy Dual	$ 289.47	$ 2.81	$ 292.28
Dual LTC	$ 239.30	$ 1.82	$ 241.12
Non-Dual LTC	$ 2,363.84	$ 31.55	$ 2,395.39
Dual Waiver	$ 299.89	$ 3.09	$ 302.98
Non-Dual Waiver	$ 1,622.05	$ 30.33	$ 1,652.38