Department of Health & Human Services
DHHS
NEBRASKA

77508 (08)

CONTRACT

BETWEEN THE

STATE OF NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF MEDICAID AND LONG-TERM CARE
AND
COVENTRY HEALTH CARE OF NEBRASKA, INC.

This contract is entered into by and between the Nebraska Department of Health and Human Services, MEDICAID AND LONG-TERM CARE (hereinafter the "State" or "DHHS") and COVENTRY HEALTH CARE OF NEBRASKA, INC. (hereinafter "Contractor" or "MCO").

I. TERM AND CONSIDERATION

A. TERM. This contract is effective from July 1, 2015 until June 30, 2017, and can be renewed for one (1) additional one (1) year period upon mutual agreement of the parties.

B. TOTAL PAYMENT. DHHS shall pay the Contractor a total amount not to exceed $375,536,220.00 (Three Hundred Seventy Five Million – Five Hundred Thirty Six Thousand – Two Hundred Twenty dollars) for the services specified herein.

C. PAYMENT STRUCTURE. Payment shall be structured in accordance with Section IV. D.

II. GLOSSARY OF TERMS

Acceptance Test Procedure: Benchmarks and other performance criteria, developed by the State of Nebraska or other sources of testing standards, for measuring the effectiveness of products or services and the means used for testing such performance.

Addendum: Something to be added or deleted to an existing document; a supplement.

Advance Directives: A written instruction, such as a living will or durable power of attorney for health care, recognized under State law, relating to the provision of healthcare when the individual is incapacitated.

Adverse Action: In the case of an MCO, an adverse action is:
1. Denial or limited authorization of a requested service, including the type or level of service;
2. Reduction, suspension, or termination of a previously authorized service;
3. Denial, in whole or in part, of payment for a service;
4. Failure to provide services in a timely manner, as defined by the State; and
5. Failure of an MCO to act within timeframes provided in Section IV.C.

Agency: Any state agency, board, or commission other than the University of Nebraska, the Nebraska State colleges, the courts, the Legislature, or any other office or agency established by the Constitution of Nebraska.

Agent/Representative: A person authorized to act on behalf of another.

Amend: To alter or change by adding, subtracting, or substituting.

Amendment: A written correction or alteration to a document.

Appeal: For the purposes of the Nebraska Medical Assistance program, the appeal is a request for review of an adverse action.

Appropriation: Legislative authorization to expend public funds for a specific purpose. Money set apart for a specific use.

ARO: After Receipt of Order

Auto Assignment: The process by which a client, who does not select a primary care provider (PCP) and/or plan within a predetermined length of time during enrollment activities is automatically assigned to a PCP/plan.

Basic Benefits Package: The minimum package of medical services that must be provided by the MCO to clients enrolled in physical health managed care.

Business: Any corporation, partnership, individual, sole proprietorship, joint-stock company, joint venture, or any other private legal entity.

Business Day: Any weekday, except State-recognized holidays.

Calendar Day: Every day shown on the calendar including Saturdays, Sundays, and State/Federal holidays.

Cancellation: To call off or revoke a purchase order without expectation of conducting or performing it at a later time.

Capitation Payment: A monthly payment by the State to the Contractor on behalf of each enrollee for the provision of medical services under the Contract. Payment is made regardless of whether the particular enrollee receives services during the period covered by the payment.

CFR: Code of Federal Regulations.

Client: For the purposes of the Medicaid program, an individual entitled to benefits under Title XIX or Title XXI of the Social Security Act and under the rules for participation in the Nebraska Medical Assistance Program.

CMS: Centers for Medicare and Medicaid Services, a U.S. federal agency that administers Medicare, Medicaid, and State Children's Health Insurance Programs.

Cold-Call Marketing: Any unsolicited personal contact by the MCO or PCCM with a potential enrollee for the purpose of marketing.

Collusion: An agreement or cooperation between two or more persons or entities to accomplish a fraudulent, deceitful, or unlawful purpose.

Competition: The effort or action of two or more commercial interests to obtain the same business from third parties.

Comprehensive Risk Contract: A risk contact that covers comprehensive services, that is, inpatient hospital services and (for purposes of Nebraska Medicaid Managed Care) services in the basic benefits package.

Confidential Information: Unless otherwise defined below, "Confidential Information" shall also mean proprietary trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In accordance with Nebraska Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive.

Contract: An agreement between two or more parties creating obligations that are enforceable or otherwise recognizable at law; the writing that sets forth such an agreement.

Contract Administration: The management of the contract which includes and is not limited to contract signing, contract amendments and any necessary legal actions.

Contract Management: The management of day to day activities at the agency which includes and is not limited to ensuring deliverables are received, specifications are met, handling meetings and making payments to the Contractor.

Contract Period: The duration of the contract.

Contractor: Any individual or entity having a contract to furnish commodities or services.

Contractor Performance Report: A report issued to the contractor when products or services delivered or performed fail to meet the terms of the purchase order, contract, and/or specifications by the agency. The contractor performance report will become a part of the permanent record for the Contractor. The State may require contractor to cure. Two such reports may be cause for immediate termination.

Conversion Period: A period of time not to exceed six (6) months, during which the State converts to a new Operating System under "Conversion" as per this RFP.

Cooperative Purchasing: The combining of requirements of two or more political entities to obtain advantages of volume purchases, reduction in administrative expenses or other public benefits.

Copyright: A property right in an original work of authorship fixed in any tangible medium of expression, giving the holder the exclusive right to reproduce, adapt and distribute the work.

Coverage Areas: Designated areas of the State for mandatory participation in Managed Care.

CPU: Any computer or computer system that is used by the State to store, process, or retrieve data or perform other functions using Operating Systems and applications software.

Critical Program Error: Any Program Error, whether or not known to the State, which prohibits or significantly impairs use of the Licensed Software as set forth in the documentation and intended in the contract.

Default: The omission or failure to perform a contractual duty.

Deviation: Any proposed change(s) or alteration(s) to either the terms and conditions or deliverables

within the scope of the written solicitation or contract.

DHHS: Nebraska Department of Health and Human Services

Disenrollment: A change in the status of a client from being enrolled with a specific managed care entity or a specific primary care provider to being enrolled with a different managed care entity or a different primary care provider or a change from being considered mandatory for participation in Managed Care to being ineligible for participation in Managed Care.

Documentation: The user manuals and any other materials in any form or medium customarily provided by the Contractor to the users of the Licensed Software which will provide the State with sufficient information to operate, diagnose, and maintain the Licensed Software properly, safely, and efficiently.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; (3) Serious dysfunction of any bodily organ or part.

Emergency Services: Covered inpatient and outpatient services that are either furnished by a provider that is qualified to furnish these services under Title 42 CFR or the services needed to evaluate or stabilize an emergency medical condition.

Encounter Data: Line-level utilization and expenditure data for services furnished to enrollees through the MCO.

Enrollee: A Medicaid recipient who is currently enrolled in an MCO or PIHP in a given managed care program. This term is used interchangeably with member.

Enrollment: The process of a client making a choice between the MCO and the PCCM Network or between two (2) MCO physical health plans.

Enrollment Broker (EB): The State's contracted entity for choice counseling and enrollment activities.

Enrollment Report: A proprietary data file provided by the State to the MCO or PCCM Network Administrator. The enrollment report is the basis for monthly payments to the MCO or PCCM Network Administrator.

Extension: Continuance of a contract for a specified duration upon the agreement of the parties beyond the original Contract Period. Not to be confused with "Renewal Period".

Family Planning Services: Covered services for family planning include initial physical examination and health history, annual and follow-up visits, laboratory services, prescribing and supplying contraceptive supplies and devices, counseling services, and prescribing medication for specific treatment.

Fee-for-Service: Payment by the NMAP directly to a provider for service provided to a client or enrollee.

Foreign Corporation: A foreign corporation that was organized and chartered under the laws of

another state, government, or country.

Grievance: An expression of dissatisfaction about any matter other than an action as "action" is defined above. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO level and access to the State fair hearing process.

Health Insurance Providers Fee: Section 9010 of the Patient Protection and Affordable Care Act (ACA) imposes a fee on each covered entity engaged in the business of providing health insurance for United States health risks.

Hospice or hospice service: A person or legal entity which provides home care, palliative care, or other supportive services to terminally ill persons and their families.

Immediate Enrollment: Individuals determined mandatory for Managed Care enrollment, will be enrolled into a Managed Care Organization (MCO), effective the first day of the month the individual selects a MCO or is auto assigned to that MCO.

Licensed Software Documentation: The user manuals and any other materials in any form or medium customarily provided by the Contractor to the users of the Licensed Software which will provide the State with sufficient information to operate, diagnose, and maintain the Licensed Software properly, safely, and efficiently.

Lock-In: A method used by the State to limit the medical services of a client who has been determined to be abusing or inappropriately utilizing services provided by the NMAP.

Managed Care Organization (MCO): An organization that has or is seeking to qualify for a comprehensive risk contract to provide services to Medicaid managed care enrollees. An entity that has, or is seeking to qualify for, a comprehensive risk contract , and that is – (1) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of Chapter 438 of the Code of Federal Regulations Title 42; or (2) Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: (i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served by the entity; and (ii) Meets the solvency standards of 42 CFR 438.116.

Managed Care Plan (Plan): Any of the contracted managed care entities that provide physical health services to clients enrolled in the NMMCP.

Mandatory/Must: Required, compulsory, or obligatory.

Marketing: Any communication from an MCO or PCCM to a Medicaid recipient who is not enrolled in that entity that can reasonably be interpreted as intended to influence the recipient to enroll in that particular MCO's or PCCM's Medicaid product or either to not enroll in or to disenroll from another MCO's or PCCM's Medicaid product.
May: Discretionary, permitted; used to express possibility.

Medical Home: The Center for Medical Home Improvement (CMHI) defines as a community-based primary care setting which provides and coordinates high quality, planned, family-centered: health promotion, acute illness care and chronic condition management.

Medical Necessity: Health care services and supplies which are medically appropriate, and –
1. Necessary to meet the basic health needs of the client;

2. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;
3. Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies;
4. Consistent with the diagnosis of the condition;
5. Required for means other than convenience of the client or his/her physician;
6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
7. Of demonstrated value; and
8. No more intense level of service than can be safely provided.

Member: A Medicaid recipient who is enrolled in a MCO or PIHP in a given managed care program. This term is used interchangeably with enrollee.

Module (see System): A collection of routines and data structures that perform a specific function of software.

Must: See Shall/Will/Must.

NAC: Nebraska Administrative Code

NMAP: The Nebraska Medical Assistance Program, administered by the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care. NMAP is also referred to as Medicaid.

NMES: The Nebraska Medicaid Eligibility System, an automated eligibility verification system for use by Medicaid service providers.

NMMCP: Nebraska Medicaid Managed Care Program

Operating System: The control program in a computer that provides the interface to the computer hardware and peripheral devices, and the usage and allocation of memory resources, processor resources, input/output resources, and security resources.

Outsourcing: The contracting out of a business process which an organization may have previously performed internally or has a new need for, to an independent organization from which the process is purchased back.

Outsourcing Company: A company that provides Outsourcing Services under contract to the State.

Payroll & Financial Center (PFC): Electronic procurement system of record.

Peer Review : An entity under contract with the State to perform a review of health care practitioners of service ordered or furnished by other practitioners in the same professional field.

Performance Bond: An insurance agreement, accompanied by a monetary commitment, by which a third party (the surety) accepts liability and guarantees that the Contractor fulfills any and all obligations under the contract.

Platform: A specific hardware and Operating System combination that is different from other hardware and Operating System combinations to the extent that a different version of the Licensed Software product is required to execute properly in the environment established by such hardware and Operating System combination.

Post Stabilization Care Services: Covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 CFR 438.114(e), to improve or resolve the enrollee's condition.

Potential Enrollee: A Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO or PCCM.

Primary Care Provider (PCP): A medical professional chosen by the member or assigned to provide primary care services. Provider types that can be PCPs are Medical Doctors (MDs) or Doctors of Osteopathy (DOs) from any of the following practice areas: General Practice, Family Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology (OB/GYN), Advanced Practice Nurses (APNs) and Physician Assistants (when APNs and Pas are practicing under the supervision of a physician specializing in Family Practice, Internal medicine, Pediatrics or Obstetrics/Gynecology who also qualifies as a PCP under this contract).

Primary Care Services: All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Product: Something that is distributed commercially for use or consumption and that is usually (1) tangible personal property, (2) the result of fabrication or processing, and (3) an item that has passed through a chain of commercial distribution before ultimate use or consumption.

Program Error: Code in Licensed Software which produces unintended results or actions, or which produces results or actions other than those described in the specifications. A program error includes, without limitation, any Critical Program Error.

Program Set: The group of programs and products, including the Licensed Software specified in the RFP, plus any additional programs and products licensed by the State under the contract for use by the State.

Project: The total scheme, program, or method worked out for the accomplishment of an objective, including all documentation, commodities, and services to be provided under the contract.

Proprietary Information: Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive.

Recommended Hardware Configuration: The data processing hardware (including all terminals, auxiliary storage, communication, and other peripheral devices) to the extent utilized by the State as recommended by the Contractor.

Renewal Period: Optional contract periods subsequent to the original Contract Period for a specified duration with previously agreed to terms and conditions. Not to be confused with Extension.

Risk Contract: A contract under which the Contractor: (1) Assumes risk for the cost of the services covered under the contract; and (2) Incurs loss if the cost of furnishing the services exceeds the payments under the contract.

Shall/Will/Must: An order/command; mandatory.

Should: Expected; suggested, but not necessarily mandatory.

Software License: Legal instrument with or without printed material that governs the use or redistribution of licensed software.

Sole Source – Services: A service of such a unique nature that the contractor selected is clearly and justifiably the only practical source to provide the service. Determination that the contractor selected as justifiably the sole source is based on either the uniqueness of the service or sole availability at the location required.

Specifications: The detailed statement, especially of the measurements, quality, materials, and functional characteristics, or other items to be provided under a contract.

Substitute Health Services: Those services a MCO has used as a replacement for or in lieu of a service covered under this Contract because the MCO has determined: (1) the MCO reimbursement for the Substitute Health Service is less than the MCO reimbursement for the Covered Service would have been, had the Covered Service been provided; and (2) that the health status and quality of life for the enrollee is expected to be the same or better using the Substitute Health Service as it would be using the Covered Service.

System (see Module): Any collection or aggregation of two (2) or more Modules that is designed to function, or is represented by the Contractor as functioning or being capable of functioning, as an entity.

Termination: Occurs when either party, pursuant to a power created by agreement or law, puts an end to the contract prior to the stated expiration date. All obligations which are still executory on both sides are discharged but any right based on prior breach or performance survives.

Third Party Resource (TPR): Any individual, entity, or program that is or may be liable to pay all or part of the cost of any medical services furnished to a client.

Trade Secret: Information, including, but not limited to, a drawing, formula, pattern, compilation, program, device, method, technique, code, or process that (a) derives independent economic value, actual or potential, from not being known to, and not being ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use; and (b) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy (see Neb. Rev. Stat. §87-502(4)).

Trademark: A word, phrase, logo, or other graphic symbol used by a manufacturer or vendor to distinguish its product from those of others, registered with the U.S. Patent and Trademark Office.

Upgrade: Any change that improves or alters the basic function of a product of service.

Will: See Shall/Will/Must.

Work Day: See Business Day.

III. TERMS AND CONDITIONS

A. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION

The Contractor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Contractors of the State of Nebraska, and their subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §48-1101 to 48-1125). The Contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Contractor shall insert a similar provision in all subcontracts.

B. PERMITS, REGULATIONS, LAWS

The Contractor shall procure and pay for all permits, licenses, and approvals necessary for the execution of the contract. The Contractor shall comply with all applicable local, state, and federal laws, ordinances, rules, orders, and regulations.

C. OWNERSHIP OF INFORMATION AND DATA

The State of Nebraska shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or derived by the Contractor pursuant to this contract.

The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, and other rights or titles (e.g. rights to licenses transfer or assign deliverables) necessary to execute this contract. The contract price shall, without exception, include compensation for all royalties and costs arising from patents, trademarks, and copyrights that are in any way involved in the contract. It shall be the responsibility of the Contractor to pay for all royalties and costs, and the State must be held harmless from any such claims.

D. INSURANCE REQUIREMENTS

The Contractor shall not commence work under this contract until all the insurance required hereunder has been obtained and such insurance has been approved by the State. The Contractor shall maintain all required insurance for the life of this contract and shall ensure that the State has the most current certificate of insurance throughout the life of this contract. If Contractor will be utilizing any subcontractors, the Contractor is responsible for obtaining the certificate(s) of insurance required herein under from any and all subcontractor(s). The Contractor is also responsible for ensuring subcontractor(s) maintain the insurance required until completion of the contract requirements. The Contractor shall not allow any subcontractor to commence work on any subcontract until all similar insurance required of the subcontractor has been obtained and approved by the Contractor. Approval of the insurance by the State shall not limit, relieve, or decrease the liability of the Contractor hereunder.

If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

1. **WORKERS' COMPENSATION INSURANCE**

The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Contractor shall require the subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. This policy shall include a waiver of subrogation in favor of the State. The amounts of such insurance shall not be less than the limits stated hereinafter.

2. **COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE**

The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor and any subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by any subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an occurrence basis, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury, and Contractual Liability coverage. The policy shall include the State, and others as required by the contract, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered excess and non-contributory. The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

3. **INSURANCE COVERAGE AMOUNTS REQUIRED**

a. **WORKERS' COMPENSATION AND EMPLOYER'S LIABILITY**

Coverage A	Statutory
Coverage B	
Bodily Injury by Accident	$100,000 each accident
Bodily Injury by Disease	$500,000 policy limit
Bodily Injury by Disease	$100,000 each employee

b. **COMMERCIAL GENERAL LIABILITY**

General Aggregate	$2,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 any one person
Bodily Injury/Property Damage	$1,000,000 per occurrence
Fire Damage	$50,000 any one fire
Medical Payments	$5,000 any one person

c. **COMMERCIAL AUTOMOBILE LIABILITY**

Bodily Injury/Property Damage	$1,000,000 combined single limit

d. **UMBRELLA/EXCESS LIABILITY**
Over Primary Insurance $1,000,000 per occurrence

e. **SUBROGATION WAIVER**
"Waiver of Subrogation on the Worker's Compensation in favor of the State of Nebraska."

f. **LIABILITY WAIVER**
"The State of Nebraska, Certificate holder, is an additionally insured, primary & noncontributory on the General Liability."

4. **EVIDENCE OF COVERAGE**
The Contractor shall furnish the State a certificate of insurance coverage complying with the above requirements to the attention of:

Heather Leschinsky
Department of Health and Human Services
Medicaid and Long-Term Care
P.O. Box 95026
Lincoln, NE 68509

These certificates or the cover sheet shall reference the contract, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Notice of cancellation of any required insurance policy must be submitted to Administrative Services State Purchasing Bureau when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

E. COOPERATION WITH OTHER CONTRACTORS

The State may already have in place or choose to enter into supplemental contracts for work related to the Scope of Work provided by the Contractor herein or any portion thereof.

1. The State reserves the right to award the contract jointly between two or more potential Contractors, if such an arrangement is in the best interest of the State.
2. The Contractor shall agree to cooperate with such other Contractors, and shall not commit or permit any act which may interfere with the performance of work by any other Contractor.

F. INDEPENDENT CONTRACTOR

It is agreed that nothing contained herein is intended or should be construed in any manner as creating or establishing the relationship of partners between the parties hereto. The Contractor represents that it has, or will secure at its own expense, all personnel required to perform the services under the contract. The Contractor's employees and other persons engaged in work or services required by the Contractor under the contract shall have no contractual relationship with the State; they shall not be considered employees of the State.

All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination against the Contractor, its officers, or its agents) shall in no way be the responsibility of the State. The Contractor will hold the State harmless from any and all such claims. Such personnel or other persons shall not require nor be entitled to any compensation, rights, or benefits from the State including without limit, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

G. CONTRACTOR RESPONSIBILITY

The Contractor is solely responsible for fulfilling the contract, with responsibility for all services offered and products to be delivered as stated in Section IV, Project Description and Scope of Work. The Contractor shall be the sole point of contact regarding all contractual matters.

If the Contractor intends to utilize any subcontractor's services, the subcontractor's level of effort, tasks, and time allocation must be clearly defined and submitted to the State for review and approval. Following execution of the contract, the Contractor shall proceed diligently with all services and shall perform such services with qualified personnel in accordance with the contract.

H. CONTRACTOR PERSONNEL

The Contractor warrants that all persons assigned to the project shall be employees of the Contractor or specified subcontractors, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor. The Contractor shall include a similar provision in any contract with any subcontractors selected to perform work on the project.

Personnel commitments shall not be changed without the prior written approval of the State. Replacement of key personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or subcontractor employee.

In respect to its employees, the Contractor agrees to be responsible for the following:

1. any and all employment taxes and/or other payroll withholding;
2. any and all vehicles used by the Contractor's employees, including all insurance required by state law;
3. damages incurred by Contractor's employees within the scope of their duties under the contract;
4. maintaining workers' compensation and health insurance and submitting any reports on such insurance to the extent required by governing State law; and
5. determining the hours to be worked and the duties to be performed by the Contractor's employees.

I. STATE OF NEBRASKA PERSONNEL RECRUITMENT PROHIBITION

The Contractor shall not, at any time, recruit or employ any State employee or agent who has worked on the contract or project, or who had any influence on decisions affecting the contract or project.

J. CONFLICT OF INTEREST

By signing this contract, the Contractor certifies that there does not now exist any relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this contract or project.

The Contractor certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or appearance of conflict of interest.

The Contractor certifies that it will not employ any individual known by bidder to have a conflict of interest.

K. ERRORS AND OMISSIONS

The Contractor shall not take advantage of any errors and/or omissions in this contract. The Contractor must promptly notify the State of any errors and/or omissions that are discovered.

L. ASSIGNMENT BY THE STATE

The State shall have the right to assign or transfer the contract or any of its interests herein to any agency, board, commission, or political subdivision of the State of Nebraska. There shall be no charge to the State for any assignment hereunder.

M. ASSIGNMENT BY THE CONTRACTOR

The Contractor may not assign, voluntarily or involuntarily, the contract or any of its rights or obligations hereunder (including without limitation rights and duties of performance) to any third party, without the prior written consent of the State, which will not be unreasonably withheld.

N. GOVERNING LAW

The contract shall be governed in all respects by the laws and statutes of the State of Nebraska. Any legal proceedings against the State of Nebraska regarding this contract shall be brought in the State of Nebraska administrative or judicial forums as defined by State law. The Contractor must be in compliance with all Nebraska statutory and regulatory law.

O. ATTORNEY'S FEES

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Contractor agrees to pay all expenses of such action, as permitted by law, including attorney's fees and costs, if the State is the prevailing party.

P. ADVERTISING

The Contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the State. News releases pertaining to the project shall not be issued without prior written approval from the State.

Q. STATE PROPERTY

The Contractor shall be responsible for the proper care and custody of any State-owned property which is furnished for the Contractor's use during the performance of the contract. The Contractor shall reimburse the State for any loss or damage of such property; normal wear and tear is expected.

R. SITE RULES AND REGULATIONS

The Contractor shall use its best efforts to ensure that its employees, agents, and subcontractors comply with site rules and regulations while on State premises. If the Contractor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to between the State and the Contractor.

S. NOTIFICATION

All communication between Contractor and the State regarding the contract shall take place between the Contractor and individuals specified by the State in writing. Written notices, including all reports and other written communication required by this contract shall be sent to the following addresses:

FOR STATE:

Heather Leschinsky
Department of Health and Human Services
Medicaid and Long-Term Care
P.O. Box 95026
Lincoln, NE 68509

FOR CONTRACTOR:

Shelley Wedergren
Aetna Better Health of Nebraska
15950 West Dodge Road
Omaha, NE 68118
Ph: 402-995-7266
Email: sdwedergren@aetna.com

Either party may change its address for notification purposes by giving notice of the change, and setting forth the new address and an effective date.

T. EARLY TERMINATION

The contract may be terminated as follows:

1. The State and the Contractor, by mutual written agreement, may terminate the contract at any time.

2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar days written notice to the Contractor. Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract. In the event of cancellation the Contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.

3. The State may terminate the contract immediately for the following reasons:

   a. if directed to do so by statute;
   b. Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;
   c. a trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court;
   d. fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders;
   e. an involuntary proceeding has been commenced by any party against the Contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Contractor has been decreed or adjudged a debtor;
   f. a voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;
   g. Contractor intentionally discloses confidential information;
   h. Contractor has or announces it will discontinue support of the deliverable;
   i. second or subsequent documented "contractor performance report" form deemed acceptable by the State Purchasing Bureau; or
   j. Contractor engaged in collusion or ones actions which could have provided Contractor an unfair advantage in obtaining this contract.

4. The Contractor may terminate this contract, without penalty, no later than ten (10) business days following the release of the finalized rates. The Contractor shall provide written notice of such termination to the State. For the purposes this provision (Article III.T.4.) only, "finalized rates" shall mean the actuarially certified monthly capitation rates in effect for the initial six (6) month contract period of July 1, 2015 through December 31, 2015. The Contractor does not retain any right to terminate this contract in connection with the release of monthly capitation rates that do not cover the initial six (6) month contract period of July 1, 2015 through December 31, 2015.

5. The Contractor shall comply with a contract provisions and all pertinent State and Federal requirements. Prior to termination under 42 CFR 438.710, the State must:
   a. Give the MCO written notice of its intent to terminate, the reason for the termination and the time and place of hearing;
   b. After the hearing, give the MCO written notice of the decision affirming or reversing the proposed termination of the contract and the effective date of the termination; and
   c. For an affirming decision, give enrollees notice of the termination and information on their options for receiving Medicaid services following the effective date of termination.

6. The Contractor shall comply with 42 CFR 434.6(a)(6) in the event of a termination by promptly supplying all information necessary for the reimbursement of any outstanding Medicaid claims to the State.

U. FUNDING OUT CLAUSE OR LOSS OF APPROPRIATIONS

The State may terminate the contract, in whole or in part, in the event funding is no longer available. The State's obligation to pay amounts due for fiscal years following the current fiscal year is contingent upon legislative appropriation of funds for the contract. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal years for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of any termination, and advise the Contractor of the location (address and room number) of any related equipment. All obligations of the State to make payments after the termination date will cease and all interest of the State in any related equipment will terminate. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.

V. BREACH BY CONTRACTOR

The State may terminate the contract, in whole or in part, if the Contractor fails to perform its obligations under the contract in a timely and proper manner. The State may, by providing a written notice of default to the Contractor, allow the Contractor to cure a failure or breach of contract within a period of thirty (30) calendar days (or longer at State's discretion considering the gravity and nature of the default). Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing the Contractor time to cure a failure or breach of contract does not waive the State's right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby.

W. ASSURANCES BEFORE BREACH

If any document or deliverable required pursuant to the contract does not fulfill the requirements of the contract, upon written notice from the State, the Contractor shall deliver assurances in the form of additional Contractor resources at no additional cost to the project in order to complete the deliverable, and to ensure that other project schedules will not be adversely affected.

X. ADMINISTRATION – CONTRACT TERMINATION

1. The Contractor must provide confirmation that upon contract termination all records (including the provisions of service, participant and data processing documents) shall become the property of the State of Nebraska and be provided to the State of Nebraska at no additional cost to the State.

2. The Contractor must provide confirmation that in the event of contract termination, all records that are the property of the State will be returned to the State within thirty (30) calendar days.

Y. PENALTY

In the event that the Contractor fails to perform any substantial obligation under the contract, the State may withhold all monies due and payable to the Contractor, without penalty, until such failure is cured or otherwise adjudicated. Failure to meet the dates for the deliverables as agreed upon by the parties may result in an assessment of penalty due the State of

$1,000.00 dollars per day, until the deliverables are approved. Contractor will be notified in writing when penalty will commence.

Z. PERFORMANCE BOND

The selected Contractor will be required to supply a certified check or a bond executed by a corporation authorized to contract surety in the State of Nebraska, payable to the State of Nebraska, which shall be valid for the life of the contract to include any renewal and/or extension periods. The amount of the certified check or bond must be ten million dollars ($10,000,000.00). The check or bond will guarantee that the Contractor will faithfully perform all requirements, terms and conditions of the contract. If the Contractor chooses to provide a certified check, the check must show an expiration date on the check. Certified checks will only be allowed for contracts for three (3) years or less, including all renewal options. Failure to comply shall be grounds for forfeiture of the check or bond as liquidated damages. Amount of forfeiture will be determined by the agency based on loss to the State. The bond or certified check will be returned when the service has been satisfactorily completed as solely determined by the State, after termination or expiration of the contract.

AA. FORCE MAJEURE

Neither party shall be liable for any costs or damages resulting from its inability to perform any of its obligations under the contract due to a natural disaster, or other similar event outside the control and not the fault of the affected party ("Force Majeure Event"). A Force Majeure Event shall not constitute a breach of the contract. The party so affected shall immediately give notice to the other party of the Force Majeure Event. The State may grant relief from performance of the contract if the Contractor is prevented from performance by a Force Majeure Event. The burden of proof for the need for such relief shall rest upon the Contractor. To obtain release based on a Force Majeure Event, the Contractor shall file a written request for such relief with the State. Labor disputes with the impacted party's own employees will not be considered a Force Majeure Event and will not suspend performance requirements under the contract.

BB. PAYMENT

State will render payment to Contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State. Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408). The State requires the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the Contractor prior to the Effective Date, and the Contractor hereby waives any claim or cause of action for any such services. Payment to the Contractor will be made pursuant to the terms of the contract. The Contractor is not required to submit an invoice for monthly capitation payments. Payment for such will be made electronically based on the enrollment file.

CC. RIGHT TO AUDIT

Contractor shall establish and maintain a reasonable accounting system that enables the State to readily audit the contract. The State and its authorized representatives shall have the right to audit, to examine, and to make copies of or extracts from all financial and related records (in whatever form they may be kept, whether written, electronic, or other) relating to or pertaining

to this contract kept by or under the control of the Contractor, including, but not limited to those kept by the Contractor, its employees, agents, assigns, successors, and subcontractors. Such records shall include, but not be limited to, accounting records, written policies and procedures; all paid vouchers including those for out-of-pocket expenses; other reimbursement supported by invoices; ledgers; cancelled checks; deposit slips; bank statements; journals; original estimates; estimating work sheets; contract amendments and change order files; backcharge logs and supporting documentation; insurance documents; payroll documents; timesheets; memoranda; and correspondence.

Contractor shall, at all times during the term of this contract and for a period of ten (10) years after the completion of this contract, maintain such records, together with such supporting or underlying documents and materials. The Contractor shall at any time requested by the State, whether during or after completion of this contract and at Contractor's own expense make such records available for inspection and audit (including copies and extracts of records as required) by the State. Such records shall be made available to the State during normal business hours at the Contractor's office or place of business. In the event that no such location is available, then the financial records, together with the supporting or underlying documents and records, shall be made available for audit at a time and location that is convenient for the State. Contractor shall ensure the State has these rights with Contractor's assigns, successors, and subcontractors, and the obligations of these rights shall be explicitly included in any subcontracts or agreements formed between the Contractor and any subcontractors to the extent that those subcontracts or agreements relate to fulfillment of the Contractor's obligations to the State.

Costs of any audits conducted under the authority of this right to audit and not addressed elsewhere will be borne by the State unless certain exemption criteria are met. If the audit identifies overpricing or overcharges (of any nature) by the Contractor to the State in excess of one-half of one percent (.5%) of the total contract billings, the Contractor shall reimburse the State for the total costs of the audit. If the audit discovers substantive findings related to fraud, misrepresentation, or non-performance, the Contractor shall reimburse the State for total costs of audit. Any adjustments and/or payments that must be made as a result of any such audit or inspection of the Contractor's invoices and/or records shall be made within a reasonable amount of time (not to exceed 90 days) from presentation of the State's findings to Contractor.

DD. TAXES

The State is not required to pay taxes of any kind, beyond those taxes which are included in the capitation payment. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor.

EE. INSPECTION AND APPROVAL

Final inspection and approval of all work required under the contract shall be performed by the designated State officials. The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

FF. CHANGES IN SCOPE/CHANGE ORDERS

The State may, at any time with written notice to the Contractor, make changes within the general scope of the contract. Changes in scope shall only be conducted with the written approval of the State's designee as so defined by the State from time to time. (The State retains the right to employ the services of a third party to perform any change order(s).)

The State may, at any time work is in progress, by written order, make alterations in the terms of work as shown in the specifications, require the performance of extra work, decrease the quantity of work, or make such other changes as the State may find necessary or desirable. The Contractor shall not claim forfeiture of contract by reasons of such changes by the State. Changes in work and the amount of compensation to be paid to the Contractor for any extra work so ordered shall be determined through an adjustment to the capitation pursuant to Section IV.D.

Corrections of any deliverable services or performance of work required pursuant to the contract shall not be deemed a modification requiring a change order.

GG. SEVERABILITY

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the particular provision held to be invalid.

HH. CONFIDENTIALITY

All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information. All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be handled in accordance with federal and state law, and ethical standards. The Contractor must ensure the confidentiality of such materials or information. Should said confidentiality be breached by a Contractor; Contractor shall notify the State immediately of said breach and take immediate corrective action.

It is incumbent upon the Contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable to Contractors by 5 U.S.C. 552a (m)(1), provides that any officer or employee of a Contractor, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

II. PROPRIETARY INFORMATION

Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, Contractors submitting information as proprietary may be required to prove specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive. Although every effort will be made to withhold information that is

properly submitted as proprietary and meets the State's definition of proprietary information, the State is under no obligation to maintain the confidentiality of proprietary information and accepts no liability for the release of such information.

IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. §84-602, all State contracts in effect as of January 1, 2014 will be posted to a public website beginning July 1, 2014. All information not specifically excluded by State Law **WILL BE POSTED FOR PUBLIC VIEWING.**

JJ. INDEMNIFICATION

1. GENERAL

The Contractor agrees to defend, indemnify, hold, and save harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Contractor, its employees, subcontractors, consultants, representatives, and agents, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. INTELLECTUAL PROPERTY

The Contractor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Contractor or its employees, subcontractors, consultants, representatives, and agents; provided, however, the State gives the Contractor prompt notice in writing of the claim. The Contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall, at the Contractor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this Contract.

3. PERSONNEL

The Contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel provided by the Contractor.

KK. NEBRASKA TECHNOLOGY ACCESS STANDARDS

Contractor shall review the Nebraska Technology Access Standards, found at http://nitc.nebraska.gov/standards/2-201.html and ensure that products and/or services provided under the contract are in compliance or will comply with the applicable standards. In the event such standards change during the Contractor's performance, the State may create an amendment to the contract to request that contract comply with the changed standard at a cost mutually acceptable to the parties.

LL. ANTITRUST

The Contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

MM. DISASTER RECOVERY/BACK UP PLAN

The Contractor shall have a disaster recovery and back-up plan, of which a copy should be provided to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under these specifications in the event of a disaster.

NN. TIME IS OF THE ESSENCE

Time is of the essence in this contract. The acceptance of late performance with or without objection or reservation by the State shall not waive any rights of the State nor constitute a waiver of the requirement of timely performance of any obligations on the part of the Contractor remaining to be performed.

OO. DRUG POLICY

Contractor certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

PP. EMPLOYEE WORK ELIGIBILITY STATUS

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html

   The completed United States Attestation Form should be submitted with the contract.

2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

QQ. CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND INELIGIBILITY

The Contractor, by signature to this contract, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency from participating in transactions (debarred). The Contractor also agrees to include the above requirements in any and all subcontracts into which it enters. The Contractor shall immediately notify the Department if, during the term of this contract, Contractor becomes debarred. The Department may immediately terminate this contract by providing Contractor written notice if Contractor becomes debarred during the term of this contract.

Contractor, by signature to this contract, certifies that Contractor has not had a contract with the State of Nebraska terminated early by the State of Nebraska. If Contractor has had a contract terminated early by the State of Nebraska, Contractor must provide the contract number, along with an explanation of why the contract was terminated early.

RR. POLITICAL SUB-DIVISIONS

The Contractor may extend the contract to political sub-divisions conditioned upon the honoring of the prices charged to the State. Terms and conditions of the Contract must be met by political sub-divisions. Under no circumstances shall the State be contractually obligated or liable for any purchases by political sub-divisions or other public entities not authorized by Neb. Rev. Stat. §81-145, listed as "all officers of the state, departments, bureaus, boards, commissions, councils, and institutions receiving legislative appropriations." A listing of Nebraska political subdivisions may be found at the website of the Nebraska Auditor of Public Accounts.

SS. PUBLIC COUNSEL

OFFICE OF PUBLIC COUNSEL

If it provides, under the terms of this contract and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Contractor shall submit to the jurisdiction of the Office of Public Counsel, pursuant to NEB. REV. STAT. §§ 81-8,240 *et seq*. This section shall survive the termination of this contract and shall not apply if Contractor is a long-term care facility subject to the Long-Term Care Ombudsman Act, NEB. REV. STAT. §§ 81-2237 et seq.

LONG-TERM CARE OMBUDSMAN

If it is a long-term care facility subject to the Long-Term Care Ombudsman Act, NEB. REV. STAT. §§ 81-2237 et seq., Contractor shall comply with the Act. This section shall survive the termination of this contract.

TT. BYRD ANTI-LOBBYING AMENDMENT

The Contractor shall file the required certification that each tier will not use Federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any Federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwarded from tier to tier up to the recipient (45 CFR part 93). The contract will contain statement that Federal funds have not been used for lobbying.

UU. CLEAN AIR ACT AND FEDERAL WATER POLLUTION CONTROL ACT

The Contractor must agree to comply with all applicable standards, orders or regulations.

VV. RETENTION REQUIREMENTS FOR RECORDS

Requirements for record retention and access to records for awards to recipients. Financial records, supporting documents, statistical records, and all other records pertinent to an award shall be retained for a period of ten years from the date of submission of the final expenditure report or, for awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report. The only exceptions are the following:

1. If any litigation, claim, financial management review, or audit is started before the expiration of the 10-year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken.
2. Records for real property and equipment acquired with Federal funds shall be retained for 10 years after final disposition.
3. When records are transferred to or maintained by the HHS awarding agency, the 10-year retention requirement is not applicable to the recipient.
4. Indirect cost rate proposals, cost allocations plans, etc., as specified in 45 CFR 74.53(g).

IV. PROJECT DESCRIPTION AND SCOPE OF WORK

A. PROJECT OVERVIEW

The State of Nebraska's Medicaid program is administered through the Department of Health and Human Services (DHHS), Division of Medicaid & Long-Term Care. The Nebraska Medicaid Managed Care Program (NMMCP) was implemented in July 1995.

The Nebraska Medical Assistance Program (Medicaid) currently provides health care coverage for approximately 248,000 individuals each month at an annual cost of approximately $1.8 billion. Approximately 188,000 of these 248,000 individuals are enrolled in physical health managed care. Of the 248,000 individuals, more than 233,000 are enrolled in the behavioral health managed care program.

The Nebraska Managed Care Program currently consists of the following program components:

1. Physical Health services through two (2) Managed Care Organization (MCO) Networks in Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Sarpy, Saunders, Seward and Washington counties;
2. Physical Health services through two (2) Managed Care Organization (MCO) Networks in Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Body, Brown, Buffalo, Burt, Butler, Cedar, Chase, Cherry, Cheyenne, Clay, Colfax, Cuming, Custer, Dakota ,Dawes, Dawson, Deuel, Dixon, Dundy, Fillmore, Franklin, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Nemaha, Nuckolls, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Richardson, Rock, Saline, Scottsbluff, Sheridan, Sherman, Sioux, Stanton, Thayer, Thomas, Thurston, Valley, Wayne, Webster, Wheeler, and York counties;
3. Behavioral health services through one (1) Prepaid Inpatient Health Plan (PIHP); and
4. Enrollment Broker Services.

B. PHYSICAL HEALTH MANAGED CARE PROGRAM DESCRIPTION

1. **Statutory Authority**
   Nebraska's Medicaid Managed Care Program (NMMCP) is authorized under section 1932 of the Social Security Act (the Act), which permits a state to operate a managed care program through its State Plan. Additionally, Nebraska operates a 1915(b) waiver in order to require special needs children and Native-Americans to participate in the physical health managed care program.

2. **Delivery Systems**
   Nebraska is currently using the following systems to deliver services:

   a. MCO: Risk-comprehensive contracts which are fully-capitated and require that the Contractor be an MCO or Health Insuring Organization (HIO). Comprehensive means that the Contractor is at risk for services in the basics benefits package.
   b. PIHP: Risk contract which is not comprehensive but is fully-capitated and requires that the Contractor be a Prepaid Inpatient Health Plan.

3. **Other Contractors**
The State currently contracts with the following Contractors to perform services for the Managed Care Program:

a. Optumas for Actuarial Services.
b. Island Peer Review Organization (IPRO) for External Quality Review Services.
c. Medicaid Enrollment Center, Inc. for Enrollment Broker Services.
d. Magellan Behavioral Health of Nebraska, Inc. for Managed Care Behavioral Health Services.

4. **Included Populations**
Nebraska operates a program of mandatory participation for the following groups of clients:

a. Families, children, and pregnant women eligible for Medicaid under Section 1931 of the Social Security Act or related coverage groups.
b. Blind/Disabled Children, Adults, and Related Populations who are eligible for Medicaid due to blindness or disability.
c. Aged and Related Populations. Those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the 1931 Adult population.
d. Foster Care Children. Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.
e. Title XXI CHIP. An optional group of targeted low-income children who are eligible to participate in Medicaid in Nebraska.

5. **Excluded Populations**
Within the groups identified above, the following groups of clients are excluded:

a. Medicaid members who have Medicare.
b. Medicaid clients who reside in Nursing Facilities (NF) at custodial levels of care or in Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD).
c. Medicaid members who participate in a Home and Community Based Services Wavier (HCBS). This includes adults with developmental disabilities or related conditions, aged persons or adults or children with disabilities, children with developmental disabilities and their families, clients receiving Developmental Disability Targeted Case Management Services, Traumatic Brain Injury waiver recipients and any other group for whom the State has received approval of the 1915(c) waiver of the Social Security Act.
d. Medicaid clients for the period of retroactive eligibility. Managed Care enrollment is immediate.
e. Members residing out-of-state or those who are considered to be out-of-state (i.e., children who are placed with relative out-of-state or those who are designated as such by DHHS personnel).
f. Aliens who are eligible for Medicaid for an emergency condition only.

g. Members who have excess income or who are designated to have a Premium Due.
h. Members eligible during the period of presumptive eligibility.
i. Members who have received a disenrollment/waiver of enrollment.
j. Individuals who are patients of Institutions of Mental Disease (IMD) who are between the ages of 21-64.
k. Participants in an approved DHHS Program for All-Inclusive Care for the Elderly (PACE) Program.
l. Organ transplant recipients (active managed care members who receive a transplant are waived out of managed care from the day of transplant forward).

C. SCOPE OF WORK

1. Regulation and Guidance

The MCO must abide by all relevant provisions found in Chapter 42 of the Code of Federal Regulation (CFR), Part 438 Managed Care; Title 471 Nebraska Administrative Code (NAC) "Nebraska Medical Assistance Program Services"; and Title 482 Nebraska Administrative Code "Nebraska Medicaid Managed Care."

2. Managed Care Organization Licensure

The MCO must have a Certificate of Authority (COA) to transact the business of health insurance in Nebraska as a Health Maintenance Organization (HMO) OR the MCO must have a COA to transact the business of health insurance in Nebraska and meet the federal definition of a Managed Care Organization (MCO). The MCO must have the COA at the time of contract award.

If the MCO does not have a COA as an HMO, they must have (or obtain by contract award) a Certificate of Authority to transact the business of health insurance in Nebraska and document how they meet the following 42CFR 438.2 definition/mandatory requirements for a Managed Care Organization:

a. Advance Directive requirements listed in Section IV.C.4.a.ii;
b. Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area serviced by the entity; and
c. Meets the solvency standards of 42 CFR 438.116 : The MCO must meet the solvency standards established by the State for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity[1] except when the entity meets any one of the following conditions:

    i. The entity does not provide both inpatient hospital services and physician services (non-applicable for this contract).
    ii. Is a public entity.
    iii. Is (or is controlled by) one or more federally qualified health centers and meets the solvency standards established by the State for those centers.
    iv. Has its solvency guaranteed by the State.

[1] Please note that this is an alternative means of compliance allowed under the cited federal regulatory authority; Nebraska does not license or certify risk bearing entities. However, the Nebraska Department of Insurance does license health insurers and HMOs, which, for the purposes of this provision, will be considered risk bearing entities.

To the extent any contract includes a partnership of risk-bearing, the Contractor must be licensed in Nebraska by the Department of Insurance as a health insurer or HMO.

3. **Geographic Areas Served**
The MCO will provide services for managed care enrollees who reside in Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Sarpy, Saunders, Seward, and Washington counties.

4. **General Provisions**

a. Contract Requirements

i. Inspection and audit of financial records. The State and the Centers for Medicare and Medicaid Services (CMS) may inspect and audit any financial records of the MCO or its subcontractors without restriction on the right of the State or Federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonable of costs.

ii. Advance Directives. Advance directives are defined in 42 CFR 489.100. The MCO must maintain written policies and procedures for advance directives. Requirements are:

a) The MCO must maintain written policies and procedures that meet the requirements for advance directives in Subpart I of Part 489.

b) The MCO must maintain written policy and procedures concerning advance directive with respect to all adult individuals receiving medical care by or through the MCO.

c) The MCO must provide written information to those individuals with respect to the following:

iii. Their rights under the law of the State.

iv. The organizations' policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.

v. The MCO must inform individuals that complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency.

a) The MCO must provide adult enrollees with written information on advance directives policies including a description of applicable State law. The written information provided by the MCO must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.

b. Information Requirements

i. Basic Rules. The MCO must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that is easily understood. Enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees must be provided at the 6th

grade level. This would include a score of up to 6.9 on the Flesh-Kincaid reading level.

ii. Mechanism. The MCO must have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan.

iii. Language Requirements. The MCO must make its written information available in the prevalent non-English languages in its particular service area. The State will establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees and provide the information to the MCO. Currently, the prevalent non-English language identified is Spanish. The MCO must make its written information available in any additional non-English languages identified by the State during the term of the contract.

iv. The MCO must make oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages not just those that the State identifies as prevalent. The enrollee is not to be charged for interpretation services. The MCO will be responsible to pay for these services. The MCO must notify its enrollees that oral interpretation is available for any language, that written information is available in prevalent non-English languages, and how to access those services.

v. Format and Alternative Format Requirements. Written material must use easily understood language and format. Written materials must be at the 6th grade level. Written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats. Enrollment information must be available to deaf and blind enrollees.

vi. Information – Enrollees. The MCO must provide the information in this section to each enrollee as follows:

a) Notify all enrollees of their disenrollment rights, at a minimum, annually. Notice must be sent no less than 60 days before the start of each enrollment period. The enrollment period is the 12 months after the enrollment of the client into a physical health MCO plan and designation of a Primary Care Provider (PCP). Clients are allowed to disenroll from their physical health MCO plan once every 12 months without cause.

b) Notify all enrollees, at the time of enrollment, of the enrollee's rights to change Primary Care Providers at any time or disenroll for cause.

c) Notify all enrollees of their right to request and obtain the information listed in Section IV.C.4.b.vii and Section IV.C.4.b.viii below, at least once a year.

d) Furnish to each of its enrollees the information specified in Section IV.C.4.b.vii and Section IV.C.4.b.viii below, within a reasonable time but not more than 30 calendar days after the MCO receives from the State or its contracted representative, notice of the recipient's enrollment.

e) Give each enrollee written notice of any change (that the State defines as "significant") in the information specified in Section IV.C.4.b.vii and Section IV.C.4.b.viii below, at least 30 days before the intended effective date of the change.

vii. Required Information to Enrollees:

a) Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. This includes, at a minimum, the information on primary care providers, specialists, and hospitals.

b) Any restrictions on the enrollee's freedom of choice among network providers.

c) Enrollee rights and protections, as specified in Section IV.C.6. Enrollee Rights and Protections.

d) Information on grievances, appeals, and State fair hearing procedures including the information specified in Section IV.C.4.b.viii below.

e) The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.

f) Procedures for obtaining benefits, including authorization requirements.

g) The extent to which, and how, enrollees may obtain benefits, including family planning services from out-of-network providers.

h) The extent to which, and how, after-hours and emergency coverage are provided, including:

1). What constitutes an emergency medical condition, emergency services, and post stabilization services, with reference to the definitions contained herein.

2). The fact that prior authorization is not required for emergency services.

3). The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent.

4). The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services covered under the contract.

5). The fact that, subject to the provisions of this section, the enrollee has the right to use any hospital or other setting for emergency care.

i) The post stabilization care services rules set forth as defined in 42 CFR 422.113(c).

j) Policy referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.

k) How and where to access any benefits that are available under the State Plan but are not covered under the contract, including any cost sharing, and how transportation is provided for those

State Plan services. For a counseling or referral service that the MCO does not cover because of moral or religious objections, the MCO need not furnish information on how and where to obtain the service. The State must provide information on how and where to obtain the service.

l) Member cost-sharing (e.g. copays for services) requirements in accordance with 471 NAC 3-008.

viii. Information to enrollees regarding grievances, appeals and State fair hearing procedures and timeframes in a State-approved description that must include the following:

a) For State fair hearing:

1). The right to hearing.
2). The method for obtaining a hearing.
3). The rules that govern representation at the hearing.

b) The right to file grievances and appeals
c) The requirements and timeframes for filing a grievance or appeal.
d) The availability of assistance in the filing process.
e) The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone.
f) The fact that, when requested by the enrollee:

1). Benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing.
2). The enrollee may be required to pay the cost of services furnished while the appeal was pending, if the final decision is adverse to the enrollee.
3). Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.
4). Advance Directives, as set forth in Section IV.C.4.a.ii General Provision.
5). Additional information that is available upon request, including:

i. Information on the structure and operation of the MCO.
ii. Physician incentive plans, if applicable.

ix. Notice of Provider Termination. The MCO must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

c. Provider Discrimination

i. An MCO may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or

her license or certification under applicable State law, solely on the basis of that license or certification.

ii. Declining Providers. If an MCO declines to include individual or group providers in its network, it must give the affected providers written notice of the reason for its decision. Federal requirements at 42 CFR 438.12(a) may not be construed to:

a) Require the MCO to contract with providers beyond the number necessary to meet the needs of its enrollees.

b) Preclude the MCO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

c) Preclude the MCO from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to enrollees.

d. **Third Party Resources (TPR)**

A member enrolled in managed care may have active commercial insurance or other TPR. When an enrollee is identified as having Third Party Liability (TPL), the following provisions apply:

i. Pursuant to federal and state law, the Medicaid program is intended to be the payer of last resort. This means all other available Third Party Liability (TPL) resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.

ii. The MCO shall exercise full assignment rights as applicable and shall be responsible for making every reasonable effort to determine third parties to pay for services rendered to enrollees under this Contract and cost avoid and/or recover any such liability for the third party.

iii. The MCO shall coordinate benefits in accordance with 42 CFR 133.135 et seq. and 471 NAC 3-004, so that costs for services otherwise payable by the MCO are cost avoided or recovered from a liable party. The two methods used are cost avoidance and post-payment recovery.

iv. The MCO, or its subcontractors or providers, must not pursue collection from the member, but directly from the liable third party payers, except as allowed in 468 NAC Chapter 4-002 and 471 NAC Chapter 3-004.

v. Establishing TPL takes place when the MCO receives confirmation that another party is, by statue, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or services delivered to an enrollee.

vi. If the probable existence of a Third Party Resource (TPR) cannot be established the MCO must adjudicate the claim. The MCO must then utilize post-payment recovery.

vii. If a Third Party Liability insurer requires the enrollee to pay any co-payment, coinsurance, or deductible, the MCO is responsible for making these payment even if the services are provided outside of the MCO network.

viii. The MCO shall treat funds recovered from third parties as offsets to claims payments. The MCO will report all cost avoidance values to DHHS in accordance with federal guidelines and will be required to include the collections and claims information in the encounter data submitted to DHHS, including any retrospective findings via encounter adjustments. The MCO must also report third party collection in the aggregates as required by DHHS.

ix. The MCO shall post all third party payments to claim level detail by enrollee.

x. Third party resources will include subrogation recoveries. The MCO will be required to seek subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines. The amount of any subrogation recoveries collected by the MCO outside of the claims processing system will be treated by the MCO as offsets to medical expenses for the purposes of reporting.

xi. The MCO shall identify the existence of potential TPL to pay for services in the basic benefits package through the use of diagnosis and trauma code editing. This editing should, at a minimum, identify claims with a diagnosis of 900.00 through 999.99 (excluding 994.6) and any other applicable trauma codes, including but not limited to E Codes in accordance with 42 CFR 433.138(e).

xII. The MCO must provide TPL data to any provider having a claim denied by the MCO based upon TPL.

xiii. DHHS will provide the MCO with a listing of known third party resources for its enrollees via the enrollment file and will contain information made available to DHHS at the time of eligibility determination and/or re-determination. If the MCO operates or administers any non-Medicaid HMO, health plan or other lines of business, the MCO shall assist DHHS with the identification of enrollees with access to other insurance.

xiv. The MCO shall provide to DHHS any third party resource information necessary in a format and media described by DHHS and shall cooperate in any manner necessary, as requested by DHHS, with DHHS and/or a cost recovery vendor at such time that DHHS acquires said services.

xv. DHHS may require a DHHS contracted TPL vendor to review paid claims that are over ninety (90) calendar days old and pursue TPL (excluding subrogation) for those claims that do not indicate recovery amounts in the MCO's reports encounter data.

xvi. The MCO must demonstrate, upon request, to DHHS that reasonable effort has been made to seek, collect and/or report third party recoveries. DHHS shall have the sole responsibility for determining whether reasonable efforts have been demonstrated. Said determination will take into account reasonable industry standards and practices.

xvii. Any money recovered by third parties shall be retained by the MCO and identified monthly to DHHS.

xviii. If DHHS determines that the MCO is not actively engaged in cost avoidance activities, the MCO shall be subject to monetary penalties in an amount not less than three times the amount that could have been cost avoided.

xix. DHHS will be solely responsible for estate recovery activities and will retain any and all funds recovered through these activities.

xx. Members who have Medicare will be excluded from managed care at the time of enrollment. A Medicaid member may become retroactively eligible for Medicare after enrollment into managed care. When these situations occur, the member will be waived out of managed care the first of the month after the Medicare statues is identified in the eligibility system. Until waiver of enrollment occurs, the plan is required to pursue TPL.

The MCO will report to DHHS on a monthly basis, those clients who have been identified as having TPL. The reporting requirements will be provided by DHHS.

5. Enrollment, Disenrollment, and Re-enrollment

a. **Transfers between Primary Care Providers (PCPs)**. The MCO must allow each enrollee to choose his or her health professional to the extent possible and appropriate. The Enrollment Broker will assist the client in assigning a PCP at initial enrollment. The MCO must allow each enrollee to change their PCP at any time.

b. **Enrollment**

i. Enrollment Process. The State maintains responsibility for the enrollment of clients into managed care plans and designating a participating Primary Care Provider through a contractual arrangement with an enrollment broker.

The State provides potential enrollees with a client guidebook, plan matrix, and provider directory to assist in choosing an MCO plan and PCP.

The Enrollment Broker provides impartial choice counseling to assist enrollees in choosing an MCO plan. The choice counseling is based on the information provided by the MCOs. Enrollees choose a specific plan to enroll in.

Enrollees are given 15 days to enroll in a physical health MCO plan and select a PCP. Enrollees that do not voluntarily enroll will be auto-assigned an MCO plan and PCP. Auto-assignment is random but will take into consideration the following factors: proximity, familial relationships, and provider-patient relationships. Auto-assignment will attempt to balance enrollment but is not guaranteed.

Enrollees that are exempt from auto-assignment (special needs population) will be nominated an MCO plan and PCP by the enrollment broker. The enrollment broker will use client and claims history in nominating a plan and PCP.

The managed care plan is required to have an understanding of the client population and the enrollment process and to assist the State and the enrollment broker in providing accurate information about the plan's participation.

The plan is also required to work cooperatively with the State to resolve issues relating to client participation and the enrollment process and to have the technological capability and resources available to interface with the State's support systems. The Contractor is expected to be able to exchange data with the State of Nebraska using a secure connection. Currently, the preferred method is SFTP and Connect:Direct. The State is also considering using Cyberfusion.

ii. Automatic Re-enrollment. The State will automatically re-enroll a recipient who is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less into the plan the recipient was previously enrolled in.

iii. Enrollment Discrimination Prohibited. The MCO must accept individuals in the order in which they apply without restriction.

iv. Enrollment Not Discriminatory. The MCO will not discriminate against individuals eligible to enroll on the basis of:

a) Health status or need for health care services.

b) Race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

v. PCP Assignment

Both the Assignment and Enrollment shall be closely monitored by the State. In assigning the enrollee to a Primary Care Provider (PCP), the following provisions apply:

a) Enrollees must be provided with an opportunity to select the PCP. At initial enrollment, if the potential enrollee voluntarily enrolls, the assignment of the PCP will be included on the Enrollment file from the State to the MCO. If the potential enrollee does not voluntarily enroll (i.e. is auto-assigned a health plan), the MCO is responsible for assigning a PCP within one month of the effective date of enrollment.

b) If no PCP is selected on the Enrollment file from the State, the MCO shall:

1) Contact the member as part of the welcome process, within then (10) business days of receiving the Enrollment file from the State to assist the member in making a selection of a PCP;
2) Inform the member that each family member has the right to choose his/her own PCP. The MCO may explain the advantages of selecting the same primary care provider for all family members as appropriate; and
3) Members who do not proactively choose a PCP within ten (10) days of enrollment with a MCO will be auto-assigned a PCP by the MCO.

c) The MCO shall have written policies and procedures for handling the assignment of its enrollees to a PCP. The MCO is responsible for linking all assigned MCO enrollees to a PCP.

d) The MCO is responsible for developing a PCP automatic assignment methodology in collaboration with DHHS to assign an enrollee to a PCP when the enrollee:

1) Does not make a PCP selection after auto-assignment of a MCO; or
2) Selects a PCP within the MCO network that has reached their maximum physician/patient ratio; or
3) Selects a PCP within the MCO network that has restrictions/limitations (e.g. pediatric practice only).

e) Assignment shall be made to a PCP with whom, based on past patient/provider relationship, the enrollee has a historical

provider relationship. If there is no historical PCP relationship, the enrollee shall be auto-assigned to a provider who is the assigned PCP for an immediate family member enrolled in the MCO plan. If other immediate family members do not have an assigned PCP, auto-assignment shall be made to a provider with who a family member has a historical provider relationship.

f) If there is no family or immediate family historical relationship, enrollees shall be auto-assigned a PCP using an algorithm developed by the MCO based on age and sex of the potential enrollee and geographic proximity.

g) The MCO shall report all PCP assignments to the State via the PCP file.

vi. TRANSFERS BETWEEN PRIMARY CARE PROVIDERS (PCPs)

a) The MCO must allow each enrollee to choose his or her health professional to the extent possible and appropriate. The MCO must have written policies and procedures for allowing members to change their PCP at any time.

b) The MCO must provide information on options for selecting a new PCP when it is has been determined that a PCP is non-compliant with provider standards (i.e. quality of care) and is terminated from the MCO, or when a PCP change is ordered as part of a resolution to a grievance proceeding.

c) The MCO must also assist the enrollee in assigning an Interim PCP when the assigned PCP terminates participation with the network.

c. Disenrollment

i. Disenrollment of an Enrollee by an MCO. The MCO may request disenrollment of an enrollee for the following reasons:

a) The MCO has sufficient documentation to establish that the client's condition or illness would be better treated by another plan; or

b) The MCO has sufficient documentation to establish fraud, forgery, or evidence of unauthorized use/abuse of services by the enrollee.

The MCO must send notification of the disenrollment request to the enrollee at the same time the request is made to the State.

ii. Change in Health Status. The MCO may not request disenrollment because of a change in the enrollee's health status or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the MCO's ability to furnish services to either this particular enrollee or other enrollees).

iii. Disenrollment. A client may request disenrollment:

a) For cause, at any time.
b) Without cause during the 90 days following the date of the recipient's initial enrollment with the MCO or the date the State sends the recipient notice of the enrollment, whichever is later.
c) Without cause once every 12 months thereafter.
d) Upon automatic re-enrollment if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.
e) When the State imposes the intermediate sanctions specified in Section IV.C.10.b.Sanctions.

iv. Request for Disenrollment by Recipient. The client (or his or her representative) must submit a written request of disenrollment from the MCO plan with cause to the State for a decision on the request.

v. Cause for Disenrollment. The following are cause for disenrollment:

a) The enrollee moves out of the MCO service area.
b) The MCO does not, because of moral or religious objections, cover the service the enrollee seeks.
c) The enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.
d) Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.

vi. Disenrollment Timeframe. The effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee or the MCO files the request. If the State agency fails to make a disenrollment determination within the timeframe specified, the disenrollment is considered approved.

6. Enrollee Rights and Protections

a. Enrollee Rights

i. General Rule. The MCO must have written policies regarding the enrollee rights specified in this section, including:

a) Each managed care enrollee is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
b) Each managed care enrollee is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.

c) Each managed care enrollee is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment. Refusal of treatment is not considered a reason the MCO could request disenrollment of the client from the plan.

d) Each managed care enrollee is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

e) Each managed care enrollee is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected as specified in 45 CFR Part 64.

ii. Free Exercise of Rights. Each enrollee is free to exercise his or her rights and entitled to a guarantee that the exercise of those rights does not adversely affect the way the MCO and its providers or the State agency treat the enrollee.

iii. Compliance with State and Federal Laws and Regulations. All contracts must comply with all 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; 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 other laws regarding privacy and confidentiality. The MCO must comply with any applicable Federal and State laws that pertain to enrollee rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees.

b. Provider - Enrollee Communication

i. Anti-Gag Clause. The MCO may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient:

a) For the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

b) For any information the enrollee needs in order to decide among all relevant treatment options.

c) For the risks, benefits, and consequences of treatment or non-treatment.

d) For the enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

ii. Moral or Religious Objections. An MCO that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service is not required to do so if the MCO objects to the service on moral or religious grounds.

iii. Information Requirements. If the MCO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows:

a) To the State.
b) With its application for a Medicaid contract.
c) Whenever it adopts the policy during the term of the contract.
d) Consistent with the provisions of 42 CFR 438.10.
e) To potential enrollees before and during enrollment.
f) To enrollees within 90 days after adopting the policy with respect to any particular service.

c. Marketing Activities

i. State Approval. The MCO may not distribute any marketing materials without first obtaining State approval. The MCO must submit all marketing material to the State for approval prior to distribution.

ii. Informed Decision. The MCO must provide assurances to the State that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud recipients or the State. Marketing materials cannot contain any assertion or statement (whether written or oral) that:

a) The recipient must enroll in the MCO in order to obtain benefits or in order not to lose benefits.
b) That the MCO is endorsed by CMS, the Federal or State government or similar entity.

iii. Marketing requirements must include the following:

a) That the MCO distributes the materials to its entire service area.
b) That the MCO does not seek to influence enrollment in conjunction with the sale or offering of any private insurance.
c) That the MCO does not, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities.

d. Emergency Services: Coverage and Payment

i. Emergency and Post Stabilization Care Services. The MCO is responsible for coverage and payment of emergency services and post stabilization care services regardless of whether the provider that furnishes the services has a contract with the MCO. Post Stabilization services remain covered until the MCO contacts the Emergency Room and takes responsibility for the enrollee.

ii. Payment for Emergency Medical Condition. The MCO may not deny payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have placed the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, resulted in serious impairment to bodily functions, or resulted in serious dysfunction of any bodily organ or part.

iii. Emergency Services. The MCO may not deny payment for treatment obtained when a representative of the MCO instructs the enrollee to seek emergency services.

iv. Emergency Medical Condition. The MCO may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

v. Coverage of Emergency Services. The MCO may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, MCO, or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.

vi. Subsequent Screening. An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

vii. Determination of Stabilization. The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO.

viii. Non-Network Provider. Any provider of emergency services that does not have in effect a contract with the MCO that establishes payment amounts for services furnished to an enrollee must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the enrollee received medical assistance under Title XIX or Title XXI through an arrangement other than enrollment in the MCO.

e. Post Stabilization Services: Coverage and Payment

i. Financial Responsibility - Pre-Approved. The MCO is financially responsible for post stabilization services obtained within or outside the MCO that are pre-approved by a plan provider or other MCO representative.

ii. Financial Responsibility - Approval Request. The MCO is financially responsible for post stabilization care services obtained within or outside the MCO which are not pre-approved by a plan provider or other MCO representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the MCO for pre-approval of further post stabilization care services.

iii. Financial Responsibility - No Pre-Approval. The MCO is financially responsible for post stabilization care services obtained within or outside the MCO which are not pre-approved by a plan provider or other MCO representative, but administered to maintain, improve or resolve the enrollee's stabilized condition if:

a) The MCO does not respond to a request for pre-approval within 1 hour.

b) The MCO cannot be contacted.

c) The MCO representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the

MCO must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or:

1). A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care.
2). A plan physician assumes responsibility for the enrollee's care through transfer to another place of service.
3). An MCO representative and the treating physician reach an agreement concerning the enrollee's care.
4). The enrollee is discharged.

iv. End of Financial Responsibility. The MCO's financial responsibility for post stabilization care services it has not pre-approved ends when:

a) A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care.
b) A plan physician assumes responsibility for the enrollee's care through transfer to another place of service.
c) An MCO representative and the treating physician reach an agreement concerning the enrollee's care.
d) The enrollee is discharged.

f. Covered Services

i. Family Planning Services. Family planning services are a mandatory Medicaid benefit. The MCO must not restrict the choice of provider from whom the enrollee may receive family planning services and supplies.
ii. Basic Benefits Package. The following physical health services represent a minimum benefit package that must be provided by the MCO to enrollees:

a) Inpatient hospital services;
b) Outpatient hospital services;
c) Ambulatory Surgical Centers (ACS) Services;
d) Services provided in Federally Qualified Health Centers (FQHCs);
e) Services provide in Rural Health Clinics (RHCs);
f) Services provided in Indian Health Service (IHS) Facilities;
g) Clinical and anatomical laboratory services including the administration of blood draws completed in the physician office or outpatient clinic for MH/SU diagnosis;
h) Radiology services;
i) HEALTH CHECK (EPSDT) services and outreach including missed appointments or lack of follow up;
j) Physician services, including nurse practitioner services, certified nurse midwife services, physician assistant services, clinic administered injections/medications, and anesthesia services including CRNA;
k) Home health agency services;
l) Private duty nursing services;

m) Therapy services (physical therapy, occupational therapy, and speech pathology and audiology);
n) Durable medical equipment and medical supplies, including hearing aids, orthotics, prosthetics and nutritional supplements;
o) Podiatry services;
p) Chiropractic services;
q) Vision services;
r) Free Standing Birth Center Services;
s) Dental Services;
t) Hospice Services;
u) Skilled/Rehabilitative and Transitional Nursing Facility Services;
v) Emergency Medical Transportation; and
w) Non-Emergency Ambulance Transportation.

iii. Substitute Health Services Permitted.
As permitted under 42 CFR 438.6(e) and to the extent consistent with provisions of State law, the MCO shall, in its discretion, offer expanded services and benefits to enrollees in addition to those core benefits and services specified in Section IV.C.6.f if such services are, in the judgment of the MCO, medically appropriate and cost-effective. These expanded services may include health care services which are currently non-covered services by the Nebraska Medicaid State Plan and/or which are in excess of the amount, duration, and scope in the Nebraska Medicaid State Plan.

These services/benefits shall be specifically defined by the MCO in regard to amount, duration and scope. DHHS will not provide any additional reimbursement for these services/benefits.

The MCO shall provide DHHS a description of the expanded services/benefits to be offered by the MCO for approval. Additions, deletions or modifications to Substitute Health Services made during the contract period must be submitted to DHHS for approval.

iv. Care Management Requirements

a) See Attachment A.
b) Care Coordination for Children who are DHHS Wards and in Out-of-Home Placement. Case Management for children who are in foster care placement must involve coordination with the child's Child and Family Services Specialist (or designee). Case Management must also include identifying and responding to the child's health care needs. The case management plan must include an outline of:

1). A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice;
2). How health needs identified through screenings will be monitored and treated;
3). How medical information for children in care will be updated and appropriately shared, which may include

the development and implementation of an electronic health record;

4). Steps to ensure continuity of health care services; and

5). The oversight of prescription medications.

v. Medical Record Content

MCO medical record content must consist of, at a minimum, the following enrollee information:

a) Identification of the enrollee.

b) The name of the enrollee's physician.

c) Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission.

d) The plan of care.

e) Initial and subsequent continued stay review dates.

f) Date of operating room reservation, if applicable.

g) Justification of emergency admission, if applicable.

h) Reasons and plan for continued stay, if the attending physician believes continued stay is necessary.

vi. CO-PAYMENTS

Cost sharing imposed on Medicaid members must be in accordance with 42 CFR §447.50 through 447.58 and cannot exceed cost sharing amounts in the Nebraska Medicaid State Plan. The MCO shall ensure that Providers collect Medicaid co-payments as specified in 471 NAC 3-008.

7. Quality Assessment and Performance Improvement

a. Quality Strategy

The MCO must abide by the State's Quality Strategy. See Attachment B.

b. External Quality Review

The MCO is subject to annual, external independent reviews of the quality outcomes, timeliness of, and access to, the services covered under the contract. The MCO must provide the necessary information required for these reviews and participate in any plan of correction to address any deficiencies identified by the EQR.

c. Operational on-site review by the State.

The MCO must allow State staff or its designee to conduct annual on-site reviews. The operational on-site review includes, but is not limited to validating reports and data previously submitted by the MCO, in-depth review of areas that have been identified as problem areas, validate the MCO's accreditation status, review the MCO's notification of adverse actions process, and identify areas of noteworthy performance and accomplishment.

d. Quality Management Committee.

The MCO must attend annual quality management committee meetings. The Quality Committee meets annually to review data and information designed to analyze the objectives of the Quality Strategy, recommend actions to improve quality of care, access, utilization, and client satisfaction, and to review the results of the Performance Improvement Projects and recommend future PIP topics. The Quality Management Committee also reviews the State's overall Quality Strategy and makes recommendations for improvement.

e. Access Standards

i. Delivery Network. The MCO must maintain a network of appropriate providers that:

a) Meets State established standards (see Attachment C).
b) Is supported by written agreements.
c) Is sufficient to provide adequate access to all services covered under the contract.

ii. State Access Standards. See Attachment C.

iii. In establishing and maintaining the network, the MCO must consider the following:

a) The anticipated Medicaid enrollment.
b) The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular MCO.
c) The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.
d) The numbers of network providers who are not accepting new Medicaid patients.
e) The geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees, and whether the location provides physical access for enrollees with disabilities.

iv. Direct Access to Women's Health Specialist. The MCO must provide female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.

v. Second Opinion. The MCO must provide for a second opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee.

vi. Out-of-Network Providers. If the MCO's network is unable to provide necessary medical services covered under the contract to a particular enrollee, the MCO must adequately and timely cover these services out of network for the enrollee, for as long as the MCO is unable to provide them.

vii. Out-of-Network Providers. Out-of-network providers must coordinate with the MCO regarding payment. The MCO must ensure that, if applicable, cost to the enrollee is no greater than it would be if the services were furnished within the network.

viii. Timely Access. The MCO must meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of need for services.

ix. Timely Access. The MCO must require that network providers offer hours of operation that are no less than the hours of operation listed in Attachment C.

x. Timely Access. Services must be available 24 hours a day, 7 days a week, when medically necessary.

xi. Timely Access Monitoring. The MCO must:

a) Establish mechanisms to ensure that network providers comply with the State established timely access requirements (see Attachment C).
b) Monitor network providers regularly to determine compliance.
c) Take corrective action if there is a failure to comply.

xii. Cultural Considerations. The MCO must participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

xiii. Documentation of Adequate Capacity and Services. The MCO must submit to the State quarterly, in a format specified by the State after contract award, documentation that it:

a) Offers an appropriate range of preventive, primary care, specialty, and ancillary services that are adequate for the anticipated number of enrollees for the service area.
b) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.
c) Meets the State established requirement for provider network and adequate capacity.
d) In addition to quarterly reporting, the MCO will report to DHHS monthly those providers that have terminated from the network. The reporting requirements will be provided by DHHS.

xiv. Documentation of Adequate Capacity and Services. The MCO must submit to the State on a quarterly basis, adequate capacity and services documentation using GeoAccess, an industry-standard tool specifically designed to measure enrollees' access to care. The standard GeoAccess report must include, but is not limited to, the following reporting features to analyze the provider network coverage:

a) Geographical Overview Maps. Overview maps display the provider locations in the geographical area requested.
b) Provider and Enrollee Location Maps. An overlay of the provider network against the enrollee base.
c) Member Accessibility Summary. A data sheet that provides an overview of the entire analysis displayed in the report showing number and percentages of clients with or without access.
d) Access Standard Comparison. Graphs that demonstrate the point at which the percentage of enrollee attains compliant status with the specified provider type and defined access standard.
e) Accessibility Detail. A data sheet which provides an in-depth look at the summary information contained on the Accessibility Summary Page.

xv. Assurances of Adequate Capacity and Services. Consistent with the Requirements in CFR 438.207, the MCO must submit the documentation assuring adequate capacity and services specifically as follows, but no less frequently than:

a) At the time it enters into a contract with the State.
b) Quarterly.
c) At any time there has been a significant change (as defined by the State) in MCO operations that would affect adequate capacity and services, including:

1). Changes in services, benefits, geographic service area or payments.
2). Enrollment of a new population in the MCO.

xvi. Primary Care and Coordination of Health Care Services. The MCO must implement procedures to ensure that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164.

xvii. Enrollees with Special Health Care Needs - Direct Access to Specialists. For enrollees determined to need a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

xviii. Coverage. The services offered under the MCO contract (basic benefits package services) must be sufficient in amount, scope, and duration to reasonably be expected to achieve the purpose for which the services are furnished and must be equal to those furnished under fee-for-service Medicaid.

xix. Coverage. The MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the enrollee.

xx. Coverage. The MCO may place appropriate limits on a service on the basis of criteria such as medical necessity, or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

xxi. Medically Necessary Services. The MCO must specify what constitutes "medically necessary services" in a manner that is no more restrictive than the State Medicaid program and addresses the extent to which the MCO is responsible for covering services related to the following:

a) The prevention, diagnosis, and treatment of health impairments.
b) The ability to achieve age-appropriate growth and development.
c) The ability to attain, maintain, or regain functional capacity.

The MCO may not limit services beyond the limitations in the State's Medicaid program.

xxii. Authorization of Services. The MCO and its subcontractors must have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services.

xxiii. Authorization of Services. The MCO must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider when appropriate.

xxiv. Authorization of Services. Per 482 NAC 4-004, abortion services must be prior authorized by the State.

xxv. Authorization of Services. The MCO must assure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be a decision made by a physician with the necessary credentials and experience and who has appropriate clinical expertise in treating the enrollee's condition or disease.

xxvi. Compensation for Utilization Management Activities. The MCO is prohibited from structuring compensation to individuals or entities that conduct utilization management activities in such a way as to provide incentives for the individual or MCO to deny, limit, or discontinue medically necessary services to any enrollee.

xxvii. INDIAN HEALTH PROTECTIONS
Per Section 5006(d) of the American Recovery and Reinvestment Act of 2009 (Recovery Act), Public Law 111-5, Medicaid Managed Care Organizations (MCOs) must:

a) Permit any Indian who is enrolled in a non-Indian MCO and eligible to receive services from a participating Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) provider, to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in the network as a primary care provider, to choose that I/T/U as his or her primary care provider, as long as that provider has capacity to provide the service;

b) Demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian enrollees who are eligible to receive services from such providers;

c) Provide I/T/U providers, whether participating in the network or not, payment for services in the Basic Benefits package provided to Indian enrollees who are eligible to receive services from such providers either:

1). At a rate negotiated between the MCO and the I/T/U provider, or

2). If there is not negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider; and

d) Make prompt payment to all I/T/U providers in its network as required for payments to practitioners in individual or group practices under federal regulations at 42 CFR sections 447.45 and 447.46.

f. Structure and Operation Standards

i. Contracts with Providers. In all contracts with health care professionals, the MCO must comply with the requirements specified in 42 CFR 438.214, 438.610, 455.104, 455.105, 455.106, and 1002.3, which include selection and retention of providers, credentialing and re-credentialing requirements, and nondiscrimination.

ii. Selection and Retention of Providers. The MCO must have written policies and procedures and a description of its policies and procedures for selection and retention of providers following the State's policy for credentialing and re-credentialing.

iii. Nondiscrimination. MCO provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

iv. Credentialing. The MCO must be able to demonstrate that its providers are credentialed. The MCO's provider credentialing process must require:

a) All providers credentialed by the MCO must also be a Medicaid-enrolled provider and agrees to comply with all pertinent Medicaid regulations;

b) Re-credentialing at a minimum, every three (3) years;

c) Disclosure by providers and fiscal agents: Information on ownership and control. The MCO must require each disclosing entity to disclose the following information in accordance with 42 CFR 455.104:

1). The name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more;

2). Whether any of the persons named is related to another as spouse, parent, child, or sibling.

3). The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must—

i. Keep copies of all these requests and the responses to them;

ii. Make them available to the federal Health and Human Services (HHS) Secretary or the Medicaid agency upon request; and

iii. Advise the Medicaid agency when there is no response to a request.

d) Provider agreements and fiscal agent contracts. An MCO shall not approve a provider agreement or a contract with a fiscal agent, and must terminate an existing agreement or contract, if

the provider or fiscal agent fails to disclose ownership or control information as required by this section.

e) Disclosure by providers and fiscal agents: Information related to business transactions-Provider agreements. An MCO must enter into an agreement with each provider under which the provider agrees to furnish to it or to the federal Health and Human Services (HHS)Secretary, on request, information related to business transactions in accordance with 42 CRF 455.105:

1). A provider must submit within 35 days of the date on a request by the HHS Secretary or the Medicaid agency, full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more the $25,000 during the 12-month period ending on the date of request or any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date or request.

f) Excluded Providers: The MCO is prohibited from employing or contracting with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act in accordance with 42 CFR 438.610.

g) Disclosure by providers: Information on persons convicted of crimes in accordance with 42 CFR 455.106. Before the MCO enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the MCO the identity of any person who:

1). Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

2). Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX services programs since the inception of these programs.

h) Notification to the Inspector General in accordance with 42 CFR 1002.3. The MCO must notify the Medicaid Agency of any disclosures made by providers on information on persons convicted of crimes within 10 working days from the date it receives the information. The MCO must also promptly notify the Medicaid Agency of any action it takes on the provider's application for participation in the program. The Medicaid Agency is responsible for notifying the Inspector General within 20 working days of notification by the MCO.

v. Confidentiality. The MCO must establish and implement procedures consistent with confidentiality requirements in 45 CFR Parts 160 and 164 for medical records and any other health and enrollment information that identifies a particular enrollee.

vi. Sub contractual Relationships and Delegation. The MCO is responsible for oversight and will be the party held accountable for any functions and responsibilities that it delegates to any subcontractor, including:

a) Meeting the Federal requirements defined 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract.
b) The prospective subcontractor's ability to perform the activities to be delegated.
c) A written agreement between the MCO and the subcontractor that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
d) Assurance that when the MCO identifies deficiencies or areas for improvement, the MCO and the subcontractor must take corrective action.

vii. Timely claims payment by MCO. Claim means 1) a bill for services 2) a line item of service or 3) all services for one recipient within a bill.

a) Clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
b) The MCO must meet the requirements of FFS timely payment as defined at 42CFR 447.5:

1). Pay 90% of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt. The date of receipt is the date the MCO receives the claim.
2). Pay 99% of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 90 days of the date of receipt.
3). Pay all other claims within 12 months of the date of receipt.

c) The date of payment is the date of the check or other form of payment.
d) The MCO will report to DHHS on a monthly basis summary data on claims payment activity and reasons for claims denials. The reporting requirements will be provided by DHHS.

viii. Protect against liability. Subcontractors and referral providers may not bill enrollees any amount greater than would be owed if the MCO provided the services (i.e., no balance billing by providers).
ix. Critical Access Hospitals. MCOs must develop programs for improving access, quality, and performance with both network and out-of-network

hospitals. The MCO must make all Critical Access Hospital (CAH) inpatient payments utilizing interim per diem rates with an annual year-end cost settlement. Outpatient rates are to be calculated on a cost-to-charge basis with an annual year end settlement. The Contractor must describe the process for determining rates and the annual year-end cost settlement process for CAHs.

g. Measurement and Improvement Standards

i. Practice Guidelines. The MCO must adopt practice guidelines that meet the following requirements:

- **a)** Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.
- **b)** Considers the needs of the enrollees.
- **c)** Are adopted in consultation with contracting health care professionals.
- **d)** Are reviewed and updated periodically as appropriate.

ii. Dissemination of Guidelines. The MCO must disseminate practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

iii. Application of Guidelines. The MCO must ensure that decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

iv. Quality Assessment and Performance Improvement (QAPI) Program. The MCO must have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees. The MCO's QAPI program must include at a minimum:

- **a)** Description of the Quality Assurance Committee;
- **b)** Designation of Individuals/Departments Responsible for the QAPI Program Implementation;
- **c)** Description of Network Participation in the QAPI Program;
- **d)** Credentialing/Re-credentialing Procedures;
- **e)** Standards of Care;
- **f)** Standards for Service Accessibility;
- **g)** Medical Records Standards;
- **h)** Utilization Review Standards;
- **i)** Quality Indicator Measures and Clinical Studies;
- **j)** QAPI Program Documentation Methods;
- **k)** Integration of Quality Assurance with other Management Functions; and
- **l)** Corrective Action Plans.

v. Quality Assessment and Performance Improvement Program. The State will specify performance measures and topics for performance improvement projects. CMS, in consultation with States and other stakeholders, may also specify performance measures and topics for performance improvement projects to be required by States in their contracts with MCOs.

vi. Quality Assessment and Performance Improvement Program. The MCO must provide documentation that it has in effect mechanisms:

a) To detect both underutilization and overutilization of services.
b) To assess the quality and appropriateness of care furnished to enrollees with special health care needs.

vii. Performance Measures. On an annual basis, the MCO must:

a) Measure and report to the State its performance, using standard measures required by the State. (See Attachment D.)
b) Submit to the State, data specified by the State, which enables the State to measure the MCO's performance.

viii. Performance Improvement Projects. The MCO must conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas expected to have a favorable effect on health outcomes and enrollee satisfaction. The MCO must report the status and results of each project to the State as requested. Performance improvement projects must involve the following:

a) Study topic and question as determined by the State;
b) Study indicators and goals;
c) Study population;
d) Measurement of performance using objective quality indicators;
e) Evaluation of findings from data collection;
f) Implementation of system interventions to achieve improvement in quality;
g) Evaluation of the effectiveness of interventions; and
h) Planning and initiation of activities for increasing and sustaining improvement.

ix. Performance Improvement Projects. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

x. Program Review by the State. The MCO must have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program. Results of the MCO's QAPI program work plans must be reported to the State annually.

xi. Health Information Systems. The MCO must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for reasons other than loss of Medicaid eligibility. Reporting formats will be determined by the State after contract award.

xii. Health Information Systems. The MCO must be able to perform the following functions electronically:

a) Provide enrollment verification in a HIPAA compliant 270/271 format;
b) Allow claims inquiry and response in a HIPAA compliant 276/277 format;
c) Accept HIPAA compliant electronic claims transactions in the 837 format;
d) Generate HIPAA compliant electronic remittance in the 835 format;
e) Make claims payments via electronic funds transfer; and
f) Accept prior authorization requests in a HIPAA compliant 278 format.

xiii. Health Information Systems. The MCO must collect data on enrollee and provider characteristics as specified by the State and on services furnished to enrollees through an encounter data system. The MCO must be able to submit encounter data in a format specified by the state. The MCO must also be capable of submitting encounter data via ASC X12 formats when the State MMIS is capable of accepting data in these formats.

The MCO must maintain an information system that includes the capability to collect data on client and provider characteristics, and claims information through an encounter data system. The MCO must submit encounter data to the Medicaid Management Information System (MMIS) monthly per Departmental specifications.
Encounter data submission must:

a) Be submitted on a monthly basis;
b) Be submitted accurately and meet the Departmental standard of 95% "good" claims submission rate;
c) Include all clean claims adjudicated by the MCO; and
d) All services provided to the managed care client, contracted or delegated.

Encounter data that does not meet the 95% submission rate will be rejected and returned to the MCO. The MCO is required to re-submit corrected encounter data in a timely manner. MCO's which fail to meet compliance standards for submission of encounter data for three (3) consecutive months will have the auto assignment algorithm changed to limit enrollment in the physical health plan until the MCO plan comes into compliance.

xiv. Health Information Systems. The MCO must provide documentation on its Health Information System that ensures data received from providers is accurate and complete by

a) Verifying the accuracy and timeliness of reported data.
b) Screening the data for completeness, logic, and consistency.
c) Collecting service information in standardized formats to the extent feasible and appropriate.

xv. Health Information Systems. The MCO must make all collected data available to the State and, upon request, to CMS.

xvi. Health Information Initiative. The MCO must describe involvement with any local or state Health Information initiatives, and any plan to collaborate with current Health Information initiatives.

xvii. CHIPRA Quality Measures
On an annual basis, the MCO must:

a) Measure and report to the State its performance using the CHIPRA Quality Measures required by CMS (see Attachment D). Submit to the State, data on the CHIPRA Quality Measures which enables the State to measure the MCO's performance.

xviii. Member Satisfaction Surveys
The MCO shall conduct annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys and methodology to assess the quality and appropriateness of care to members. The MCO shall enter into an agreement with a NCQA certified vendor to perform CAHPS®. The vendor shall perform CAHPS® Adult surveys and CAHPS® Child surveys with Children with Chronic Conditions (CCC) supplemental items.

The MCO shall use the most current version of CAHPS® for Medicaid enrollees. For the CAHPS® Child Surveys with CCC supplemental items, the MCO must separately sample the Title XIX (Medicaid) and Title XXI (CHIP) populations and must separate data and results for children enrolled in Title XIX and Title XXI when submitting reports to the State to fulfill the CHIPRA requirement.

Survey results and descriptions of the survey process shall be reported to the State separately for each required CAHPS® survey. And each survey shall be administered to a statistically valid random sample of members who are enrolled in the MCO at the time of the survey. Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards. Survey results are due 45 days after the end of the contract plan year (State Fiscal Year ending June 30).

xix. Per Section 2701 of the Affordable Care Act, the MCO must on an annual basis:

a) Measure and report to the State its performance using the ACA Adult Quality Core Measures as defined by CMS and listed in Attachment D.

b) Submit to the State data on the Adult Quality Measurers which enable the State to measure the MCO's performance.

h. Enforcement

i. Plan of Correction. MCO's that are determined to be performing below quality standards (which will be considered deficiencies) identified

through the State's Quality Strategy will be required to submit a Plan of Correction (POC) which addresses each deficiency specifically and provides a timeline by which corrective action will be completed. Follow-up reporting is required by the MCO to assess progress in implementing the POC.

ii. Additional Enforcement Actions. Upon completion of the POC, if the MCO has not come into compliance, additional actions will be taken against the MCO. These additional actions include:

a) Instituting a restriction on the type of enrollees.
b) Changing the auto assignment algorithm to limit the number of enrollees into the plan.
c) Banning new assignments into the plan.

8. Grievance Systems

a. Service Authorizations and Notices of Action.

i. Service Authorization. The MCO must provide a definition of service authorization that, at least, includes the enrollee's request for the provision of a service.

ii. Service Authorization Process – Procedure. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

iii. Notice of Adverse Action for Service Authorizations. The MCO must notify the requesting provider, and give the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 CFR 438.404 as set forth in Section IV.C.8.a.vi.

iv. Notice of Action. The MCO must give the enrollee written notice of any action (not just service authorization actions) within the timeframes for each type of action.

v. Notice of Adverse Action - Content. The notice must explain:

a) The action the MCO or its Contractor has taken or intends to take.
b) The reasons for the action.
c) The enrollee's or the provider's right to file an appeal.
d) The enrollee's right to request a State fair hearing.
e) Procedures for exercising enrollee's rights to appeal or grieve.
f) Circumstances under which expedited resolution is available and how to request it.
g) The enrollee's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

vi. Notice of Adverse Action - Language and Format. The notice must be in writing and must meet the language and format requirements described in Section IV.C.4.b. Information Requirements.

vii. Timeframes for Notice of Action – Termination, Suspension, or Reduction of Services. The MCO must provide notice at least 10 days before the date of action when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services. The period of advanced notice is shortened to 5 days if probable recipient fraud has been verified. The MCO must give notice by the date of the action for the following circumstances:

a) In the death of a recipient.
b) A signed written recipient statement requesting service termination or giving information requiring termination or reduction of services (where he or she understands that this must be the result of supplying that information).
c) The recipient's admission to an institution where he or she is ineligible for further services.
d) The recipient's address is unknown and mail directed to him or her has no forwarding address.
e) The recipient has been accepted for Medicaid services by another local jurisdiction.
f) The recipient's physician prescribes the change in the level of medical care.
g) An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1989.
h) The safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for 30 days (applies only to adverse actions for nursing facility transfers).

viii. Timeframes for Notice of Action - Denial of Payment. The MCO must provide notice on the date of action when the action is a denial of payment.

ix. Timeframes for Notice of Action - Standard Service Authorization Denial. The MCO must give notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service. Timeframe may be extended up to 14 additional calendar days if the enrollee or the provider requests an extension or the MCO justifies a need for additional information and how the extension is in the enrollee's interest.

x. If the MCO extends the timeframe, the enrollee must be provided written notice of the reason for the decision to extend the timeframe and the right to file an appeal if he or she disagrees with that decision. The MCO must issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

xi. Timeframes for Notice of Action - Expedited Service Authorization Denial. For cases in which a provider indicates or the MCO determines that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service. The MCO may extend the time period by up to 14 calendar days if the enrollee requests an extension or if the MCO justifies a need for additional information and how the extension is in the enrollee's interest.

xii. Timeframes for Notice of Action - Untimely Service Authorization Decisions. The MCO must provide notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions.

b. General Requirements of Grievance Systems

i. Grievance System. The MCO must have a grievance system for enrollees that meet all regulation requirements, including a grievance process, an appeal process, and access to the State's fair hearing system. The MCO must distinguish between grievance system, grievance process, and a grievance.

a) A grievance is an enrollee's expression of dissatisfaction with any aspect of care other than the appeal of actions, which is considered an appeal.

b) The grievance system includes a grievance process, an appeal process, and access to the State's fair hearing system. Any grievance system requirements apply to all three components of the grievance system not just to the grievance process.

c) A grievance process is the procedure for addressing enrollee's grievances.

ii. Grievance System - General Requirements. The MCO must:

a) Give enrollees any reasonable assistance in completing forms and other procedural steps not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

b) Acknowledge receipt of each grievance and appeal.

c) Ensure that individuals completing review of grievances and appeals are not the same individuals involved in previous levels of review or decision-making and are health care professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply:

1). A denial appeal based on lack of medical necessity.

2). A grievance regarding denial of expedited resolutions of an appeal.

3). Any grievance or appeal involving clinical issues.

iii. Grievance System - Information to Providers and Subcontractors. The MCO must provide the following grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time of entering into a contract:

a) The enrollee's right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing.
b) The enrollee's right to file grievances and appeals and the requirements and timeframes for filing.
c) The availability of assistance in filing grievances and appeals.
d) The toll-free numbers to file oral grievances and appeals.
e) The enrollee's right to request continuation of benefits during an appeal or State fair hearing filing and, if the MCO action is upheld in a hearing, that the enrollee may be liable for the cost of any continued benefits.
f) Any State-determined provider appeal rights to challenge the failure of the organization to cover a service.

iv. Grievance System - Record Keeping and Reporting. The MCO must maintain records of grievances and appeals.

c. Appeal Process

i. Appeal Process - Authority to File. An enrollee may file an MCO-level appeal. A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal.
ii. Appeal Process - Timing. The enrollee or provider may file an appeal within 90 days from the date on the MCO's Notice of Action.
iii. Appeal Process - Procedures. The enrollee or provider may file an appeal either orally or in writing and must follow an oral filing with a written, signed, appeal.
iv. Appeal Process – Procedures. The MCO must:

a) Ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the enrollee or the provider requests expedited resolution.
b) Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.
c) Allow the enrollee and representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records.
d) Consider the enrollee, representative, or estate representative of a deceased enrollee as parties to the appeal.

v. Appeal Process - Resolution and Notification. The MCO must resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within 45 days from the day the MCO receives the appeal. The MCO may extend the timeframes by up to 14 calendar days if the enrollee requests the extension or the MCO shows that there

is need for additional information and how the delay is in the enrollee's interest. For any extension not requested by the enrollee, the MCO must give the enrollee written notice of the reason for the delay.

vi. Appeal Process - Format and Content of Resolution Notice. The MCO must provide written notice of disposition. The written resolution notice must include:

a) The results and date of the appeal resolution.

1). For decisions not wholly in the enrollee's favor:
2). The right to request a State fair hearing.
3). How to request a State fair hearing.
4). The right to continue to receive benefits pending a hearing.
5). How to request the continuation of benefits.
6). If the MCO action is upheld in a hearing, that the enrollee may be liable for the cost of any continued benefits.

vii. Appeal and State Fair Hearing Process - Continuation of Benefits. The MCO must continue the enrollee's benefits if:

a) The appeal is filed timely, meaning on or before the later of the following:

1). Within 10 days of the MCO mailing the Notice of Action.
2). The intended effective date of the MCO proposed action

b) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
c) The services were ordered by an authorized provider.
d) The authorization period has not expired.
e) The enrollee requests extension of benefits.

viii. Appeal and State Fair Hearing Process - Duration of Continued or Reinstated Benefits. If the MCO continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

a) The enrollee withdraws the appeal.
b) The enrollee does not request a fair hearing within 10 days from when the MCO mails an adverse MCO decision.
c) A State fair hearing decision adverse to the enrollee is made.
d) The authorization expires or authorization service limits are met.

ix. Appeal and State Fair Hearing Process - Enrollee Responsibility for Services Furnished While the Appeal is Pending. The MCO may recover the cost of the continuation of services furnished to the enrollee while the appeal was pending if the final resolution of the appeal upholds the MCO action.

x. Appeal and State Fair Hearing Process - Effectuation When Services Were Not Furnished While Appeal was Pending. The MCO must authorize or provide the disputed services promptly, and as

expeditiously as the enrollee's health condition requires if the services were not furnished while the appeal is pending and the MCO or the hearing decision reverses a decision to deny, limit, or delay services.

xi. Appeal and State Fair Hearing Process - Effectuation When Services Were Furnished While Appeal was pending. The MCO must pay for disputed services if the MCO or state hearing decision reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending.

d. Expedited Appeals Process

i. Expedited Appeals Process - General. The MCO must establish and maintain an expedited review process for appeals when the MCO determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. Expedited appeals must follow all standard appeal regulations for expedited requests except where differences are specifically noted in the regulation for expedited resolution.

ii. Expedited Appeals Process - Authority to File. The enrollee or provider may file an expedited appeal either orally or writing. No additional enrollee follow-up is required.

iii. Expedited Appeals Process - Procedures. The MCO must inform the enrollee of the limited time available for the enrollee to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

iv. Expedited Appeal Process - Resolution and Notification. The MCO must resolve each expedited appeal and provide notice, as expeditiously as the enrollee's health condition requires, within 3 working days after the MCO receives the appeal. The MCO may extend the timeframes by up to 14 calendar days if the enrollee requests the extension or the MCO shows that there is need for additional information and how the delay is in the enrollee's interest.

v. Requirements Following Extension. For any extension not requested by the enrollee, the MCO must give the enrollee written notice of the reason for the delay.

vi. Expedited Appeal Process - Format of Resolution Notice. In addition to written notice, the MCO must also make reasonable efforts to provide oral notice of resolution.

vii. Expedited Appeal Process - Punitive Action. The MCO must ensure that no punitive action is taken against a provider who either requests an expedited resolution or supports an enrollee's appeal.

viii. Expedited Appeal Process - Action Following Denial of a Request for Expedited Resolution. If the MCO denies a request for expedited resolution of an appeal, it must:

a) Transfer the appeal to the standard timeframe of no longer than 45 days from the day the MCO receives the appeal with a possible 14-day extension.

b) Make reasonable effort to give the enrollee prompt oral notice of the denial and a written notice within 2 calendar days.

e. Access to State Fair Hearing

i. State Fair Hearing Process - MCO Notification of State Procedures. If the MCO takes action and the enrollee requests a State fair hearing, the State (not the MCO) must grant the enrollee a State fair hearing. The right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the enrollee and provider by the MCO. Other information for enrollees and providers would include:

ii. State Fair Hearing Process-Authority to File. An enrollee may request a State fair hearing. The provider may request a State fair hearing if the provider is acting as the enrollee's authorized representative.

iii. State Fair Hearing-Timing. The enrollee or provider may request a State fair hearing within 90 days from the date on the MCO Notice of Action.

iv. State Fair Hearing-Resolution. The State must reach its decisions within the specified timeframes:

a) Standard resolution: within 90 days of the date the enrollee filed the appeal with the MCO if the enrollee filed initially with the MCO (excluding the days the enrollee took to subsequently file for a State fair hearing) or the date the enrollee filed for direct access to a State fair hearing.

b) Expedited resolution (if the appeal was heard first through the MCO appeal process): within 3 working days from agency receipt of a hearing request for a denial of a service that:

1). Meets the criteria for an expedited appeal process but was not resolved using the MCO expedited appeal timeframes, or

i. Was resolved wholly or partially adversely to the enrollee using the MCO expedited appeal timeframes.

ii. Expedited resolution (if the appeal was made directly to the State fair hearing process without accessing the MCO appeal process) within 3 working days from agency receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.

v. State Fair Hearing - Parties. The parties to the State fair hearing include the MCO as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

vi. The State ensures that any enrollee dissatisfied with a State agency determination denying an enrollee's request to transfer plans/disenroll is given access to a State fair hearing.

f. Grievance Process

i. Grievance Process - Procedures. The enrollee is allowed to file a grievance (complaint) only with the MCO.

ii. Grievance Process - Authority to File a Grievance. An enrollee may file a grievance either orally or in writing. A provider may file a grievance when acting as the enrollee's authorized representative.

iii. Grievance Process - Disposition and Notification. The MCO must dispose of each grievance and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes not to exceed 90 days from the day the MCO receives the grievance.

iv. Grievance Process - Format of Disposition Notice. The State will establish the method the MCO will use to notify an enrollee of the disposition of a grievance.

9. Certifications and Program Integrity

a. Certification

i. Data Certification. Data submitted by the MCO to the State must be certified as provided in 42 CFR 438.606.

a) The data that must be certified includes, but is not limited to, all documents specified by the State, enrollment information, encounter data, and other information contained in contracts and proposals. The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness and truthfulness of the documents and data. The MCO must submit the certification concurrently with the certified data and documents.

b) Data and documents the MCO submits to the State must be certified by the MCO Chief Executive Officer, the MCO Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to, the MCO Chief Executive Officer or Chief Financial Officer.

b. Program Integrity

i. General Requirements. The MCO must have administrative and management arrangements or procedures, and a mandatory compliance plan, that are designed to guard against fraud and abuse. The MCO arrangements or procedures must include the following:

a) Written policies, procedures, and standards of conduct that particulate the organization's commitment to comply with all applicable Federal and State standards.

b) The designation of a compliance officer and a compliance committee that are accountable to senior management.

c) Effective training and education for the compliance officer and the organization's employees.

d) Effective lines of communication between the compliance officer and the organization's employees.

e) Enforcement of standards through well-publicized disciplinary guidelines.

f) Provision for internal monitoring and auditing.

g) Provision for prompt response to detected offenses and for development of corrective action initiatives relating to the MCO contract.

The MCO must comply promptly with requests from the State agency or the Medicaid Fraud Control Unity (MFCU) for access to and copies of any records kept by the MCO, and computerized data stored by the MCO, or information kept by MCO providers to which the State agency is authorized to have access.

ii. Prohibited Affiliations with Individuals Debarred by Federal Agencies - General Requirement. An MCO may not knowingly have a relationship with the following:

a) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

b) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of:

1). A director, officer, or partner of the MCO.

2). A person with beneficial ownership of five percent or more of MCO equity.

3). A person with an employment, consulting or other arrangement with the MCO under its contract with the State.

c) If the State finds that a MCO is not in compliance with the above requirements, the State must notify the HHS Secretary of the noncompliance and may not renew or otherwise extend the duration of an existing agreement with the MCO unless the Secretary provides to the State and to Congress a written Statement describing compelling reasons that exist for renewing or extending the agreement.

iii. Excluded Providers. Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or CHIP, except for emergency services.

iv. Disclosure of 5% Ownership - The MCO must notify the State of any person or corporation that has 5% or more ownership or controlling interest in the entity. The SMM requires financial statements for all owners with over 5% ownership are submitted.

v. Ownership and Control. Federal Financial Participation is not available in payments made to a provider of fiscal agent that fails to disclose ownership or control information.

vi. Information related to business transactions. Federal Financial Participation (FFP) is not available in expenditures for services furnished by providers who fail to comply with a request made by the HHS Secretary or the Medicaid agency. FFP will be denied in expenditures for services furnished during the period beginning on the day following

the date the information was due to the HHS Secretary or the Medicaid Agency and ending on the day before the date on which the information was supplied.

vii. Physician Identifier. The MCO must require each physician to have a unique identifier. This unique identifier must be included on the provider file submitted to the State at such time when systems are put in place at the State to allow for National Provider Identifier numbers.

viii. Report. The MCO must report fraud and abuse information to the State, including the number of fraud and abuse complaints that warrant preliminary investigation. For each case which warrants investigation, the MCO must report:

a) The name and ID number of the relevant party;
b) The source of the complaint;
c) The type of provider;
d) The nature of the complaint;
e) The approximate dollars involved; and
f) The legal and administrative disposition of the case.

The MCO must report the above information to the State immediately if the severity of the complaint impacts the care and treatment of the client, or quarterly upon investigation.

ix. Service Verification. The MCO must have in place a method for verifying that services were actually provided. Minimum sampling criteria to ensure a representative sample must be included. The MCO must report the results of monitoring to the State quarterly.

x. State Conflict of Interest Safeguards. The MCO may not contract with the State unless such safeguards at least equal to Federal safeguards (41 USC 423, section 27) are in place.

xi. False Claims Act Information. The MCO must comply with 1902(a)(68) of the Social Security Act.

a) The MCO shall establish written policies for all employees of the entity, and any Contractor or agent of the entity, that provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs;
b) The MCO shall include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and
c) Include in any employee handbook for the entity, a specific discussion of the laws described in 1902(a)(68) subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

xii. Federal Access to Records. The MCO must allow Federal agencies to require changes, remedies, changed conditions, access and records retention, suspension of work, and other clauses approved by the Office of Federal Procurement Policy. In addition, HHS awarding agencies, the

HHS Inspector General, the US Comptroller General, or any of their duly authorized representatives, have the right of timely and unrestricted access to any books, documents, papers, or other records of Contractor that are pertinent to the awards, in order to make audits, examinations, excerpts, transcripts and copies of such documents.

10. Sanctions

a. General

i. Violations Subject to Sanction. The following violations are grounds for State-established intermediate sanctions that may be imposed when the MCO acts or fails to act as follows:

a) The MCO fails substantially to provide medically necessary services that the MCO is required to provide, under law or under its contract with the State, to an enrollee covered under the contract.

b) The MCO imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

c) The MCO acts to discriminate among enrollees on the basis of their health status or need for health care services.

d) The MCO misrepresents or falsifies information that it furnishes to CMS or to the State.

e) The MCO misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.

f) The MCO fails to comply with the requirements for physician incentive plans, if applicable.

g) The MCO has distributed directly or indirectly through any agent or independent Contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.

h) The MCO has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.

b. Intermediate Sanctions

i. Intermediate Sanctions - Types. The State may impose the following intermediate sanctions:

a) Civil monetary penalties in the following specified amounts:

1). A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to enrollees, potential enrollees or health care providers; failure to comply with physician incentive plan requirements; or marketing violations.

2). A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or the State.

3). A maximum of $15,000 for each recipient the State determines was not enrolled because of a discriminatory practice (subject to the $100,000 overall limit above).

4). A maximum of $25,000 or double the amount of the excess charges, (whichever is greater) for charging premiums or charges in excess of the amounts permitted under the Medicaid program. The State must deduct from the penalty the amount of overcharge and return it to the affected enrollee(s).

b) Appointment of temporary management as described in Section III. T. Early Termination.

c) Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll.

d) Suspension of all new enrollments, including default enrollment, after the effective date of the sanction.

e) Suspension of payment for clients enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

ii. Payments under the contract will be denied for new enrollees when, and for as long as, payment for those enrollees is denied by CMS in accordance with the requirements in 42 CFR 438.730.

c. Special Rules for Temporary Management

i. The State may impose optional temporary management if it finds that there is continued egregious behavior by the MCO, including, but not limited to behavior that is described in 42 CFR 438.700, or that is contrary to any requirements of sections 1903(m)and 1932 of the Act; or

ii. The State must impose temporary management if it finds that an MCO has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Act. The State must also grant enrollees the right to terminate enrollment without cause and must notify the affected enrollees of their right to terminate enrollment. The State may not delay imposition of temporary management to provide a hearing before imposing this sanction. In addition, the State may not terminate temporary management until it determines that the MCO can ensure that the sanctioned behavior will not recur.

d. Notice of Sanction

Except as provided in Section IV.10.b.i.b) above, before imposing any intermediate sanction, the State must give the MCO timely written notice that explains the following:

i. The basis and nature of the sanction; and

ii. The MCO's right to a hearing.

11. Coordination with Enrollment Broker

The State maintains responsibility for the enrollment of clients into managed care plans and designating a participating Primary Care Provider through a contractual arrangement with an enrollment broker. The State provides potential enrollees with a member guidebook, plan matrix, and provider directory to assist in choosing an MCO plan and PCP. The Enrollment Broker provides impartial choice counseling to assist enrollees in choosing an MCO plan. The choice counseling is based on the information provided by the MCOs. Enrollees choose a specific plan to enroll in. Enrollees are given 15 days to enroll in a physical health MCO plan and select a PCP. Enrollees that do not voluntarily enroll will be auto-assigned an MCO plan. Auto-assignment is random but will take into consideration the following factors: proximity, familial relationships, and provider-patient relationships. Auto-assignment will attempt to balance enrollment but is not guaranteed. The MCO plan will be responsible for assignment of the PCP within one month of the effective date of enrollment in that MCO plan. Enrollees that are exempt from auto-assignment (special needs population) will be nominated an MCO plan by the enrollment broker. The enrollment broker will use member and claims history in nominating a plan.

The managed care plan is required to have an understanding of the potential enrollee population and the enrollment process and to assist the State and the enrollment broker in providing accurate information about the plan's participation and provider network. The plan is also required to work cooperatively with the State to resolve issues relating to potential enrollee participation and the enrollment process and to have the technological capability and resources available to interface with the State's support systems. The Contractor is expected to be able to exchange data with the State of Nebraska using a secure connection and also be capable of exchanging data via ASC X12 formats. Currently, the preferred method for secure connection is SFTP.

Clients determined mandatory for managed care will be immediately enrolled into managed care. This supersedes the process of prospective enrollment. Under the immediate enrollment process, mandatory managed care clients are required to enroll with an MCO plan and a primary care provider within 15 days. In the event that a client does not enroll, the client will be auto assigned to an MCO plan. The managed care enrollment will be effective the first day of the month in which the client enrolls in an MCO plan or is auto assigned to an MCO plan.

The MCO is responsible for basic benefit package services provided in the first 30 days of the client's enrollment, including prior authorizations and services provided by out of network providers. DHHS will enroll unborns into managed care if the unborn has either a mother or sibling enrolled in managed care. Once DHHS is notified of a live birth, the newborn will be immediately enrolled in either the mother's MCO plan or an eligible sibling's MCO plan. The mother's plan supersedes the sibling's plan, in the event that both mother and sibling are enrolled in managed care. A newborn child born to a mother enrolled in a MCO plan or who has a sibling that is enrolled in a MCO plan is immediately enrolled into the same plan of the mother or sibling.

12. Provider Network

The MCO's provider network must include a network to meet the state standard for adequate capacity for PCP's, Hospitals, Urgent Care Centers, Federally Qualified Health Centers (FQHC), and Rural Health Clinics (RHC) The MCO's network must include Specialists and ancillary providers (Home Health, DME, PT/OT/SLP therapies, nursing facilities, hospice facilities, dental providers) as part of the network.

13. **Coordination with Behavioral Health Vendor**
The State contracts with a Pre-paid Inpatient Health Plan (PIHP) for the provision of Behavioral Health (Mental Health/Substance Use)(MH/SU) services. The current Contractor is Magellan Behavioral Health of Nebraska, Inc. The managed care plan is required to have an understanding of the State's Medicaid behavioral health services and shall demonstrate a plan to coordinate, per 482 NAC 4-004.05, ER services for MH/SU services, admissions for twenty-four (24) hour observation, chemical detoxification services and substance abuse treatment, history and physical exams for in-patient admissions for MH/SU and ambulance services for MH/SU treatment for its clients enrolled in the MH/SU managed care.

14. **Approach to Radiology Management**
The State requires prior-authorization for all non-emergency outpatient Computerized (CT) scans, Magnetic Resonance Angiogram (MRA) scans, Magnetic Resonance Imaging (MRI) scans, Magnetic resonance spectroscopy (MRS) scan, Nuclear Medicine Cardiology scans, Positron Emission Tomography (PET) scans, Single Photon Emission Computed Tomography (SPECT) scans. The prior authorization requirements must be completed prior to the scan being performed. These requirements do not apply to these scans when performed during an inpatient hospitalization or as an emergency through the hospital's emergency room.

15. **Accreditation**
The State requires the MCO to have NCQA or another national certification (including URAC accreditation) at the time of contract implementation. The national certification must be related to the specific functions of Managed Care entities.

The State also requires that the MCO physical health plan be NCQA accredited or another national certification or become accredited during the contract period.

16. **Primary Care Provider (PCP) Network**
The MCO must provide an adequate network of Primary Care Provider (PCPs) to ensure that clients have access to all services in the basics benefits package. All Medicaid Managed Care clients will be allowed the opportunity to select or change their PCP. PCPs may include Family Practice Physicians, Pediatricians, Obstetrics/Gynecology Physicians, and Internal Medicine Physicians.

17. **Medical Homes**
The Department is interested in the delivery of health services in a medical home model. A Medical Home is defined by the Center for Medical Home Improvement as a community-based primary care setting which provides and coordinates high quality, planned, and family-centered: health promotion, acute illness and chronic condition management. Requirements of a medical home include:

a. Provide comprehensive, coordinated health care for enrollees and consistent, ongoing contact with enrollees throughout their interactions with the health care system, including but not limited electronic contacts and ongoing care coordination and health maintenance tracking;
b. Provide primary health care services for enrollees and appropriate referral to other health care professionals or behavioral health professionals as needed;
c. Focus on the ongoing prevention of illness and disease;

d. Encourage active participation by an enrollee and the enrollee's family, guardian, or authorized representative, when appropriate, in health care decision making and care plan development;
e. Facilitate the partnership between the enrollees, their personal physician, and when appropriate, the enrollee's family; and
f. Encourage the use of specialty care services and supports.

18. Solvency Requirements

a. Insolvency. The MCO must provide that its Medicaid enrollees are not held liable for:

   i. The MCO's debts in the event of the MCO's insolvency.
   ii. The covered services provided to the enrollee, for which the State does not pay the MCO.
   iii. The covered services provided to the enrollee, for which the State or the MCO does not pay the individual or health care provider that furnishes the services under a contractual, referral or other arrangement.
   iv. Payments for covered services furnished under a contract, referral or other arrangement to the extent that those payments are in excess of the amount that the enrollee would owe if the MCO provided the services directly.

b. Solvency - Each non-federally qualified HMO must provide assurances that Medicaid enrollees will not be liable for the entity's debt if the entity becomes insolvent.
c. Continue Services During Insolvency - An MCO must cover continuation of services to enrollees for duration of period for which payment has been made, as well as for inpatient admissions up until discharge.

19. Physician Incentive Plan (PIP)

a. Regulations- The MCO's PIP must meet the requirements in 42 CRF 422.208 and 422.210.
b. Prohibition – The MCO may operate a PIP only if no specific payment can be made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.
c. Disclosure to State. The disclosure to the State includes the following:
   i. The MCO must report whether services not furnished by physicians/groups are covered by an incentive plan. No further disclosure is required if the PIP does not cover services not furnished by physician/group.
   ii. The MCO must report the type of incentive arrangement, e.g. withhold, bonus, capitation.
   iii. The MCO must report the percent of withhold or bonus (if applicable).
   iv. The MCO must report the panel size, and if patients are pooled, and the approved method used.
   v. If the physician/group is at substantial financial risk, the MCO must report proof that the physician/group has adequate stop loss coverage, including amount and type of stop-loss.

d. Substantial Financial Risk - If the physician/group is put at substantial financial risk for services not provided by the physician/group, the MCO must ensure adequate stop-loss protection to individual physicians and conduct annual enrollee surveys.

e. Disclosure to Beneficiaries - The MCO must provide information on its PIP to any Medicaid beneficiary upon request (this includes the right to adequate and timely information on a PIP).

f. Disclosure to State - Survey - If required to conduct beneficiary survey (as required in Section IV.C.20.d), survey results must be disclosed to the State and, upon request, disclosed to beneficiaries.

20. University of Nebraska Medical Center (UNMC) Physician/Practitioner and Dental Supplemental Payments

The MCO must implement an alternative payment methodology for services provided by practitioners (physician and other licensed independent practitioners credentialed by Nebraska Medicaid) and dental providers who are acting in the capacity of an employee or Contractor of the University of Nebraska Medical Center (UNMC) or its affiliated medical practices. Under the Medicaid Fee-for-Service, the payment amount is the difference between payments otherwise made to these practitioners and the average rate paid for the services by commercial insurers. These payments are made in addition to payments otherwise provided under the State Plan to practitioners that qualify for such payments.

21. Provider-Preventable Conditions (PPCs) Including Healthcare-Acquired Conditions

In accordance with Section 2702 of the Affordable Care Act, the MCO must have mechanisms in place to preclude payment to providers for PPCs. The MCO shall require provider self reporting through claims systems. The MCO will track the PPC data and report to the State via the encounter file. PPCs including Health Care Acquired Conditions apply to the Medicaid inpatient hospital settings and are defined as the full list of Medicare's HAC, with the exception of Deep Vein Thrombosis/Pulmonary Embolism following total knee replacement or hip replacement in pediatric and obstetric patients. To ensure enrollee access care, any reductions in payment to providers must be limited to the added cost resulting from the PPC. The MCO must use existing claims systems to be used as platform for provider self-reporting and report to the State via the encounter data. See Attachment E for a listing of PPCs that apply to this provision.

22. Supplemental Maternity Payments

The MCO shall be responsible for all costs and services included in the Basic Benefits Package associated with the maternity care of an Enrollee. In instances where the Enrollee is enrolled in the MCO's health plan on the date of the delivery of a child, the MCO shall be entitled to receive a Supplemental Maternity Payment. The Supplemental Maternity Capitation Payment reimburses the MCO for the inpatient and outpatient costs of services normally provided as part of maternity care, including prenatal care, delivery and post-partum care. The Supplemental Maternity Payment is in addition to the monthly Capitation Rate paid to the MCO for the Enrollee.

In instances where the Enrollee was enrolled in the MCO's health plan for only part of the pregnancy, but was enrolled on the date of the delivery of the child, the MCO shall be entitled to receive the entire Supplemental Maternity Payment. The Supplemental

payment shall not be pro-rated to reflect that the Enrollee was not enrolled in the MCO health plan for the entire duration of the pregnancy.
In instances where the Enrollee was enrolled in the MCO's health plan for part of the pregnancy, but was not enrolled on the date of the delivery of the child, the MCO shall not be entitled to receive the Supplemental Maternity Payment, or any portion thereof.
Costs of inpatient and outpatient care associated with maternity cases that end in termination or miscarriage shall be reimbursed to the Contractor through the monthly Capitation Rate for the Enrollee and the MCO shall not receive the Supplemental Maternity Payment.

The MCO may not bill a Supplemental Maternity Payment until the hospital inpatient delivery is paid by the MCO, and the MCO must submit encounter data evidence of the delivery, plus any other inpatient and outpatient services for the maternity care of the Enrollee to be eligible to receive a Supplemental Maternity Payment. The MCO must request payment for the Supplemental Maternity Payment no later than 12 months following the date of service for the delivery. Failure to have supporting records may, upon audit, result in recoupment of the Supplemental Maternity Payment.

D. RATE SETTING

1. Capitated Managed Care Organization Rates

DHHS will contract with the MCO using a full-risk arrangement that will pay the MCO a prepaid monthly capitation payment to cover all services included in the MCO contract. Capitation is designed to provide the Contractor with a determined monthly payment so it may provide services that meet program standards. DHHS will develop cost-effective and actuarially sound capitation rates in accordance with generally accepted actuarial principles and practices and are appropriate for the populations covered and the services provided under the Scope of Work described in this contract. DHHS will also develop capitation rates according to all applicable CMS rules and regulations. Federal requirements stipulate that the State can only contract for rates that are within actuarially sound rate ranges.

DHHS has developed monthly capitation rates that will be offered to Contractors on a "take it or leave it" basis. The monthly capitation rates offered will be in effect for the initial six (6) month contract period, July 1, 2015 through December 31, 2015. See Attachment F for the table of rates. The rates included in Attachment F are considered preliminary rates and will be updated prior to July 1, 2015 with the consideration of additional financial experience and program changes.

The Categories of Aid (COA) rate structure is as follows:

a. AABD Under 1 M & F
b. AABD 01-20 M & F
c. AABD 21+ M & F
d. CHIP Under 1 M & F
e. CHIP 01-19 M & F
f. Family Under 1 M & F
g. Family 01-05 M & F
h. Family 06-20 F
i. Family 06-20 M
j. Family 21+ M & F
k. Foster Care Under 1 M & F

l. Foster Care 01-19 M & F
m. Katie Beckett 00-18 M & F
n. **Delivery** A supplemental maternity payment which covers five months prenatal services, delivery costs and two months post-partum services. The supplemental maternity payment is generated after documentation of a live birth outcome. A live birth outcome is defined by any birth not resulting in miscarriage, still birth or any other birth not resulting in life. There is one maternity payment generated regardless of the number of births during one delivery.

*Family Category of Aid - Section 1931 Children and Related and Section 1931 Adults and Related populations.

New Populations added to this contract will be included in the existing Category of Aid groups as follows:

Members who are participating in the Breast and Cervical Cancer Prevention and Treatment Act of 2000 will be included in the AABD Adult Category of Aid.

Participants in subsidized adoption programs will be included in the Foster Care Category of Aid.

Members receiving hospice services will be included in their regularly assigned Category of Aid.

2. **Development of Prepaid Capitation Payments**
Capitation payments were developed using fee-for-service and MCO financial and encounter data for the eligible populations from Calendar Years 2012, 2013, and 2014 and using the following adjustments:

a. Utilization trend
b. Unit cost trend
c. Medicaid program changes
d. Coordinated care savings
e. MCO administrative allowance

Rates to be prepaid to the Contractors for the provision of services outlined in this contract will be determined by DHHS. In the event any change occurs in federal law, federal regulations, state law, state regulations, state policies, or state Medicaid plan coverage, and DHHS determines that these changes impact materially on pricing, DHHS reserves the right to amend rates paid to Contractors. The Contractor will be required to accept these changes. All contracts shall be based upon the provisions of federal and state laws and regulations and DHHS's approved Medicaid State Plan coverage in effect on the issuance date of this contract, unless this contract is amended in writing to include changes prior to the contract start date.

3. **Annual Capitation Rate Determinations**
For each State Fiscal year, the State and its actuaries will jointly review the information necessary to develop actuarially sound capitation rate ranges. This review will include an analysis of any anticipated fee schedule changes and/or other programmatic changes to the NMMCP, rate-setting information collected from the Contractor, Department of Insurance (DOI) annual statements, various trend data sources, and

administrative experience. The State may require the Contractor to provide certified encounter data or other supplemental information to support rate development for future contract periods.

Capitation Rates may be adjusted outside of the annual capitation rate determination to assure additional program changes are included in the projection of expenditures as required for actuarially sound capitation rates.

4. HEALTH INSURANCE PROVIDERS FEE

Health Insurance Providers Fee (HIPF) under Section 9010 of the Patient Protection and Affordability Act of 2010. The State of Nebraska will compensate the MCO the cost of the HIPF that the MCO incurs and becomes obligated to pay pursuant to Section 9010 of the Patient Protection and Affordability Act of 2010 due to its receipt of Nebraska Medicaid premiums pursuant to the Contract. The full cost of the HIPF will include both the HIPF and the allowance to reflect the federal income tax liability related to the health insurer fee occurred. Payment to the MCO shall be made as part of the monthly capitation payment following the submission of sufficient documentation detailing liability for such fee. Documentation of liability shall be due to the State no later than 60 days from IRS Notification.

E. DELIVERABLES

All deliverables are subject to review by the State and will not be considered complete until deemed as such by a representative of the State. The format and content of each deliverable shall be defined and agreed upon in detail prior to the onset of work. The State will not review a deliverable unless the format and content has been approved.

The State may grant approval, reject all or some part of the deliverable, or request that revisions be made by the Contractor. Additional review periods shall be required whenever revisions are requested or a deliverable is rejected. Each deliverable must be consistent with previously approved deliverables. The State reserves the right to require the Contractor to revise deliverables previously approved or to reject current deliverables based on inconsistency with previously approved deliverables.

1. Provider-Enrollee Communication

Information about the services the MCO elects not to provide, reimburse for, or provide coverage of because of an objection on moral or religious grounds.

2. Grievance Systems

A description of the proposed grievance system, including the definition of a service authorization, procedures and timelines for grievance, appeal, and fair hearing.

3. Provider Network

- **a.** Individual GeoAccess maps for hospitals, PCP's, Specialists, FQHCs, RHCs, Urgent Care Centers, Dental service providers and ancillary providers for whom letters of intent have been signed;
- **b.** Written provider agreements that provide adequate access for enrollees; and
- **c.** A listing by provider type/specialty of the providers from whom a signed letter of intent to participate in the provider network has been received.

The following deliverables, at a minimum, will be due under a contract resulting from this procurement:

4. **Enrollee Communication**
   Client correspondence proposed to send to enrollees.

5. **Provider Communication**
   Provider correspondence proposed to send to providers.

6. **Quality Assessment and Performance Improvement**
   - **a.** Timely access monitoring.
   - **b.** Documentation of adequate capacity and services.
   - **c.** Primary care and coordination of health care services.
   - **d.** Direct access to specialists for enrollees with special health care needs.
   - **e.** Policies and procedures for authorizing services.
   - **f.** Policies and procedures for selection and retention of providers.
   - **g.** Policies and procedures for safeguarding enrollee confidentiality.
   - **h.** Documentation of sub contractual relationships and delegation.
   - **i.** Clinical practice guidelines.
   - **j.** A documented Quality Assessment and Performance Improvement (QAPI) Program including, at a minimum:
     - **i.** Description of Quality Assurance committee structure.
     - **ii.** Designation of individuals/departments responsible for the QAPI program.
     - **iii.** Description of the network participation in the QAPI program.
     - **iv.** Credentialing/re-credentialing procedures
     - **v.** Standards of Care
     - **vi.** Standards for service accessibility
     - **vii.** Medical records standards
     - **viii.** Mechanisms to detect underutilization and overutilization of services.
     - **ix.** Mechanisms to assess quality and appropriateness of care.
     - **x.** QAPI program documentation methods.
     - **xi.** Integration of quality assurance with other management functions.
     - **xii.** Corrective Action plans.
     - **xiii.** A health information system.
   - **k.** Policies and procedures for Care Management as reflected in Attachment A.
   - **l.** Provider Satisfaction Survey Tool and Methodology.

7. **Certifications and Program Integrity**
   - **a.** Data certification.
   - **b.** Mandatory Compliance plan to guard against fraud and abuse.

8. **Monthly Reporting to the State**
   - **a.** Claims Processing Reports
   - **b.** Provider Termination Report
   - **c.** Third Party Liability Report

9. **Quarterly Reporting to the State**
   - **a.** Enrollment/disenrollment statistics including reason for disenrollment other than the loss of Medicaid.
   - **b.** Provider network adequacy. Provider network reports must include identifying PCPs with closed panels.

c. Provider accessibility analysis for PCP's, Specialists, Hospitals, and ancillary providers.
d. Results of fraud and abuse monitoring.
e. Geo-mapping reports showing provider network for PCPs, Specialist, Urgent Care centers, Hospitals, Federally Qualified Health Centers, and ancillary providers.
f. Grievance and appeals process compliance.
g. Timely access standards monitoring.
h. Results of Utilization Management monitoring.
i. Results of Service verification monitoring.
j. Out of network referrals monitoring.
k. Case management results.
l. Quality Oversight Committee Report.
m. Financial Cost Reporting.

10. Annual Reporting to the State

a. Annual Quality Management Work Plan for Upcoming year
b. Performance Measures data.
c. Results of Quality Management Work Plan
d. Performance Improvement Project data and results.
e. Member Satisfaction Survey Results.
f. Provider Survey Results.
g. Results of any corrective action/sanctions of providers.
h. Direct Medical Education (DME/Indirect Medical Education (IME) Verification Reporting.

11. PCP ASSIGNMENT

Policy and procedures for handling the assignment of its enrollees to a PCP including the PCP automatic assignment methodology including reporting the assignment to the State.

12. POLICIES AND PROCEDURES FOR THE FOLLOWING:

a. Advance Directives
b. Enrollee Communications
c. Third Party Resource (TPR)
d. Enrollee Rights
e. Enrollee Free Exercise of Rights
f. Compliance with Federal and State laws and Regulations
g. Marketing Materials
h. Coverage of Emergency and Post- Stabilization Services
i. Coverage of Family Planning Services
j. Substitute Health Services
k. Disease Management Services
l. EPSDT Services
m. Health Risk Assessment
n. Enrollees with Special Needs
o. Indian Health Protections
p. Direct Access to Women's Health Specialists for female enrollees
q. Direct Access to Specialists for enrollee with special health needs
r. Access to a Second Opinion

s. Provider Credentialing and Re-Credentialing
t. Selection and Retention of Providers
u. Subcontractor Oversight
v. Clinical Practice Guidelines
w. Utilization Management
x. Member Satisfaction
y. Provider Satisfaction Surveys
z. Fraud, Waste, and Abuse Prevention
aa. Service Verification
bb. Provider-Preventable Conditions Including Health Care-Acquired Conditions
cc. Medical Home Collaboration/Support.

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

FOR DHHS:

Kerry T. Winterer
Chief Executive Officer
Department of Health and Human Services

DATE: 12/17/2014

FOR CONTRACTOR:

Name Debra J. Bacon
Title Vice President, CFO Medicaid
Coventry Health Care of Nebraska, Inc.

DATE: December 10, 2014

482-000-8 Care Management Requirements

Note: For purposes of this guide, the term plan is defined to mean physical health plan.

Overview

Care management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost effective outcomes.

The Department expects the plans participating in the Nebraska Health Connection (NHC) to provide proactive medical case management to the managed care client.

Care management is an integral part of managed care as part of the administrative requirements for utilization management and quality assurance activities, and is included in the Department's managed care policies and contractual agreements.

Each plan is required to comply with the Department's Quality Strategy (see 482-000-12). The health plans are required to provide care management separate from, but integrated with utilization management and quality improvement activities.

The major components of care management are assessment, planning, facilitation, coordination, and evaluation. The major activities of care management include advocacy, communication, problem solving, collaboration, and empowerment. Disease management programs must focus on diseases that are chronic or very high cost and include comprehensive health education.

Desired Outcomes

The NHC will offer managed care clients expanded choices, increased access to care, greater coordination and continuity of care, cost-effective health services, and better health outcomes through effective care management and disease management. Achievement of the best possible health outcomes for NHC clients will be measured by defined care management/health risk assessment outcomes indicators through the Department's Quality Strategy.

Departmental Expectations

The Department's expectation is for the NHC to provide a proactive approach in a client/family-centered manner to achieve and maintain the maximum health status possible for each client enrolled in the NHC. A proactive approach assures that the client experiences a seamless, integrated health care delivery system that is culturally competent.

A) Each health plan must conduct a Health Risk Assessment and offer Care Management activities to the following groups of clients at a minimum:
   1. Clients falling under the Medicaid eligibility category of the Aged, Blind and Disabled, i.e., AABD.
   2. Special Needs clients.
   3. Children who are in Foster Care Placement.
   4. Clients with chronic and/or special health needs.
   5. Clients at risk for poor health outcomes.
   6. Children with positive results from lead testing.
   7. Clients discharging from the hospital.
   8. Clients in Lock-In status.
   9. Clients with multiple missed medical appointments.
   10. Clients with screening results indicating referral treatment without follow up.
   11. Clients requesting case management activities.
   12. Clients whose PCP has made a referral for care management activities.

B) Any client identified for care management activities through the Health Risk Assessment must be offered care management services. Clients declining care management activities must have this documentation in the client record.

   When a client is identified and accepting of care management, the care manager must:
   1. Review the client's needs;
   2. Initiate a care coordination plan in collaboration with the client, the PCP, any Specialists, family member(s), and all other members of the health care team;
   3. Establish a care coordination plan that identifies goals to achieve and maintain optimal health outcomes, interventions, and duration of the plan; and
   4. Monitor progress towards goals.

In addition to the medical needs, the care coordination plan should consider the client's need for social, educational, and other non-medical services as well as the strengths o of the family/caregiver. All case information must be documented in the client record.

C) Disease Management. Disease management programs may be provided in conjunction with care management or separate from. Disease management programs must focus on diabetes, asthma, hypertension, and obesity at a minimum. The disease management program must empower the client, in concert with the medical home, any Specialists, and other care providers, to effectively manage disease and prevent complications through adherence to medication regimens, regular monitoring of vital signs and healthful diet, exercise and other lifestyle choices. The disease management program must engage clients in self-management strategies to improve their health. The program must assess the disease processes and its affect on life events and educates the member on disease self-management. All case information must be documented in the client record.

D) Children who are DHHS wards and in out-of-home placement. Care Management for children who are in foster care placement must involve coordination with the child's Child and Family Service Specialist (or designee). Care Management must also include identifying and responding to the child's health care needs including mental health and dental health needs. The case management plan must include an outline of:

1. A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice;
2. How health needs identified through screenings will be monitored and treated;
3. How medical information for children in care will be updated and appropriately shared, which may include the development and implementation of an electronic health record;
4. Steps to ensure continuity of health care services; and
5. The oversight of prescription medications.

E) Lock-in requirements per 471NAC 2-004 Client Lock-In. When the Department identifies a client for Lock-in status, care management staff (or other designee) must assist the client with designating their (Primary Care Physician) PCP as their lock-in provider and notify the Department (see 482-000-8).

F) HEALTH CHECK (Early and Periodic Screening, Diagnosis and Treatment Program)(EPSDT) Outreach. Per 471 NAC 33, the EPSDT program's objectives are ensuring the availability and accessibility of required health care resources and helping Medicaid-eligible children and their parents or caretakers effectively use them. Care coordination must include:

1. Provision of effective outreach/education activities which informs parents (or caretakers) of the benefits of having their children receive HEALTH CHECK screening, diagnosis, and treatment services;
2. Provision of consumer education to parents (or caretakers) which assists in making responsible decisions about participation in preventive health care and appropriate utilization of health care resources;
3. Assurance of continuing and comprehensive health care beginning with the screening through diagnosis and treatment for conditions identified during screening;
4. Provision of assistance to families in making medical and dental appointments and in obtaining needed transportation; and

5. Establishment of case management of screening services to monitor and document that all HEALTH CHECK (EPSDT) services are delivered within established time frames.

G) Client request in change of PCP. Client requests to change PCP's must be made to the health plan that the client is enrolled in. Care management staff (or other designee) are responsible for processing PCP transfer requests received from the client and assisting in identifying a new PCP which is enrolled provider in that plan.

Managed Care Quality Strategy 2013

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Section One: Introduction

1. Managed Care Goals, Objectives and Overview

A. A History of Medicaid and CHIP Managed Care in Nebraska

The State of Nebraska's Medicaid (Nebraska Medical Assistance Program [NMAP]) and CHIP program are administered by the Medicaid and Long Term Care Agency within Nebraska's Department of Health and Human Services. In 1993, the Nebraska Legislature directed Medicaid (hereafter The Department) to develop a managed care program as authorized under Section 1932 of the Social Security Act. Managed Care was developed to increase access to comprehensive health care services for Nebraska's Medicaid and CHIP clients while being mindful of cost-effectiveness for the state[1]. The Nebraska Medicaid Managed Care Program, entitled the Nebraska Health Connection (NHC), was implemented in July, 1995 with two, separate 1915(b) waivers: one for physical health, and one for Mental Health and Substance Abuse. Although the NHC has included mental health and substance abuse coverage throughout its existence, full-risk behavioral health managed care will come into effect on September 1, 2013. This quality strategy, originally created and approved in 2003, and updated in 2010, has been updated, effective April 1, 2013, to reflect this change.

The NHC consists of the following program components:

1. Nebraska Medicaid Managed Care Program Benefits
    a. Basic Benefits Package for physical health
    b. Behavioral Health benefits package
2. Enrollment Broker Services (EBS)
3. Data Management Services

The Basic Benefits package for physical health was implemented on July 1, 1995 in a limited coverage area (Douglas, Sarpy and Lancaster counties). A predecessor to the current Behavioral Health package, a Mental Health/ Substance Abuse package, was implemented statewide on July 17, 1995. From July, 1995 until June, 2001, the NHC utilized on Primary Care Case Management (PCCM) Network and two risk-capitated Managed Care Organizations (i.e. Prepaid Health Plan) for delivery of physical health services. In July, 2001, one of the managed care organizations (MCOs) terminated its contract with The Department, leaving one MCO in the program. The Department completed a smooth transition of all active NHC members into the remaining MCO and the PCCM network between July, 2001 and September, 2001. On January 1, 2002, The Department changed the management of the Mental Health/ Substance Abuse component of the NHC from a risk-capitated model (MCO) to a non-risk model (i.e. Administrative Service Organization). In April, 2010, following a Request for Proposal, The Department contracted with two contractors to administer the physical health managed care program. At this time, The Department also expanded MCO coverage to 10 counties in Nebraska (Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Sarpy, Saunders, Seward, and Washington). On September 30, 2011, The Department released a Request for Proposals to identify two MCOs for the remaining counties in Nebraska. This RFP resulted in a contract with an existing MCO, and one with a new MCO.

[1] 482 NAC 1-001.02

MCO coverage expanded to statewide inclusive coverage on July 1, 2012 using these 3 providers. A Request for Proposals for a full-risk Behavioral Health MCO was released on October 24, 2012. A provider was selected, and statewide MCO coverage for behavioral health will commence on September 1, 2013. Medicaid and CHIP recipients will be enrolled in this plan if they meet qualifications whether they plan to access services or not.

In Nebraska, MCO enrollment is mandatory for five groups[2]:

a) "Families, children, and pregnant women eligible for Medicaid under Section 1931 of the Social Security Act or related coverage groups.
b) Blind/Disabled Children, Adults, and Related Populations who are eligible for Medicaid due to blindness or disability.
c) Aged and Related Populations. Those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the 1931 Adult population.
d) Foster Care Children. Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.
e) Title XXI CHIP. An optional group of targeted low-income children who are eligible to participate in Medicaid in Nebraska."

The groups of people who are not eligible for managed care (and are, instead, enrolled in Fee-for-Service care when eligible for and enrolled in Nebraska's Medicaid program) varies between the Behavioral Health, and the Physical Health managed care programs. The more general list of excluded populations is found in Behavioral Health[3]:

a) "Medicaid members for any period of retroactive eligibility;
b) Aliens who are eligible for Medicaid for an emergency condition only;
c) Members eligible during the period of presumptive eligibility;
d) Participants in an approved DHHS PACE program; and
e) Clients with Medicare coverage where Medicaid only pays co-insurance and deductibles."

In physical health, the list is more extensive, targeting more specific groups:

a) Medicaid members who have Medicare.
b) Medicaid members who reside in Nursing Facilities (NF) at custodial levels of care or in Intermediate Care Facilities for the Mentally Retarded (ICF/MR) or in Psychiatric Residential Treatment Facilities (PRTF).
c) Medicaid members who participate in a Home and Community Based Services Wavier (HCBS). This includes adults with mental retardation or related conditions, aged persons or adults or children with disabilities, children with mental retardation and their families, members receiving Developmental Disability Targeted Case Management Services, Traumatic Brain Injury waiver members and any other group for whom the State has received approval of the 1915(c) waiver of the Social Security Act.
d) Medicaid members for any period of retroactive eligibility. Managed Care enrollment is prospective only.

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[2] RFP 3792Z1: Section IV. B.4; RFP 4166Z1: Section IV. D
[3] RFP 4166Z1: Section IV. E

e) Members residing out-of-state or those who are considered to be out-of-state (i.e., children who are placed with relative out-of-state or those who are designated as such by DHHS personnel).
f) Certain children with disabilities who are receiving in-home services, also known as the Katie Beckett program.
g) Aliens who are eligible for Medicaid for an emergency condition only.
h) Members participating in the Refugee Resettlement Program.
i) Members who have excess income or who are designated to have a Premium Due.
j) Members participating in the State Disability Program.
k) Members eligible during the period of presumptive eligibility.
l) Organ transplant recipients (active managed care members who receive a transplant are waived out of managed care from the day of transplant forward).
m) Members who have received a disenrollment/waiver of enrollment.
n) Members who are participating in the Breast and Cervical Cancer Prevention and Treatment Act of 2000.
o) Members receiving Medicaid Hospice Services.
p) Individuals who are patients of Institutions of Mental Disease (IMD) who are between the ages of 21-64.
q) Participants in subsidized adoption programs.
r) Participants in an approved DHHS PACE program."

B. Goals and Objectives

The objectives of the NHC program continue to be improved access to quality care and services, improved client satisfaction, reduction of racial and ethnic health disparities, cost reduction, and the reduction/prevention of inappropriate/unnecessary utilization. Performance-driven objectives for demonstrating success or identifying challenges in meeting the program objectives have been implemented using data that reflects physical health plan quality performances, access to covered services, utilization, and client satisfaction with care.

2. Development and Review of the Quality Strategy

A. Formal Processes used to develop the quality strategy

This update of the quality strategy was carried out through collaboration across units within Medicaid and Long Term Care. It incorporated the original, approved information and language wherever possible and appropriate, while reorganizing and expanding sections to satisfy Federal requirements. This Quality Strategy is set to be modified or updated when significant changes, defined as substantial programmatic changes, such as incorporating new populations into Managed Care, are implemented into the NHC. Besides this, the Quality Strategy will be updated when quality indicators suggest that new or different approaches must be implemented to improve the quality of care of enrollees. The units involved with creating this strategy intend to make it available for public comment by making it available to the public on Medicaid and Long Term Care's state website. It is also the intention of the document creators that it will be presented to the Medical Assistance Advisory Council to obtain stakeholder input.

Section 2: Assessment

I. Quality and appropriateness of care

A. Methods and Procedures.

The State requires that all MCOs have methods to determine the quality and appropriateness of care for both the general MCO enrollee population, and specifically for people with special needs. MCOs are required to report to the Quality of Care Reporting System, as developed by The State in 2010. This system is based on performance measures, and other data that are reported by the MCOs. In-depth information about these performance measures will be expanded upon throughout this document.

The State supplies MCOs with race, ethnicity and primary language information about Medicaid enrollees that has been collected during intake and eligibility procedures. This information is optional to provide at this time. To meet new federal requirements for reporting and use of this information, the procedures specific to this data collection may be altered in the future. The State expects the MCO to use the information, as provided currently, and as will be provided in the future, to promote delivery of services in a culturally competent manner, and to reduce racial and ethnic health disparities for enrollees.

II. National Performance Measures

A. Required Performance Measures

At this time, the only performance measure that is required to be reported to CMS is the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS), as performed on the title XXI population of eligible enrollees. Physical Health MCOs are mandated contractually to perform this survey[4]. Results of client satisfaction surveys, including an independent survey carried about by The Department's contracted Enrollment Broker allow for an overall composite and an MCO to MCO comparison. The results of the survey are made available to Medicaid beneficiaries through the DHHS managed care website to assist them in the process of selecting an appropriate MCO.

B. Voluntary Performance Measures

The State reports on five voluntary performance measures from the Children's Core Measure set through the CARTs report:

1. Well-Child Visits in the First 15 Months of Life
2. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
3. Percentage of Eligibles that Received Preventative Dental Care
4. Child and Adolescent Access to Primary Care Practitioners
5. Percentage of Eligibles that Received Dental Treatment Services.

[4] RFP 3792Z1: Section IV.C.7.g.xi

6. Monitoring and Compliance

A. State Monitoring of Federal Requirements.

The State monitors MCOs for compliance with Federal Requirements through quarterly reports. These reports will be further discussed later in this report.

B. Monitoring and evaluation procedures to ensure MCO compliance with the standards of subpart D (access, structure and operations, and measurement and improvement standards)

The State requires that MCOs use and report established performance measures, CAHPS surveys, performance improvement projects and grievance and appeal logs to ensure that they are compliant. Further information about each of these standards will be provided later in this document [except in the case of the CAHPS survey, which was previously discussed].

1. CAHPS
   - Please see Section Two, Part II, Item A
2. HEDIS® results, Required MCO reporting of performance measures, and Required MCO reporting on performance improvement projects
   - Please see Section Three, Part c. Item a.ii
3. Grievance/ appeal logs
   - Please see Section Three, Part b, Item v

7. External quality review (EQR)

A. External Quality Review Activities[5]

The Department has contracted with IPRO as an External Quality Review Organization (EQRO) to conduct External Quality Review of contracted MCOs. IPRO is a national healthcare assessment organization that is accredited by the National Committee for Quality Assurance (NCQA) and URAC, amongst others. The Department contracts with its EQRO to prepare an annual Technical Report for each MCO. This report includes a compendium of plan-specific descriptive data reflecting the CMS protocols for external review quality reports. Analysis within the report includes validation of performance measures, compliance with access standards, structure and operation standards, and validation of performance improvement projects. The EQRO compiles a profile for each plan, including a summary of strengths and weaknesses. With this analysis in mind, each year The Department and the EQRO reassess each MCO's progress in addressing and improving identified problem areas.

B. Accreditation standards

The State requires that MCOs have National Committee for Quality Assurance (NCQA) or other national certification related specifically to Managed Care Organizations (such as URAC) when they submit a proposal for a state contract[6]. Proposals must include details about their certification, including time period for current certification. If the MCO is accredited by a certification other than NCQA, the

[5] RFP 3792Z1: Section IV.C.7.b; RFP 4166Z1: Section IV.12.a.x
[6] RFP 3792Z1: Section IV.C.17; RFP 4166Z1: Section IV. J

state requires that they obtain NCQA certification during the awarded contract term. Proposals must include specific information related to acquiring this certification.

Section Three: State Standards

A. Access Standards

i. Accessibility of services

As federally mandated, MCOs in Nebraska are contractually required by The Department to maintain a network that provides enrollees with a range of qualified providers in such a way as they will be reasonably able to access them[7]. To comply with this requirement, MCOs must meet specific contract provisions outlining the accessibility standards in terms of location, the qualifications of providers, and the types of providers that must be accessible. Accessibility in terms of location offers a special challenge for states like Nebraska. Nebraska is a largely rural state with a low-population density (but not uninhabited) for much of its area, along with several urban centers and micropolitan areas: to serve a state-wide network requires provisions for accessibility of services for multiple regional situations. As such, the state has established Urban, Rural and Frontier Access standards[8] to ensure quality care for all Nebraska residents.

The Department requires that MCOs have sufficient numbers and locations within their prescribed service area (the original 10 counties for 1 MCO, the remaining 83 counties for 1 MCO, and the entire state for 2 MCOs [one being Behavioral Health]) to provide adequate access and quality for all services offered in the benefits package. The State requires that MCOs anticipate Medicaid enrollment and expected service utilization (taking into account the health characteristics of the population in the areas served) to ensure that an adequate amount and range of services be provided. The MCO must also ensure that it can provide or arrange continuous access to care (24 hours per day, 7 days per week) to all enrollees[9], and all network providers must offer hours of operation that meet standard requirements[10]. MCOs must regularly monitor providers to ensure compliance, and take corrective action when necessary[11].

ii. Assurance of adequate capacity and services

As Behavioral Health MCO coverage is separate from Physical Health MCO coverage, access to services and service providers may be specific to the type of MCO. While both types of MCOs must meet general accessibility requirements, such as timeliness of services and cultural competencies, accessibility of particular providers are MCO type specific. The MCOs are required to maintain a network of providers that are credentialed as required by federal standards[12]. These providers must provide culturally

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[7] RFP 3792Z1: Section IV.C.12
[8] RFP 3792Z1: Attachment C. Please see Appendix B.
[9] RFP 3792Z1: Section IV.C.7. x; RFP 4166Z1: Section IV. L.9.a.1
[10] RFP 3792Z1: Section IV.C.7. e.ix, Attachment C. Please see Appendix B.; RFP 4166Z1: Section IV. B.l.10
[11] RFP 3792Z1: Section IV.C.7.e.xi
[12] RFP 4166Z1: Section IV. J.10

competent services to all enrollees[13]. The physical health network must be extensive enough that female enrollees will have direct access to women's health specialists[14], and enrollees with special needs will have direct access to pertinent specialists[15]. Enrollees with special health care needs are identified through eligibility information; however, MCOs use an algorithm to identify special needs populations[16]. Behavioral Health MCOs include several extra, behavioral health specific special needs groups:

i. "Any individual with IV drug use, pregnant substance uses, and substance using women with dependent children (including those with co-occurring mental health and substance use disorders);
ii. Children with SED or with behavioral health challenges and are in contact with multiple agencies serving children;
iii. Adults with SPMI, including adults with co-occurring SPMO and substance use disorders; and
iv. Members with co-occurring developmental disabilities and mental health or substance use disorders.[17]"

All enrollees must be able to access second opinions from in-network, qualified health professionals[18]. Behavioral Health MCOs must have inpatient and residential services accessible within 60 miles or 60 minutes travel time from all enrollees' residences, unless a rural area necessitates extending this requirement to 120 miles or 120 minutes travel time[19]. Other covered services, besides emergency psychiatric services that are coordinated with Department of Behavioral Health's crisis networks, must be within 20 miles or 30 minutes of travel time of enrollees' residences[20]. Once again, these access standards may be altered for rural areas[21]. In the cases where an MCO's network CANNOT provide a medically necessary service to an enrollee, it must provide timely and adequate coverage for the enrollee to access these services out-of-network[22], and must coordinate with this provider directly for billing purposes[23]. To access out-of-network Behavioral Health care, the enrollee must meet special circumstances[24].

iii. Coordination and Continuity of Care

The MCOs contracted will have a network that is extensive enough to allow for enrollees to select or change their primary care provider (PCP). PCPs must be physicians (MDs or Dos), or Advance

[13] RFP 3792Z1: Section IV.C.7.xii; RFP 4166Z1: Section IV. L.1.f
[14] RFP 3792Z1: Section IV.C.7.e.iv; Documentation: Section IV.D.12.p
[15] RFP 3792Z1: Section IV. C. 7.e.xviii; Documentation: Section IV.D.12.q
[16] 1915(B) Waiver Section A.II.C.2.b
[17] RFP 4166Z1: Section IV.M. 4.Ii.b.I.11.i-iv
[18] RFP 3792Z1: Section IV.C.7.e.v; RFP 4166Z1: Section IV. B.I.10
[19] RFP 4166Z1: Section IV. L.9.a.ii.a
[20] RFP 4166Z1: Section IV. L.9.a.ii.b-c
[21] RFP 4166Z1: Section IV. L.9.a.ii.d
[22] RFP 3792Z1: Section IV.C.7.e.vi; RFP 4166Z1: Section IV. L.8.b
[23] RFP 3792Z1: Section IV.C.7.e.vii; RFP 4166Z1: Section IV. L.8.c.iv
[24] RFP 4166Z1: Section IV. L.8.a

Practice Nurses or Physician's Assistants that are supervised by a physician[25]. To enhance accessibility and coordination of care, The Department promotes the use of Patient-Centered Medical Home models[26]. This method of care delivery promotes care planning that includes input from the enrollee and, if appropriate, their family members[27]. It also promotes access to specialists for all enrollees[28], including the directive that enrollees with special needs have access to needed specialists[29]. With this increased access to interdisciplinary care comes increased concern about confidentiality for enrollees. MCOs are charged with maintaining enrollee confidentiality while coordinating services across providers[30]. When services are provided across MCOs, in most cases, when an enrollee is accessing both physical and behavioral health services, all services must be coordinated through the MCOs[31]. People with special health care needs are to receive assessments to identify a network of providers that will adequately meet their needs, and case management tracking, to allow for both management and coordination of care[32].

iv. Coverage and authorization of services

The basic benefits package provided by MCOs must provide for services in an amount, duration and scope that are both sufficient to meet the needs and can be reasonably expected to achieve the purpose of the services. These services are to be furnished at no less of an amount as the services provided to fee-for-service Medicaid enrollees[33]. Services cannot be denied or reduced arbitrarily or on a decision based solely on diagnosis, type of illness, or condition[34]. That said, MCOs are allowed to restrict access to services based on reasonable causes, such as medical necessity[35] (or lack thereof). In Nebraska, clinical guidelines define social and medical necessity as:

- "Necessary to meet the basic health needs of the client.
- Rendered in the most cost-effective manner and type of setting appropriate for the delivery of the covered service.
- Consistent in type, frequency, duration of treatment with scientifically based guidelines of national, medical, research or health coverage organizations or government agencies.
- Consistent with the diagnosis of the condition.
- Required for means other than convenience of the client or his or her physician.
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.
- Of demonstrated value.

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[25] RFP 3792Z1: Section IV.C.13
[26] RFP 3792Z1: Section IV.C.14.a
[27] RFP 3792Z1: Section IV.C.14.e
[28] RFP 3792Z1: Section IV.C.14.f
[29] RFP 3792Z1: Section IV. C. 7.xviii; Documentation: Section IV.D.12.q
[30] RFP 3792Z1: Section IV.C.7.xvii; RFP 4166Z1: Section IV.M. 4.Ii.b.I.9
[31] RFP 3792Z1: Section IV.C.15; RFP 4166Z1: Section IV. F
[32] 1915(B) Waiver Section A.II.C.2.c
[33] RFP 3792Z1: Section IV.C.7.e.xix;
[34] RFP 3792Z1: Section IV.C.7.e.xx; RFP 4166Z1: Section IV. F
[35] RFP 3792Z1: Section IV.C.7.e.xxi; RFP 4166Z1: Section IV. M.9.c.iii

- No more intense level of service than can be safely provided." [36]

Decisions made to deny or reduce services must be made by an appropriate health care professional[37], and the MCO must notify the provider who requested the service, and give the enrollee notice in writing of any decisions made to deny or reduce services. The same is true for decisions to authorize the requested services at a lower amount, duration or scope than was requested by the provider and enrollee[38]. MCOs must have their policies and procedures for authorization of services in writing[39], and have mechanisms in place to ensure that these decisions are made in a consistent manner[40]. MCO policies around compensation cannot incentivize denying, limiting, or discontinuing medically necessary services[41].

B. Structure and Operation Standards

i. Provider selection

The Department requires MCOs to develop and maintain written policies and procedures with a description of the policies and procedures for selection and retention of providers, following the State's policy for credentialing and re-credentialing[42]. The MCOs selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

The Department has a documented process that MCOs must adhere to for credentialing and re-credentialing of providers. The process is as follows:

a. "All providers credentialed by the MCO must also be a Medicaid-enrolled provider and agrees to comply with all pertinent Medicaid regulations;
b. Re-credentialing every three years;
c. Disclosure by providers and fiscal agents on information of ownership and control;
d. MCOs shall not approve a provider agreement or contract with a fiscal agent, and must terminate an existing agreement or contract, if the provider or fiscal agent fails to disclose ownership or control information;
e. Disclosure by providers and fiscal agents on information related to business transactions – Provider agreements;
f. MCOs are prohibited from employing or contracting with providers excluded from participation in Federal health care programs in accordance with Federal regulations;
g. Disclosure by providers on information for persons convicted of crimes in accordance with Federal regulations;

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[36] Clinical Guidelines for the State of Nebraska Medicaid Managed Care: 5.1.2
[37] RFP 3792Z1: Section IV.C.8.ii; RFP 4166Z1: Section IV. M.9.c
[38] RFP 3792Z1: Section IV.C.8.iii; RFP 4166Z1: Section IV. K.1.i.c
[39] RFP 3792Z1: Section IV.C.8.i; RFP 4166Z1: Section IV.M.9.c.vi
[40] RFP 3792Z1: Section IV.C.7.e.xxiv; RFP 4166Z1: Section IV.M.9.c.iv.
[41] RFP 3792Z1: Section IV.C.8.xxvii; RFP 4166Z1: Section IV. M.9.d
[42] RFP 3792Z1: Section IV.C.7.f; RFP 4166Z1: Section IV.L

h. MCOs must notify the Department of any disclosures made by providers on information on persons convicted of crimes within ten working days from the date it receives the information. The Department is responsible for notifying the Inspector General within 20 working days of notification by the MCOs[43]".

ii. Enrollee Information

MCOs must fully inform enrollees and family members about their rights and responsibilities and how to exercise them upon enrollment. MCOs comply with any applicable Federal and State laws that pertain to enrollee rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees[44].

MCOs are required to provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner that is easily understood. MCOs must provide the information in languages identified by the Department, which includes Spanish as a prevalent non-English language. Oral interpretation services are available free of charge to enrollees and potential enrollees. In addition, enrollment information must be available to deaf and blind enrollees.

The Department requires the MCOs to furnish the information listed below to each of its enrollees within a reasonable time but no more than 30 calendar days after the MCOs receive notice of the enrollment. The Department requires MCOs to furnish the following information to enrollees:

a. "Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. This includes, at a minimum, the information on primary care providers, specialists, and hospitals.
b. Any restrictions on the enrollee's freedom of choice among network providers.
c. Enrollee rights and protections as specified [as specified in contract].
d. Information on grievances, appeals, and State fair hearing procedures including [information below].
e. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.
f. Procedures for obtaining benefits, including authorization requirements.
g. The extent to which, and how enrollees may obtain benefits, including family planning services from out-of-network providers.
h. The extent to which, and how, after-hour and emergency coverage are provided [including definitions of emergency conditions, processes, procedures and locations] .
i. The post stabilization care services rules set forth [as defined by federal requirement].
j. Policy referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.
k. How and where to access any benefits that are available under the State Plan but are not covered under the contract, including any cost sharing, and how transportation is provided

[43] RFP 3792Z1: Section IV.C.7.f.iv
[44] RFP 3792Z1: Section IV.C.4.d; RFP 4166Z1: Section IV.K

for those State Plan services. For a counseling or referral service that the MCOs do not cover because of moral or religious objections, the MCOs need not furnish information on how and where to obtain the service. The State must provide information on how and where to obtain the service."[45]

There must also be "notification of provider termination to each enrollee who actively receives services from the provider that has been terminated from the network, within 15 days after issuance of the provider termination notice[46]".

iii. Confidentiality

All materials and information provided by the Department or acquired by the MCOs on behalf of the Department are regarded as confidential information. MCOs are required to adhere to Federal and State Law, and ethical standards[47]. A breach of confidentiality must be reported to the Department immediately and MCOs must take immediate corrective action.

iv. Enrollment and disenrollment

The Department is responsible for the enrollment of members into managed care plans through the use of an enrollment broker[48]. If the Department has multiple MCOs, a member guidebook, plan matrix, and provider directory are given to potential enrollees to assist in choosing an MCO plan and designating a Primary Care Physician (PCP). The Enrollment Broker provides impartial choice counseling to assist enrollees in choosing a plan. Enrollees are given 15 days to enroll in an MCO plan and select a PCP. Enrollees that do not select a plan are auto-assigned and the plan will assign a PCP within once month of the effective date of enrollment into the plan.

The MCO may request disenrollment of a member for the following reasons:

a. The MCO has sufficient documentation to establish that the enrollee's condition or illness would be better treated by another plan; or,
b. The MCO has sufficient documentation to establish fraud, forgery, or evidence of unauthorized use/abuse of services by the enrollee.

The MCO must send the notification of the disenrollment request to the enrollee at the same time the request is made to the Department.

The MCO may not request disenrollment due to a change in the enrollee's health status or enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. An exception could be made if the enrollee's continued enrollment in the MCO seriously impairs the MCO's ability to furnish services to either this particular enrollee or other enrollees.

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[45] RFP 3792Z1: Section IV.C.4.d.x.a-m
[46] RFP 3792Z1: Section IV.C.4.d.ix
[47] RFP 3792Z1: Section IV.C.7.f; RFP 4166Z1: Section III.OO
[48] RFP 3792Z1: Section IV.C.5

The enrollee may request disenrollment for the following reasons:

a. For cause, at any time;
b. Without cause during the 90 days following the date of the member's initial enrollment with the MCO or the date the Department sends the member notice of the enrollment, whichever is later;
c. Without cause every 12 months thereafter;
d. Upon automatic re-enrollment if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity;
e. When the Department imposes the intermediate sanctions.

The enrollee must submit a written request of disenrollment from the MCO plan with cause to the Enrollment Broker for a decision by the Department on the request.

The following are cause for disenrollment:

a. The enrollee moves out of the MCO service area;
b. The MCO does not, because of moral or religious objections, cover the service the enrollee seeks;
c. The enrollee needs related services to be performed at the same time and not all related services are available within the network;
d. Other reasons, including but not limited to, poor quality of care, lack of access to services, or lack of access to providers experienced in dealing with the enrollee's health care needs.

The effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee or the MCO files the request. If the Department fails to make a disenrollment determination within the timeframe specified, the disenrollment is considered approved.

v. Grievance systems

The MCOs are required to notify the requesting provider, and give the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested[49]. The notice must explain:

a. The action the MCO has taken or intends to take;
b. The reasons for the action;
c. The enrollee's or the provider's right to file an appeal;
d. The enrollee's right to request a State Fair Hearing;
e. Procedures for exercising the enrollee's rights to appeal or grieve;
f. Circumstances under which expedited resolution is available and how to request it;

[49] RFP 3792Z1: Section IV.C.8; RFP 4166Z1: Section IV.K.1.i

g. The enrollee's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

The MCOs must provide the notice of adverse action at least ten days before the date of action when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services. The period is shortened to five days if probably member fraud has been verified.

MCOs are required to have a grievance system for enrollees that meet all regulation requirements, including a grievance process, an appeal process, and access to the State's Fair Hearing system. MCOs must:

a. Give enrollees any reasonable assistance in completing forms and other procedural steps not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability;
b. Acknowledge receipt of each grievance and appeal;
c. Ensure that individuals completing review of the grievances and appeals are not the same individuals involved in previous levels of review or decision-making and are health care professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply:
    i. A denial appeal based on lack of medical necessity.
    ii. A grievance regarding denial of expedited resolutions of an appeal.
    iii. Any grievance or appeal involving clinical issues.

An enrollee or a provider, acting on behalf of the enrollee, may file an appeal within 90 days from the date on the MCO's Notice of Action. The MCOs must resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within 45 days from the day the MCOs receive the appeal. The MCOs may extend the timeframes by up to 14 calendar days if the enrollee requests the extension or the MCOs show that there is need for additional information and how the delay is in the enrollee's interest.

The MCOs must establish and maintain an expedited review process for appeals when determined that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to maintain, or regain maximum function. The MCOs must resolve each expedited appeal and provide notice, as expeditiously as the enrollee's health condition requires, within three working days after MCOs receive the appeals. MCOs may extend the timeframes by up to 14 calendar days if the enrollee requests the extension or the MCOs show that there is a need for additional information and how the delay is in the enrollee's interest.

The MCOs must provide written notice of disposition which must include the results and date of the appeal resolution:

a. For decisions not wholly in the enrollee's favor;
b. The right to request a State Fair Hearing

c. How to request a State Fair Hearing
d. The right to continue to receive benefits pending a hearing;
e. How to request the continuation of benefits;
f. If the MCO action is upheld in a hearing, that the enrollee may be liable for the cost of any continued benefits.

MCOs must maintain records of grievances and appeals and submit quarterly data to the Department.

Within 90 days from the date on the Notice of Action, enrollees may request a State Fair Hearing and the Department, not the MCOs, must grant the request. The MCOs are required to provide information on how to obtain a hearing and representation rules at a hearing must be explained to the enrollees and providers. For standard resolution, the MCOs must provide resolution within 90 days of the date the enrollees filed the appeals with the MCOs or the date the enrollees filed for direct access to a State Fair Hearing. Expedited resolution must take place within three working days from receipt of a hearing request for a denial of service that meets the criteria for an expedited appeal process but was not resolved using the MCOs expedited appeal timeframes.

vi. Subcontractual Relationships and Delegation

MCOs may provide services directly or may enter in subcontracts with providers who will provide services to the enrollees in exchange for payment by the MCOs for services rendered[50]. Any plan to delegate the responsibilities of the MCOs to major subcontractors shall be submitted to the Department for approval. The MCOs are responsible for oversight and are accountable for any functions and responsibilities that it delegates to the subcontractors, including:

a. Meeting Federal requirements that are appropriate to the service or activity delegated under the subcontract;
b. The prospective subcontractor's ability to perform the activities to be delegated;
c. A written agreement between the MCO and the subcontractor that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate; and,
d. Assurance that when the MCO identifies deficiencies or areas for improvement, the MCO and the subcontractor must take corrective action.

All services provided through the MCO must be verified[51].

C. Measurement and Improvement Standards

i. Practice Guidelines

To ensure that all enrollees receive consistently high-quality care, MCOs that contract with The State are required to adopt and implement practice guidelines that meet certain criteria. The MCO must

[50] RFP 3972Z1: Section IV.C.7.f; RFP 4166Z1: Section IV.J.11
[51] RFP 3792Z1: Section IV.C.9.b.ix; RFP 4166Z1: Section IV.O.11.a.iv

ensure that the guidelines are implemented in decisions regarding utilization management, enrollee education, coverage of services, and other areas to which the guidelines might apply[52].

Practice guidelines must meet the follow criteria:

a) "Are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field.
b) Considers the needs of enrollees.
c) Are adopted in consultation with contracting health care professionals.
d) Are reviewed and updated periodically, as appropriate."[53]

Practice guidelines should be disseminated to all providers to which they apply. They should also be available to enrollees by request[54].

ii. Quality Assessment and Performance Improvement Program

Each MCO must have mechanisms to detect both underutilization and overutilization of services[55] and the quality and appropriateness of care furnished to enrollees with special health care needs[56]. MCOs must also have an ongoing quality assessment and performance improvement program (QAPI) specifically for the services provided to enrollees[57]. To meet this requirement, each QAPI program is required to include at least these twelve components:

a) "Description of the Quality Assurance Committee;
b) Designation of the Individuals/Departments Responsible for the QAPI Program Implementation;
c) Description of Network participation in the QAPI Program;
d) Credentialing/Re-credentialing Procedures;
e) Standards of Care;
f) Standards for Service Accessibility;
g) Medical Records Standards;
h) Utilization Review Standards;
i) Quality Indicator Measures and Clinical Studies;
j) QAPI Program Documentation Methods;
k) Integration of Quality Assurance with other Management Functions; and
l) Corrective Action Plans" [58]

Each MCO must submit performance measurement data to the State in the specified, appropriate, way (please see Appendix A for a schedule of deliverables). The performance measures chosen by The Department are derived from HEDIS measures. Please see Appendix B for a full list of these measures.[59] MCOs must also conduct Performance Improvement Projects (PIPs) that are designed to achieve sustained, significant improvement in areas expected to improve health outcomes and enrollee satisfaction[60]. The number of PIPs currently in effect varies from MCO to MCO, depending

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[52] RFP 3792Z1: Section IV.C.7.g.iii; RFP 4166Z1: Section IV.M.3
[53] RFP 3792Z1: Section IV.C.7.g.i; RFP 4166Z1: Section IV.M.11.a
[54] RFP 3792Z1: Section IV.C.7.g.ii; RFP 4166Z1: Section IV.M.11.d
[55] RFP 3792Z1: Section IV.C.7.g.vii.a; RFP 4166Z1: Section IV.P.6.d.ix.h
[56] RFP 3792Z1: Section IV.C.7.g.vii.b;
[57] RFP 3792Z1: Section IV.C.7.g.iv; RFP 4166Z1: Section IV.M.12.a. ix.a.3
[58] RFP 3792Z1: Section IV.C.7.g.iv.a-l; RFP 4166Z1: Section IV.M.12. ix.a.3
[59] RFP 3792Z1: Section IV.C.7.g.viii, Attachment F;
[60] RFP 3792Z1: Section IV.C.7.g.xiii; RFP 4166Z1: Section IV.M.12.c

mainly on the length of tenure with The Department as a provider organization. All Physical Health PIPs must, however must involve aspects to meet eight requirements:

a) "Study topic and question as determined by the State;
b) Study indicators and goals;
c) Study population;
d) Measurement of performance using objectives and quality indicators;
e) Evaluation of findings from data collection;
f) Implementation of system interventions to achieve improvement in quality;
g) Evaluation of the effectiveness of interventions; and
h) Planning and initiation of activities for increasing and sustaining improvement." [61]

Behavioral Health MCOs have slightly different, but similar requirements for their PIPs. Behavioral Health PIPs must involve:

i. "Measurement of performance using objective quality indicators;
ii. Implementation of system interventions to achieve improvement in quality;
iii. Evaluation of the effectiveness of the interventions;
iv. Planning and initiation of activities for increasing or sustaining improvement; and
v. The Contractor shall include among its performance improvement projects at least one clinical issues study each contract year. The Contractor may submit more than one study idea, among which MLTC and the QAPI Committee will select one for approval.[62]"

PIPs are required to be carried out within a timeframe that will allow for success to be measured annually[63]. MCOs must have their own processes to evaluate their QAPI's impact and effectiveness. These results must be reported to The State annually[64].

viii. Health Information Systems

MCOs must maintain a health information system with the capability of collecting, analyzing, integrating and reporting data to the State's specifications[65]. The data required by The State includes encounter data[66], MCO drug rebates[67], utilization, grievances and appeals, and disenrollments (other than loss of eligibility disenrollments)[68]. Encounter data is to be submitted to The State monthly, within the 5% error rate threshold[69]. Encounter data must be collected on enrollee and provider characteristics and on services furnished to enrollees[70]. Each MCO must ensure data received is accurate and complete[71].

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[61] RFP 3792Z1: Section IV.C.7.g.xiii.a-h;
[62] RFP 4166Z1: Section IV.M.12.c.i-v
[63] RFP 3792Z1: Section IV.C.7.g.xiv; RFP 4166Z1: Section IV.M.12.c
[64] RFP 3792Z1: Section IV.C.7.g.xv; RFP 4166Z1: Section IV.M.12.c
[65] RFP 3792Z1: Section IV.C.7.f.xii; RFP 4166Z1: Section IV.N
[66] RFP 3792Z1: Section IV.C.7.f.xv; RFP 4166Z1: Section IV.N.3
[67] RFP 3792Z1: Section IV.C.7.f.xvi
[68] RFP 3792Z1: Section IV.C.7.f.xii; RFP 4166Z1: Section IV.N
[69] RFP 3792Z1: Section IV.C.7.f.xv; RFP 4166Z1: Section IV.N.4
[70] RFP 3792Z1: Section IV.C.7.f.xv; RFP 4166Z1: Section IV.N.3
[71] RFP 3792Z1: Section IV.C.7.f.xiii

Section Four: Improvement and Interventions

I. Intermediate Sanctions

A. Grounds for and consequences of Intermediate Sanctions.

The State has established intermediate sanctions that may be imposed in response to behavior by a contracted MCO. These sanctions may be put into effect when:

a) "The MCO fails substantially to provide medically necessary services that the MCO is required to provide, under law or under its contract with the State, to an enrollee covered under the contract.
b) The MCO imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
c) The MCO acts to discriminate among enrollees on the basis of their health status or need for health care services.
d) The MCO misrepresents or falsifies information that it furnishes to CMS or The State.
e) The MCO misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.
f) The MCO fails to comply with the requirements for physician incentive plans, if applicable.
g) The MCO has distributed directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.
h) The MCO has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.
i) Any other action or inaction that The State deems a violation that merits a fine consistent with this section."[72]

It is expected that any violations will be uncovered based on findings from the on-site operational reviews, client or other stakeholder complaints, financial status, or other sources. When The State has determined that a violation has occurred, it can, at its sole discretion, impose the following sanctions:

a) "Civil monetary penalties [please see Appendix A for specific amounts]
b) Appointment of temporary management [Please see Appendix A for stipulations from Section III.Y: Early Termination].
c) Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll.
d) Suspension of all new enrollments, including default enrollment, after the effective date of the sanction.

[72] RFP 3792Z1: Section IV.C.10.c.i;

e) Suspension of payment for potential enrollees enrolled after the effective date of the sanction and until CMS or The State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
f) Any other remedy, right, or sanction allowed under [the contract] agreement.[73]"

In addition to these sanctions, The State will deny payments for new enrollees when payment for those enrollees is denied by CMS[74].

B. Use of Intermediate Sanctions to address identified health care quality issues.

Intermediate Sanctions have been put into place to address the aforementioned specific violations. These violations include both contract management issues, and quality of care standards. To avoid these intermediate sanctions, MCOs must ensure that they are operating within compliance standards.

MCOs that are determined to be performing below quality standards through periodic reporting, performance measures, client satisfaction surveys, encounter data submission, on-site operational reviews, and/or review and analysis of the Quality Management Work Plan will be required to submit a Plan of Correction (POC) which addresses each deficiency specifically and provides a timeline by which corrective action will be completed. Follow-up reporting is required by the MCO to assess progress in implementing the POC. Successful return to compliance upon completion of the POC can help the MCO avoid other penalties.

Behavioral Health MCO(s) are charged with a different method of ensuring compliance. Instead relying solely on sanctions, the State has implemented incentives and performance guarantees. Using established metrics reported monthly (or otherwise specified), the MCO will report performance. If performance falls below standard, goal or previous levels, the MCO will develop and/or implement a corrective action plan (as approved by The Department)[75].

II. Health Information Technology

A. Initial and Ongoing Operation and Review of the State's Quality Strategy using information technology.

The Department contractually requires MCOs to have information systems that record and can be used to report on factors that were identified as specified by The Department (please see Appendix A for schedule of deliverables for reporting, and Section 3, Part c, item a.iii for more information about requirements for MCO health information systems). The Department and State require that Health Information Technology is in place at the level required so that this information can be provided because of the value of the information to monitor quality of care provided and the contract compliance levels of MCOs.

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[73] RFP 3792Z1: Section IV.C.10.c.ii;
[74] RFP 3792Z1: Section IV.C.10.c.iii;
[75] RFP 4166Z1: Section IV.O.11.a

Section Five: Delivery System Reforms

A. The Decision to Use Full-Risk Behavioral Health Managed Care.

Behavioral Health managed care will be offered through automatic enrollment for all managed care enrollees; Behavioral health services will be available for all NHC enrollees, regardless of expected need. Use of these services, like all services offered through MCOs, will be based on medical necessity. The State decided to return to Managed Care for Behavioral Health for the same reason that it uses Managed Care for physical health: access to the highest quality of care and largest range of services for enrollees with substantial monetary efficiency.

B. Behavioral Health Performance Measures.

The State has outlined 25 performance measures for its Behavioral Health MCO, with the stipulation that the MCO should collect on those that are applicable, and that it is not limited to collecting only these measures[76]. Please see Appendix A for a full list of these measures.

C. Behavioral Health Performance Improvement Projects

The State's contracted Behavioral Health MCO is required to conduct at least two performance improvement projects. These should be outlined in its annual Quality Management Work Plan, and should be designed to achieve significant, sustained improvement in clinical care and nonclinical areas. The chosen areas should be expected to have a favorable effect on behavioral health outcomes and Member satisfaction[77].

Section Six: Conclusions and Opportunities

A. Successes and Promising Practices

The State has had success with prenatal incentive and Emergency Room divergence programs. Building on these successes, and successful Performance Improvement Projects carried out by MCOs, the State hopes to continuing improving clinical and non-clinical care aspects with pro-active and effective programming.

B. Ongoing Challenges for Quality of Care

One of the greatest challenges faced by The State in maintaining the quality of care for enrollees in the NHC is the rapid expansion of this program. This expansion is due both to the expansion of managed care from 10 counties into a state-wide program, and from an anticipated increase in Medicaid enrollment in the coming years. The Department will work hard to ensure that the quality of care is maintained while addressing system and budgetary constraints. The State has received an analysis to assist in planning for extra expenses for the growing Medicaid population, many of whom will qualify for Managed Care. MCOs are responsible to ensure that enrollees that are in their care have sufficient access to providers, as previously discussed.

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[76] RFP 4166Z1: Section IV.M.12. ix.a.3.i-xxv
[77] RFP 4166Z1: Section IV.M.12.c

C. Challenges and opportunities with data collection systems.

This is an exciting time for the department in terms of data collection systems and health information technology. Mandates and funding from the Affordable Care Act have led to collaboration with Nebraska's Public Health department, outreach to and collaboration with providers, and a forward-thinking approach to data, data collection, and the systems that will enable The State to reach its quality goals. Currently, MLTC's Medicaid Information Technology Initiatives (MITI) unit is joining conversations with Public Health and a vendor to meet the requirements for the Immunization Gateway. MITI is injecting visions for an extensive Health Information Exchange in the collaboration's future into these conversations. The collaboration across departments and into the private sector has been a fruitful vehicle to better understand and recognize the different needs and viewpoints of very important stakeholders in Nebraska's health realm. Nebraska's federally funded Electronic Health Records (EHR) System incentive program has succeeded beyond expectations in terms of numbers of practices and hospitals implementing EHRs. This will set The Department up in the future to be able to readily access clinical data for analysis of quality indicators.

One sustaining challenge for The Department's data collection and reporting systems is the age of its Medicaid Management Information System (MMIS). Nebraska's MMIS was certified in 1978 and, while still functional, relies on outdated systems that do not allow for the maneuverability and accessibility of data necessary for today's evidence-driven performance evaluation needs. As of today, there is no budget to address this need by replacing the system, and so The Department is tasked with utilizing the system in the most effective and efficient way to successfully meet its needs.

Appendix A

Intermediate Sanctions- Civil Monetary Penalties

a) A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to enrollees, potential enrollees or health care providers; failure to comply with physician incentive plan requirements; marketing violations or any such action or inaction that the State deems a violation that merits a fine consistent with this section.
b) A maximum of $100,000 for each determination of discrimination; misrepresentation or false statements to CMS or the State or any such action or inaction that the State deems a violation that merits a fine consistent with this section.
c) A maximum of $15,000 for each member the State determines was not enrolled because of a discriminatory practice (subject to the $100,000 overall limit above) or any such action or inaction that the State deems a violation that merits a fine consistent with this section.
d) A maximum of $25,000 or double the amount of the excess charges, (whichever is greater) for charging premiums or charges in excess of the amounts permitted under the Medicaid program; or any such action or inaction that the State deems a violation that merits a fine consistent with this section. The State must deduct from the penalty the amount of overcharge and return it to the affected enrollee(s).

Section III. Y: Early Termination

1. The State and the contractor, by mutual written agreement, may terminate the contract at any time.
2. The State, in its sole discretion, may terminate the contract for any reason upon 30 days written notice to the contractor. Such termination shall not relieve the contractor of warranty or other service obligations incurred under the terms of the contract. In the event of cancellation the contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.
3. The State may terminate the contract immediately for the following reasons:
    a. if directed to do so by statute;
    b. contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;
    c. a trustee or receiver of the contractor or of any substantial part of the contractor's assets has been appointed by a court;
    d. fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its contractor, its employees, officers, directors or shareholders;
    e. an involuntary proceeding has been commenced by any party against the contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) days; or (ii) the contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the contractor has been decreed or adjudged a debtor;
    f. a voluntary petition has been filed by the contractor under any of the chapters of Title 11 of the United States Code;
    g. contractor intentionally discloses confidential information;
    h. contractor has or announces it will discontinue support of the deliverable;

i. second or subsequent documented "vendor performance report" form deemed acceptable by the State Purchasing Bureau.

Section IV.D 7-9: Reports to DHHS and the State

7. MONTHLY REPORTING TO DHHS

a) Claims Processing Reports
b) Out of Service Area Report
c) Provider Termination Report
d) Third Party Liability Report

8. QUARTERLY REPORTING TO DHHS

a) Enrollment/disenrollment statistics including reason for disenrollment other than the loss of Medicaid.
b) Provider network adequacy. Provider network reports must include identifying PCPs with closed panels.
c) Provider accessibility analysis for PCP's, High Volume Specialists, Hospitals, FQHC's, RHC's, Urgent Care Centers, and ancillary providers.
d) Results of fraud and abuse monitoring.
e) Geo-mapping reports showing provider network for PCPs, Specialist, Urgent Care centers, Hospitals, Federally Qualified Health Centers, and ancillary providers.
f) Grievance and appeals process compliance.
g) Timely access standards monitoring.
h) Results of Utilization Management monitoring.
i) Results of Service verification monitoring.
j) Out of network referrals monitoring.
k) Care management results.
l) Quality Oversight Committee Report.

9. ANNUAL REPORTING TO THE STATE

a) Annual Quality Management Work Plan for Upcoming Year
b) Performance Measures data.
c) Results of Quality Management Work Plan
d) Performance Improvement Project data and results.
e) Member Satisfaction Survey Results.
f) Provider Survey Results.
g) Results of any corrective action/sanctions of providers.
h) Financial Cost Reporting.
i) Direct Medical Education (DME)/Indirect Medical Education (IME) Verification

RFP 4166Z1: Section IV.M.12. ix.a.3.i-xxv

3). Outcomes and quality indicators will include to the extent practicable, but are not limited to, the following:

i. All of the metrics involved in the performance guarantees and incentives described in the Financial Section;
ii. Call center performance;
iii. Service utilization, including trends, outliers, expenditures, and length of stay in each service by level of care, including new services developed (for example, peer support and respite).

This will include standard measures, such as use/days per 1000 Members and penetration rates overall and by level of care. This will also include breakouts by age group;

iv. Seven and 30-day post-discharge (residential and acute care) ambulatory follow-up appointments; and

v. Racial and ethnic disparities (e.g., under-utilization of services by particular racial/ethnic groups) and cultural and linguistic competency. The Contractor is encouraged to utilize indicators consistent with the National Standards on Culturally and Linguistically Appropriate Services (CLAS) to include, but not limited to:

    1. Racial & Ethnic Disparities: PRTF admissions over 90 days; and
    2. Differences in service penetration rates across population groups.

vi. Access – Differences in service penetration rates across population groups;

vii. Perceptions of Care – Differences across population groups' perceptions that services are effective, understandable and respectful (this includes consumer satisfaction);

viii. Restraint and seclusion use – Track by provider the number of incidents of restraints and seclusion by program location. Involve consumer and family advocates, along with inpatient and residential providers, in the development of restraint and seclusion reporting requirements;

ix. Provider network adequacy;

x. Results of targeted quality assurance network activities for high volume providers;

xi. Monitoring psychotropic medications for children ages 12 years and under, including vulnerable populations such as children in foster care or in state custody;

xii. Performance related to grievances and appeals, including types, resolution time frames, and analysis of trends. This will include reporting of individual provider appeal rates and outcomes by level of care;

xiii. The actual number and percentage of Members involuntarily presenting for Mental Health and Substance Use Disorder treatment to 24- hour inpatient settings;

xiv. The actual number and percentage of Members presenting to hospital emergency departments (ED) within thirty (30) days of the discharge date from an acute level of care for any psychiatric or substance use disorder diagnosis – without an admission;

xv. Proportion of youth in PRTF and other residential settings with lengths of stay under 90 days;

xvi. Wait times for residential placement that measure time from initial referral to authorization to actual placement;

xvii. Admissions and readmissions to psychiatric inpatient (including PRTF) and residential facilities;
xviii. Continuity of care measures (within 7 days) from psychiatry inpatient facilities to community services;
xix. Number of children placed in residential treatment settings, relative to number of Medicaid Members, and relative to national benchmarks;
xx. Screening for Clinical Depression and Follow Up Plan;
xxi. Antidepressant Medication Management;
xxii. Adherence to Antipsychotics for Individuals with Schizophrenia;
xxiii. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment;
xxiv. Crisis services utilization, relative to number of persons (broken out by child/adolescent and adult) served and to national benchmarks; and
xxv. Emergency department utilization, using benchmarks and age breakouts.

Appendix B

RFP 3792Z1: Attachment C

DHHS Managed Care Expansion Area Access Standards

Specialists who are serving in the in PCP role (i.e., Internal Medicine, Pediatrics, or Ob/Gyn) are subject to the PCP access standards.

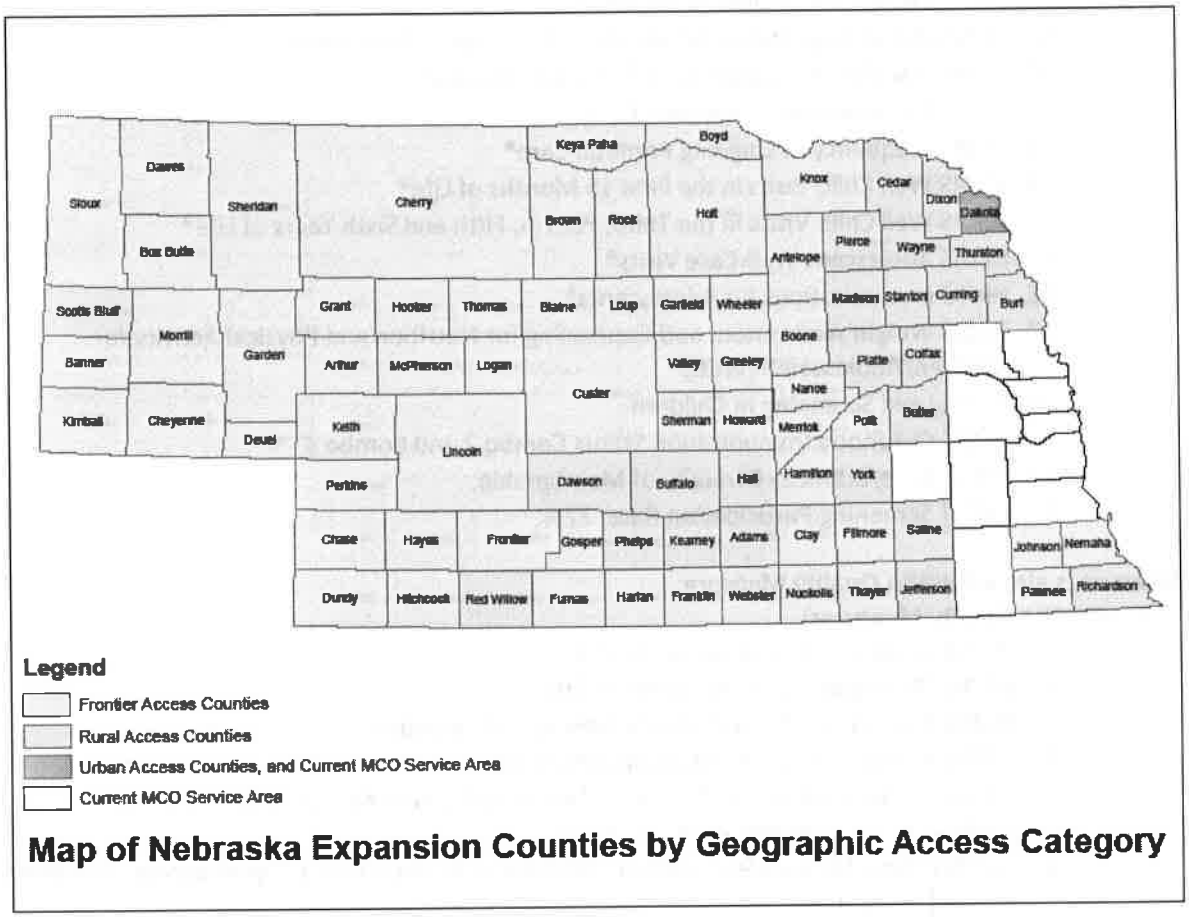
A. Timely Access-Standards for appointment availability for Primary Care Physicians (PCPs) and Specialists:

Timely Access		
Physician Type	**Appointment Type**	**Availability Standard**
Primary Care Physician (PCP)	Emergency	Twenty-four (24) hours per day, seven (7) days per week
	Urgent Care	Two (2) calendar days
	Routine	Fourteen (14) working days
High Volume Specialists (Cardiologist, Neurologist, Hematologist/Oncologist, Orthopedics)	Routine	Thirty (30) working days
Prenatal	First (1st) Trimester	Fourteen (14) working days
	Initial Second (2nd) Trimester	Seven (7) working days
	High Risk	Three (3) working days

B. Timely Access-Standards for hours of operation for PCP's"
   1. One (1) Medical Doctor (MD) proactice-20 hours per week.
   2. Two (2) or more MD practice- 30 hours per week

C. Geographic Access-Standards for provider location to clients:
   1. PCP Access[78]:
      a. Urban Counties- Two (2) PCPs within thirty [30] miles of residence
      b. Rural Counties- One (1) PCP within forty-five (45) miles of residence
      c. Frontier Counties- One (1) PCP within sixty (60) miles of residence
   2. One (1) High Volume Specialist (i.e., Cardiologist, Neurologist, Hematologist/Oncologist, Ob/Gyn, Orthopedics) within ninety (90) miles of residence
   3. Inclusion of Urgent Care Centers within the network
   4. Inclusion of all FQHC's and RHC's within the network

[78] The State of Nebraska has classified its 83 expansion counties into three geographic access categories to implement its geographic access standards for Medicaid members and providers. The geographic access categories-urban and rural- are based on the Metropolitan Statistical Area (MSA) designation and population density per square mile according to the 2000 U.S. Census. The Frontier counties are defined by the Nation Center for Frontier Communities. Please see illustration.



Map of Nebraska Expansion Counties by Geographic Access Category

D. Cultural Competency Access[79]- Provider access of more than one (1) PCP that is multi-lingual and culturally diverse.

RFP 3792Z1: Amended Revised Attachment F

A. Performance Measures-the following Performance Measures will be used to establish baseline data and also to be compared to national benchmark standards, if available. Data related to each of the performance measures must be submitted by August 15 of the year following the measurement year. If a measure has a performance standard already set, this standard is listed:
   1. HEDIS Comprehensive Diabetes Care
   2. HEDIS Adult BMI Assessment
   3. HEDIS Chlamydia Screening in Women
   4. HEDIS Cervical Cancer Screening
   5. HEDIS Breast Cancer Screening
   6. HEDIS Colorectal Cancer Screening
   7. HEDIS Cholesterol Management for Patients With Cardiovascular Conditions

[79] Note: Multi-lingual does not mean use of a language line to communicate with non-English speaking members

8. HEDIS Controlling High Blood Pressure
9. HEDIS Use of Appropriate Medications for People With Asthma
10. CAHPS Medical Assistance With Smoking Cessation
11. HEDIS Prenatal and Postpartum Care*
12. HEDIS Frequency of Ongoing Prenatal Care*
13. HEDIS Well Child Visits in the First 15 Months of Life*
14. HEDIS Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
15. HEDIS Adolescent Well-Care Visits*
16. HEDIS Immunizations for Adolescents*
17. HEDIS Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)*
18. HEDIS Lead Screening in Children
19. HEDIS Childhood Immunization Status Combo 2 and Combo 3
20. HEDIS Race/Ethnicity Diversity of Membership
21. EPSDT Screening Participation Rate: 72%

***Measure is also a CHIPRA Quality Measure**

B. CHIPRA Quality Measures:

1. HEDIS Childhood Immunization Status
2. HEDIS Chlamydia Screening (ages 16-20)
3. HEDIS Appropriate Testing for Children with Pharyngitis
4. HEDIS Ambulatory Care: Emergency Department Visits
5. Alabama Medicaid Annual Number of Asthma Patients Ages 2-20 with 1 or More Asthma-related Emergency Room Visits
6. HEDIS Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication
7. NCAQ Annual Pediatric Hemoglobin A1C Testing
8. CAHPS® 4.0 Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items
9. HEDIS Child and Adolescent Access to Primary Care Practitioners

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services
Children and Adults Health Programs Group

CMS State Quality Strategy Approval Letter

August 14, 2013

Heather Leschinsky
Managed Care Program Coordinator
Division Medicaid and Long-Term Care
P.O. Box 95026
Lincoln, NE 68509

Dear Ms. Leschinsky:

Thank you for your submission of Nebraska's 2013 quality strategy and teleconferencing with the Centers for Medicare & Medicaid Services (CMS) on August 5th. We have reviewed the submitted document for compliance with 42 CFR 438, subparts D. The purposes of this review are to provide technical assistance and better support your State's efforts to provide high quality care to Medicaid and CHIP enrollees, which is safe, effective, efficient, patient-centered, and equitable.

This letter serves as notice of CMS approval of Nebraska's 2013 quality strategy, contingent on subsequent submission and approval of an accreditation crosswalk for deeming targeted elements of the external quality review process. We look forward to our scheduled conversation on this topic August 16th.

If you have any questions about the information contained in this correspondence, please contact TJ (Thomas) Shumard, Division of Quality, Evaluation & Health Outcomes, at Thomas.Shumard@cms.hhs.gov. CMS encourages Nebraska to contact us with topics or key questions for which you would like additional technical assistance.

Sincerely,

/s/

Barbara Dailey, RN, BSN, MS, CPHQ
Deputy Director
Division of Quality, Evaluation and Health Outcomes

cc: Vivianne Chaumont, Director
Sylvia Robinson-Tibbs, CMS-DIHS
Benton Williams, CMS-RO
Kristin Younger, CMS-DQEHO

Attachment C

DHHS Managed Care Access Standards

Specialists who are serving in the PCP role (i.e., Internal Medicine, Pediatrics, or Ob/Gyn) are subject to the PCP Access Standards.

A. Timely Access-Standards for appointment availability for Primary Care Physicians (PCPs) and Specialists:

Timely Access		
Physician Type	Appointment Type	Availability Standard
Primary Care Physician (PCP)	Emergency	Twenty-four (24) hours per day, seven (7) days per week
	Medically Necessary/ Urgent Care	Same Day
	Routine	Fourteen (14) working days
High Volume Specialists (Cardiologist, Neurologist, Hematologist/Oncologist, Orthopedics)	Routine	Thirty (30) working days
Prenatal	First (1st) Trimester	Fourteen (14) working days
	Initial Second (2nd) Trimester	Seven (7) working days
	High Risk	Three (3) working days
Dental	Annual Routine	Fourteen (14) working days
	Emergency	Forty-eight (48) hours

B. Timely Access-Standards for hours of operation for PCP's:
   1. One (1) Medical Doctor (MD) practice-20 hours per week
   2. Two (2) or more MD practice-30 hours per week

C. Geographic Access-Standards for provider location to clients:
   1. PCP Access*:
      a. Urban Counties-Two (2) PCPs within thirty (thirty) miles of residence
      b. Rural Counties-One (1) PCP within forty-five (45) miles of residence
      c. Frontier Counties-One (1) PCP within sixty (60) miles of residence
   2. High Volume Specialist (i.e. Cardiologist, Neurologist, Hematologist/Oncologist, Ob/Gyn, Orthopedics):
      a. Urban Counties-One (1) High Volume Specialist within thirty (30) miles of residence

b. Rural Counties-One (1) High Volume Specialist within sixty (60) miles of residence
c. Frontier Counties-One (1) High Volume Specialist within ninety (90) miles of residence

3. Inclusion of Urgent Care Centers within the network
4. Inclusion of all FQHC's and RHC's within the network
5. Dental
    a. Urban Counties-Two (2) Dentists, One (1) oral surgeons, One (1) orthodontist, One (1) periodontist and One (1) pediadontist within forty-five (45) miles of residence
    b. Rural Counties-One (1) Dentist, One (1) oral surgeon, One (1) orthodontist , One (1) periodontist and One (1) pediadontist within sixty (60) miles of residence
    c. Frontier Counties-One (1) Dentist, One (1) oral surgeon, One (1) orthodontist, One (1) periodontist and One (1) pediadontist within one-hundred (100) miles of residence

D. Cultural Competency Access**-Provider access of more than one (1) PCP that is multi-lingual and culturally.

**Note: Multi-lingual does not mean use of a language line to communicate with non-English speaking members.

Performance Measures: The following performance measures will be used to establish baseline data and also to be compared to national benchmark standards, if available. Data related to each of the performance measures must be submitted by August 15 of the year following the measurement year. If a measure has a performance standard already set, this standard is listed. The Adult, Child, and HEDIS measures can be updated as new measures are introduced, deleted, and as The Department determines necessary.

Adult Core Measures

1. Flu Shots for Adults Age 50 to 64 *
2. Adult Body Mass Index (BMI) Assessment *
3. Breast Cancer Screening *
4. Cervical Cancer Screening *
5. Medical Assistance with Smoking and Tobacco Use *
6. Plan All-Cause Readmission Rate *
7. PQI 01: Diabetes Short-Term Complications Admission Rate
8. PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate
9. PQI 08: Congestive Heart Failure (CHF) Admission Rate
10. PQI 15: Adult Asthma Admission Rate
11. Chlamydia Screening in Women Ages 21 to 24 *
12. PC-01: Elective Delivery
13. PC-03: Antenatal Steroids
14. Controlling High Blood Pressure *
15. Comprehensive Diabetes Care: Hemoglobin A1c Testing *
16. Annual Monitoring for Patients on Persistent Medications *
17. CAHPS Health Plan Survey 5.0H – Adult Questionnaire *
18. Postpartum Care Rate *

***Measure is also a HEDIS Measure**

Child Core Measures

1. HPV: Human Papillomavirus Vaccine for Female Adolescents *
2. WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: Body Mass Index Assessment for Children/Adolescents *
3. CAP: Children And Adolescent Access to Primary Care Practitioners (PCP) *
4. CIS: Childhood Immunization Status *
5. IMA: Immunization Status for Adolescents *
6. FPC: Frequency of Ongoing Prenatal Care *
7. PPC: Timeliness of Prenatal Care *
8. CSEC: Cesarean Rate for Nulliparous Singleton Vertex
9. DEV: Developmental Screening in the First Three Years of Life
10. W15: Well-Child Visits in the First 15 Months of Life *
11. W34: Well-Child Visits in the Third, Fourth, Fifth, And Sixth Years Of Life *
12. AWC: Adolescent Well-Care Visits *
13. CHL: Chlamydia Screening in Women *
14. PDENT: Percentage Of Eligibles that Received Preventive Dental Services
15. TDENT: Percentage Of Eligibles that Received Dental Treatment Services

16. MMA: Medication Management for People with Asthma *
17. ADD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication *
18. AMB: Ambulatory Care - Emergency Department Visits *
19. CPC: Consumer Assessment of Healthcare Providers and Systems® (CAHPS) 5.0h (Child Version Including Medicaid and Children With Chronic Conditions Supplemental Items) *
20. Percentage of eligible who received preventative dental screens
21. Percentage of eligible who received dental treatment services
22. EPSDT Screening Participation Rate

***Measure is also a HEDIS Measure**

HEDIS Measures

1. Comprehensive Diabetes Care
2. Cholesterol Management for Patients with Cardiovascular Conditions
3. Medication Management for People with Asthma (Adults)
4. Lead Screening in Children
5. Appropriate Testing for Children With Pharyngitis
6. Race/Ethnicity Diversity of Membership
7. Appropriate Treatment for Children With Upper Respiratory Infection (URI)
8. Use of Spirometry Testing in the Assessment and Diagnosis of COPD
9. Pharmacotherapy Management of COPD Exacerbation
10. Use of Appropriate Medications for People With Asthma
11. Annual Monitoring for Patients on Persistent Medications
12. Adults' Access to Preventive/Ambulatory Health Services
13. Annual Dental Visit
14. Antibiotic Utilization
15. Frequency of Ongoing Prenatal Care
16. Timeliness of Prenatal Care

Provider-Preventable Conditions (PPCs) Including Health Care-Acquired Conditions

An HAC can be defined by a single diagnosis code, a combination of a diagnosis code and surgical procedure or, a combination of a diagnosis code, a surgical procedure and a principal diagnosis code.

CC: Complications and Comorbidities
MCC: Major Complications and Comorbidities

PPC	ICD-9-CM Code
Foreign Object Retained After Surgery	998.4 (CC) 998.77 (CC)
Air Embolism	999.1 (CC)
Blood Incompatibility	999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63 (CC) 999.69 (CC)
Pressure Ulcer Stages III & IV	707.23 (MCC) 707.24 (MCC)
Falls and Trauma: • Fracture • Dislocation • Intracranial Injury • Crushing Injury • Burn • Electric Shock	Codes within these ranges on the CC/MCC list: 800-829 830-839 850-854 925-929 940-949 991-994
Catheter-Associated Urinary Tract Infection (UTI)	996.64 (CC) Also excludes the following form acting as a CC/MCC (i.e. all of these diagnosis codes are considered an CMS defined HAC): 112.2 (CC) 590.10 (CC) 590.11 (MCC) 590.2 (MCC) 590.3 (CC) 590.8 (CC) 590.81 (CC) 595.0 (CC) 597.0 (CC) 599.0 (CC)
Vascular Catheter-Associated Infection	999.31 (CC)
Manifestations of Poor Glycemic Control: • Diabetic Ketoacidosis	250.10-250.13 (MCC) 250.20-250.23 (MCC) 251.0 (CC)

PPC	ICD-9-CM Code
• Nonketotic Hyperosmolar Coma • Hypoglycemic Coma • Secondary Diabetes with Ketoacidosis • Secondary Diabetes with Hyperosmolarity	249.10-249.11 (MCC) 249.20-249.21 (MCC)
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)	519.2 (MCC) And one of the following procedure codes: 36.10-36.19
Surgical Site Infection Following Certain Orthopedic Procedures: • Spine • Neck Shoulder • Elbow	996.67 (CC) 998.59 (CC) And one of the following procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83 or 81.85
Surgical Site Infection Following Bariatric Surgery for Obesity: • Laparoscopic Gastric Bypass • Gastroenterostomy • Laparoscopic Gastric Restrictive Surgery	*Principal Diagnosis* 278.01 998.59 (CC) And one of the following procedure codes: 44.38, 44.39 or 44.95
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures: • Total Knee Replacement • Hip Replacement	415.11 (MCC) 415.19 (MCC) 453.40-453.42 (MCC) And one of the following procedure codes: 00.85-00.87, 81.51-81.52 or 81.54

Exempt Providers

The table below lists the types of providers that are exempt from POA reporting, per CMS (https://www.cms.gov/HospitalAcqCond/03 AffectedHospitals.asp#TopOfPage):

1	Critical Access Hospitals	These providers have a Peer Group 7 in the MMIS and are therefore included in the group of providers that will be defined as exempt from POA reporting.
2	Long Term Care Hospitals	Nebraska has two providers that fall into this category. The providers will be added to the Validate Value table: 1. Select Specialty (100256413-00)
3	Maryland Waiver Hospitals	State/Postal Code = MD **Note**: Maryland is the only State that has a Medicare Waiver. Under this agreement, Medicare reimburses Maryland hospitals according to Healthcare Services Cost Review Commission (HSCRC) rates. Based on a federal waiver from Medicare, the HSCRC sets rates for all payers: private insurance companies, HMOs, Medicare, and Medicaid. This system is referred to as the "all-payer" system because all payers pay for their fair share of hospital costs.
4	Cancer Hospitals	These providers would be added to the Validate Value table as they manually identify themselves. This would most likely occur because the MMIS reported they must submit POA and they respond advising they are POA exempt.
5	Children's Inpatient Facilities	The word 'child' will be queried in the provider names and the identified providers will be added to the Validate Value table.
6	Rural Health Clinics	This provider type does not submit claim types 07 or 10 and therefore will be indirectly excluded from being required to submit POA information.
7	Federally Qualified Health Centers	This provider type does not submit claim types 07 or 10 and therefore will be indirectly excluded from being required to submit POA information.
8	Religious Non-Medical Health Care Institutions	These providers would be added to the Validate Value table as they manually identify themselves. This would most likely occur because the MMIS reported they must submit POA and they respond advising they are POA exempt.
9	Inpatient Psychiatric Hospitals	These providers would be identified by Specialty = 26 and either included in the code as exempt providers or added to the Validate Value table.
10	Inpatient Rehabilitation Facilities	These providers have a Peer Group 5 in the MMIS and are therefore included in the group of providers that will be defined as exempt from POA reporting.
11	VA/Dept of Defense Hospitals	These providers are paid from federal funds and do not submit claims to State Medicaid agencies.

ICD-9-CM Diagnosis Codes Exempt from POA Reporting

Per the ICD-9-CM Official Guidelines for Coding and Reporting, Effective October 1, 2010 (http://www.cdc.gov/nchs/data/icd9/icdguide10.pdf):

Code/Code Range 137-139	Description Late effects of infectious and parasitic diseases
268.1	Rickets, late effect
326	Late effects of intracranial abscess or pyogenic infection
412	Old myocardial infarction
438	Late effects of cerebrovascular disease
650	Normal delivery
660.7	Failed forceps or vacuum extractor, unspecified
677	Late effect of complication of pregnancy, childbirth, and the puerperium
740-759	Congenital anomalies
905-909	Late effects of injuries, poisonings toxic effects, and other external causes
V02	Carrier or suspected carrier of infectious diseases
V03	Need for prophylactic vaccination and inoculation against bacterial diseases
V04	Need for prophylactic vaccination and inoculation against certain viral diseases
V05	Need for other prophylactic vaccination and inoculation against single diseases
V06	Need for prophylactic vaccination and inoculation against combinations of diseases
V07	Need for isolation and other prophylactic or treatment measures
V10	Personal history of malignant neoplasm
V11	Personal history of mental disorder
V12	Personal history of certain other diseases
V13	Personal history of other diseases
V14	Personal history of allergy to medicinal agents
V15	Other personal history presenting hazards to health
V16	Family history of malignant neoplasm
V17	Family history of certain chronic disabling diseases
V18	Family history of certain other specific conditions
V19	Family history of other conditions
V20	Health supervision of infant or child
V21	Constitutional states in development
V22	Normal pregnancy
V23	Supervision of high-risk pregnancy
V24	Postpartum care and examination
V25	Encounter for contraceptive management
V26	Procreative management
V27	Outcome of delivery
V28	Antenatal screening
V29	Observation and evaluation of newborns for suspected condition not found

Code/Code Range	Description
V30-V39	Live born infants according to type of birth
V42	Organ or tissue replaced by transplant
V43	Organ or tissue replaced by other means
V44	Artificial opening status
V45	Other post-procedural states
V46	Other dependence on machines and devices
V49.60-V49.77	Upper and lower limb amputation status
V49.81-V49.85	Other specified conditions influencing health status
V50	Elective surgery for purposes other than remedying health states
V51	Aftercare involving the use of plastic surgery
V52	Fitting and adjustment of prosthetic device and implant
V53	Fitting and adjustment of other device
V54	Other orthopedic aftercare
V55	Attention to artificial openings
V56	Encounter for dialysis and dialysis catheter care
V57	Care involving use of rehabilitation procedures
V58	Encounter for other and unspecified procedures and aftercare
V59	Donors
V60	Housing, household, and economic circumstances
V61	Other family circumstances
V62	Other psychosocial circumstances
V64	Persons encountering health services for specific procedures, not carried out
V65	Other persons seeking consultation
V66	Convalescence and palliative care
V67	Follow-up examination
V68	Encounters for administrative purposes
V69	Problems related to lifestyle
V70	General medical examination
V71	Observation and evaluation for suspected condition not found
V72	Special investigations and examinations
V73	Special screening examination for viral and chlamydial diseases
V74	Special screening examination for bacterial and spirochetal diseases
V75	Special screening examination for other infectious diseases
V76	Special screening for malignant neoplasms
V77	Special screening for endocrine, nutritional, metabolic, and immunity disorders
V78	Special screening for disorders of blood and blood-forming organs
V79	Special screening for mental disorders and developmental handicaps
V80	Special screening for neurological, eye, and ear diseases
V81	Special screening for cardiovascular, respiratory, and genitourinary diseases

Code/Code Range	Description
V82	Special screening for other conditions
V83	Genetic carrier status
V84	Genetic susceptibility to disease
V85	Body Mass Index
V86	Estrogen receptor status
V87.32	Contact with and (suspected) exposure to algae bloom
V87.4	Personal history of drug therapy
V88	Acquired absence of other organs and tissue
V89	Suspected maternal and fetal conditions not found
V90	Retained foreign body
V91	Multiple gestation placenta status
E000	External cause status
E001-E030	Activity
E800-E807	Railway accidents
E810-E819	Motor vehicle traffic accidents
E820-E825	Motor vehicle non-traffic accidents
E826-E829	Other road vehicle accidents
E830-E838	Water transport accidents
E840-E845	Air and space transport accidents
E846-E848	Vehicle accidents not elsewhere classifiable
E849	Place of occurrence (Except E849.7)
E883.1	Accidental fall into well
E883.2	Accidental fall into storm drain or manhole
E884.0	Fall from playground equipment
E884.1	Fall from cliff
E885.0	Fall from (non-motorized) scooter
E885.1	Fall from roller skates
E885.2	Fall from skateboard
E885.3	Fall from skis
E885.4	Fall from snowboard
E886.0	Fall on same level from collision, pushing, or shoving, by or with other person, in sports
E890.0-E890.9	Conflagration in private dwelling
E893.0	Accident caused by ignition of clothing, from controlled fire in private dwelling
E893.2	Accident caused by ignition of clothing, from controlled fire not in building or structure
E894	Ignition of highly inflammable material
E895	Accident caused by controlled fire in private dwelling
E897	Accident caused by controlled fire not in building or structure
E917.0	Striking against or struck accidentally by objects or persons, in sports without subsequent fall

Code/Code Range	Description
E917.1	Striking against or struck accidentally by objects or persons, caused by a crowd, by collective fear or panic without subsequent fall
E917.2	Striking against or struck accidentally by objects or persons, in running water without subsequent fall
E917.5	Striking against or struck accidentally by objects or persons, object in sports with subsequent fall
E917.6	Striking against or struck accidentally by objects or persons, caused by a crowd, by collective fear or panic with subsequent fall
E919	Accident caused by machinery (Except E919.2)
E921	Accident caused by explosion of pressure vessel
E922	Accident caused by firearm and air gun missile
E926.2	Visible and ultraviolet light sources
E928.0-E928.8	Other and unspecified environmental and accidental causes
E929.0-E929.9	Late effects of accidental injury
E959	Late effects of self-inflicted injury
E970-E978	Legal intervention
E979	Terrorism
E981	Poisoning by gases in domestic use, undetermined whether accidentally or purposely inflicted
E982	Poisoning by other gases, undetermined whether accidentally or purposely inflicted
E985	Injury by firearms, air guns and explosives, undetermined whether accidentally or purposely inflicted
E987.0	Falling from high place, undetermined whether accidentally or purposely inflicted, residential premises
E987.2	Falling from high place, undetermined whether accidentally or purposely inflicted, natural sites
E989	Late effects of injury, undetermined whether accidentally or purposely inflicted
E990-E999	Injury resulting from operations of war

Attachment F

Nebraska Physical Health Draft Rates
July 1, 2015 through December 31, 2015 Draft Rates

Service Area 1

Category Of Aide	FY13 MMs	UNMC Physician Supplemental	UNMC Dental Supplemental	HIPF	Draft July-December 2015 Rate
AABD Under 1 M&F	686	$ 79.23	$ 0.04	$ 111.58	$ 3,945.24
AABD 01-20 M&F	30,009	$ 12.57	$ 1.28	$ 20.30	$ 717.09
AABD 21+ M&F	85,445	$ 25.06	$ 1.16	$ 25.16	$ 898.06
CHIP Under 1 M&F	2,837	$ 13.99	$ 0.03	$ 9.93	$ 358.02
CHIP 01-19 M&F	193,402	$ 4.42	$ 1.86	$ 3.88	$ 140.58
Family Under 1 M&F	70,859	$ 16.77	$ 0.03	$ 14.33	$ 513.28
Family 01-05 M&F	295,702	$ 5.58	$ 1.08	$ 4.01	$ 145.70
Family 06-20 F	212,881	$ 4.02	$ 1.85	$ 3.49	$ 126.91
Family 06-20 M	199,732	$ 3.49	$ 1.72	$ 3.24	$ 117.59
Family 21+ M&F	168,512	$ 10.78	$ 1.21	$ 8.23	$ 297.18
Foster Care Under 1 M&F	1,506	$ 30.63	$ 0.03	$ 24.91	$ 893.79
Foster Care 01-19 M&F	73,163	$ 5.70	$ 1.67	$ 4.94	$ 178.39
Katie Beckett 00-18 M&F	333	$ 18.08	$ 0.44	$ 438.76	$ 15,220.23
Maternity	4,706	$ 420.26	$ 7.71	$ -	$ 7,932.98
Total	1,335,067	$ 9.08	$ 1.44	$ 6.85	$ 274.14

Notes:

1. These draft rates include the following additional services, which are added benefits as of July 1, 2015: Dental, Hospice, and NEMT Ambulance. Pharmacy costs are not included in these draft rates.

2. These draft rates include the following additional populations, whom will be eligible for managed care beginning July 1, 2015: Subsidized Adoption and Women Participating in the Breast and Cervical Cancer Prevention and Treatment Act of 2000. These members fall into the Foster Care cohorts and AABD 21+ M&F cohorts, respectively.

3. All known policy and program changes effective for the contract period have been accounted for in the draft rates.

4. The underlying base data for the draft Service Area I July 1, 2015 – December 31, 2015 rates shown, is SFY12 and SFY13 FFS and Encounter data. The State and Optumas plan to use emerging data to set the final July 1, 2015 - December 31, 2015 rates.