Department of Health & Human Services
DHHS
NEBRASKA

MEDICAID MANAGED CARE PHYSICAL HEALTH SERVICES CONTRACT
BETWEEN
THE STATE OF NEBRASKA, DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAID AND LONG-TERM CARE
AND
AMERIHEALTH NEBRASKA, INC.

AMENDMENT FIVE, DECEMBER 2015

This Amendment Five is entered into by the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care ("DHHS") and Amerihealth Nebraska, Inc. ("Contractor" or "MCO"), the parties to Contract 64632 O4 (the "Contract").

The parties mutual agree to amend the Contract as follows:

1. Article II is amended as follows:

   Primary care provider (PCP): A medical professional chosen by or assigned to the member to provide primary care services. Provider types practicing within the scope of their respective Practice Acts may be doctors of medicine (MDs), doctors of osteopathic medicine (DOs), nurse practitioners, and physician assistants.

   Primary care services: All health care services and laboratory services customarily furnished by or through primary care provider, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

2. A revised copy of Attachments "D", "E" and "G" is attached.

All other terms and conditions remain in full force and effect.

IN WITNESS THEREOF, the parties have executed this Amendment and each acknowledges its receipt.

FOR DHHS:	FOR CONTRACTOR: Amerihealth Nebraska, Inc.
By:	By:
Name: ~~[illegible]~~ CALDER LYNCH	Name: Jerry Feilmeier
Date: 1/12/16	Date: 1-6-16

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. (reserved)
13. (reserved)
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. (reserved)
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. (reserved)
15. (reserved)

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. (reserved)
21. (reserved)
22. EPSDT Screening Participation Rate

***Measure is also a HEDIS Measure**

HEDIS Measures

1. Comprehensive Diabetes Care
2. (reserved)
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. (reserved)
14. (reserved)
15. Frequency of Ongoing Prenatal Care
16. Timeliness of Prenatal Care

Patient-Centered Medical Home Standards

MINIMUM STANDARDS

Core Competency 1: Facilitate ongoing patient relationship with a primary care practice team.

1.1	Practice utilizes written plan for patient communication including accommodation for hearing and visually impaired and English as a Second Language patients.
1.2	Practice utilizes written materials for patients explaining the features and essential information related to the medical home published in primary language(s) of the community.
1.3	Practice utilizes patient-centered care planning (includes patient's goals, values and priorities) to engage patients in their care. Practice plan can include a written "After Visit Summary" outlining future care plan that is given to patient at every visit.
1.4	Practice utilizes reminder/notification system for health care services such as, appointments, preventive care, preparation information for upcoming visits, follow up with patients regarding periodic tests or screening and when planned appointments have been missed.
1.5	Practice provides patient education and self-management tools and support to patients, families, and caregivers.
1.6	Practice utilizes medical home team that provides team-based care composed of, but not limited to, the primary care provider(s), care coordinator, and office staff with a structure that values separate but collaborative functions and responsibilities of all members from clerical staff to physician.
1.7	Practice creates and uses a written plan for the implementation of the medical home including a description of work flow for team members.

Core Competency 2: Coordinate continuous patient-centered care across the health care system.

2.1	Practice utilizes written protocol with hospital(s) outlining referral and follow-up care coordination, and admission and discharge notifications.
2.2	Practice provides care coordination and supports family participation in care including providing connections to community resources.
2.3	Practice utilizes a system to maintain and review a list of patient's medications.
2.4	Practice team tracks diagnostic tests and provides written and verbal follow-up on results with patient plus follows up after referrals, specialist care and other consultations.
2.5	Practice utilizes a patient registry.
2.6	Practice team defines and identifies high-risk patients in the practice who will benefit from care planning and provides a care plan to these individuals.

2.7	Practice team provides and coordinates Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) services.
2.8	Practice team provides transitional care plan for patients transferring to another physician or medical home.
2.9	Clinical data is organized in a paper or electronic format for each individual patient.
2.10	Practice utilizes a system to organize and track and improve the care of high risk and special needs patients.

Core Competency 3: Provide for patient accessibility to the services of the medical home.

3.1	Patient has on-call access to the medical home team 24 hours/day, 7 days/week.
3.2	Practice offers appointments outside traditional business hours of Monday – Friday, 9 a.m. to 5 p.m.
3.3	Practice utilizes a system to respond promptly to prescription refill requests and other patient inquiries.
3.4	Practice provides day-of-call appointments.
3.5	Practice utilized written practice standards for patient access.

Core Competency 4: Commitment to efficiency of care by reducing unnecessary healthcare spending, reducing waste, and improving cost-effective use of health care services.

4.1	Practice implements an intervention to reduce unnecessary care or preventable utilization that increases cost without improving health.
4.2	Practice establishes at least 2 out of 3 of these specific waste reduction initiatives: generic medication utilization, reducing avoidable ER visits or reducing

Core Competency 5: Engage in a quality improvement process with a focus on patient experience, patient health, and cost-effectiveness of services.

5.1	Practice has established a quality improvement team that, at a minimum includes one or more clinicians who deliver services within the medical home; one or more care coordinators, one or more patient representatives, and if a clinic, one or more representatives from administration/management.
5.2	Practice develops a formal plan to measure effectiveness of care management.
5.3	Practice develops an operational quality improvement plan for the practice with at least one focus area.
5.4	Practice utilizes a patient survey on their experience of care and sets a schedule for utilization. (May be developed or provided through technical assistance.)
5.5	Practice identifies one or more patient health outcomes to improve through a clinical quality improvement program using evidence-based guidelines.

AMERIHEALTH NEBRASKA, INC.
64632 O4

Amended Revised Attachment G
Contract Rate Exhibit
January 1, 2016 through June 30, 2016
Service Area 2

Category of Aid	Portion of Rate at Regular FMAP (non-UNMC)	UNMC Supplemental at Regular FMAP	HIPF	Payment Rate
AABD 00-20 M&F	$ 684.87	$ 8.16	$ 24.48	$ 717.51
AABD 21+ M&F	$ 1,000.45	$ 8.77	$ 35.68	$ 1,044.90
AABD 21+ M&F-WWC	$ 2,410.34	$ 23.49	$ 86.34	$ 2,520.17
CHIP M&F	$ 110.31	$ 1.22	$ 3.93	$ 115.46
Family Under 1 M&F	$ 464.00	$ 4.03	$ 16.57	$ 484.59
Family 01-05 M&F	$ 130.34	$ 1.34	$ 4.63	$ 136.32
Family 06-20 F	$ 110.24	$ 1.09	$ 3.92	$ 115.25
Family 06-20 M	$ 90.71	$ 0.99	$ 3.23	$ 94.94
Family 21+ M&F	$ 358.92	$ 3.56	$ 12.74	$ 375.22
Foster Care M&F	$ 159.11	$ 2.73	$ 5.70	$ 167.54
Katie Beckett 00-18 M&F	$ 12,828.53	$ 39.21	$ 459.96	$ 13,327.70
Maternity	$ 7,725.66	$ 57.68	$ -	$ 7,783.34