State of Nebraska Department of Health and Human Services
REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES

SOLICITATION NUMBER	RELEASE DATE
RFP 112209 O3	April 15, 2022
OPENING DATE AND TIME	**PROCUREMENT CONTACT**
July 1, 2022 2:00 p.m. Central Time	Greg Walklin

PLEASE READ CAREFULLY!

SCOPE OF SERVICE

The State of Nebraska (State), Department of Health and Human Services (DHHS), is issuing this Request for Proposal (RFP) Number 112209 O3 for the purpose of selecting a qualified bidder to provide a full-risk, capitated Medicaid Managed Care program for physical health, behavioral health, pharmacy, and dental services. A more detailed description can be found in Section V. The resulting contract may not be an exclusive contract as the State reserves the right to contract for the same or similar services from other sources now or in the future.

The term of the contract will be five (5) years commencing upon notice to proceed. The Contract includes the option to renew for two (2) additional one (1) year periods upon mutual agreement of the Parties. The State reserves the right to extend the period of this contract beyond the termination date when mutually agreeable to the Parties.

ALL INFORMATION PERTINENT TO THIS REQUEST FOR PROPOSAL CAN BE FOUND ON THE INTERNET AT: http://das.nebraska.gov/materiel/purchasing.html and https://dhhs.ne.gov/Pages/Grants-and-Contract-Opportunities.aspx .

A mandatory Pre-Proposal Conference will be held on April 28, 2022 via WebEx.

PUBLIC POSTING NOTICE:
Pursuant to the Taxpayer Transparency Act (Neb. Rev. Stat. §§ 84-602.02 to 84-602.0) and in furtherance of public records law, State contracts must be posted to a public website. The resulting contract, the solicitation, and the successful Bidder's proposal and response will be posted to a public website managed by DAS, which can be found at

http://statecontracts.nebraska.gov **and** http://das.nebraska.gov/materiel/index.html

These postings will include the entire proposal and response. If the Bidder wishes to withhold proprietary or other commercial information from disclosure, the Bidder must identify the proprietary information, mark the proprietary information according to State law, and submit only the proprietary information in a separate file named conspicuously "PROPRIETARY INFORMATION". The Bidder may submit a detailed written document showing that the release of the proprietary information would give a business advantage to named business competitor(s) and explain how the named business competitor(s) will gain an actual business advantage by disclosure of information. The mere assertion that information is proprietary or that a speculative business advantage might be gained is not sufficient. (See Attorney General Opinion No. 92068, April 27, 1992) THE BIDDER MAY NOT ASSERT THAT THE ENTIRE PROPOSAL IS PROPRIETARY. COST PROPOSALS WILL NOT BE CONSIDERED PROPRIETARY AND ARE A PUBLIC RECORD IN THE STATE OF NEBRASKA. The State will then determine, in its sole discretion, if the disclosure of the information designated by the Bidder as proprietary would 1) give advantage to business competitors and 2) serve no public purpose. The Bidder will be notified of the State's decision. Absent a determination by the State that the information may be withheld pursuant to Neb. Rev. Stat. § 84-712.05, the State will consider all information a public record subject to disclosure. If the State determines it is required to release proprietary information, the Bidder will be informed. It will be the Bidder's responsibility to defend the Bidder's asserted interest in non-disclosure.

If the agency determines it is required to release proprietary information, the bidder will be informed. It will be the bidder's responsibility to defend the bidder's asserted interest in non-disclosure.

To facilitate such public postings, with the exception of proprietary information, the State of Nebraska reserves a royalty-free, nonexclusive, and irrevocable right to copy, reproduce, publish, post to a website, or otherwise use any contract, proposal, or response to this solicitation for any purpose, and to authorize others to use the documents. Any individual or entity awarded a contract, or who submits a proposal or response to this solicitation, specifically waives any copyright or other protection the contract, proposal, or response to the solicitation may have; and, acknowledges that they have the ability and authority to enter into such waiver. This reservation and waiver is a prerequisite for submitting a proposal or response to this solicitation, and award of a contract. Failure to agree to the reservation and waiver will result in the proposal or response to the solicitation being found non-responsive and rejected.

Any entity awarded a contract or submitting a proposal or response to the solicitation agrees not to sue, file a claim, or make a demand of any kind, and will indemnify and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials 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, sustained or asserted against the State, arising out of, resulting from, or attributable to the posting of the contract or the proposals and responses to the solicitation, awards, and other documents.

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GLOSSARY OF TERMS

ACCESSNebraska: The State service delivery system for public benefits, accessible through a toll-free telephone number and website.

Accompanying Adults: A legally responsible adult/guardian, or an adult selected by the legally responsible adult, to accompany a minor to a Medicaid coverable service.

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

Adjudicate: To pay or deny a claim.

Adjustment: Modification to an adjudicated claim.

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

Administrative expense rate: The percentage of qualifying revenue a MCO may spend on administrative expenses. Administrative expense rate equals the costs that were incurred in the contract year. These costs are subject to review to verify that the administrative services were actually provided and that the costs included for these services is reasonable. In the event the MCO paid any amounts for administrative services to a related party, only those administrative costs actually incurred by the related party in connection with the administration of this contract will be included in such costs.

Advance directive: A written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated.

Adverse Benefit Determination (formerly referred to as "Action"):

1. The reduction, suspension, or termination of a previously authorized service.
2. The denial, in whole or in part, of payment for a service.
3. The failure to provide services in a timely manner, as defined by the State.
4. The failure of the MCO to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
5. The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments and other enrollee financial liabilities.

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.

Allowable quality improvement expense: A MCO's expenditure on qualified quality improvement activities described in Attachment 7 - Medical Loss Ratio Requirements of this RFP.

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

Amendment: A written correction or alteration to a document.

Appeal: A request for review of an action.

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

Auto assignment: The process by which an enrollee, who does not select a MCO or PCP within a predetermined length of time during enrollment activities is automatically assigned to a MCO and PCP.

Automated Clearing House: (ACH) Electronic network for financial transactions in the United States.

Award: All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the solicitation.

Best and Final Offer (BAFO): In a competitive proposal, the final offer submitted which contains the bidder's most favorable terms for price.

Best Value Evaluation Criteria: The criteria against which all responses to the Technical Questions, and any Oral Presentation, will be measured; may also be referred to as "Best Value Criteria" and "BVC."

Bid Bond: An insurance agreement, accompanied by a monetary commitment, by which a third party (the surety) accepts liability and guarantees that the bidder will not withdraw the bid.

Bidder: A vendor who submits a proposal in response to a written solicitation.

Breach: Violation of a contractual obligation by failing to perform or repudiation of one's own promise.

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 an MCO on behalf of each member of an MCO for the provision of covered services under the contract. Payment is made regardless of whether any particular member receives services during the period covered by the payment.

CAQH: An online data repository of credentialing data. Practitioners self-report demographic, education and training, work history, malpractice history, and other relevant credentialing information for insurance companies to access.

Care management: The personalized plan developed for a beneficiary to address the physical health, behavioral health, or social determinant needs. Care management planning includes the Health Risk Screen which is the initial and ongoing screen to identify care management needs of a beneficiary. Care management planning is the process of creating and implementing of a personalized plan to then improve the health and wellness of the beneficiary.

Case Management: Case management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet the beneficiaries' health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.

Referrals for case management can be identified through:

- Analysis and evaluation of historical claims data performed by the MCO
- Provider referrals
- Health Risk Screen
- Homeless attestations
- Self-identification by the beneficiary

Change Order: Document that provides an addendum and/or amendments to an executed purchase order or contract.

Children's Health Insurance Program (CHIP): Nebraska's CHIP program is a combination Medicaid CHIP state with a Medicaid CHIP expansion program under Title XXI called "Kid's Connection". Kid's Connection provides health care coverage to targeted low-income uninsured children, from birth through age 18, in families with incomes at or below 200 percent of the federal poverty level. The separate CHIP program established July 19, 2012 provides Medicaid coverage for the unborn children of pregnant women who are otherwise not Medicaid eligible.

Choice counseling: The provision of information about available MCO's and unbiased decision support for selection of an MCO by the enrollment broker for Medicaid enrollees.

Clean claim: A claim, received by a MCO for adjudication, that requires no further information, adjustment, or alteration by the provider of the services, or by a third party, in order to be processed and paid by the MCO. 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.

Claim: A bill for services, a line item of service, or all services for one member within a bill.

Cold-call marketing: Any unsolicited personal contact by a MCO 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.

Commodities: Any equipment, material, supply or goods; anything movable or tangible that is provided or sold.

Common Carrier: Any commercial provider who transports passengers by motor vehicle for hire and is licensed as such with the Public Service Commission (PSC).

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

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.

Consecutive Appointments: Appointments beginning, or scheduled to begin, within thirty (30) minutes of the last completed appointment.

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 administration of the contract which includes and is not limited to; contract signing, contract amendments and any necessary legal actions.

Contract Award: Occurs upon execution of the State document titled "Service Contract Award" by the proper authority.

Contract Execution Date: The date of full execution of the contract by all necessary parties.

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.

Contract Start Date: The date of implementation for the MCO to provide services to Heritage Health members.

Contractor: An individual or entity lawfully conducting business in the State, who provides goods or services under the terms of a written solicitation.

Core benefits and services: The minimum package of services to which a member is entitled under the Nebraska Medicaid State Plan and that must be provided by a MCO to members enrolled in the MCO.

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.

Customer Service: The process of ensuring customer satisfaction by providing assistance and advice on those products or services provided by the Contractor.

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.

Disenroll: See Disenrollment, below.

Disenrollment: A change in the status of a member from being enrolled with a specific MCO to being enrolled with a different MCO, or a change from being considered mandatory for participation in managed care to being ineligible for participation in managed care.

Dispensing fee: The fee paid by a MCO to reimburse the overhead and labor expense incurred by pharmacy providers, and the professional services provided by a pharmacist when dispensing a prescription.

System 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 that will provide the State with sufficient information to operate, diagnose, and maintain the licensed software properly, safely, and efficiently.

Drug encounter: Submission by a MCO of prescriptions billed by a pharmacy or medical professionals.

Earned hold-back: The portion of the hold-back a MCO may keep based upon MLTC's determination of the MCO's results compared with identified performance measures.

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; or (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 members through a MCO. [42 CFR 438.242.]

Enrollee: 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.

Enrollment: The process of an enrollee selecting a MCO.

Enrollment broker: The State's contracted entity for choice counseling and enrollment activities.

Enrollment file: A proprietary data file provided by the State to a MCO. It is the basis for monthly payments to the MCO.

Escort/Attendant Provider: A paid or unpaid individual or caregiver accompanying a program eligible member who is physically, mentally, or developmentally disabled and unable to travel or wait without assistance or supervision to receive a Nebraska Medicaid coverable service. The escort/attendant provider may drive or utilize transportation services with the program eligible member.

Evaluation: The process of examining an offer after opening to determine the bidder's responsibility, responsiveness to requirements, and to ascertain other characteristics of the offer that relate to determination of the successful award.

Evaluation Committee: Committee(s) appointed by the requesting agency that advises and assists the procuring office in the evaluation of proposals (offers made in response to written solicitations).

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.

Federally Qualified Health Center: A designation that includes all organizations receiving grants under Section 330 of the Public Health Service Act.

Federally qualified MCO: An MCO that CMS has determined is a qualified MCO under Section 1310(d) of the Public Health Services Act.

Fee-for-service: A method of provider reimbursement based on payments for each service rendered.

FIDE DSNP: Fully integrated dual eligible dual special needs plan (FIDE DSNP). FIDE SNPs fully integrate care for dually eligible beneficiaries under a single managed care organization.

Forfeited hold-back: The portion of the hold-back a MCO must forfeit, based upon MLTC's determination of the MCO's results compared with identified performance measures. Forfeited hold-back may also be referred to as unearned hold-back.

Formulary: A list maintained by a MCO giving details of medications payable by the MCO's health plan.

Foreign Corporation: A foreign corporation that was organized and chartered under the laws of another state, government, or country.

Generally accepted actuarial principles: The common set of actuarial standards, as determined by the American Academy of Actuaries.

Grievance: A written or verbal expression of dissatisfaction to the MCO about any matter other than an action.

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

Health Equity Committee: A diversity, equity and inclusion committee is a task force of diverse staff members who are responsible for helping bring about the cultural, and possibly ethical, changes necessary for MCO business.

Health Risk Screening (HRS): The HRS includes a set of Department of Health and Human Services (DHHS) developed questions about physical health, behavioral health, and Social Determinants of Health (SDoH). SDoH questions are designed to assess a member's economic stability, housing stability, food security, education and job opportunities, intimate partner violence, community and social support, and access to health care, while the physical health and behavioral health questions are designed to assess a member's health status.

Health Risk Assessment (HRA): A more detailed assessment for those members who have been deemed to potentially qualify for care management services. The health risk assessment is used to collect information on a member's health status that includes, but is not limited to, member demographics, personal and family medical history, and lifestyle.

Heritage Health Adult Expansion: Initiative 427, which expands Medicaid eligibility to able-bodied Nebraska residents, ages 19 to 64, whose income is at or below 138 percent of the federal poverty level.

Hold-back: The portion of the MCO's revenue that the MCO must reserve in the holding account and may potentially earn based upon MLTC's determination of the MCO's results on identified performance measures.

Hold-back account: The account a MCO must establish for the purpose of reserving the hold-back.

Individual Provider: A person who is not in the business of providing transportation for hire; for example, a friend, neighbor, or non-legally responsible relative, exempted from Public Service Commission (PSC) licensure by law (Neb. Rev. Stat. §75-303.01).

Information system(s): A combination of computing and telecommunications hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e., structured data that may include digitized audio and video and documents, as well as non-digitized audio and video; and/or (b) the processing of information and non-digitized audio and video for purposes of enabling or facilitating a business process or related transaction.

In-Network Provider: a physical or behavioral health provider, a NEMT provider, a dental provider, or a pharmacy that has a contract with a health insurance plan.

Insolvency: A financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceed its assets**.**

Interested Party: A person, acting in their personal capacity, or an entity entering into a contract or other agreement creating a legal interest therein.

Late Proposal: An offer received after the Opening Date and Time.

Liquidated damages: Damages that may be assessed whenever a MCO, its providers, and/or subcontractor fail to achieve certain performance standards and other items defined in this contract.

Long-term services and supports: Specific Medicaid-covered services including intermediate care facility services for individuals with developmental disabilities, any institutional long-term care or nursing facility services at a custodial level of care, services provided via a Home and Community Based Waiver program, Targeted Case Management, or Medicaid State Plan Personal Assistance Services.

Managed Care Organization (MCO): A private entity that contracts with MLTC to provide benefits and services to Nebraska Medicaid enrollees in exchange for a monthly prepaid capitated amount per member. The entity is regulated by the Nebraska Department of Insurance with respect to licensure and financial solvency. The entity is regulated by DHHS with respect to its products and services offered pursuant to Heritage Health.

Mandatory/Must: Required, compulsory, or obligatory.

Marketing: Any communication from a MCO to a Medicaid enrollee who is not enrolled in that entity that can reasonably be interpreted as intended to influence the enrollee to enroll in that particular MCO or either to not enroll in or to disenroll from another MCO.

Marketing materials: Materials that are produced in any medium, by or on behalf of the MCO, and can reasonably be interpreted as intended to market to potential enrollees.

Material Change: Material change means a change to a provider contract, the occurrence and timing of which is not otherwise clearly identifiable in the provider contract, that decreases the provider's payment or compensation for services to be provided or changes the administrative procedures in a way that may reasonably be expected to significantly increase (greater than 10%) the provider's administrative expense, including altering an existing prior authorization, precertification, or notification.

May: Discretionary, permitted; used to express possibility.

Meaningful use: Using certified electronic health records technology in a meaningful way, as established in the Health Information Technology for Economic and Clinical Health Act.

Medicaid fraud: Fraud is defined by Federal law (42 CFR 455.2) as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law."

Medical incentive bonuses: Payments made by a MCO to providers and other unrelated risk sharing entities to share savings.

Medical loss ratio (MLR): The percentage of qualifying revenue (for the risk corridor and MLR calculations) spent on covered services for members and allowable QI expenses under this contract.

Medical necessity: Health care services and supplies that are medically appropriate and:

1. Necessary to meet the basic health needs of the member;
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 intensive level of service than can be safely provided.

Medically Complex: For an individual to be determined medically complex, he or she must have a documented medical condition identified through analysis and evaluation performed by the MCO, or identified through information supplied by the Department, that falls into one or more of the following categories:

1. A disabling mental disorder;
2. A chronic substance abuse disorder;
3. A physical, intellectual, or developmental disability with functional impairment that significantly impairs the individual from performing one or more activities of daily living each time the activity occurs, see 471 NAC 12 for the definition of activities of daily living for adults;
4. A disability determination based on Social Security criteria;
5. A serious and complex medical condition; or
6. Chronically homeless.

Member: A Medicaid enrollee who is currently enrolled with a specific MCO.

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

Must: See Mandatory/Must and Shall/Will/Must.

National Drug Code (NDC): The universal product identifier for human drugs.

National Institute for Governmental Purchasing (NIGP): National Institute of Governmental Purchasing – Source used for assignment of universal commodity codes to goods and services.

Nebraska Medicaid Program (NE Medicaid or Medicaid): NE Medicaid provides health care services to eligible elderly and disabled individuals and eligible low-income pregnant women, children and parents. NE Medicaid also includes the Children's Health Insurance Program and home and community-based services for individuals qualified for Medicaid waivers. NE Medicaid is administered by the Division of Medicaid and Long Term Care (MLTC) of the Nebraska Department of Health and Human Services (DHHS).

Net qualified medical expense (for the medical loss ratio): The sum of:

1. Claims incurred;
2. Claims incurred but not paid, plus provisions for adverse deviation and loss adjustment expense;
3. Medical incentive bonuses;
4. Reinsurance premiums less reinsurance recoveries;
5. Activities that improve health care quality, per 45 CFR 158.150; and
6. Less related-party medical margin.

Net qualified medical expense (for the risk corridor): The sum of:

1. Claims incurred;
2. Claims incurred but not paid, plus provisions for adverse deviation and loss adjustment expense;
3. Medical incentive bonuses;
4. Reinsurance premiums less reinsurance recoveries; and
5. Less related-party medical margin.

Non-quality improvement (QI) administrative expenses: All non-benefit expenses of operating pursuant to the requirements of this contract, other than medical, prescription drugs, DME, and other benefits for the contract year. Non-benefit, administrative expenses include:

1. Direct administration: customer service, enrollment, medical management, claims administration, etc.;
2. Indirect administration: accounting, actuarial, legal, human resources, etc.; or
3. Net cost of reinsurance: reinsurance premium less projected reinsurance recoveries. Net cost of related party reinsurance is excluded.

Non-QI administrative expense rate: Non-QI Administrative Expenses divided by Qualifying Revenue.

Non-responsive proposal: A proposal that does not meet the requirements of the solicitation or cannot be evaluated against the other proposals

Open Market Purchase: Authorization may be given to an agency to purchase items above direct purchase authority due to the unique nature, price, quantity, location of the using agency, or time limitations by the AS Materiel Division, State Purchasing Bureau.

Opening Date and Time: Specified date and time for the public opening of received, labeled, and sealed formal proposals.

Out-of-Network Provider: A physical or behavioral health provider, a NEMT provider, a dental provider, or a pharmacy which does not have a contract with a health insurance plan.

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.

Patient-Centered Medical Home (PCMH): A health care delivery model in which a patient establishes an ongoing relationship with a primary care practice team to provide comprehensive, accessible, and continuous evidence-based primary and preventative care, and to coordinate the patient's health care needs across the health care system in order to improve quality, safety, access and health outcomes in a cost effective manner.

Patient centeredness: Health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care. Patient centeredness focuses on the patient, not the illness, and is supported by good provider-patient relations.

Peer review: A process of evaluating work completed by 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.

Point of Contact (POC): The person designated to receive communications and to communicate.

Potential enrollee: A Medicaid recipient who is subject to mandatory enrollment with an HMO, but is not yet a member of a specific MCO.

Post stabilization care services: Covered services, related to an emergency medical condition, that are provided after an enrollee/member 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/member's condition.

Practitioner: A Medicaid enrolled provider who is licensed, registered, or certified by MLTC to practice in the State.

Pre-Proposal Conference: A meeting scheduled for the purpose of clarifying a written solicitation and related expectations.

Prepaid Ambulatory Health Plan (PAHP): For purposes of this contract, a PAHP is an entity that:

1. Provides medical services to enrollees under contract with the State agency, and based on prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; and
2. Does not have a comprehensive risk contract.

Prepaid inpatient health plan (PIHP): As defined by 44 NAC Sections 4701 to 4727, and 42 CFR 438.2, a PIHP is an entity that:

1. Provides medical services to enrollees under contract with MLTC on the basis of prepaid capitation payments or other payment arrangements that do not use Medicaid State Plan payment rates; and
2. Provides, arranges for, or otherwise has responsibility for, the provision of any inpatient hospital or institutional services for its enrollees, and does not have a comprehensive risk contract.

Preferred drug list (PDL): A list maintained by MLTC, in partnership with the State Pharmaceutical and Therapeutics Committee, that indicates whether drugs are preferred or non-preferred by the State and therefore also by the MCO under the terms of this RFP.

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 a primary care provider, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Program Set: The group of programs and products, including the Licensed Software specified in the solicitation, 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.

Proposal: An offer, bid, or quote submitted by a bidder in a response to a written solicitation

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 serves 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) advantaged by release of the information and the demonstrated advantage the named competitor(s) would gain by the release of information.

Protest: A complaint about a governmental action or decision related to a solicitation or resultant contract, brought by a bidder who has timely submitted a proposal response in connection with the award in question, to AS Materiel Division or another designated agency with the intention of achieving a remedial result.

Provider: Any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency under the FFS model, or for the managed care program, any individual or entity who/that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services.

Provider-preventable condition: Preventable healthcare-acquired or other provider-preventable conditions and events identified by MLTC for non-payment, such as but not limited to, bed pressure ulcers or decubitus ulcers; or events such as surgical or invasive procedures performed on the wrong body part or wrong patient, or the wrong surgical procedure performed on a patient.

Public Proposal Opening: The process of opening correctly submitted offers at the time and place specified in the written solicitation and in the presence of anyone who wished to attend.

Public Transportation: A fixed or non-fixed route public transit system regulated as such with the Nebraska Department of Transportation (NDOT) (See Neb. Rev. Stat. §13-1203).

Qualifying revenue (for the risk corridor calculation): The aggregate of revenue earned by a MCO and related parties, including parent and subsidy companies and risk bearing partners under this contract, including capitation payments and ignoring federal and state premium taxes and non-operating income. Any unearned hold-back is not factored into the calculation.

Qualifying revenue (for the administrative cap calculation): The aggregate of revenue earned by the MCO and related parties, including parent and subsidy companies and risk bearing partners under this contract, including capitation payments and ignoring federal and state premium taxes and non-operating income. Any earned hold-back is factored into the calculation.

Quality improvement (QI) administrative rate: Equals the QI Expenses divided by Qualifying Revenue.

Quality management: The continuous process of assuring appropriate, timely, accessible, available, and medically necessary delivery of services. Maintaining established guidelines and standards reflective of the current state of physical and behavioral health knowledge.

Readiness review: MLTC's assessment of the MCO's ability to fulfill the RFP requirements. Such review may include but not be limited to review of proper licensure, operational protocols, MCO standards, and MCO systems. This review may be done as a desk review, on-site review, or combination and may include interviews with pertinent MCO personnel.

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.

Re-enrollment: The process by which the State automatically re-assigns a member who is disenrolled solely because he or she loses Medicaid eligibility, when a loss of eligibility does not exceed two months, into the same MCO.

Reinsurance: An insurance product, also known as stop-loss insurance, risk control, or excess insurance, which provides protection against catastrophic or unpredictable losses. An MCO may purchase reinsurance to protect itself against part or all of the losses incurred in the process of honoring the claims of members.

Release Date: The date of public release of the written solicitation to seek offers.

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.

Request for Proposal (RFP): A written solicitation utilized for obtaining competitive offers.

Responsible Bidder: A bidder who has the capability in all respects to perform fully and lawfully all requirements with integrity and reliability to assure good faith performance.

Responsive Bidder: A bidder who has submitted a proposal which conforms to all requirements of the solicitation document.

Restricted services: 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 HERITAGE HEALTH.

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.

Risk corridor: A risk sharing mechanism in which the State and MCO share in both profits and losses under a contract outside of a predetermined threshold amount, so that after an initial corridor in which the MCO is responsible for all losses or retains all profits, the State contributes a portion toward any additional losses and receives a portion of any additional profits.

Risk corridor calculation: The computation of an MCO's profit or loss by MLTC's actuary, as a percentage of the aggregate of qualifying revenue for the MCO and related parties, including parent and subsidiary companies and risk-bearing parties under a contract. The calculation ignores revenue taxes, non-operating income, and any forfeited hold-back.

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

Script: A standard promulgated by the National Council for Prescription Drug Programs (NCPDP) for the electronic transmittal of prescription information in the United States.

Secretary: United States Secretary of Health and Human Services

Serious Mental Illness: is as defined in 42 CFR 438.102

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

Should: Expected; suggested, but not necessarily mandatory.

Significant Business Transactions: Any business transaction or series of transactions during any State fiscal year that exceed(s) $25,000 (twenty-five thousand dollars) or five percent (5%) of the MCO's total operating expenses, whichever is greater.

Social determinants of health: The daily context in which people live, work, play, pray, and age and that affect health. Social determinants of health encompass multiple levels of experience from social risk factors (such as socioeconomic status, education, or employment) to structural and environmental factors (such as structural racism and poverty created by economic, political, and social policies). These latter factors are also known as upstream factors, or root causes of inequities. Factors closer to the individual level are known as downstream factors.

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

Solicitation: The process of notifying prospective bidders that the State wishes to receive proposals for furnishing services. The process may consist of public advertising, posting notices, or electronic notification of RFPs or a RFP announcement letter to prospective bidders.

Solvency: The minimum standard of financial health for a MCO, where assets exceed liabilities and timely payment requirements can be met.

Specialty drug: A drug not typically available at community retail pharmacies or under limited distribution per manufacturer/FDA; or which has a minimum of two (2) of the following characteristics:

1. Requires inventory management controls, including but not limited to, unique storage specifications, short shelf life, and special handling;
2. Must be administered, infused, or injected by a health care professional;
3. Is indicated primarily for the treatment or prevention of:
    a. A complex or chronic medical condition, defined as a physical, behavioral, or developmental condition that may have no known cure, is progressive, or can be debilitating or fatal if left untreated or under-treated, such as, but not limited to, multiple sclerosis, hepatitis C, cancer, or rheumatoid arthritis;
    b. A rare medical condition, defined as any disease or condition that typically affects fewer than 200,000 people in the United States; or
4. The total monthly cost is $10,000 or more.

Special Health Care Needs (SCHN): Members with SHCN are individuals who have complex health care needs, multiple chronic conditions, mental illness, substance use disorders, functional disabilities, or live with health or social conditions that place them at risk.

The prioritized population definition includes:

- Individuals with severe and persistent mental illness (SPMI)
- Individuals at risk of first episode psychosis
- Individuals within the Intellectual and Developmental Disabilities (I/DD) population
- Individuals in Medication Assisted Treatment for SUD
- Intravenous drug users
- Individuals with SUD in need of withdrawal management
- Individuals with HIV/AIDS
- Individuals with tuberculosis

- Children 0-5 at risk of maltreatment
- Children showing early signs of social/emotional or behavioral problems and/or have a serious emotional disturbance (SED) diagnosis
- Children with neonatal abstinence syndrome
- Children in Child Welfare
- Pregnant women and parents with dependent children
- Veterans and their families
- Other prioritized members

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

State: The State of Nebraska or Nebraska, as the context may require.

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

State share: A portion of funds originally contributed by the State, rather than the Federal government, to the operation of the Medicaid program.

Statutory: These clauses are controlled by state law and are not subject to negotiation.

Subcontractor: Individual or entity with whom the contractor enters a contract to perform a portion of the work awarded to the contractor.

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: Any person or entity, including but not limited to fiduciaries, shareholders, owners, officers, managers, employees, legally disinterested persons, and subcontractors or agents, and their employees. It shall not include any entity or person who is an interested Party to the contract or agreement.

Third-party resource: 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 member.

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 contractor 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 or service.

Value-added services: Those services a MCO provides in addition to a service covered under this contract because the MCO has determined that the health status and quality of life for the member is expected to be the same or better using the value-added health service as it would be using the covered service.

Vendor Performance Report:
A report issued to a Contractor by the DHHS when products or services delivered or performed fail to meet the terms of the purchase order, contract, and/or specifications, as reported to DHHS by the agency. The DHHS shall contact the Contractor regarding any such report. The vendor performance report will become a part of the permanent record for the Contractor. DHHS may require a vendor to cure. Two reports or more may be cause for immediate termination, at the sole discretion of the DHHS, which right is not waived by any particular instance in which it is not exercised.

Vendor: An individual or entity lawfully conducting business in the State or licensed to do so, who seeks to provide goods or services under the terms of a written solicitation.

Waiver of enrollment: A change in the status of a member from being considered mandatory for participation in managed care to being ineligible for participation in managed care.

Will: See Mandatory/Shall/Will/Must.

Work Day: See Business Day.

ACRONYM AND INITIALISM LIST

ACH – Automated Clearing House

ACT – Assertive Community Treatment

ADA – Americans with Disabilities Act

ADHD – Attention Deficit Hyperactivity Disorder

AIDS – Acquired Immunodeficiency Syndrome

API – Application Programming Interface

APR DRG – All Patients Refined Diagnosis Related Groups

ARO – After Receipt of Order

ASAM – American Society of Addiction Medicine

ASC: Ambulatory Surgical Center

BAFO – Best and Final Offer

BCP – Business Continuity Plan

BH – Behavioral Health

BVC – Best Value Criteria

CAC- Clinical Advisory Committee

CAH – Critical Access Hospital

CAHPS – Consumer Assessment of Healthcare Providers and Systems

CAP – Corrective Action Plan

CAQH – Council for Affordable Quality Healthcare

CCAA – Comprehensive Child and Adolescent Assessment

CCC – Children with Chronic Conditions

CLIA – Clinical Laboratory Improvement Amendments

CFR – Code of Federal Regulations

CHCQM – Certified in Health Care Quality Management

CHIP – Children's Health Insurance Program

CHIPRA – Children's Health Insurance Program Reauthorization Act

CM – Case Management

CME – Confirmation of MCO Enrollment

CMS – Centers for Medicare and Medicaid Services

COA – Certificate of Authority

COB – Coordination of Benefits

COI – Certificate of Insurance

CPA – Certified Public Accountant

CPHQ – Certified Professional in Health Care Quality

CPT – Current Procedural Terminology

CPU – Central Processing Unit

CTA – Community Treatment Aide

DAS – Department of Administrative Services

DBH – Division of Behavioral Health

DBM – Dental Benefits Manager

DCFS – Division of Children and Family Services

DDD – Division of Developmental Disabilities

DHHS – Department of Health and Human Services

DM – Disease Management

DME – Durable Medical Equipment

DOI – Department of Insurance

DPH – Division of Public Health

DRP – Disaster Recovery Plan

DUR – Drug Utilization Review

EAPG – Enhanced Ambulatory Patient Group

ECM – Electronic Claims Management

ED – Emergency Department

EFT – Electronic Funds Transfer

EOB – Explanation of Benefits

EPSDT – Early and Periodic Screening, Diagnostic, and Treatment

EQR – External Quality Review

EQRO – External Quality Review Organization

FDA – United States Food and Drug Administration

FDB – First Databank

Federal DHHS – U.S. Department of Health and Human Services

FFP – Federal Financial Participation

FFS – Fee-for-Service

FIDE DSNP – Fully Integrated Dual Eligible Dual Special Needs Plan

F.O.B. – Free on Board

FQHC – Federally Qualified Health Center

FWA – Fraud, Waste, and Abuse

GAO – General Accounting Office

HCBS – Home and Community Based Services

HCPCS – Healthcare Common Procedure Coding System

HEDIS – Healthcare Effectiveness Data and Information Set

HHA – Heritage Health Adult

HHS – United States Department of Health and Human Services

HIE – Health Information Exchange

HIPAA – Health Insurance Portability and Accountability Act

HIPP: Health Insurance Premium Payment

HIV – Human Immunodeficiency Virus

HMO – Health Maintenance Organization

HRA – Health Risk Assessment

HRS – Health Risk Screening

ICD-10-CM – International Classification of Diseases, Tenth Revision, Clinical Modification

ID – Identification

IHS – Indian Health Service

IMD – Institutions for Mental Diseases

IS – Information Systems

I/T/U – Indian Health Services/Tribal 638/Urban Indian Health

IVR – Interactive Voice Response

MAC – Maximum Allowable Costs

MCE – Managed Cared Entity

MCO – Managed Care Organization

MFPAU – Medicaid Fraud and Patient Abuse Unit

MH – Mental Health

MHPAEA – Mental Health Parity and Addiction Equity Act

MITA – Medicaid Information Technology Architecture

MLR – Medical Loss Ratio

MLTC – Nebraska DHHS, Division of Medicaid and Long Term Care

MMIS – Medicaid Management Information System

MSR – Member Service Representatives

MTM – Medication Therapy Management

NAC – Nebraska Administrate Code

NCCI – National Correct Coding Initiative

NCPDP – National Council for Prescription Drug Programs

NCQA – National Committee for Quality Assurance

NDC – National Drug Code

NET – Non-Emergency Transportation

NEMT – Non-Emergency Medical Transportation

NESIIS – Nebraska State Immunization Information System

NF – Nursing Facility

NIGP – National Institute for Governmental Purchasing

NMPI – Nebraska Medicaid Program Integrity Unit

NPI – National Provider Identifier

OEM – Original Equipment Manufacturer

OIG – Office of the Inspector General

OTC – Over-the-Counter

PACE – Program of All-Inclusive Care for the Elderly

PAHP – Prepaid Ambulatory Health Plan

PBM – Pharmacy Benefits Manager

PCMH – Patient-Centered Medial Home

PCP – Primary Care Provider

PDL – Preferred Drug List

PHI – Protected Health Information

PIHP – Prepaid Inpatient Health Plan

PII – Personal Identifiable Information

PIP – Performance Improvement Project

PMPM – Per Member Per Month

PPC – Provider Preventable Condition

PRTF – Psychiatric Residential Treatment Facility

PSC – Public Service Commission

QAPI – Quality Assurance and Performance Improvement Committee

QI – Quality Improvement

QM – Quality Management

QPP – Quality Performance Program

RA – Remittance Advice

RFP – Request for Proposal

RHC – Rural Health Clinic

RMAP – Refugee Medical Assistance Program

SDF – Softw are Development Firm

SDOH – Social Determinants of Health

SDP Medical – State Disability Program-Medical

SHCN – Special Health Care Needs

SHD – Systems Help Desk

SMI – Serious Mental Illness

SPB – State Purchasing Bureau

STI – Sexually Transmitted Infections

SUD – Substance Use Disorder

TPL – Third Party Liability

TTY/DDD ; Teletypew riter and Telecommunications Device for the Deaf

UM – Utilization Management

UNMC – University of Nebraska Medical Center

UR – Utilization Review

VBP – Value-Based Purchasing

VHC – Vaccine for Children

VPN – Virtual Private Netw ork

WIC – Special Supplemental Nutrition Program for Women, Infants and Children

WWC – Women With Cancer

I. PROCUREMENT PROCEDURE

A. GENERAL INFORMATION

The solicitation is designed to solicit proposals from qualified bidders who will be responsible for providing a Medicaid Managed Care program. Terms and Conditions, Project Description and Scope of Work, Proposal instructions, and Cost Proposal Requirements may be found in Sections II through VI.

Proposals shall conform to all instructions, conditions, and requirements included in the solicitation. Prospective bidders are expected to carefully examine all documents, schedules, and requirements in this solicitation, and respond to each requirement in the format prescribed. Proposals may be found non-responsive if they do not conform to the solicitation.

B. PROCURING OFFICE AND COMMUNICATION WITH STATE STAFF AND EVALUATORS

Procurement responsibilities related to this solicitation reside with DHHS. The point of contact (POC) for the procurement is as follows:

RFP #: 112209 O3
Name: Greg Walklin
Agency: Department of Health and Human Services
Address: 301 Centennial Mall South
Lincoln, NE 68509

Telephone: 402-471-6474

E-Mail: DHHS.RFPQuestions@nebraska.gov

From the date the solicitation is issued until the Intent to Award is issued, communication from the bidder is limited to the POC listed above. After the Intent to Award is issued, the bidder may communicate with individuals the State has designated as responsible for negotiating the contract on behalf of the State. No member of the State Government, employee of the State, or member of the Evaluation Committee is empowered to make binding statements regarding this solicitation. The POC will issue any answers, clarifications or amendments regarding this solicitation in writing. Only DHHS can award a contract. Bidders shall not have any communication or attempt to communicate with or influence any evaluator involved in this solicitation.

The following exceptions to these restrictions are permitted:

1. Contact made pursuant to pre-existing contracts or obligations;
2. Contact required by the schedule of events or an event scheduled later by the solicitation POC; and
3. Contact required for negotiation and execution of the final contract.

The State reserves the right to reject a bidder's proposal, withdraw an Intent to Award, or terminate a contract if the State determines there has been a violation of these procurement procedures.

C. SCHEDULE OF EVENTS

The State expects to adhere to the procurement schedule shown below, but all dates are approximate and subject to change.

	ACTIVITY	DATE/TIME
1.	Release Solicitation	April 15, 2022
2.	Virtual Mandatory Pre-Proposal Conference **Join from the meeting link** https://sonvideo.webex.com/sonvideo/j.php?MTID=med5a8792d268fb042d070 29e8b53a0e6 **Join by meeting number** Meeting number (access code): 2492 952 4967 Meeting password: j3KZQg3Q9mT **Join by phone** +1-408-418-9388 United States Toll **Join from a video system or application** Dial 24929524967@sonvideo.webex.com You can also dial 173.243.2.68 and enter your meeting number. ** Registration Advisement:* *Proposals will only be accepted from those Companies/Firms which properly register their attendance at this meeting by completing all of the required information on the Form B - State Registration Sheet.*	April 28, 2022 11 AM CST
3.	Last day to submit first round of written questions	May 2, 2022
4.	State responds to first round of written questions through Solicitation "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html and https://dhhs.ne.gov/Pages/Grants-and-Contract-Opportunities.aspx	May 16, 2022
5.	Last day to submit second round of written questions	May 23, 2022
6.	State responds to second round of written questions through Solicitation "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html and https://dhhs.ne.gov/Pages/Grants-and-Contract-Opportunities.aspx	June 6, 2022

	ACTIVITY	DATE/TIME
7.	Virtual Proposal Opening **Join from the meeting link** **https://sonvideo.webex.com/sonvideo/j.php?MTID=m1f74f154c96bfb55** **Join by meeting number** Meeting number (access code): 2481 840 0125 Meeting password: JMmF5rJnG83 **Join by phone** +1-408-418-9388 United States Toll Global call-in numbers **Join from a video system or application** 24818400125@sonvideo.webex.com You can also dial 173.243.2.68 and enter your meeting number.	July 1, 2022 2:00 PM Central Time
8.	Review for conformance to solicitation requirements	July 1, 2022
9.	Evaluation period	July 5 – August 18, 2022
10	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
11	Post "Notification of Intent to Award" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	August 19, 2022
12	Contract finalization period	August 19 – September 8, 2022
13	Anticipated Contract Execution Date	September 9, 2022
14	Contract Start Date	July 1, 2023

D. WRITTEN QUESTIONS AND ANSWERS

Questions regarding the meaning or interpretation of any solicitation provision must be received by DHHS and clearly marked "RFP Number 112209 O3; Medicaid Managed Care Program Questions." The POC is not obligated to respond to questions that are received late, per the Schedule of Events.

Bidders should present, as questions, any assumptions upon which the bidder's proposal is or might be developed. Any proposal containing assumptions may be deemed non-responsive. Non-responsive proposals may be rejected by the State. Proposals will be evaluated without consideration of any known or unknown assumptions of a bidder. The contract will not incorporate any known or unknown assumptions of a bidder.

It is preferred that questions be sent via https://nebraska.sharefile.com/r-ra34898a56193460ca59f1ed7674cc861.

It is preferred that second round questions be sent via https://nebraska.sharefile.com/r-r7808f143be544ef8817396cecc7aa0f8.

It is recommended that bidders submit questions using the following format.

Solicitation Section Reference	Solicitation Page Number	Question

Written answers will be posted at http://das.nebraska.gov/materiel/purchasing.html, per the Schedule of Events.

E. MANDATORY PRE-PROPOSAL CONFERENCE

A pre-proposal conference will be held per the Schedule of Events. Attendance at the pre-proposal conference is mandatory. Prospective bidders will have an opportunity to ask questions at the conference to assist in the clarification and understanding of the solicitation requirements. Questions that have a material impact on the solicitation or process, and questions that are relevant to all vendors, will be answered in writing and posted at http://das.nebraska.gov/materiel/purchasing.html and https://dhhs.ne.gov/Pages/Grants-and-Contract-Opportunities.aspx . An answer must be posted to be binding on the State. During the conference, the State will attempt to provide verbal answers to questions that do not impact the solicitation or process, and are only of interest to an individual vendor. If a prospective bidder feels it necessary to have a binding answer to a question that was answered verbally, the question should be submitted in writing per the Schedule of Events.

F. NOTICE OF INTENT TO ATTEND MANDATORY PRE-PROPOSAL CONFERENCE

Prospective bidders should notify the POC of their intent to attend by submitting a "Notification of Intent to Attend the Pre-Proposal Conference Form" (see Form B) via https://nebraska.sharefile.com/r-r22b43987ff014c89a54f5703ae0ab612.

G. SECRETARY OF STATE/TAX COMMISSIONER REGISTRATION REQUIREMENTS (Statutory)

All bidders must be authorized to transact business in the State of Nebraska and comply with all Nebraska Secretary of State Registration requirements. The bidder who is the recipient of an Intent to Award maybe required to certify that it has complied and produce a true and exact copy of its current (within ninety (90) calendar days of the Intent to Award) Certificate of Good Standing, or in the case of a sole proprietorship, provide written documentation of sole proprietorship and complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html. This must be accomplished prior to the Contract Execution Date.

H. ETHICS IN PUBLIC CONTRACTING

The State reserves the right to reject proposals, withdraw an Intent to Award or award, or terminate a contract if a contractor commits or has committed ethical violations, which include, but are not limited to:

1. Offering or giving, directly or indirectly, a bribe, fee, commission, compensation, gift, gratuity, or anything of value to any person or entity in an attempt to influence the bidding process;
2. Utilize the services of lobbyists, attorneys, political activists, or consultants to influence or subvert the bidding process;
3. Being considered for, presently being, or becoming debarred, suspended, ineligible, or excluded from contracting with any state or federal entity:
4. Submitting a proposal on behalf of another Party or entity; and
5. Collude with any person or entity to influence the bidding process, submit sham proposals, preclude bidding, fix pricing or costs, create an unfair advantage, subvert the proposal, or prejudice the State.

The Contractor shall include this clause in any subcontract entered into for the exclusive purpose of performing this contract.

Bidder shall have an affirmative duty to report any violations of this clause by the bidder throughout the bidding process, and throughout the term of this contract for the successful Contractor and their subcontractors.

I. DEVIATIONS FROM THE REQUEST FOR PROPOSAL

The requirements contained in the solicitation (Sections II thru VI) become a part of the terms and conditions of the contract resulting from this solicitation. Any deviations from the solicitation in Sections II through VI must be clearly defined by the bidder in its proposal and, if accepted by the State, will become part of the contract. Any specifically defined deviations must not be in conflict with the basic nature of the solicitation, requirements, or applicable state or federal laws or statutes. "Deviation", for the purposes of this solicitation, means any proposed changes or alterations to either the contractual language or deliverables within the scope of this solicitation. The State discourages deviations and reserves the right to reject proposed deviations.

J. SUBMISSION OF PROPOSALS

The State is accepting either electronically submitted responses or hard copy, paper responses for this RFP.

Pages should be consecutively numbered for the entire proposal or may be numbered consecutively within sections. Figures and tables should be numbered and referenced in the text by that number. They should be placed as close as possible to the referencing text. The Technical Proposal should not contain any reference to dollar amounts of the proposal, if. However, Information such as data concerning labor hours and categories, materials, subcontracts and so forth, shall be considered in the Technical Proposal so that the bidder's understanding of the scope of work may be evaluated. The Technical Proposal shall disclose the bidder's technical approach in as much detail as possible, including, but not limited to, the information required by the Proposal Response Instructions.

It is the bidder's responsibility to ensure the RFP is received electronically and submitted by the date and time indicated in the Schedule of Events. Proposals must be submitted by the date and time of the proposal opening per the Schedule of Events. No late proposals will be accepted.

It is the responsibility of the bidder to check the website for all information relevant to this RFP to include addenda and/or amendments issued prior to the opening date. Website address is as follows: http://das.nebraska.gov/materiel/purchasing.html and https://dhhs.ne.gov/Pages/Grants-and-Contract-Opportunities.aspx

Emphasis should be concentrated on conformance to the RFP instructions, responsiveness to requirements, completeness, and clarity of content. If the bidder's proposal is presented in such a fashion that makes evaluation difficult or overly time consuming the State reserves the right to reject the proposal as non-conforming.

1. For bidders submitting electronic responses:

Note to bidders: Not all browsers are compatible with ShareFile. Currently Chrome, Internet Explorer and Firefox are compatible. After the bidder clicks the proposal submission link, the bidder will be prompted to enter contact information including an e-mail address. By entering an e-mail address, the bidder should receive a confirmation email confirming the successful upload directly from ShareFile.

a. Bidders submitting electronically can upload the response via ShareFile here:

- **i.** https://nebraska.sharefile.com/r-ra6e4c5e528c04c608115e04a2ba7ea28
- **ii.** If duplicated proposals are submitted, the State will retain only the most recently submitted response.
- **iii.** If it is the bidder's intent to submit multiple proposals, the bidder must clearly identify the separate submissions.
- **iv.** It is the bidder's responsibility to allow time for electronic uploading. All file uploads must be completed by the Opening date and time per the Schedule of Events. No late proposals will be accepted.

a. ELECTRONIC PROPOSAL FILE NAMES

The bidder should clearly identify the uploaded RFP proposal files. To assist in identification the bidder should use the following naming convention:

- **i.** RFP 112209 O3, Company Name, Description of Service
- **ii.** If multiple files are submitted for one RFP proposal, add number of files to file names: RFP 112209 O3 Company Name, File 1 of 2.
- **iii.** If multiple RFP proposals are submitted for the same RFP, add the proposal number to the file names: RFP 112209 O3 Company Name Proposal 1 File 1 of 2.

Proposal responses should include the completed Form A, "Contact Information." Proposals must reference the RFP number. The RFP number should be included in all correspondence.

2. For bidders submitting paper/hard copy responses:

a. Bidders who are submitting a paper response should submit one proposal marked on the first page: "ORIGINAL". If multiple proposals are submitted, the State will retain only one copy marked "ORIGINAL" and destroy the other copies. The bidder is solely responsible for any variance between the copies submitted. Proposal responses should include the completed Form A, "Bidder Point of Contact". Proposals must reference the RFP number and be sent to the specified address. Please note that the address label should appear as specified in Section I B. on the face of each container or bidder's proposal response packet. If a recipient phone number is required for delivery purposes, 402-471-6484 should be used. The RFP number should be included in all correspondence. The State will not furnish packaging and sealing materials. It is the bidder's responsibility to ensure the solicitation is received in a sealed envelope or container and submitted by the date and time indicated in the Schedule of Events. Sealed proposals must be received by DHHS by the date and time of the proposal opening per the Schedule of Events. No late proposals will be accepted.

United States Postal Services (USPS) delivered proposal responses shall be mailed to:
ATTN: Greg Walklin
RFP: 112209 O3
DHHS – Office of Procurement and Grants
PO BOX 94926
Lincoln, NE 68509

Hand delivered proposal responses or responses delivered by Federal Express (FedEx), United Parcel Service (UPS), etc. shall be delivered to:

ATTN: Greg Walklin
RFP: 112209 O3
DHHS - 3rd Floor Reception Desk
301 Centennial Mall South
Lincoln, NE 68509

b. The Cost Proposal and Proprietary Information should be presented in separate sections (loose-leaf binders are preferred) on standard 8 ½" x 11" paper, except that charts, diagrams and the like may be on fold-outs which, when folded, fit into the 8 ½" by 11" format. Pages may be consecutively numbered for the entire proposal, or may be numbered consecutively within sections. Figures and tables should be numbered consecutively within sections and be referenced in the text by the number within the section, and should be placed as close as possible to the referencing text.

K. PROPOSAL PREPARATION COSTS

The State shall not incur any liability for any costs incurred by bidders in replying to this solicitation, including any activity related to bidding on this solicitation.

L. FAILURE TO COMPLY WITH REQUEST FOR PROPOSAL

Violation of the terms and conditions contained in this solicitation or any resultant contract, at any time before or after the award, shall be grounds for action by the State which may include, but is not limited to, the following:

1. Rejection of a bidder's proposal;
2. Withdrawal of the Intent to Award;
3. Withdrawal of the Award;
4. Negative Vendor Performance Report(s)
5. Termination of the resulting contract;
6. Legal action; and
7. Suspension of the bidder from further bidding with the State for the period of time relative to the seriousness of the violation, such period to be within the sole discretion of the State.

M. PROPOSAL CORRECTIONS

A bidder may correct a mistake in a proposal prior to the time of opening by either:

1. Uploading a revised and completed RFP proposal if the original proposal was electronically submitted

a. If a corrected RFP proposal is submitted, the file name(s) date/time stamped with latest date/time stamp will be accepted as final proposal. The corrected RFP file name(s) should be identified as **Corrected** 112209 O3 ABC Company Proposal #1, **Corrected** 112209 O3 ABC Company Proposal #2, etc. or

2. Giving written notice to the State of:
- **a.** Intent to withdraw the proposal for modification or
- **b.** To withdraw the proposal completely.

Changing a proposal after opening may be permitted if the change is made to correct a minor error that does not affect price, quantity, quality, delivery, or contractual conditions. In case of a mathematical error in extension of price, unit price shall govern.

N. LATE PROPOSALS

Proposals received after the time and date of the proposal opening will be considered late proposals, and will not be evaluated. The State is not responsible for proposals that are late or lost regardless of cause or fault.

O. PROPOSAL OPENING

The opening of proposals will be public via WebEx and the bidders will be announced. Proposals **WILL NOT** be available for viewing by those present at the proposal opening. Proposals will be posted to the State Purchasing Bureau website once an Intent to Award has been posted to the website. Information identified as proprietary by the submitting bidder, in accordance with the solicitation and state statute, will not be posted. If the State determines submitted information should not be withheld, in accordance with the public records law, or if ordered to release any withheld information, said information may then be released. The submitting bidder will be notified of the release and it shall be the obligation of the submitting bidder to take further action, if it believes the information should not be released. (See page one of the RFP for further details) Once proposals are opened, they become the property of the State of Nebraska and will not be returned. A Respondents List will be posted to the website after the proposal opening.

P. REQUEST FOR PROPOSAL/PROPOSAL REQUIREMENTS

The proposals will first be examined to determine if all requirements listed below have been addressed and whether further evaluation is warranted. Proposals not meeting the requirements may be rejected as non-responsive. The requirements are:

1. Original Request for Proposal for Contractual Services form signed in ink or via DocuSign;
2. Clarity and responsiveness of the proposal;
3. Completed Corporate Overview;
4. Completed Sections II through VI;
5. Completed Proposal Response Instructions;
6. Completed Optional Services Proposal Response Instructions (Optional); and
7. Completed Optional Services State Cost Proposal Template (Optional).

Q. EVALUATION COMMITTEE

Proposals are evaluated by members of an Evaluation Committee(s). The Evaluation Committee(s) will consist of individuals selected at the discretion of the State. Names of the members of the Evaluation Committee(s) will not be published.

Any contact, attempted contact, or attempt to influence an evaluator that is involved with this solicitation may result in the rejection of this proposal and further administrative actions.

R. EVALUATION OF PROPOSALS

All proposals that are responsive to the solicitation will be evaluated. Each evaluation category will either have pass/fail criteria or have a maximum point potential. The State will conduct a fair, impartial, and comprehensive evaluation of all proposals in accordance with the criteria set forth below.

For Managed Care services, areas that will be addressed and scored during the evaluation include:

1. Corporate Overview should include but is not limited to:
- **a.** the ability, capacity, and skill of the bidder to deliver and implement the system or project that meets the requirements of the solicitation;
- **b.** the character, integrity, reputation, judgment, experience, and efficiency of the bidder;
- **c.** whether the bidder can perform the contract within the specified time frame;
- **d.** the quality of vendor performance on prior contracts;

e. such other information that may be secured and that has a bearing on the decision to award the contract; and

2. Provide a detailed response on how managed care services will be provided as found within the Proposal Response Instructions.

Section V. AA. Optional Fee-for-Service will be addressed and scored during the evaluation include:

1. Optional Services Proposal Response Instructions (Optional); and
2. Completed Optional Services State Cost Proposal Template (Optional).

Neb. Rev. Stat. §81-161 allows the quality of performance of previous contracts to be considered when evaluating responses to competitively bid solicitations in determining the lowest responsible bidder. Information obtained from any Vendor Performance Report (See Terms & Conditions, Section H) may be used in evaluating responses to solicitations for goods and services to determine the best value for the State.

Neb. Rev. Stat. §73-107 allows for a preference for a resident disabled veteran or business located in a designated enterprise zone. When a state contract is to be awarded to the lowest responsible bidder, a resident disabled veteran or a business located in a designated enterprise zone under the Enterprise Zone Act shall be allowed a preference over any other resident or nonresident bidder, if all other factors are equal.

Resident disabled veterans means any person (a) who resides in the State of Nebraska, who served in the United States Armed Forces, including any reserve component or the National Guard, who was discharged or otherwise separated with a characterization of honorable or general (under honorable conditions), and who possesses a disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense and (b)(i) who owns and controls a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection and (ii) the management and daily business operations of the business are controlled by one or more persons described in subdivision(a) of this subsection. Any contract entered into without compliance with this section shall be null and void.

Therefore, if a resident disabled veteran or business located in a designated enterprise zone submits a proposal in accordance with Neb. Rev. Stat. §73-107 and has so indicated on the solicitation cover page under "Bidder must complete the following" requesting priority/preference to be considered in the award of this contract, the following will need to be submitted by the bidder within ten (10) business days of request:

1. Documentation from the United States Armed Forces confirming service;
2. Documentation of discharge or otherwise separated characterization of honorable or general (under honorable conditions);
3. Disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense; and
4. Documentation which shows ownership and control of a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection; and the management and daily business operations of the business are controlled by one or more persons described in subdivision (a) of this subsection.

Failure to submit the requested documentation within ten (10) business days of notice will disqualify the bidder from consideration of the preference.

Evaluation criteria will be released with the solicitation.

S. ORAL INTERVIEWS/PRESENTATIONS AND/OR DEMONSTRATIONS (Cost Proposal References only applicable to evaluation of Section V. AA Optional Fee-for-Service)

The State may determine after the completion of the Technical and Cost Proposal evaluation that oral interviews/presentations and/or demonstrations are required. Every bidder may not be given an opportunity to interview/present and/or give demonstrations. The State reserves the right, at its discretion, to select only the top scoring bidders to present/give oral interviews. The scores from the oral interviews/presentations and/or demonstrations will be added to the scores from the Technical and Cost Proposals. The presentation process will allow the bidders to demonstrate their proposal offering, explaining and/or clarifying any unusual or significant elements related to their proposals. Bidders' key personnel, identified in their proposal, may be requested to participate in a structured interview to determine their understanding of the requirements of this proposal, their authority and reporting relationships within their firm, and their management style and philosophy. Only representatives of the State and the presenting bidder will be permitted to attend the oral interviews/presentations and/or demonstrations. A written copy or summary of the presentation, and demonstrative information (such as

briefing charts, et cetera) may be offered by the bidder, but the State reserves the right to refuse or not consider the offered materials. Bidders shall not be allowed to alter or amend their proposals.

Once the oral interviews/presentations and/or demonstrations have been completed, the State reserves the right to make an award without any further discussion with the bidders regarding the proposals received.

Any cost incidental to the oral interviews/presentations and/or demonstrations shall be borne entirely by the bidder and will not be compensated by the State.

T. BEST AND FINAL OFFER (Only applicable to Section V. AA. Optional Fee-for-Service)

If best and final offers (BAFO) are requested by the State and submitted by the bidder, they will be evaluated (using the stated BAFO criteria), scored, and ranked by the Evaluation Committee. The State reserves the right to conduct more than one Best and Final Offer. The award will then be granted to the highest scoring bidder. However, a bidder should provide its best offer in its original proposal. Bidders should not expect that the State will request a best and final offer.

U. REFERENCE AND CREDIT CHECKS

The State reserves the right to conduct and consider reference and credit checks. The State reserves the right to use third parties to conduct reference and credit checks. By submitting a proposal in response to this solicitation, the bidder grants to the State the right to contact or arrange a visit in person with any or all of the bidder's clients. Reference and credit checks may be grounds to reject a proposal, withdraw an intent to award, or rescind the award of a contract.

V. AWARD

The State reserves the right to evaluate proposals and award contracts in a manner utilizing criteria selected at the State's discretion and in the State's best interest. After evaluation of the proposals, or at any point in the solicitation process, the State of Nebraska may take one or more of the following actions:

1. Amend the solicitation;
2. Extend the time of or establish a new proposal opening time;
3. Waive deviations or errors in the State's solicitation process and in bidder proposals that are not material, do not compromise the solicitation process or a bidder's proposal, and do not improve a bidder's competitive position;
4. Accept or reject a portion of or all of a proposal;
5. Accept or reject all proposals;
6. Withdraw the solicitation;
7. Elect to rebid the solicitation;
8. Award single lines or multiple lines to one or more bidders; or
9. Award one or more all-inclusive contracts.

Any protests must be filed by a bidder within ten (10) business days after the intent to award decision is posted to the Internet. Protest procedure is available on the Internet at:
https://dhhs.ne.gov/Pages/Grants-and-Contract-Opportunities.aspx

W. LUMP SUM OR "ALL OR NONE" PROPOSALS (Only applicable to Section V. AA. Optional Fee-for-Service)

The State reserves the right to purchase item-by-item, by groups or as a total when the State may benefit by so doing. Contractors may submit a proposal on an "all or none" or "lump sum" basis, but should also submit a proposal on an item-by-item basis. The term "all or none" means a conditional proposal which requires the purchase of all items on which proposals are offered and Contractor declines to accept award on individual items; a "lump sum" proposal is one in which the Contractor offers a lower price than the sum of the individual proposals if all items are purchased, but agrees to deliver individual items at the prices quoted.

X. REJECTION OF PROPOSALS

The State reserves the right to reject any or all proposals, wholly or in part, in the best interest of the State.

Y. RESIDENT BIDDER

Pursuant to Neb. Rev. Stat. §§ 73-101.01 through 73-101.02, a Resident Bidder shall be allowed a preference against a Non-resident Bidder from a state which gives or requires a preference to Bidders from that state. The preference shall be equal to the preference given or required by the state of the Nonresident Bidders. Where the lowest responsible bid from a resident Bidder is equal in all respects to one from a nonresident Bidder from a state which has no preference law, the resident Bidder shall be awarded the contract. The provision of this preference shall not apply to any contract for any project upon which federal funds would be withheld because of the provisions of this preference.

II. TERMS AND CONDITIONS

Bidders should complete Sections II through VI as part of their proposal. The State of Nebraska is soliciting proposals in response to this solicitation. Bidder is expected to read the Terms and Conditions and should initial either accept, reject, or reject and provide alternative language for each clause. The bidder should also provide an explanation of why the bidder rejected the clause or rejected the clause and provided alternate language. By signing the solicitation, bidder is agreeing to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the proposal. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the proposal. The State of Nebraska reserves the right to reject proposals that attempt to substitute the bidder's commercial contracts and/or documents for this solicitation.

The bidders should submit with its proposal any license, user agreement, service level agreement, or similar documents that the bidder wants incorporated in the Contract. These documents shall be subject to negotiation and will be incorporated as addendums if agreed to by the Parties. The State will not consider incorporation of any document not submitted with the bidder's proposal as the document will not have been included in the evaluation process.

If a conflict or ambiguity arises after the Addendum to Contract Award have been negotiated and agreed to, the Addendum to Contract Award shall be interpreted as follows:

1. If only one Party has a particular clause then that clause shall control;
2. If both Parties have a similar clause, but the clauses do not conflict, the clauses shall be read together;
3. If both Parties have a similar clause, but the clauses conflict, the State's clause shall control.

A. GENERAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contract resulting from this solicitation shall incorporate the following documents:

1. Request for Proposal, including attachments and addenda;
2. Amendments to the solicitation;
3. Written Questions and answers;
4. Contractor's proposal (Contractor's response to the solicitation and properly submitted documents); and
5. Amendments and addenda to the contract, including the Service Contract Award.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a future contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendments and addenda, including the Service Contract Award with the most recently dated amendment or addenda, respectively, having the highest priority, 2) Amendments to solicitation 3) Questions and answers, 4) The original solicitation document and any addenda, and 5) the Contractor's submitted Proposal.

Any ambiguity or conflict in the contract discovered after its execution, not otherwise addressed herein, shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

B. NOTIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Contractor and State shall each identify the contract manager who shall serve as the point of contact for the executed contract.

Communications regarding the executed contract shall be in writing and shall be deemed to have been given if delivered electronically, personally, or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the identified contract manager, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or five (5) calendar days following deposit in the mail.

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.

C. NOTICE (POC)

The State reserves the right to appoint a Procurement Contracts Officer's Representative to manage [or assist the Procurement Contracts Officer in managing] the contract on behalf of the State. The Procurement Contract Officer's Representative will be appointed in writing, and the appointment document will specify the extent of the Procurement Contract Officer's Representative authority and responsibilities. If a Procurement Contract Officer's Representative is appointed, the Contractor will be provided a copy of the appointment document, and is expected to cooperate accordingly with the Procurement Contract Officer's Representative. The Procurement Contract Officer's Representative has no authority to bind the State to a contract, amendment, addendum, or other change or addition to the contract.

D. GOVERNING LAW (Statutory)

Notwithstanding any other provision of this contract, or any amendment or addendum(s) entered into contemporaneously or at a later time, the parties understand and agree that, (1) the State of Nebraska is a sovereign state and its authority to contract is therefore subject to limitation by the State's Constitution, statutes, common law, and regulation; (2) this contract will be interpreted and enforced under the laws of the State of Nebraska; (3) any action to enforce the provisions of this agreement must be brought in the State of Nebraska per state law; (4) the person signing this contract on behalf of the State of Nebraska does not have the authority to waive the State's sovereign immunity, statutes, common law, or regulations; (5) the indemnity, limitation of liability, remedy, and other similar provisions of the final contract, if any, are entered into subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity; and (6) all terms and conditions of the final contract, including but not limited to the clauses concerning third party use, licenses, warranties, limitations of liability, governing law and venue, usage verification, indemnity, liability, remedy or other similar provisions of the final contract are entered into specifically subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity.

The Parties must comply with all applicable local, state and federal laws, ordinances, rules, orders, and regulations.

E. BEGINNING OF WORK

The awarded bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Contractor. The Contractor will be notified in writing when work may begin.

F. AMENDMENT

This Contract may be amended in writing, within scope, upon the agreement of both parties. Changes or additions to the contract beyond the scope of the RFP are not permitted; however, this RFP must meet all applicable federal law, including Medicaid laws, rules and regulations, and any future amendments to this RFP that are required to bring Nebraska into compliance with federal law shall be deemed part of the scope of the requested bid.

G. CHANGE ORDERS OR SUBSTITUTIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The State and the Contractor, upon the written agreement, may make changes to the contract within the general scope of the solicitation. Changes may involve specifications, the quantity of work, or such other items as the State may find necessary or desirable. Corrections of any deliverable, service, or work required pursuant to the contract shall not be deemed a change. The Contractor may not claim forfeiture of the contract by reasons of such changes.

The Contractor shall prepare a written description of the work required due to the change and an itemized cost sheet for the change. Changes in work and the amount of compensation to be paid to the Contractor shall be determined in accordance with applicable unit prices if any, a pro-rated value, or through negotiations. The State shall not incur a price increase for changes that should have been included in the Contractor's proposal, were foreseeable, or result from difficulties with or failure of the Contractor's proposal or performance.

No change shall be implemented by the Contractor until approved by the State, and the Contract is amended to reflect the change and associated costs, if any. If there is a dispute regarding the cost, but both parties agree that immediate implementation is necessary, the change may be implemented, and cost negotiations may continue with both Parties retaining all remedies under the contract and law.

H. VENDOR PERFORMANCE REPORT(S)

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The State may document any instance(s) of products or services delivered or performed that exceed or fail to meet the terms of the purchase order, contract, and/or solicitation specifications. DHHS may contact the Contractor regarding any such report. Vendor performance report(s) will become a part of the permanent record of the Contractor.

I. NOTICE OF POTENTIAL CONTRACTOR BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

If Contractor breaches the contract or anticipates breaching the contract, the Contractor shall immediately give written notice to the State. The notice shall explain the breach or potential breach, a proposed cure, and may include a request for a waiver of the breach if so desired.The State may, in its discretion, temporarily or permanently waive the breach. By granting a waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the contract. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach.

J. BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Either Party may terminate the contract, in whole or in part, if the other Party breaches its duty to perform its obligations under the contract in a timely and proper manner. Termination requires written notice of default and a thirty (30) calendar day (or longer at the non-breaching Party's discretion considering the gravity and nature of the default) cure period. Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing time to cure a failure or breach of contract does not waive the 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.

The State's failure to make payment shall not be a breach, and the Contractor shall retain all available statutory remedies and protections.

K. NON-WAIVER OF BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The acceptance of late performance with or without objection or reservation by a Party shall not waive any rights of the Party nor constitute a waiver of the requirement of timely performance of any obligations remaining to be performed.

L. SEVERABILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

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 provision held to be invalid or illegal.

M. INDEMNIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

1. GENERAL

The Contractor agrees to defend, indemnify, and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all third party claims, liens, demands, damages, penalties, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, reimbursement requests or other penalties from regulatory authorities, and attorney fees and expenses ("the claims"), sustained by or asserted against the State for personal injury, death, property loss or damage, noncompliance with public records laws or other information requests, or noncompliance with governing Medicaid laws and regulations 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, resulting from this contract, 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 solicitation.

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, including subcontractor's and their employees, provided by the Contractor.

4. SELF-INSURANCE

The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01 (Reissue 2008). If there is a presumed loss under the provisions of this agreement, Contractor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,829 – 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Section 81-8,294), Tort (Section 81-8,209), and Contract Claim Acts (Section 81-8,302), as outlined in Neb. Rev. Stat. § 81-8,209 et seq. and under any other provisions of law and accepts liability under this agreement to the extent provided by law.

5. The Parties acknowledge that Attorney General for the State of Nebraska is required by statute to represent the legal interests of the State, and that any provision of this indemnity clause is subject to the statutory authority of the Attorney General.

N. ATTORNEY'S FEES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Parties agree to pay all expenses of such action, as permitted by law and if ordered by the court, including attorney's fees and costs, if the other Party prevails.

O. PERFORMANCE BOND

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contractor will be required to supply 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 bond must be an established dollar amount of fifty million dollars ($50,000,000) The bond will guarantee that the Contractor will faithfully perform all requirements, terms and conditions of the contract. Failure to comply shall be grounds for forfeiture of the bond as liquidated damages. Amount of forfeiture will be determined by the agency based on loss to the State. The bond will be returned when the contract has been satisfactorily completed as solely determined by the State, after termination or expiration of the contract.

P. LIQUIDATED DAMAGES

Liquidated damages are referenced in Section V.V. Contract Non-Compliance and Attachment 10 – Liquidated damages.

Q. ASSIGNMENT, SALE, OR MERGER

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Either Party may assign the contract upon mutual written agreement of the other Party. Such agreement shall not be unreasonably withheld.

The Contractor retains the right to enter into a sale, merger, acquisition, internal reorganization, or similar transaction involving Contractor's business. Contractor agrees to the terms of Section V.C. Business Requirements and Section V.D. Staffing Requirements. Contractor agrees to cooperate with the State in executing amendments to the contract to allow for the transaction. If a third party or entity is involved in the transaction, the Contractor will remain responsible for performance of the contract until such time as the person or entity involved in the transaction agrees in writing to be contractually bound by this contract and perform all obligations of the contract.

R. FORCE MAJEURE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Neither Party shall be liable for any costs or damages, or for default resulting from its inability to perform any of its obligations under the contract due to a natural or manmade event outside the control and not the fault of the affected Party ("Force Majeure Event"). The Party so affected shall immediately make a written request for relief to the other Party, and shall have the burden of proof to justify the request. The other Party may grant the relief requested; relief may not be unreasonably withheld. Labor disputes with the impacted Party's own employees will not be considered a Force Majeure Event.

S. CONFIDENTIALITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

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

It is incumbent upon the Parties to inform their 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 by 5 U.S.C. 552a (m)(1), provides that any officer or employee, 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.

T. OFFICE OF PUBLIC COUNSEL (Statutory)

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.

U. LONG-TERM CARE OMBUDSMAN (Statutory)

Contractor must comply with the Long-Term Care Ombudsman Act, per Neb. Rev. Stat. §§ 81-2237 et seq. This section shall survive the termination of this contract.

V. EARLY TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

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 day 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 termination the Contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.

3. Pursuant to 42 CFR § 438.708 the State may enroll that contractor's members in other MCOs or provide their benefits through other options included in the Medicaid State Plan if the State, at its sole discretion determines that the Contractor has failed to carry out the substantive terms of the contract, or meet applicable requirements in Section 1932, 1903(m) or 1905(t) of the Social Security Act.

- **a.** Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.
- **b.** The State will provide the Contractor with timely written Notice of Intent to Terminate (Notice) that states the nature and basis of the penalty or sanction and pre-termination hearing rights.
- **c.** The Contractor may, at the discretion of the State, be allowed to correct the deficiencies within the thirty (30) calendar day notice period, unless other provisions in this Section demand otherwise, prior to the issuance of a Notice of Termination.
- **d.** In accordance with 42 CFR § 438.710 , the State will conduct a pre-termination hearing upon the request of the MCO as outlined in the Notice to provide MCO the opportunity to contest the nature and basis of the sanction.
  - **i.** The request must be submitted in writing to the State prior to the determined date of termination stated in the Notice.
  - **ii.** The MCO shall receive a written notice of the outcome of the pre-termination hearing, if applicable, indicating decision reversal or affirmation.
- **e.** The State will notify Medicaid members enrolled in the MCO in writing, consistent with 42 CFR § 438.710 and 438.722, of the affirming termination decision and of their options for receiving Medicaid services and to disenroll immediately.
- **f.** The State may terminate the contract immediately for the following reasons:
  - **i.** If directed to do so by statute;
  - **ii.** 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;
  - **iii.** A trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court;
  - **iv.** Fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders;
  - **v.** 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;
  - **vi.** A voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;
  - **vii.** Contractor intentionally discloses confidential information;
  - **viii.** Contractor has or announces it will discontinue support of the deliverable;
  - **ix.** Second or subsequent documented "vendor performance report" form deemed unacceptable by the State Purchasing Bureau;

x. Contractor engaged in collusion or actions which could have provided Contractor an unfair advantage in obtaining this contract; and

xi. In the event funding is no longer available.

W. CONTRACT CLOSEOUT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Upon contract closeout for any reason the Contractor shall within thirty (30) days, unless stated otherwise herein:

1. Transfer all completed or partially completed deliverables to the State;
2. Transfer ownership and title to all completed or partially completed deliverables to the State;
3. Return to the State all information and data, unless the Contractor is permitted to keep the information or data by contract or rule of law. Contractor may retain one copy of any information or data as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures;
4. Cooperate with any successor Contactor, person or entity in the assumption of any or all of the obligations of this contract;
5. Cooperate with any successor Contactor, person or entity with the transfer of information or data related to this contract;
6. Return or vacate any state owned real or personal property; and
7. Return all data in a mutually acceptable format and manner.

Nothing in this Section should be construed to require the Contractor to surrender intellectual property, real or personal property, or information or data owned by the Contractor for which the State has no legal claim.

III. CONTRACTOR DUTIES

A. INDEPENDENT CONTRACTOR / OBLIGATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

It is agreed that the Contractor is an independent contractor and that nothing contained herein is intended or should be construed as creating or establishing a relationship of employment, agency, or a partnership.

The Contractor is solely responsible for fulfilling the contract. The Contractor or the Contractor's representative shall be the sole point of contact regarding all contractual matters.

The Contractor shall secure, at its own expense, all personnel required to perform the services under the contract. The personnel the Contractor uses to fulfill the contract shall have no contractual or other legal relationship with the State; they shall not be considered employees of the State and shall not be entitled to any compensation, rights or benefits from the State, including but not limited to, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

By-name personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of these personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

All personnel assigned by the Contractor to the contract shall be employees of the Contractor or a subcontractor, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor or a subcontractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor or the subcontractor respectively.

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

1. Any and all pay, benefits, and 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 that complies with state and federal law and submitting any reports on such insurance to the extent required by governing law;
5. Determining the hours to be worked and the duties to be performed by the Contractor's employees; and
6. All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination alleged against the Contractor, its officers, agents, or subcontractors or subcontractor's employees)

If the Contractor intends to utilize any subcontractor, the subcontractor's level of effort, tasks, and time allocation should be clearly defined in the contractor's proposal. The Contractor shall agree that it will not utilize any subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State.

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

Contractor shall insure that the terms and conditions contained in any contract with a subcontractor does not conflict with the terms and conditions of this contract.

The Contractor shall include a similar provision, for the protection of the State, in the contract with any subcontractor engaged to perform work on this contract.

B. EMPLOYEE WORK ELIGIBILITY STATUS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

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

2. The completed United States Attestation Form should be submitted with the solicitation response.

3. 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.

4. 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.

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION (Statutory)

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 for goods and services to be covered by any contract resulting from this solicitation.

D. COOPERATION WITH OTHER CONTRACTORS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Contractor may be required to work with or in close proximity to other contractors or individuals that may be working on same or different projects. The Contractor shall agree to cooperate with such other contractors or individuals, and shall not commit or permit any act which may interfere with the performance of work by any other contractor or individual. Contractor is not required to compromise Contractor's intellectual property or proprietary information unless expressly required to do so by this contract.

E. DISCOUNTS

Prices quoted shall be inclusive of ALL trade discounts. Cash discount terms of less than thirty (30) days will not be considered as part of the proposal. Cash discount periods will be computed from the date of receipt of a properly

executed claim voucher or the date of completion of delivery of all items in a satisfactory condition, whichever is later.

F. PRICES

This section only applies to Section V. AA. FFS CLAIMS MANAGEMENT AND PROCESSING – OPTIONAL SERVICES in the scope of work.

Prices quoted shall be net, including transportation and delivery charges fully prepaid by the contractor, F.O.B. destination named in the solicitation. No additional charges will be allowed for packing, packages, or partial delivery costs. When an arithmetic error has been made in the extended total, the unit price will govern.

All prices, costs, and terms and conditions submitted in the proposal shall remain fixed and valid commencing on the opening date of the proposal until the contract terminates or expires.

The State reserves the right to deny any requested price increase. No price increases are to be billed to any State Agencies prior to written amendment of the contract by the parties.

The State will be given full proportionate benefit of any decreases for the term of the contract.

G. COST CLARIFICATION

The State reserves the right to review all aspects of cost for reasonableness and to request clarification of any proposal where the cost component shows significant and unsupported deviation from industry standards or in areas where detailed pricing is required.

H. PERMITS, REGULATIONS, LAWS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The contract price shall include the cost of all royalties, licenses, permits, and approvals, whether arising from patents, trademarks, copyrights or otherwise, that are in any way involved in the contract. The Contractor shall obtain and pay for all royalties, licenses, and permits, and approvals necessary for the execution of the contract. The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, software, and other items used to execute this contract.

I. OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

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

The State shall own and hold exclusive title to any deliverable developed as a result of this contract. Contractor shall have no ownership interest or title, and shall not patent, license, or copyright, duplicate, transfer, sell, or exchange, the design, specifications, concept, or deliverable.

J. INSURANCE REQUIREMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contractor shall throughout the term of the contract maintain insurance as specified herein and provide the State a current Certificate of Insurance/Acord Form (COI) verifying the coverage. The Contractor shall not commence work on the contract until the insurance is in place. If Contractor subcontracts any portion of the Contract the Contractor must, throughout the term of the contract, either:

1. Provide equivalent insurance for each subcontractor and provide a COI verifying the coverage for the subcontractor;
2. Require each subcontractor to have equivalent insurance and provide written notice to the State that the Contractor has verified that each subcontractor has the required coverage; or
3. Provide the State with copies of each subcontractor's Certificate of Insurance evidencing the required coverage.

The Contractor shall not allow any subcontractor to commence work until the subcontractor has equivalent insurance. The failure of the State to require a COI, or the failure of the Contractor to provide a COI or require subcontractor insurance shall not limit, relieve, or decrease the liability of the Contractor hereunder.

In the event that any policy written on a claims-made basis terminates or is canceled during the term of the contract or within five (5) years of termination or expiration of the contract, the contractor shall obtain an extended discovery or reporting period, or a new insurance policy, providing coverage required by this contract for the term of the contract and five (5) years following termination or expiration of the contract.

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.

Notwithstanding any other clause in this Contract, the State may recover up to the liability limits of the insurance policies required herein.

4. REINSURANCE

- **a.** The MCO must file all contracts of reinsurance, or a summary of the plan of self-insurance.
- **b.** All reinsurance agreements or summaries of plans of self-insurance must be filed with MLTC and must remain in full force and effect for a minimum of thirty (30) calendar days following written notice by registered mail of cancellation by either party. Pursuant to the Health Maintenance Organization Act, Neb. Rev. Statute 44-3292 et seq. and other relevant laws.
- **c.** The MCO must maintain reinsurance agreement throughout the contract period, including any extension(s) or renewal(s). The MCO must provide prior notification to MLTC of its intent to purchase or modify reinsurance protection for any members enrolled in the MCO.
- **d.** The MCO must provide to MLTC the risk analyses, assumptions, cost estimates, and rationales supporting its proposed reinsurance arrangements for prior approval. If any reinsurance is provided through related parties, disclosure of the entities and details causing the related-party relationship must be specifically disclosed.

5. 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. The policy shall include a waiver of subrogation in favor of the State. The COI shall contain the mandatory COI subrogation waiver language found hereinafter. The amounts of such insurance shall not be less than the limits stated hereinafter. For employees working in the State of Nebraska, the policy must be written

by an entity authorized by the State of Nebraska Department of Insurance to write Workers' Compensation and Employer's Liability Insurance for Nebraska employees.

6. 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 Inssounurance 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 documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory. The COI shall contain the mandatory COI liability waiver language found hereinafter. The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

REQUIRED INSURANCE COVERAGE	
COMMERCIAL GENERAL LIABILITY	
General Aggregate	$2,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 per occurrence
Bodily Injury/Property Damage	$1,000,000 per occurrence
Medical Payments	$10,000 any one person
Damage to Rented Premises (Fire)	$300,000 each occurrence
Contractual	Included
Independent Contractors	Included
Abuse & Molestation	Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$5,000,000 per occurrence
PROFESSIONAL LIABILITY	
All Other Professional Liability (Errors & Omissions)	$10,000,000 Per Claim / Aggregate
COMMERCIAL CRIME	
Crime/Employee Dishonesty Including 3rd Party Fidelity	$1,000,000
CYBER LIABILITY	
Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties	$10,000,000
MANDATORY COI SUBROGATION WAIVER LANGUAGE	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
MANDATORY COI LIABILITY WAIVER LANGUAGE	
"Commercial General Liability & Commercial Automobile Liability policies shall name the State of Nebraska as an Additional Insured and the policies shall be primary and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory as additionally insured."	

7. EVIDENCE OF COVERAGE

The Contractor shall furnish a certificate of insurance coverage complying with the above requirements prior to beginning work to the identified contract manager.

These certificates or the cover sheet shall reference the RFP number, 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.

Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

8. DEVIATIONS

The insurance requirements are subject to limited negotiation. Negotiation typically includes, but is not necessarily limited to, the correct type of coverage, necessity for Workers' Compensation, and the type of automobile coverage carried by the Contractor.

K. NOTICE OF POTENTIAL CONTRACTOR BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

If Contractor breaches the contract or anticipates breaching the contract the Contractor shall immediately give written notice to the State. The notice shall explain the breach or potential breach, and may include a request for a waiver of the breach if so desired. The State may, at its discretion, temporarily or permanently waive the breach. By granting a temporary waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the contract. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach.

L. ANTITRUST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

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.

M. CONFLICT OF INTEREST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

By submitting a proposal, bidder certifies that no relationship exists between the bidder and any person or entity which either is, or gives the appearance of, a conflict of interest related to this Request for Proposal or project.

Bidder further certifies that bidder will not employ any individual known by bidder to have a conflict of interest nor shall bidder take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its contractual obligations hereunder or which creates an actual or appearance of conflict of interest.

If there is an actual or perceived conflict of interest, bidder shall provide with its proposal a full disclosure of the facts describing such actual or perceived conflict of interest and a proposed mitigation plan for consideration. The State will then consider such disclosure and proposed mitigation plan and either approve or reject as part of the overall bid evaluation.

N. ADVERTISING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

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 goods or services are endorsed or preferred by the State. Any publicity releases pertaining to the contract award shall not be issued without prior written approval from the State.

O. NEBRASKA TECHNOLOGY ACCESS STANDARDS (Statutory)

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 to the greatest degree possible. In the event such standards change during the Contractor's performance, the State may create an amendment to the contract to request the contract comply with the changed standard at a cost mutually acceptable to the parties.

P. DRUG POLICY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Contractor certifies it maintains a drug free workplace 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.

Q. CLEAN AIR ACT (REGULATORY)

Contractor shall ensure that it complies with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. §§ 7401 et seq., and the Federal Water Pollution Control Act as amended, 33 U.S.C. §§ 1251 et seq.

R. LOBBYING (REGULATORY)

No federal appropriated funds shall be paid, by or on behalf of Contractor, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this contract or (a) the awarding of any federal agreement; (b) the making of any federal grant; (c) the entering into of any cooperative agreement; and (d) the extension, continuation, renewal, amendment, or modification of any federal agreement, grant, loan, or cooperative agreement.

If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this contract, Contractor shall complete and submit Federal Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

S. STATE OF NEBRASKA PERSONNEL RECRUITMENT PROHIBITION

Contractor shall not, at any time, recruit or employ any person who evaluated proposals received for this RFP.

The prohibition under this section shall last two (2) years after the Contract Execution Date.

IV. PAYMENT

A. TAXES (Statutory)

The State is not required to pay taxes and assumes no such liability as a result of this solicitation. The Contractor may request a copy of the Nebraska Department of Revenue, Nebraska Resale or Exempt Sale Certificate for Sales Tax Exemption, Form 13 for their records. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor

B. INSPECTION AND APPROVAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

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.

C. PAYMENT (Statutory)

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2403). The State may require 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 goods and services provided by the Contractor prior to the Effective Date of the contract, and the Contractor hereby waives any claim or cause of action for any such services.

D. LATE PAYMENT (Statutory)

The Contractor may charge the responsible agency interest for late payment in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. § 81-2401 through 81-2408).

E. SUBJECT TO FUNDING / FUNDING OUT CLAUSE FOR LOSS OF APPROPRIATIONS (Statutory)

The State's obligation to pay amounts due on the Contract for a fiscal years following the current fiscal year is contingent upon legislative appropriation of funds. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal year(s) 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 termination. All obligations of the State to make payments after the termination date will cease. 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. PROJECT DESCRIPTION AND SCOPE OF WORK

The bidder should provide the following information in response to this solicitation:

A. PROGRAM DESCRIPTION

1. Description of Current Program

a. The State of Nebraska's Medicaid program is administered by the Department of Health and Human Services (DHHS), Division of Medicaid & Long-Term Care (MLTC). DHHS is comprised of five (5) divisions:

i. The Division of Behavioral Health (DBH) provides funding, oversight, and technical assistance to the six (6) local behavioral health regions. The regions contract with local programs to provide public inpatient, outpatient, emergency, community, mental health, and substance use disorder services.

ii. The Division of Children and Family Services (DCFS) administers child welfare, adult protective services, economic support programs, and youth rehabilitation and treatment centers.

iii. The Division of Developmental Disabilities (DDD) provides funding and oversight for Medicaid Home and Community-Based Services (HCBS) Waivers.

iv. MLTC administers the Medicaid program, which provides health care services to eligible elderly and disabled individuals; low-income pregnant women, children, and parents; and individuals eligible through Medicaid expansion. MLTC also administers non-institutional home and community-based services for qualified individuals, the aged, adults and children with disabilities, and infants and toddlers with special needs.

v. The Division of Public Health (DPH) is responsible for preventive and community health programs and services. It also regulates and licenses health-related professionals, health care facilities, and services.

b. MLTC currently provides health care coverage for approximately three hundred and forty thousand (340,000)individuals each month at an annual cost of approximately $1.8 billion.

c. Approximately three hundred and forty-seven thousand (347,000) individuals are enrolled in managed care. Those individuals who are not enrolled in managed care receive their physical health (PH) and behavioral health (BH) services from the Nebraska Medical Assistance Program under a fee-for-service (FFS) reimbursement model.

d. Heritage Health is authorized under section 1932 of the Social Security Act, which permits a state to operate a managed care program through its Medicaid State Plan. Additionally, Nebraska operates under a 1915(b) waiver requiring special needs children and Native Americans to participate in the managed care program. The 1915(b) waiver permits MLTC to operate the behavioral health managed care program.

e. Heritage Health currently includes:
Physical health, behavioral health, and pharmacy managed care provided, through risk-comprehensive contracts that are fully capitated and require the contracted entity to be a Managed Care Organization (MCO) or health insuring organization. "Risk-Comprehensive" means that the contracted entity is at financial risk to provide all the services in the core benefits package.

f. MLTC currently contracts with vendors to perform the following services for the Heritage Health:

i. PH, BH, and pharmacy benefit managed care services;

ii. Dental Benefit Management services;

iii. Enrollment broker services;

iv. External quality review services; and

v. Actuarial services.

g. With implementation of this contract, notable changes in the managed care program will include:

i. Integration of dental services through a minimum of two (2) and maximum of three (3) MCO contracts for all ninety-three (93) counties in Nebraska; and

ii. All MCOs must have a FIDE Dual Special Needs Plan (FIDE DSNP) in place no later than January 1, 2024.

MLTC intends to award a minimum of two (2) and a maximum of three (3) MCO contracts through this procurement process, which will provide integrated managed care health services statewide for all 93 counties in Nebraska.

2. Included Populations

Medicaid populations who are mandated to participate in the Nebraska Medicaid managed care program include:

a. Families, children, and pregnant women eligible for Medicaid under Section 1931 of the Social Security Act or related coverage groups;

b. Children, adults, and related populations who are eligible for Medicaid due to blindness or disability;
c. Medicaid beneficiaries who are age sixty-five (65) or older and not members of the blind/disabled population or members of the Section 1931 adult population;
d. Low-income children who are eligible to participate in Medicaid in Nebraska through Title XXI, the Children's Health Insurance Program (CHIP);
e. Medicaid beneficiaries who are receiving foster care or subsidized adoption assistance through Title IV-E, are in foster care, or are otherwise in an out-of-home placement;
f. Medicaid beneficiaries who participate in an HCBS Waiver program (This includes adults with intellectual disabilities or related conditions; children with intellectual disabilities and their families, aged persons, and adults and children with disabilities; members receiving targeted case management through DDD; Traumatic Brain Injury Waiver participants; and any other group covered by the State's 1915(c) waiver of the Social Security Act);
g. Women who are eligible for Medicaid through the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Every Woman Matters);
h. Medicaid beneficiaries for the period of retroactive eligibility, when mandatory enrollment for managed care has been determined;
i. Members eligible during a period of presumptive eligibility;
j. Members eligible for the Refugee Medical Assistance Program (RMAP);
k. Members eligible for the State Disability Program-Medical (SDP Medical);
l. Members with continuous eligibility who have a share of cost;
m. Members eligible for Heritage Health Adult (HHA) expansion; and
n. Transitional Medical Assistance and Medicaid Insurance for Workers with Disabilities.

3. Excluded Populations

Within the groups identified above, the following categories of beneficiaries are excluded from managed care:

a. Aliens who are eligible for Medicaid for an emergency condition only;
b. Beneficiaries who have excess income or who are required to pay a premium, and are intermittently eligible;
c. Beneficiaries who have received a disenrollment or waiver of enrollment;
d. Participants in the Program for All-Inclusive Care for the Elderly;
e. Beneficiaries with Medicare coverage where Medicaid only pays co-insurance and deductibles; and
f. Inmates of public institutions.

4. Changes to Population Groups and Services

MLTC may add, delete, or otherwise modify included and excluded population groups and services. If changed, the contract will be amended, and the MCO will be given as much advance notice as reasonably possible.

B. ELIGIBILITY AND ENROLLMENT

1. Eligibility

a. DHHS administers and manages eligibility for Medicaid and economic assistance programs through ACCESSNebraska in accordance with state and federal rules and regulations. Details on how individuals can apply for benefits are found on the ACCESSNebraska website, currently available at ACCESSNebraska.ne.gov.
b. Regulations covering eligibility for Nebraska Medicaid are available in Title 477 of the Nebraska Administrative Code.
c. Medicaid and CHIP eligibility renewals are conducted annually.

2. Member Enrollment/Assignment

a. The MCO and all its staff and subcontractors must understand the Medicaid population and the enrollment process. The MCO must work cooperatively with MLTC to resolve issues relating to enrollee participation and the enrollment process.
b. MLTC maintains responsibility for the enrollment of managed care eligible individuals into MCOs through a contractual arrangement with its enrollment broker. MLTC or its enrollment broker provides enrollees with access to a member guidebook, plan matrix, and provider directory to assist each enrollee in choosing an MCO plan and a Primary Care Provider (PCP). The enrollment broker provides impartial choice counseling to assist each enrollee in choosing an MCO. The enrollment broker is the only entity, other than MLTC, authorized to assist a Medicaid enrollee in the selection of an MCO.
c. Potential enrollees determined mandatory for managed care will be immediately enrolled in an MCO. The MCO's eligibility system must show the member's effective date with the MCO as the

first day of the month in which the member is determined Medicaid eligible, but in no instance shall be prior to the Contract Start Date. Though a member's effective date with the MCO will not typically exceed three (3) months prior to the month of MCO selection, there may be cases in which this is required.

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

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

f. MLTC, through its enrollment broker, will automatically re-enroll a member who is disenrolled solely because they lose Medicaid eligibility, when the loss of eligibility does not exceed two (2) months, into the same MCO and assign the individual to the same PCP.

3. Auto-Assignment Algorithm

a. Prior to the Contract Start Date, all current Heritage Health members and enrollees will be allowed an open enrollment period to select an MCO and choose a PCP. Current MCO members who do not select an MCO during that time frame will be assigned automatically to one as of the Contract Start Date.

b. Auto-assignment algorithms and decisions are at the sole discretion of MLTC, and all MCOs must abide by the auto-assignment decisions.

c. The enrollment broker will auto-assign enrollees who do not select a specific MCO.

d. When an enrollee cannot be enrolled into their requested MCO because of an MLTC-imposed sanction or for another reason, the enrollee will be auto-assigned to another MCO.

e. The automatic assignment methodology will seek to preserve existing provider-recipient relationships and relationships with providers that have traditionally served Medicaid recipients. After consideration of provider-recipient relationships, the methodology will assign recipients among MCOs, excluding those subject to an intermediate sanction. The automatic assignment methodology will not take into consideration the enrollee's previous MCO assignment during the initial Heritage Health enrollment period.

f. The automatic assignment methodology is based on the following considerations:

- **i.** If an enrollee has immediate family or household members enrolled in an MCO, the enrollee will be enrolled in the same MCO.
- **ii.** If the enrollee's PCP is not currently in-network, the enrollment broker will use a round-robin method to determine the MCO assignment that maximizes the preservation of existing provider relationships.
- **iii.** MLTC reserves the right to remove the MCO from the auto-assignment round-robin process at any time, but enrollees can continue to proactively select the MCO during the time frame of their removal from this auto-assignment process.
- **iv.** MCO quality measures may be factored into the algorithm for auto-assignment, at the discretion of MLTC.

4. MCO Enrollment Procedures

a. Acceptance of All Eligible Individuals

- **i.** The MCO must accept all eligible individuals who select it as their MCO or are assigned to it as their MCO. The MCO must not discriminate against MCO members on the basis of their health history, health status, need for health care services, or adverse change in health status; or on the basis of age, religious belief, gender, sexual orientation, race, color, national origin, ethnicity, or language needs.
- **ii.** This applies to enrollment, re-enrollment, or disenrollment from the MCO. The MCO may be subject to monetary penalties and other sanctions if it is determined by MLTC that the MCO has requested disenrollment for any of these reasons.
- **iii.** The MCO must accept enrollees in the order in which they are assigned without restriction, up to the enrollment capacity limits set by MLTC.

b. Effective Date of Enrollment

- **i.** The effective date of enrollment in the MCO is the date provided on the outbound ANSI ASC X12 834 electronic transaction initiated by MLTC or the enrollment broker. In standard circumstances, an enrollee's effective date of enrollment in a MCO is the first day of the month of the enrollee's eligibility for Medicaid.
- **ii.** Because individuals can be retroactively eligible for Medicaid, and the effective date of initial enrollment in a MCO is the effective date of eligibility, the effective date of

enrollment may occur prior to the MCO being notified of the individual's enrollment. Though a member's effective date with the MCO will not typically exceed three (3) months prior to the month of MCO selection, there may be cases in which this is required.

iii. The MCO is not liable for the cost of any covered services provided to a Medicaid enrollee prior to the effective date of enrollment, but is responsible for the cost of covered services obtained on or after the effective date of enrollment.

c. Change in Status

i. The MCO must notify MLTC via ACCESSNebraska, of any changes in contact information or living arrangements for families or individual members within five (5) business days of identification, including changes in mailing address, residential address, email address, and telephone number, in a manner and format required by MLTC.

ii. The MCO must initiate a request for disenrollment through the enrollment broker for other known changes in status, including but not limited to, death, entry into involuntary custody, or incarceration.

d. Newborn Enrollment

i. Once the MLTC eligibility system is updated with a record of a live birth, the newborn will be immediately enrolled in either the mother's or an eligible sibling's MCO. In the event of immediate family members being enrolled with different MCOs the mother's MCO assignment supersedes any sibling's. Otherwise, the sibling's assignment will govern.

ii. After receiving notice of a pregnancy, the MCO must contact the pregnant member a minimum of sixty (60) calendar days prior to the expected delivery date to encourage mothers to choose a PCP for their newborns. In the event that a pregnant member does not select a PCP, the MCO must give the member a minimum of fourteen (14) calendar days after the birth to select a PCP prior to the MCO assigning one.

iii. The MCO must ensure that hospital providers report births of members to the MCO within twenty-four (24) hours of the birth. If the member makes a PCP selection during the hospital stay and one was not already identified, the MCO must ensure the hospital provider reports this information to the MCO.

e. Retroactive Enrollment

For members who are enrolled with retroactive enrollment dates, the MCO must establish processes for appropriate payment of providers for services provided. The process must:

i. Allow providers to request retroactive determination of medical necessity for services, with a denial allowed only after consultation with the provider and the MCO determines the service was not medically necessary;

ii. Allow for reimbursement of out-of-network Medicaid providers for services provided prior to MCO selection; and

iii. Establish a method for waiving the claim timely filing limit if the provider submitted the claim within MLTC's established timely filing limit from the date of member MCO selection.

5. PCP Assignment

a. At initial enrollment, if an enrollee selects an MCO and a PCP, the assignment of the PCP will be included on the enrollment file sent to the MCO.

b. If no PCP selection is indicated on the enrollment file, the MCO must:

i. Contact the member within ten (10) business days of receiving the enrollment file to assist the member in selecting a PCP; and

ii. Inform the member that each family member has the right to choose their own PCP, explaining the advantages of selecting the same PCP for all family members, as appropriate.

c. Members who do not choose a PCP within ten (10) business days of enrollment with an MCO must be auto-assigned a PCP by the MCO within one (1) month of the enrollment date.

d. The MCO must develop a PCP auto-assignment methodology in collaboration with MLTC to assign a member to a PCP when the member:

i. Does not make a PCP selection;

ii. Selects a PCP within the MCO's network that has reached its maximum physician/patient ratio or has a closed panel; or

iii. Selects a PCP within the MCO's network that has restrictions or limitations (e.g., pediatric practice only).

iv. If any one of the three (3) situations set forth in provisions d.i through d.iii immediately above occur, the MCO must contact the member telephonically and ask them to make an alternate PCP selection. If the MCO cannot reach the member after three (3) attempts or the member does not wish to choose a different PCP, only then may the MCO auto-assign the member to a PCP.

v. If appropriate, assignment must be made to a PCP with whom the member had a historical provider relationship. If there is no historical PCP relationship, the member must be assigned to a provider who is the PCP for an immediate family member in the MCO. If there is no family or historical relationship, members must be auto-assigned a PCP using an algorithm developed by the MCO based on the age and sex of the member and geographic proximity.

vi. If a member is a dual eligible individual, the MCO must not require them to choose a new PCP through the MCO and must not prevent the member from receiving primary care services from the member's existing Medicaid-enrolled Medicare PCP.

vii. The MCO must report all PCP assignments to either MLTC or the enrollment broker at a frequency defined by MLTC.

viii. The MCO must have written policies and procedures for PCP assignment. These policies and procedures must be approved in advance of their implementation by MLTC.

6. MCO Changes

a. Each member will be given ninety (90) calendar days from the effective date of MCO enrollment (or the postmark date of the member's notification of enrollment with the MCO, whichever is later) in which they may change to another MCO for any reason.

b. After the initial ninety (90) calendar day period, Medicaid members will be locked in to their MCO selection until the next annual open enrollment period. The annual open enrollment period will take place November 1 through December 31 each year of the contract.

7. Disenrollment

a. Disenrollment is any action taken by MLTC or its designee to remove a Medicaid MCO member from the MCO following the receipt and approval of a written request for disenrollment or a determination made by MLTC or its designee that the member is no longer eligible for Medicaid or the Heritage Health Managed Care Program.

b. The enrollment broker is the single point of contact with the MCO member regarding notification of disenrollment.

c. A member may initiate a request for disenrollment from an MCO for cause, at any time, under any one of the following circumstances:

i. The MCO does not, because of moral or religious objections, cover the service the member seeks;

ii. The member needs related services to be performed at the same time, and not all of the related services are available with the MCO, and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk;

iii. Lack of access to MCO benefits and services covered under the contract; or

iv. Other reasons including but not limited to, poor quality-of-care, or lack of access to providers experienced in dealing with the member's health care needs.

d. A member may initiate a request for disenrollment from an MCO without cause for the following reasons:

i. Once a year during the member's annual enrollment choice period;

ii. Upon automatic re-enrollment under 42 CFR § 438.56(g), if a temporary loss of Medicaid eligibility caused the member to miss the annual enrollment choice opportunity; or

iii. If MLTC imposes the intermediate sanction provisions specified in 42 CFR § 438.702(a)(4) on the MCO.

e. The member (or their representative) must submit an oral or written request of disenrollment with cause to the enrollment broker for action by MLTC.

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

8. MCO-Initiated Disenrollment

a. The MCO may not request disenrollment because of a member's health diagnosis; adverse change in health status; utilization of medical services; diminished medical capacity; pre-existing medical condition; refusal of medical care or diagnostic testing; uncooperative or disruptive behavior resulting from their special needs, unless it seriously impairs the MCO's ability to furnish services to the member or other MCO members; or the member attempts to exercise their rights under the MCO's grievance system, or attempts to exercise their right to change, for cause, the PCP that they chose or was assigned (42 CFR § 438.56(b)(2)).

b. The following are the only reasons for which the MCO may request disenrollment of a member:

i. The MCO has sufficient documentation to establish fraud, forgery, or evidence of unauthorized use/abuse of services by the member, including circumstances in which the member misuses or loans the member's ID card to another person to obtain services. If this occurs, the MCO must report it to MLTC; or

ii. The member's behavior is disruptive, unruly, abusive, or uncooperative to the extent that enrollment in the MCO seriously impairs the organization's ability to furnish services to either the member or other members.

c. The MCO must take reasonable measures, as determined by MLTC, to correct member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

d. When the MCO requests a member disenrollment, it must notify the member in writing of this request, the reason for the request, and the date of anticipated disenrollment.

e. The MCO must submit disenrollment requests to the enrollment broker that must include, at a minimum, the member's name, ID number, detailed reasons for requesting the disenrollment, and a description of the measures taken to correct member behavior prior to requesting disenrollment. The MCO must send notification of the disenrollment request to the member at the same time the request is made to the enrollment broker. The MCO must include documentation with the disenrollment request, as indicated in 482 NAC § 004.04(A).

f. The MCO must not submit a disenrollment request for an effective date earlier than forty-five (45) calendar days after the event that prompted the disenrollment request. The MCO must ensure that disenrollment documents are maintained in an identifiable member record.

g. All requests will be reviewed on a case-by-case basis and decisions are at the sole discretion of MLTC or its designee. All decisions are final and not subject to the state's dispute resolution process.

h. The enrollment broker will provide written notice of disenrollment to the member and request the member to choose a new MCO. The notice will include a statement that if the member disagrees with the decision to disenroll the member from the MCO, the member has the right to file an appeal directly to the State through the fair hearing process.

i. Until the member is disenrolled by the enrollment broker, the MCO is responsible for the provision of all benefits and services to the member.

9. Disenrollment Effective Date

a. The effective date of disenrollment will be no later than the first day of the second month following the calendar month in which the request for disenrollment is filed.

b. If MLTC fails to make a disenrollment determination by the first day of the second month following the month in which the request for disenrollment was filed, the disenrollment is considered approved.

c. The MCO, the enrollment broker, and MLTC must reconcile enrollment/disenrollment issues at the end of each month utilizing an agreed upon written procedure.

10. MLTC-Initiated Disenrollment

MLTC or the enrollment broker will notify the MCO of the member's disenrollment for the following reasons:

a. Member is no longer Medicaid eligible;

b. Member's death;

c. Member's intentional submission of fraudulent information;

d. Member becomes an inmate in a public institution;

e. Member moves out-of-state; and/or

f. A disenrollment decision is made by a hearing officer or court of law.

11. Enrollment and Disenrollment Updates

a. MLTC will notify each MCO at specified times each month of the Medicaid-eligible individuals that are enrolled, re-enrolled, or disenrolled from the MCO for the following month. The MCO will receive this notification through the ASC X12N 834 Benefit Enrollment and Maintenance electronic transaction.

b. MLTC will use its best efforts to ensure that the MCO receives timely and accurate enrollment and disenrollment information. In the event of discrepancies or irresolvable differences between MLTC and the MCO regarding enrollment, disenrollment, or termination, MLTC's decision is final.

12. Daily Updates

MLTC will provide daily updates to the MCO via electronic media (ASC X12N 834 Benefit Enrollment and Maintenance transaction) of members newly enrolled with the MCO. The MCO must have written policies and procedures for receiving these updates, incorporating them into its management information system, and ensuring this information is available to its providers. Policies and procedures must be provided to MLTC for review and approval as part of the readiness review processes.

13. Weekly Reconciliation

a. The MCO is responsible for weekly reconciliation of the enrollment/disenrollment file received from the enrollment broker.

b. The MCO must provide written notification to the enrollment broker of any data inconsistencies within ten (10) calendar days of receipt of the file.

c. The MCO will receive a monthly electronic file (ASC X12N 820 transaction) from MLTC listing all members for whom the MCO has received a capitation payment from and the amount received. The MCO is responsible for reconciling this file against its internal records. It is the MCO's responsibility to notify MLTC of any discrepancies within sixty (60) calendar days of file receipt. Lack of compliance with reconciliation requirements may result in the withholding of a portion of future monthly payments or other liquidated damages as defined in Section V.V. Contract Non-Compliance of the RFP.

C. BUSINESS REQUIREMENTS

1. Compliance with State and Federal Laws and Regulations

a. The MCO must abide by all relevant provisions found in 42 CFR, Part 438, Managed Care; Title 471 Nebraska Administrative Code (NAC) Nebraska Medical Assistance Program Services; Title 477 NAC, Medicaid Eligibility; and Title 482 NAC, Nebraska Medicaid Managed Care.

b. The MCO and all of its subcontractors must comply with all applicable federal and state laws and regulations including, but not limited to, Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding educational programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; Section 1557 of the Affordable Care Act; and the Americans with Disabilities Act. The MCO must comply with any other applicable federal and state laws (such as Title VI of the Civil Rights Act of 1964, etc.) and 45 CFR parts 160 and 164 (the Health Insurance Portability and Accountability Act [HIPAA] privacy rule).

c. The MCO and its subcontractor(s) must comply with any applicable federal and state laws that pertain to member rights and ensure that its staff and affiliated providers also comply when furnishing services to members.

2. Managed Care Organization Licensure

a. The MCO must have a Certificate of Authority (COA) to transact the business of health insurance in Nebraska as a health maintenance organization (HMO) by the Contract Start Date.

b. If the MCO is not licensed as required by the Nebraska Department of Insurance (DOI) at the time of proposal submittal, the MCO must obtain the appropriate licensure prior to Contract Execution Date with MLTC.

3. Accreditation

a. The MCO must attain health plan accreditation from the National Committee for Quality Assurance (NCQA). If the MCO is not currently accredited by NCQA, the MCO must attain NCQA accreditation no later than eighteen (18) months after the Contract Execution Date.

b. The MCO's application for accreditation must be submitted as soon after the Contract Execution Date as allowed by NCQA. The MCO must provide MLTC with a copy of all correspondence between the MCO and NCQA regarding the application process, the accreditation requirements, and the MCO's progress toward accreditation.

c. Achievement of provisional accreditation status will require the implementation of a corrective action plan (CAP) no later than thirty (30) calendar days after receipt of the final report from NCQA. The CAP will outline what steps the MCO will take to obtain full accreditation.

d. Any failure to obtain full NCQA accreditation no later than eighteen (18) months after the Contract Execution Date and to maintain the accreditation thereafter will be considered a breach of the contract and will be subject to Section V. Y. Termination of Contract.

4. Business Location

The MCO must establish and maintain a business office or worksite within Nebraska, staffed with the primary contract personnel and managers responsible for the services provided under the contract. The MCO is responsible for all costs related to securing and maintaining the facility for start-up and ongoing operations. The MCO must provide meeting space to MLTC as requested when onsite at the MCO's location.

5. Cooperation with Other Entities and Programs

a. The MCO must develop processes and procedures and designate points of contact for collaboration with other entities and programs that serve members including, but not limited to:

- **i.** DBH-funded programs;
- **ii.** DCFS-funded programs that support the safety, permanency, and well-being of children in the care and custody of the State;
- **iii.** DDD programs that involve rehabilitative and habilitative services for persons with developmental disabilities;
- **iv.** The Nebraska Department of Education Early Development Network;
- **v.** Community agencies including, but not limited to, the Area Agencies on Aging and League of Human Dignity Waiver Offices;
- **vi.** The Office of Probation; and
- **vii.** Other programs and initiatives within MLTC related to primary care and behavioral health integration/coordination and pharmacy management.

b. The MCO must collaborate with these entities and programs when serving members and identifying and responding to members' needs. It must address and attempt, as expeditiously as possible, to resolve any coordination of care issues with other MCOs and other State agencies and their contractors, tribes, and other community providers.

c. The MCO must also collaborate with these entities and program network providers regarding MLTC-identified planning initiatives and system transformation.

6. Service Orientation, Interoperability, and Data Exchange

The State's Medicaid program is undergoing significant modernization across many projects. In alignment with the Center for Medicare and Medicaid Services (CMS) – Medicaid Information Technology Architecture (MITA) guidance, key objectives shared by all MLTC projects include high levels of capability/maturity with respect to service orientation, interoperability, and data exchange. MLTC requires the MCO to transmit and receive data in compliance with all applicable current and future federal (including but not limited to HIPAA) and state standards and mandates. The MCO must work with MLTC to develop and support an effective data exchange between the MCO and all stakeholders involved in the Medicaid program, including MLTC. The MCO must also provide to MLTC, at its request, reports via electronic data exchanges to support enhanced analytics and report drill-down capabilities.

7. Participation in the Nebraska Health Information Initiative

The MCO is required to enter into a participation agreement with the CyncHealth - Nebraska Health Information Initiative. CyncHealth is a non-profit organization that includes health care providers, payers, and the State. CyncHealth's purpose is to achieve health care transformation through the creation of a secure, web-based health information exchange to serve the State. More information on CyncHealth can currently be found at https://cynchealth.org/.

8. Participation in MLTC Committees

The MCO must participate in any committees that MLTC determines to be critical for the administration of the Medicaid benefit to its members.

9. Financial Viability/Solvency Requirements

a. Insolvency

The MCO must ensure that its Medicaid members are not held liable for:

- **i.** The MCO's debts in the event of the MCO's insolvency;
- **ii.** The cost of covered services provided to the member, for which MLTC does not pay the MCO; and
- **iii.** The cost of covered services provided to the member, for which MLTC or the MCO does not pay the individual or health care provider that furnishes the services under a contract, referral, or other arrangement.

b. Solvency
Each non-federally-qualified HMO must provide binding assurances that Medicaid enrollees will not be liable for the MCO's debt if the MCO becomes insolvent.

c. Continue Services During Insolvency
The MCO must continue to cover services for members for the duration of time for which payment has been made, as well as for inpatient admissions up until discharge.

10. Merger, Reorganization, and Change of Ownership

a. The MCO must submit notification to MLTC of a merger, reorganization, or change of ownership one-hundred-and-twenty (120) calendar days prior to its proposed effective date. The MCO must also submit a detailed merger, reorganization, or transition plan to MLTC for review prior to the effective date of the proposed merger, reorganization, or change of ownership. The purpose of the transition plan is to ensure uninterrupted services to members, evaluate the new entity's ability to maintain and support the contract requirements, and ensure that services to members are not diminished. In addition, the MCO must provide adequate assurances to MLTC that the major components of its organization and programs are not adversely affected by such merger, reorganization, or change in ownership. This plan must be approved by MLTC prior to any merger, reorganization, or change of ownership. One organization may not own or manage more than one MCO contract under the Nebraska Medicaid program.

b. Upon a merger, reorganization, or change of ownership of any MCO, MLTC may offer an open enrollment period of no more than ninety (90) calendar days to all Medicaid members. During this period of open enrollment, each member may change to another MCO for any reason. Each MCO must notify its respective members of the open enrollment period and their rights therein.

11. Written Policies and Procedures

a. The MCO must develop and maintain written policies and procedures. The MCO must provide MLTC with written guidelines for developing, reviewing, and approving all policies and procedures.

b. All policies and procedures must be reviewed by the MCO, at a minimum annually, to ensure they reflect current practices. After review, the policies must be dated and signed by the MCO's appropriate manager, coordinator, director, or administrator.

c. Policies and procedures that are updated must be submitted to MLTC for review and approval forty-five (45) calendar days prior to implementation.

d. All clinical and quality management policies must be approved and signed by the MCO's Medical Director.

e. Based on provider or member feedback, if MLTC determines in its sole discretion that a MCO policy or process is inefficient or places an unnecessary burden on the members or providers, the MCO will be required to work with MLTC to change the policy or procedure by a time specified by MLTC.

f. All policies and procedures must be submitted to MLTC for review and approval during Readiness Review, prior to implementation.

g. The MCO must notify providers and members of approved impending policy changes a minimum of forty-five (45) calendar days prior to implementation.

12. Audit Requirements

a. The MCO must:

i. Maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, health records, and the administrative costs and expenses incurred pursuant to this contract, as well as medical information relating to members as required for purposes of audit; or administrative, civil, or criminal investigations or prosecution per all retention requirements of this RFP. The MCO must ensure that this provision also applies to subcontractors, providers, or other entities providing goods or services under this contract. The MCO must provide MLTC access to un-redacted contracts, subcontracts, and other agreements, upon request, to ensure compliance with this requirement; and

ii. Establish and maintain an internal audit function responsible for providing an independent review and evaluation of the MCO's accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. The MCO's internal audit function must perform audits to ensure the economical and efficient use of resources by all of its departments to accomplish the objectives and goals of each department. Further, the MCO's internal audit department is responsible for performing

the claims payment accuracy tests described in Section V.S.9. Claims Management - Claims Payment Accuracy.

b. Department of Insurance Financial Report

i. The MCO must obtain an audit of its business transactions from a licensed Certified Public Accountant (CPA) including, but not limited to, the financial transactions made under this contract. The MCO will provide MLTC with a SOC 1 audit annually, including management response letters and user controls.

ii. No later than June 1 of each year, the MCO must submit a full and complete copy of the audit report to MLTC per Attachment 13 – Reporting Requirements.

c. MLTC and CMS may inspect and audit any records of the MCO or its subcontractors. There is no restriction on the right of MLTC or the federal government to conduct all inspections and audits necessary to ensure quality, appropriateness, or timeliness of services, and reasonableness of costs.

d. The MCO shall be subject to an audit of Managed Care Data operations, finances, and underlying security, privacy, and isolation controls, no more often than every three (3) months, to ensure that the required controls for data isolation, access, and usage are operational. The audit will be conducted by a third party to be selected by MLTC and approved by the MCO. The MCO will provide open and complete access to the underlying systems, subject to appropriate security controls as required by law. Any and all relevant and/or necessary documentation to support the audit must be provided by the MCO no less than ten (10) calendar days prior to the on-site audit. The said audit will be conducted at MCO's expense.

13. 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, the United States Department of Health and Human Services (HHS) awarding agencies, the Federal 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 the MCO that are pertinent to the contract in order to make audits, examinations, excerpts, transcripts, and copies of such documents.

14. Compliance

The MCO is responsible for compliance with all contract requirements, regardless of whether the MCO enters into a subcontract to delegate performance of the contract requirements. The MCO must submit all proposed subcontracts for the provision of any contract services to MLTC for prior review and approval a minimum of one-hundred-and-twenty (120) calendar days prior to their planned implementation. Prior to selecting a subcontractor, the MCO must evaluate the prospective subcontractor's ability to perform the activities to be delegated a minimum of ninety (90) calendar days prior to the planned Contract Start Date. MLTC reserves the right to participate in these evaluations, and the MCO must submit a copy of its findings to MLTC a minimum of thirty (30) calendar days prior to the Contract Start Date. The MCO must monitor and formally review a subcontractor's performance on an ongoing basis.

15. Confidentiality

The MCO must establish and implement procedures consistent with the confidentiality requirements in 45 CFR Parts 160 and 164 for health records and any other health and enrollment information that identifies a particular member, as well as any and all other applicable provisions of privacy law.

16. Protections Against Liability

The MCO must ensure that providers do not bill members any amount greater than would be owed if the MCO provided the services directly (i.e., no balance billing by providers is permitted).

17. Data Certification

Data submitted by the MCO to MLTC must be certified as required by 42 CFR § 438.606.

a. The data that must be certified includes, but is not limited to, all documents specified by MLTC, 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 this certification concurrently with the certified data and documents.

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

18. Moral or Religious Objections

a. 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.

b. If the MCO elects to not provide, reimburse for, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, it must furnish this information to MLTC with its proposal to this RFP or whenever it adopts the policy during the term of the contract. The information provided must be consistent with the requirements of 42 CFR § 438.10. The MCO's members and potential members must be informed of this policy before and during enrollment and within ninety (90) calendar days after adopting the policy with respect to any particular service.

c. If the MCO elects to not provide, reimburse for, or provide coverage of a counseling or referral service, the MCO must inform the member where and how to access the covered service.

19. Loss of Program Authority

Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the MCO must do no work on that part after the effective date of the loss of program authority. MLTC will adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the MCO works on a program or activity no longer authorized by laws after the date the legal authority for the work ends, the MCO will not be paid for that work. If MLTC paid the MCO in advance to work on a no-longer-authorized program or activity, and under the terms of this contract the work was to be performed after the date of the legal authority ended, the payment for that work must be returned to MLTC. However, if the MCO worked on a program or activity prior to the date legal authority ended for that program or activity, and MLTC included the cost of performing that work in its payments to the MCO, the MCO may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

20. Dual Special Needs Plans

The MCO must have a FIDE Dual Special Needs Plan (DSNP) in place no later than the Contract Start Date.

D. STAFFING REQUIREMENTS

1. General Requirements

a. The MCO must have organizational, operational, managerial, and administrative systems in place that are capable of fulfilling all contract requirements. The MCO must be staffed by qualified persons in numbers appropriate to the MCO's enrollment.

b. For the purposes of this contract, the MCO must not employ or contract with any individual who has been debarred, suspended, or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR § 438.610(a) and (b), 42 CFR § 1001.1901(b), and 42 CFR § 1003.102(a)(2)]. The MCO must screen all employees and subcontractors to determine whether any of them have been excluded from participation in federal health care programs. The HHS Office of Inspector General website, which can be searched by the name of any individual, may currently be accessed at: https://oig.hhs.gov/exclusions/index.asp.

c. The MCO must employ sufficient staff and utilize appropriate resources to achieve contractual compliance. The MCO's resource allocation must be adequate to achieve required outcomes in all functional areas within the organization. Adequacy is evaluated based on outcomes and compliance with contractual and MLTC policy requirements, including the requirement for providing culturally competent services. If the MCO does not achieve the desired outcomes or maintain compliance with contractual obligations, additional monitoring and regulatory action may be employed by MLTC including, but not limited to, requiring the MCO to hire additional staff and application of monetary penalties as specified in this contract.

d. The MCO must perform criminal background checks on all employees of the MCO and subcontractor staff assigned to, or proposed to be assigned to, any aspect of this contract and who have access to electronic protected health information of Medicaid applicants and recipients. The MCO must, upon request, provide MLTC with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for these MCO staff or subcontractor staff.

e. The MCO will be responsible for any additional costs associated with on-site audits or other oversight activities that result when required systems are located outside of the state.

f. The MCO must remove or reassign, upon written request from MLTC, any MCO employee or subcontractor's employee that MLTC deems at its sole discretion to be unacceptable. The MCO must hold MLTC harmless for actions taken as a result.

2. Key Staff Positions

a. The MCO must comply with minimum key staffing requirements in Table 1, Key Staff below.

i. For each key staff position marked with an asterisk in the table, the staff member must be based in Nebraska.

ii. All positions listed in the table must be full time, i.e. a minimum of 40 hours per week, with the exception of the Business Continuity Planning and Emergency Coordinator, which shall be an additional duty assignment.

b. An individual staff member may not occupy more than two (2) key staff positions listed below unless prior approval is obtained from MLTC. Exceptions include the Chief Executive Officer (CEO), Medical Director (MD), and Dental Director, each of whom may only hold one (1) position.

c. During the Readiness Review process, the MCO must submit a Human Resources and Staffing Plan to MLTC for review and approval. This plan must describe how the MCO will obtain and maintain the staffing level needed to accomplish the duties outlined in this RFP. The MCO is required to recruit, hire, train, supervise, and, if necessary, terminate such professional and support personnel as are necessary to carry out the terms of this contract. All staff must have experience and expertise in working with the populations served by the Medicaid program.

d. The MCO must provide to MLTC, in writing, a list of all officers and members of the MCO's Board of Directors. This information must be provided to MLTC prior to the Contract Start Date. The MCO must notify MLTC, in writing, within ten (10) business days of any change to its officers or Board members.

e. The MCO must submit to MLTC the names, resumes, and contact information for all key staff listed below a minimum of sixty (60) calendar days prior to the Contract Start Date.

f. In the event of a change of any key staff at any point during the contract's duration, the MCO must notify MLTC, in writing, within two (2) business days of the change. The name of the interim contact person shall be included with this notification. Key staff member replacements must have equivalent experience, knowledge and talent. Upon replacing a key staff member, the name and resume of the new staff member, along with a revised organizational chart (complete with key staff time allocation) must be sent to MLTC.

g. Replacement of the CEO, Medical Director, or Dental Director requires prior written approval from MLTC. This approval will not be unreasonably withheld, provided a suitable candidate is proposed.

h. In addition to the key staff requirements, the MCO must have full-time clinical and support staff to conduct daily business in an efficient and effective manner. This includes, but is not limited to, administration; accounting and finance; fraud and abuse; Utilization Management (UM); Quality Management and Improvement (QM); member services, education, and outreach; grievances and appeals; provider services; claims processing; and reporting.

Table 1. Key Staff *Must be based in Nebraska	
Title	**Minimum Duties**
Chief Executive Officer (CEO)*	The CEO must work full time on this contract, a minimum of 40 (forty) hours per week. The CEO is responsible for: **1.** Providing overall direction and prioritization for the MCO; **2.** Developing and carrying out leadership strategies; **3.** Ensuring that policies and contractual requirements are followed; **4.** Providing operational oversight to ensure that goals are met; and **5.** Developing and implementing integration models that ensure coordination with system partners.
Medical Director/Chief Medical Officer*	The Medical Director must be a currently practicing physician, with an unrestricted license in the state to practice medicine. The Medical Director must have a minimum of three (3) years of training in a medical specialty and five (5) years of experience providing clinical services. The Medical Director must devote a minimum of forty (40) hours per week to the MCO's operations to ensure timely medical decisions, including after-hours consultation as needed. The Medical Director must be board-certified in their specialty, and be actively involved in all major clinical, UM, and QM decisions of the MCO. When the Medical Director is unavailable, the MCO must have a physician staff person or subcontractor to provide competent medical direction at any time. The Medical Director is responsible for: **1.** Developing, implementing, and interpreting medical policies and procedures. Duties may include, but are not limited to: service authorizations, claims review, discharge planning, credentialing, referral management, and medical review of grievances and appeals; **2.** Administrating the medical management activities of the MCO; **3.** Participating via telephone or in person (at MLTC's discretion) at every Quality meeting with MLTC and other system partners, and as requested by MLTC; and **4.** Leading the UM, QM, Credentialing, and Provider Advisory committees.
Dental Director	**1.** The Dental Director must be currently licensed in the state as a Doctor of Dentistry ("dentist") with no restrictions or other licensure limitations. **2.** The Dental Director must be licensed to practice in the state. **3.** The Dental director must comply with applicable federal and state statutes and regulations. **4.** The Dental Director must be available Monday through Friday, between 8 AM and 5 PM Central Time for Utilization Review decisions, and must be authorized and empowered to represent the Dental Benefit Manager (DBM) regarding clinical issues, Utilization Review and quality-of-care inquiries.
Behavioral Health Clinical Director	The Behavioral Health Clinical Director must be a currently practicing psychiatrist or psychologist with an unrestricted license in the state. The Behavioral Health Clinical Director must have a minimum of five (5) years of combined clinical experience in MH and substance use disorder services and be knowledgeable about primary care/behavioral health integration. This individual must oversee and be responsible for all BH activities within the MCO and take an active role in the MCO's medical management team, and in clinical and policy decisions. The Behavioral Health Clinical Director is responsible for:

	1. Providing clinical case management consultations and clinical guidance for contracted PCPs treating BH-related concerns not requiring referral to BH specialists; 2. Developing comprehensive care management programs for youth and adults with behavioral health concerns, typically treated by PCPs, such as Attention Deficit Hyperactivity Disorder (ADHD) and depression; and 3. Developing targeted education and training for the MCO's PCPs that commonly encounter behavioral health issues.
Behavioral Health Manager*	The Behavioral Health Manager must be a state-licensed BH professional, such as a psychologist, psychiatrist, social worker, psychiatric nurse, marriage and family therapist, or mental health counselor. The responsibilities of the Behavioral Health Manager include, but are not limited to: 1. Ensuring that the MCO's BH operations, providers, and any subcontractors are in compliance with the terms of this contract; and 2. Coordinating with all areas of the MCO, including quality management, utilization management, network development and management, provider services, member outreach and education, member services, contract compliance, and reporting.
Chief Operating Officer (COO)*	The COO is responsible for: 1. Managing the day-to-day operations of the MCO's departments, staff, and functions to ensure that performance measures and MLTC and Federal requirements are met; and 2. May serve as the primary contact with MLTC for all MCO operational issues.
Chief Financial Officer (CFO)*	The CFO is responsible for overseeing all financial-related supervision of activities implemented by the MCO, including all audit activities, accounting systems, financial reporting, and budgeting.
Program Integrity Officer*	The Program Integrity Officer must have experience in health care and/or risk management and report directly to the CEO. The Program Integrity Officer is responsible for: 1. Overseeing all activities required by state and federal rules and regulations related to the monitoring and enforcement of the fraud, waste, abuse (FWA) and erroneous payment compliance program; 2. Developing/overseeing methods to prevent and detect potential FWA and erroneous payments; 3. Developing policies and procedures, investigating unusual incidents, and designing/implementing any corrective action plans; 4. Reviewing records and referring suspected member FWA to MLTC and other duly authorized enforcement agencies; 5. Managing the MCO's Special Investigations Unit to communicate with the State's Medicaid Fraud Control Unit; and 6. Being the primary point of contact for MLTC Program Integrity.
Grievance System Manager*	The Grievance System Manager is responsible for: 1. Managing/adjudicating member grievances, appeals, and requests for fair hearing; and 2. Managing/adjudicating provider grievances and appeals.
Business Continuity Planning and Emergency Coordinator	The Business Continuity Planning and Emergency Coordinator is responsible for: 1. Ensuring continuity of benefits and services for members who may experience evacuation to other areas of the state, or out-of-state, during disasters; and 2. Managing and overseeing the MCO's emergency management plan.
Contract Compliance Officer*	The Contract Compliance Officer will be the primary contact with MLTC on all MCO contract compliance issues and report directly to the CEO. This individual is responsible for: 1. Overseeing all activities required by the contract, state and federal rules and regulations related to the coordination, preparation, and execution of contract requirements; 2. Coordinating the tracking and submission of all contract deliverables;

	3. Answering inquiries from MLTC; and **4.** Coordinating/performing random and periodic audits and ad hoc visits.
Quality Management (QM) Coordinator*	The QM Coordinator must be a state-licensed registered nurse, physician, or physician's assistant; a Certified Professional in Health Care Quality (CPHQ), certified by the National Association for Health Care Quality; or certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers. This position must be committed to this contract on a full-time basis (a minimum of 40 hours per week). The QM Coordinator must have quality management and improvement experience as described in 42 CFR §§ 438.200 - 438.242. This individual is responsible for: **1.** Ensuring systemic and individual quality of care; **2.** Identifying and implementing process improvements; **3.** Integrating quality throughout the organization; **4.** Ensuring a network of credentialed providers; **5.** Resolving, tracking, and trending quality of care grievances; and **6.** Serving as a member of the Quality Assurance Performance Improvement Committee and member/ad hoc member of other quality related committees.
Performance and Quality Improvement Coordinator*	The Performance and Quality Improvement Coordinator must, at minimum, be a CPHQ or CHCQM or have comparable experience and education in data and outcomes measurement as described in 42 CFR §§ 438.200 - 438.242. The Performance and Quality Improvement Coordinator serves as MLTC's contact person for quality performance measures. Primary responsibilities include: **1.** Focusing organizational efforts on the improvement of clinical quality performance measures; **2.** Utilizing data to develop intervention strategies to improve outcomes; **3.** Developing and implementing performance improvement projects, both internal and across MCOs; and **4.** Reporting quality improvement and performance outcomes to MLTC.
Maternal Child Health (MCH)/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coordinator*	The MCH/EPSDT Coordinator must be a current, Nebraska-licensed registered nurse, physician, or physician's assistant; have a master's degree in health services, public health, health care administration, or other related field; or be a CPHQ or CHCQM. Staffing under this position must be sufficient to meet quality and performance measure goals. The coordinator is responsible for: **1.** Designing programs to ensure that all member children receive necessary EPSDT services; **2.** Promoting family planning services; **3.** Promoting preventive health strategies; **4.** Designing programs to ensure that all pregnant members receive maternal and postpartum care; **5.** Identifying and coordinating assistance for identified member needs, specific to maternal/child health and EPSDT; and **6.** Interfacing with community partners.
Medical Management Coordinator*	The Medical Management Coordinator must be a state-licensed registered nurse, physician, or physician's assistant if they are required to make medical necessity determinations. If the position is not required to make medical necessity determinations, this individual may have a master's degree in health services, health care administration, or business administration. The Medical Management Coordinator's responsibilities include: **1.** Developing, implementing, and monitoring the provision of care coordination, disease management (DM), and case management functions; **2.** Ensuring the adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria; **3.** Ensuring the completion of appropriate concurrent review and discharge planning of inpatient stays; **4.** Monitoring, analyzing, and implementing appropriate interventions based on utilization data, including the identification and correction of over- or under-utilization of services; and

	5. Monitoring prior authorization functions and ensuring that decisions are made in a consistent manner, based on clinical criteria, and that all decisions meet timeliness standards.
Provider Services Manager*	The Provider Services Manager is responsible for: **1.** Coordinating communications between the MCO and its subcontracted providers; **2.** Managing the Provider Services staff; **3.** Working collaboratively with the Provider Advisory Committee to establish methodologies for processing and responding to provider concerns; **4.** Developing provider training in response to identified needs or changes in protocols, processes, and forms; **5.** Enhancing MCO-provider communication strategies; **6.** Notifying MLTC of correspondence sent to providers for informational and training purposes; and **7.** Participating in the MLTC Administrative Simplification Committee.
Member Services Manager*	The Member Services Manager is responsible for: **1.** Coordinating communications between the MCO and its members; **2.** Ensuring that there are sufficient member services representatives, including sufficient culturally and linguistically appropriate services, to enable members to receive prompt resolution of their problems or questions and appropriate education about participation in the Medicaid managed care program; and **3.** Managing the Member Services staff.
Claims Administrator	The Claims Administrator is responsible for: **1.** Developing, implementing, and administering a comprehensive Nebraska Medicaid Managed Care claims processing system capable of paying claims in accordance with state and federal requirements and the terms of this contract; **2.** Developing cost avoidance processes; **3.** Meeting claims processing timelines; **4.** Ensuring minimization of claims recoupments; and **5.** Meeting MLTC encounter reporting requirements.
Provider Claims Educator	The Provider Claims Educator must be knowledgeable concerning the MCO's Nebraska Medicaid Managed Care grievance, claims processing, and provider services systems and facilitate the exchange of information between these systems and providers. This individual must have a minimum of five (5) years management and supervisory experience in a health care field. The Provider Claims Educator is responsible for: **1.** Educating in-network and out-of-network providers on claims submission requirements, coding updates, electronic claims transactions and electronic fund transfers, and available MCO resources, such as provider manuals, websites, provider training materials, and fee schedules; **2.** Communicating frequently with providers to ensure the effective exchange of information and to obtain feedback regarding the extent to which providers are informed about appropriate claims submission practices; **3.** Identifying trends and guiding the development and implementation of strategies to improve provider satisfaction; and **4.** Working with the MCO's call center to compile, analyze, and disseminate information from provider calls that indicate a need for education or process improvements.
Case Management Administrator*	The Case Management Administrator must have experience as a case manager with a minimum of five (5) years management or supervisory experience in a health care field. The Case Management Administrator is responsible for: **1.** Overseeing the MCO's case management functions; **2.** Working with other MCO staff to ensure that members' case management needs are met; and **3.** Working with the Medical Director and other medical management staff to ensure that the MCO has case management policies/protocols that comply with federal and state requirements.

Information Management and Systems Director	The Information Management and Systems Director must have relevant training and a minimum of seven (7) years of experience in information systems, data processing, and data reporting to oversee all MCO information systems functions. The Information Management and Systems Director is responsible for: **1.** Establishing and maintaining connectivity with MLTC information systems; and **2.** Providing necessary and timely data and reports to MLTC.
Encounter Data Quality Coordinator	The Encounter Data Quality Coordinator is responsible for: **1.** Organizing and coordinating services and communication between MCO administration and MLTC for the purpose of identifying, monitoring, and resolving encounter data validation and management issues; **2.** Serving as the MCO's encounter expert to answer questions, provide recommendations, and participate in problem-solving and decision-making related to encounter data processing and submissions; and **3.** Analyzing activities related to the processing of encounter data and data validation studies to enhance accuracy and output.
Tribal Network Liaison*	The Tribal Network Liaison is responsible for: **1.** Planning and working with Provider Services staff to expand and enhance physical, behavioral health, and dental services for American Indian members; **2.** Serving as the single point of contact with tribal entities and all MCO staff on American Indian issues and concerns; and **3.** Advocating for American Indian members with case management and member services staff.
Pharmacist/Pharmacy Director*	The MCO Pharmacist/Pharmacy Director must be a registered pharmacist with a current state license. The MCO Pharmacist/Pharmacy Director must have a minimum of three (3) years of experience supporting formularies, designing prior authorization requirements, and working with clinical information. The Pharmacist/Pharmacy Director is responsible for: **1.** Overseeing the prescription drug and pharmacy benefits; **2.** Leading and coordinating formulary and preferred drug list implementation, evaluation, training, reporting, and problem solving; **3.** Consulting on and coordinating pharmacy program changes; **4.** Understanding clinical pharmacy and drug product information to support plan benefit design in the point of sale system; **5.** Overseeing, monitoring, and assisting with the management of pharmacy benefit manager (PBM) activities; **6.** Managing the prospective and retrospective drug utilization review (DUR) activities; **7.** Supporting call center prior authorization programs and their development/modification; **8.** Attending MLTC Pharmacy and Therapeutics Committee and DUR Board meetings; and **9.** Meeting with MLTC staff and the MCO's PBM, no less than monthly, to discuss operational status updates, including the call center, POS system, grievances, and prior authorizations; as well as review performance standards and restricted services grievances and appeals.

3. Additional Staffing Requirements

a. Prior authorization staff must include a state-licensed registered nurse or physician's assistant. Staff must work under the direction of the Medical Director or the Medical Management Coordinator (if this person is a state-licensed registered nurse or physician's assistant) to **authorize health care services (in compliance with contract requirements) at any time.**

b. Prior authorization dental staff must include a state-licensed dentist or dental hygienist. Staff must work under the direction of the Dental Director or the Dental Management Coordinator (if this person is a state-licensed dentist or dental hygienist) to authorize dental health care services (in compliance with contract requirements) at any time.

c. Concurrent review staff must include a state-licensed registered nurse or physician's assistant. Staff must work under the direction of the Medical Director or the Medical Management Coordinator (if this person is a state-licensed registered nurse or physician's assistant) to conduct inpatient concurrent reviews.

d. Concurrent dental review staff must include a state-licensed dentist or dental hygienist. Staff must work under the direction of the Dental Director or the Dental Management Coordinator (if this person is a state-licensed dentist or dental hygienist) to conduct inpatient concurrent reviews.

e. The MCO must employ clerical and support staff to ensure the proper functioning of the MCO's operation.

f. The MCO must employ provider services staff to enable providers to receive prompt resolution of their problems and inquiries and appropriate education about participation in the MCO program. There must be sufficient staff to maintain/enhance the MCO's provider network to meet MLTC's network standards and work with grievances and appeals staff to resolve provider grievances and disputes on a timely basis. The MCO must designate a local individual to serve as a liaison for behavioral health providers and dental providers.

g. The MCO must employ member services staff to enable members to receive prompt responses and assistance. There must be sufficient member services staff at all times to provide culturally and linguistically appropriate services.

h. The MCO must employ claims processing staff to ensure the timely and accurate processing/adjudication of original claims and resubmissions. The MCO must have a staff of qualified, trained and appropriately licensed personnel, consistent with National Committee for Quality Assurance accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity.

i. The MCO must employ encounter processing staff to ensure the timely and accurate processing and submission to MLTC of encounter data and reports.

j. The MCO must employ care management staff to assess, plan, facilitate, and advocate options and services to meet members' health and social needs. The staff must use communication and available resources to promote quality, cost-effective outcomes. The MCO is required to provide and maintain appropriate levels of care management staff in Nebraska to ensure adequate local geographical coverage for face-to-face contact with physicians and members as appropriate and may include additional out-of-state staff providing telephone consultation and support.

k. The MCO must employ FWA investigative staff to detect and investigate FWA activities. The staff is responsible for preparing and updating the fraud and abuse compliance plan, conducting MCO employee training and monitoring, investigating a sample of paid claim discrepancies, and responding to provider investigation-related inquiries/issues. Each FWA investigator must have a bachelor's degree; an associate's degree plus a minimum of two (2) years' experience as a licensed health care provider or auditor; a minimum of four (4) years' experience as a certified coder or billing specialist; or, a minimum of five (5) years law enforcement, health care oversight, compliance, or auditing experience. The MCO must have a minimum of one (1) investigator for every fifty thousand (50,000) members or fewer.

l. All additional required staff in this section must be located in Nebraska with the exception of claims and encounter processing staff, customer services representatives staffing the toll-free call center, and certain care management staff.

m. The MCO must employ a Non-Emergency Medical Transportation (NEMT) Network Coordinator, responsible for receiving and processing provider inquiries and complaints, investigating provider complaints, and referring complaints to the Public Service Commission (PSC) for transportation providers governed by the PSC. The NEMT Network Coordinator is also responsible for resolving provider issues to include, but not be limited to, payment delays. This position must be available to meet personally with transportation providers, but is not required to be located in Nebraska**.**

4. Care Management and Utilization Management Staff Requirements

a. As part of its care management operations, the MCO must employ a multidisciplinary clinical staff, care coordinators, and care managers to arrange, assure delivery of, monitor, and evaluate basic and comprehensive care, treatment, and services to members. The MCO must ensure an adequate ratio of staff to members to perform all care management functions as described in

Section V.L Care Management of the RFP. Sufficient staff must be available to respond at any time to members, their families/caregivers, or other interested parties calling on behalf of a member.

b. The MCO must ensure that only licensed clinical staff operating within the scope of their training and professional licenses make decisions regarding medical necessity.

5. Position Descriptions

The MCO must develop and maintain written position descriptions for each functional area, consistent in format and style. All job descriptions must be reviewed by the MCO on an annual basis, at a minimum, to ensure they reflect current practices.

6. Staff Training and Meeting Attendance

a. The MCO must ensure that all staff members, including subcontractors, have training, education, experience, and orientation to complete their job responsibilities. MLTC may require additional staffing for an MCO that has substantially failed to maintain compliance with any provision of the contract or MLTC policies.

b. The MCO must provide initial and ongoing staff training that includes an overview of MLTC and its policies, the contract, and state and federal requirements specific to individual job functions. The MCO must ensure that all staff members who have contact with members or providers receive initial and ongoing training with regard to program changes, prior authorization modifications, and the appropriate identification and handling of quality-of-care/service concerns.

c. The MCO must educate staff concerning its policies and procedures on advance directives in accordance with 42 CFR §422.128.

d. A growing body of evidence points to a correlation between social factors and increased occurrences of specific health conditions and a general decline in health outcomes. All MCO staff must be trained on how social determinants affect members' health and wellness. This training must include, but not be limited to, issues related to housing, education, food, physical and sexual abuse, violence, and risk and protective factors for BH concerns. Staff must also be trained on finding community resources and making referrals to these agencies and other programs that might be helpful to members.

e. The MCO must provide training for staff on the needs of the Long-Term Services and Supports (LTSS) population, including individuals with developmental disabilities and mental health concerns.

f. New and existing prior authorization, provider services, and member services staff must be trained in the geography of Nebraska, as well as the culture and correct pronunciation of cities, towns, and surnames. Appropriate staff must have access to a global positioning system or a mapping search engine for the purposes of authorizing services, recommending providers, and transporting members to the most geographically appropriate locations.

g. The MCO must provide the appropriate staff representation in meetings or events scheduled by MLTC. All meetings are considered mandatory unless otherwise notified by MLTC.

h. MLTC reserves the right to attend any and all training programs and seminars conducted by the MCO. The MCO must provide MLTC a list of any training dates, times, and locations a minimum of fourteen (14) calendar days prior to their occurrences.

E. COVERED SERVICES AND BENEFITS

1. General Provisions

a. The MCO must have available, for members immediately upon their Medicaid effective date, at a minimum, those benefits and services specified in the RFP, and as defined in the Nebraska Medicaid State Plan, administrative rules, and MLTC policy and procedures. The MCO must possess the expertise and resources to ensure the delivery of quality health care services to its members in accordance with Nebraska Medicaid program standards and the prevailing local and national medical standards.

b. The MCO must provide a mechanism to reduce clinically inappropriate and duplicative use of health care services including, but not limited to, non-emergent use of hospital emergency departments (EDs).

c. The MCO must provide care coordination of services for members. The MCO must ensure that in the process of coordinating care that each member's privacy is protected in accordance with federal and state requirements.

d. MCO must provide a network of health care services rendered by credentialed providers who are licensed or certified in Nebraska, enrolled as MLTC providers, and practicing within their scopes of practice. The MCO must ensure equitable health care for all its members, regardless of the member's eligibility category.

e. The MCO must comply with any future legislative and regulatory changes regarding covered services and benefits unless those changes specifically exempt managed care.

f. The MCO must provide its policies regarding this section to MLTC for approval a minimum of sixty (60) calendar days prior to their implementation.

2. Amount, Duration and Scope

a. MCO must provide services that are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and must be no less than those furnished under FFS Medicaid, as specified in 42 CFR § 438.210(a). Upward variances of amount, duration, and scope of these services are allowed.

b. The MCO must ensure access to and timeliness of services in a similar amount, duration, and scope as those available to other insured individuals in the same service area.

c. The MCO may not arbitrarily deny or reduce the amount, duration, or scope of a clinically appropriate service solely because of the diagnosis, type of illness, or condition of the member. However, the MCO may place clinically appropriate limits on service delivery, such as applying medical necessity criteria or clinical practice guidelines for utilization control, provided the services that are delivered can be reasonably expected to achieve their purpose within that time frame.

3. Behavioral Health Parity

a. The MCO must comply with the most current Mental Health Parity and Addiction Equity Act (MHPAEA)

b. The MCO must:

i. Employ medical management techniques to MH and substance use disorder benefits comparable to, and applied no more strictly than, the medical management techniques applied to medical and surgical benefits;

ii. Ensure compliance with MHPAEA for any benefits offered by the MCO to members beyond those specified in the Medicaid State Plan;

iii. Make the medical necessity criteria used for coverage determinations for MH and substance use disorder benefits available to the member or the member's requesting provider if requested;

iv. Provide the rationale for a denial of coverage for MH or substance use disorder benefits to the member and the requesting provider;

v. Provide access to out-of-network MH and substance use disorder benefits comparable with out-of-network medical and surgical benefits; and

vi. Submit the Mental Health and Substance Use Disorder Parity report. Reporting requirements and frequency of submission are contained in Attachment 13 – Reporting Requirements. The MCO will report on the design and application of managed care practices such as prior authorization, reimbursement rate setting, and network design.

c. The MCO may not impose an annual dollar limit on MH or substance use disorder benefits per 42 CFR § 438.905 (b). Any financial, quantitative or non-quantitative limits in force must be applied consistently for medical/surgical, MH, and substance use disorder benefits per 42 CFR § 438.910.

d. The MCO may not impose a non-quantitative treatment limitation for MH or substance use disorder benefits in any classification unless, under the policies and procedures of the MCO, Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to MH or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the process, strategies, and evidentiary standards or other factors used in applying the limitation for medical/surgical benefits in the classification per 42 CFR § 438.910.

4. Medically Necessary Services

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

i. The prevention, diagnosis, and treatment of health impairments;

ii. The ability to achieve age-appropriate growth and development; and

iii. The ability to attain, maintain, or regain functional capacity.

b. The MCO must provide at minimum the services set forth in the Nebraska Medicaid program.

5. Second Opinion

When requested by the member, the MCO must provide a second opinion from a qualified health care professional within the network or arrange for the member to obtain one outside the network, at no cost to the member.

6. Value-Added Services

a. As permitted under 42 CFR § 438.3(e), and to the extent consistent with provisions of state law, the MCO may, in its discretion, offer expanded services and benefits to members in addition to those benefits and services specified in this section of the RFP.

b. These expanded services and benefits must, in the judgment of the MCO, be medically appropriate and bring value to the health outcomes of its members. These value-added services may include health care services that are currently non-covered services by the Medicaid State Plan. They may include services that are in excess of the amount, duration and scope within the Medicaid State Plan.

c. Value-added services must be specifically defined by the MCO with regard to amount, duration, and scope. MLTC will not provide any additional reimbursement to the MCO for value-added Services. Encounter data for these value-added services must not be submitted to MLTC.

d. MCO must provide to MLTC a description of the value-added services to be offered by the MCO for approval at a date to be determined by MLTC. Additions, deletions, or modifications to value-added services made during the contract period must be submitted to MLTC for approval a minimum of forty-five (45) calendar days prior to their implementation.

e. MLTC priorities that can be addressed through value-added services may include:

i. Reduction in non-emergent use of the ED through increased access to:

a) Same day clinic visits;
b) After-hours clinic care;
c) Urgent care; or
d) Member education.

ii. Improved maternal and child outcomes in prenatal, postnatal, and inter-pregnancy care through:

a) Screening for maternal depression;
b) Reduction in substance use disorder (SUD) and tobacco use through screening and prevention services;
c) Reduction in primary cesarean sections;
d) Support personnel to help patients navigate complex health systems; and
e) Home visits.

f. Value-added services are not Medicaid-funded and, as such, are not subject to appeal and fair hearing rights. A denial of these services will not be considered an action for purposes of grievances and appeals. The MCO must send the member a notification letter if a value-added service is not approved.

g. Transportation to obtain value-added services is the responsibility of the member or the MCO, at the discretion of the MCO.

7. Telehealth Services

a. The MCO must cover medically necessary telehealth services at a rate comparable to an in-person clinic encounter.

b. The MCO may reimburse the originating site if encounter occurs in a clinic setting.

c. The MCO must ensure health care providers that provide telehealth follow all applicable federal and state and regulations governing their practice and the services they provide.

d. All telehealth communications must comply with all applicable federal and state requirements regarding privacy and security, as well as those related to efficiency, economy, and quality of care.

8. Telemonitoring Services

a. The MCO must, at a minimum, cover telemonitoring services for medical conditions as specified by MLTC.

b. The MCO must ensure that the health care provider's medical record contains documentation to support:

i. Medical necessity for telemonitoring;
ii. All transmitted data;
iii. Health care provider review of the transmitted data;
iv. Application of the transmitted data for continuous development and implementation of the member's plan of care;
v. The member is cognitively capable of operating the equipment or has a willing and able person to assist in the transmission of the electronic data; and
vi. The originating site has space for all program equipment and full transmission capability.

9. Core Benefits and Services

a. At a minimum, the MCO must provide the following Physical Health Services to its members:

- **i.** Inpatient hospital services;
- **ii.** Outpatient hospital services;
- **iii.** Ambulatory surgical center (ASC) services;
- **iv.** Acute rehabilitation services;
- **v.** Skilled (rehabilitation) nursing facility services;
- **vi.** Swing-bed services;
- **vii.** Transplant services;
- **viii.** Free-standing birth center services;
- **ix.** Hospice services, except when provided in a nursing facility;
- **x.** Physician services, including services provided by nurse practitioners, certified nurse midwives, and physician assistants;
- **xi.** Anesthesia services including those provided by a certified registered nurse anesthetist;
- **xii.** Services provided in federally-qualified health centers (FQHCs) and rural health clinics (RHCs);
- **xiii.** Services provided in Indian Health Service (IHS) facilities;
- **xiv.** Clinical and anatomical laboratory services, including specimen collection when applicable, and blood draws in a behavioral health clinic;
- **xv.** Radiology services;
- **xvi.** EPSDT services;
- **xvii.** Home health services;
- **xviii.** Private duty nursing services;
- **xix.** Therapy services such as physical therapy, occupational therapy, speech therapy, audiology, and respiratory therapy;
- **xx.** Durable medical equipment and medical supplies, including hearing aids, orthotics, prosthetics, and nutritional supplements;
- **xxi.** Podiatry services;
- **xxii.** Chiropractic services;
- **xxiii.** Eye care and vision services;
- **xxiv.** Clinic-administered injections/medications;
- **xxv.** Nutrition services;
- **xxvi.** Ambulance services; and
- **xxvii.** Non-emergency medical transportation.

b. At a minimum, the MCO must provide the following Behavioral Health Services to its members:

- **i.** Services for children in Distinct Age Ranges including:
  - a) Child-parent psychotherapy ages birth to five (5);
  - b) Parent child interaction therapy ages two (2) to twelve(12);
  - c) Functional family therapy-ages ten (10) to eighteen (18); and
  - d) Multi-systemic therapy ages twelve (12) to seventeen (17).

- **ii.** Services for individuals age twenty (20) and under including:
  - a) Crisis stabilization services including treatment crisis intervention;
  - b) Inpatient psychiatric hospital: acute and sub-acute;
  - c) Psychiatric residential treatment facility; and
  - d) Outpatient assessment and treatment including:
    - **1).** Initial diagnostic interview;
    - **2).** Partial hospitalization;
    - **3).** Intensive outpatient;
    - **4).** Day treatment;
    - **5).** Medication management including long-acting psychotropics;
    - **6).** Outpatient therapy: individual, family, and group;
    - **7).** Psychological evaluation and testing;
    - **8).** Substance use disorder treatment;
    - **9).** Sex offender risk assessment;
    - **10).** Community treatment aide (CTA) services;
    - **11).** Hospital observation room services up to twenty-three (23) hours and fifty-nine (59) minutes;
    - **12).** Applied behavioral analysis; and
    - **13).** Peer support.

- **iii.** Rehabilitation services including:
  - a) Intensive outpatient;

b) Day treatment;
c) Therapeutic group home;
d) CTA services;
e) Professional resource family care; and
f) Community support.

iv. Services for individuals age eighteen (18) and older including:
a) American Society of Addiction Medicine (ASAM) Level 3.2D - Social detoxification (per diem);
b) ASAM Level 2.1 - Adult Intensive Outpatient (per hour);
c) ASAM Level 3.5 Short-Term Residential (co-occurring diagnosis capable) per diem;
d) ASAM Level 3.5 Dual-Disorder Residential (co-occurring diagnosis enhanced) per diem;
e) ASAM Level 3.3 - Intermediate Residential (co-occurring diagnosis capable) per diem; and
f) ASAM Level 3.3 Therapeutic Community (co-occurring diagnosis capable) per diem.

v. Services for individuals age nineteen (19) and twenty (20) including, rehabilitation services:
a) ASAM Level 1 Community Support;
b) Day rehabilitation; and
c) ASAM Level 3.1 Halfway House.

vi. Services for adults ages twenty-one (21) and over including:
a) Crisis stabilization services includes treatment crisis intervention;
b) Inpatient psychiatric hospital services: acute and sub-acute; and
c) Outpatient assessment and treatment:
1). Intensive diagnostic interview;
2). Partial hospitalization;
3). Intensive outpatient;
4). Day treatment;
5). Medication management. Including long-acting psychotropics;
6). Outpatient therapy: individual, family, and group;
7). Psychological evaluation and testing;
8). Substance use disorder treatment;
9). Electroconvulsive therapy;
10). In-home psychiatric nursing; and
11). Peer support.

vii. Rehabilitation services including:
d) Dual-disorder residential;
e) Short-term residential;
f) Intermediate residential for SUD;
g) Halfway house;
h) Therapeutic community for SUD only;
i) Community support;
j) Psychiatric residential rehabilitation;
k) Secure residential rehabilitation;
l) Assertive community treatment (ACT) and alternative (alt) ACT;
m) Social detoxification;
n) ASAM Level 1 Community Support;
o) Day rehabilitation; and
p) ASAM level 3.1 Halfway House.

10. Laboratory and Radiology Services

a. The MCO must provide coverage for inpatient and outpatient laboratory testing, therapeutic radiology, and radiology services ordered or performed by network providers.

b. The MCO must provide coverage for clinical lab services and portable (mobile) X-rays for members who are unable to leave their place of residence without special transportation or assistance to obtain these services.

c. The MCO may require authorization for laboratory and radiology services ordered or performed by any provider.

11. Eye Care and Vision Services

The MCO must provide to all members any medically necessary eye care, vision examinations, prescriptive lenses, frames, and treatments. Eye care and vision services are to be performed by a state licensed ophthalmologist or optometrist, conforming to accepted methods of screening, diagnosis, and treatment.

12. Pharmacy Services

a. The MCO must provide coverage for all drugs and therapeutic classes of drugs covered by the Nebraska Medicaid pharmacy benefit and must follow the Nebraska Medicaid preferred drug list (PDL).

b. The MCO must provide its members with a network of outpatient pharmacy services as set forth under Section 1927 of the Social Security Act and described in the Medicaid State Plan.

c. The MCO must provide coverage for medications to prevent or treat disease for members under twenty-one (21) years of age.

d. The MCO may manage utilization of drugs through processes that may include, but are not limited to, prior authorization, utilization, and clinical edits.

e. The MCO must submit any proposed pharmacy service or coverage changes to MLTC for review and approval a minimum of one hundred and twenty (120) calendar days prior to the Contract Start Date and forty-five (45) calendar days prior to the proposed implementation date of any change following the Contract Start Date.

f. The MCO must have procedures in place to provide a seventy-two (72) hour supply of medication to a member in the event of an emergency situation on the weekends, holidays, or during off-hours.

- **i.** A seventy-two (72) hour emergency supply is available when waiting for a prior authorization after reasonable attempt to notify a prescriber.
- **ii.** Emergency supply should not be used for routine and continuous over-rides.
- **iii.** Follow 42 CFR § 1306.13 on seventy-two (72) hours supply and prior authorization.

g. For restricted service members, emergency care is defined as medically necessary services provided to a member who requires immediate medical attention to sustain life or to prevent any condition which could cause permanent disability to body functions as defined in 471 NAC § 1 005.03(A).

h. The MCO must maintain a website with current and accurate information on its pharmacy services. Such information must include, but is not limited to the following:

- **i.** An MCO drug formulary and the Nebraska Medicaid PDL;
- **ii.** An over-the-counter (OTC) drug list;
- **iii.** OTC products covered under the durable medical equipment (DME) or pharmacy service benefit;
- **iv.** A list of covered vaccines;
- **v.** Compound prescriptions specifications;
- **vi.** Prior authorization and step-therapy requirements for medications covered under MCO pharmacy services and Nebraska Medicaid PDL;
- **vii.** MCO's maximum allowable cost (MAC) pricing;
- **viii.** Instructions for members on how and whom to contact for questions regarding filling a prescription;
- **ix.** Toll-free call center numbers and hours of operation; and
- **x.** Instructions for providers on pharmacy claim submission that must include, but is not limited to:
  - a) A payer sheet;
  - b) Paper claim submission instructions;
  - c) Compound prescription claim submission instructions; and
  - d) Other claims submitted under pharmacy benefit or point-of-sale transactions such as DME, medical supplies, or vaccine administration.

i. MCO Formulary

- **i.** The MCO must cover medications that meet the definition of outpatient pharmacy services eligible for Medicaid coverage as set forth under Section 1927 of the Social Security Act.
- **ii.** The MCO must submit the formulary for review and approval by MLTC a minimum of one hundred and twenty (120) calendar days prior to the Contract Start Date.
- **iii.** The MCO must submit all proposed formulary changes to MLTC for review and approval a minimum of forty-five (45) calendar days prior to the proposed implementation date.
- **iv.** The MCO must submit any proposed changes to the formulary, prior authorization and step-therapy criteria to MLTC for review and approval a minimum of forty-five (45) calendar days prior to the proposed implementation date.
- **v.** The MCO formulary may only exclude coverage for drugs or drug categories permitted under Section 1927(d) of the Social Security Act.
- **vi.** The MCO must provide coverage for prescription drugs that are approved by the United States Food and Drug Administration (FDA), distributed by a labeler who participates in the Medicaid Drug Rebate Program, and are medically necessary either by addition of the drugs to the formulary or through prior authorization within ten (10) calendar days from their availability in the marketplace.
- **vii.** The MCO must, at a minimum, follow the Nebraska Medicaid PDL for specifics on off-label drug use.
- **viii.** The MCO must support e-prescribing transactions including, but not limited to, member eligibility, formulary and benefit, and medication history. All transactions and data feeds to support e-prescribing must remain compliant with the National Council for Prescription Drug Programs (NCPDP) and the CMS-defined NCPDP SCRIPT standard version and supporting transactions. All changes to support updates to the SCRIPT standard are the responsibility of the MCO and must be updated on a timeline to meet CMS-defined implementation dates at no cost to MLTC.
- **ix.** The MCO may require prior authorization for an outpatient prescription drug, or medical device and must:
  - a) Comply with the requirements for prior authorization in accordance with Section 1927 of the Social Security Act; and
  - b) Provide coverage determination to the prescriber and pharmacy, via means such as telephone, fax, provider portal, email, or electronic transmission, indicating approval or denial of the prior authorization request within one (1) business day of the request.
- **x.** The MCO must be able to cross-reference drug databases such as Medi-Span and First Databank (FDB). MLTC may communicate coverage decisions using either classification system. The MCO must determine equivalent benefit designation for either drug database.

j. Nebraska Medicaid Preferred Drug List

- **i.** The MCO must follow the Nebraska Medicaid PDL and its class criteria. Preferred drugs must be adjudicated as payable without prior authorization, unless they are subject to clinical or utilization edits, as defined by MLTC. The PDL is subject to change on an ongoing basis.
- **ii.** MLTC's PDL vendor will provide, to the MCO, a weekly national drug code (NDC) file delegating the preferred or non-preferred status of each NDC. The MCO must begin updating the pharmacy claim system within twenty-four (24) hours or one (1) business day of receiving the PDL file. Loading must be completed within five (5) business days.
- **iii.** At the direction of MLTC, the MCO must perform off-cycle PDL file updates within twenty-four (24) hours of file receipt of the PDL file. Loading must be complete within five (5) business days.
- **iv.** The MCO must implement on the first day after the thirty (30) calendar day public notice posting, all PDL changes recommended by the Pharmaceutical and Therapeutics Committee that have been approved by MLTC and posted to the MLTC PDL website.
- **v.** The MCO is not authorized to and must not negotiate rebates with manufacturers for drugs listed on the PDL. MLTC or its designee will negotiate rebate agreements. Regardless if the MCO or its PBM has an existing rebate agreement with a manufacturer, all Nebraska Medicaid outpatient drug claims, including provider-administered drugs, must be rebatable exclusively to MLTC.
- **vi.** The MCO must nominate a non-voting member to attend the Nebraska Pharmaceutical and Therapeutics Committee's biannual meetings during the term of this contract. The MCO must obtain MLTC's written approval of the nominee.

k. OTC Medications, Supplies and Devices

- **i.** MCO must provide coverage for and maintain a current rebatable OTC drug list.
- **ii.** The MCO must, at a minimum, cover the OTC drugs listed in the Nebraska Medicaid preferred drug list (PDL).
- **iii.** The MCO must submit a list of covered OTC drugs for review and approval by MLTC a minimum of one hundred and twenty (120) calendar days prior to the Contract Start Date.

13. EPSDT Services

a. EPSDT is a comprehensive and preventive child health program for members under the age of twenty-one (21). The EPSDT statute and Federal Medicaid regulations require that states cover all services within the scope of the Federal Medicaid program, including services not included in a state's Medicaid State Plan, if necessary, to correct or ameliorate a known medical condition (42 U.S.C. § 1396d(r)(5) and the CMS Medicaid State Manual). The program consists of two (2) mutually supportive, operational components: (1) ensuring the availability and accessibility of required health care services; and (2) helping Medicaid members and their parents or guardians effectively use these services. The intent of the EPSDT program is to direct attention to the importance of preventive health services and early detection and treatment of identified problems.

b. The MCO must provide:

- **i.** Comprehensive medically necessary health care services encompassing screening, prevention, diagnosis and treatment;
- **ii.** Education that informs parents and guardians of the benefits of EPSDT screening, diagnosis, and treatment services;
- **iii.** Education that assists parents and guardians to make responsible decisions about preventive health care and appropriate utilization of health care services for their children;
- **iv.** Assistance to families in making medical appointments and obtaining needed transportation; and
- **v.** Tracking and follow up to ensure medically necessary EPSDT services are provided, within established time frames as defined by the American Academy of Pediatrics periodicity schedule.

c. The MCO must have written policies and procedures for EPSDT services in compliance with 42 CFR Part 441 Subpart B, as well as the CMS State Medicaid Manual, Part 5 – EPSDT. These regulations and resources outline the requirements for EPSDT, including assurance that all MCO members eligible for EPSDT are notified of EPSDT available services.

d. The MCO must provide coverage for all medically necessary services including behavioral health services even if not specified in the Nebraska Medicaid State Plan, except those services that are listed as excluded services in this RFP.

e. The MCO must facilitate access to medically necessary health care services, including behavioral health services, recommended during an EPSDT examination when requested by the member or their parent/guardian.

f. The MCO must accurately report, via encounter data submissions, all EPSDT and well-child services, blood lead screening, access to preventive services, and any other services required for MLTC to comply with federally mandated CMS 416 reporting requirements.

14. Immunizations

a. The MCO must provide all vaccines in accordance with the Advisory Committee on Immunization Practices guidelines to all members under twenty-one (21) years of age.

b. The MCO must ensure that all Vaccine for Children (VFC) providers use vaccines available to them at no cost under the VFC program. This program provides vaccines to Medicaid children eighteen (18) years old and younger.

c. The MCO must reimburse VFC providers for the VFC vaccine administration fee even when the member has insurance primary to Nebraska Medicaid coverage.

d. MCO must contractually require providers to report required vaccination data to the Nebraska State Immunization Information System (NESIIS), administered by DHHS/Division of Public Health.

15. Emergency Medical and Post-Stabilization Services

a. Emergency Services

i. The MCO must provide coverage for emergency medical services regardless of whether the provider who furnishes the services has a contract with the MCO or not.

ii. The MCO must not deny payment for treatment obtained when a member had an emergency medical condition as defined in 42 CFR § 438.114(a). The MCO must not deny payment for treatment obtained when a member had an emergency medical condition as defined in 42 CFR § 438.114(c)(1)(ii)(A).

iii. The MCO must ensure that emergency medical services be rendered without the requirement of prior authorization.

iv. The MCO must not deny payment for emergency medical services when a representative of the MCO instructs the member to seek emergency services.

v. The MCO must not limit what constitutes an emergency medical condition on the basis of diagnoses or symptoms.

vi. The MCO must not refuse to cover emergency services based on the emergency department provider, hospital, or fiscal agent failing to notify the member's primary care provider, MCO, or applicable state entity of the member's screening and treatment within ten (10) calendar days of presentation for emergency services.

vii. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to stabilize and diagnose the specific condition.

viii. The emergency department provider, or the provider treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO.

ix. The MCO must reimburse non-contracted providers for emergency medical services at no less than the Nebraska Medicaid FFS rate in effect on the date of service.

b. Post-Stabilization Services

i. MCO must provide coverage for post-stabilization care services as specified in 42 CFR § 438.114(e) and 42 CFR § 422.113(c)(2)(i), (ii) and (iii), regardless of whether the provider who furnishes the services has a contract with the MCO or not. The MCO must cover post-stabilization care services if they are:

a) Pre-approved by a network provider or other MCO representative; or

b) Not pre-approved by a network provider or other MCO representative, but:

1). Administered to maintain the member's stabilized condition within one (1) hour of a request to the MCO for prior authorization of further post-stabilization care services, or

2). Administered to maintain, improve, or resolve the member's stabilized condition, and

I. The MCO did not respond to a request for prior authorization within one (1) hour;

II. The MCO cannot be reached; or

III. The MCO representative and the treating physician cannot reach an agreement regarding the member's care and a network physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of 42 CFR § 422.133(c)(3) is met.

ii. The MCO's financial responsibility for post-stabilization care services that have not been pre-approved ends when:

a) A contracted provider with privileges at the treating hospital assumes responsibility for the member's care;

b) A contracted provider assumes responsibility for the member's care through transfer to another place of service;

c) An MCO representative and the treating physician reach an agreement concerning the member's care; or

d) The member is discharged.

16. Emergency Ancillary Services Provided at a Hospital

Emergency ancillary services that are provided in a hospital include, but are not limited to, radiology, laboratory, emergency medicine, and anesthesiology. The MCO must reimburse emergency ancillary services rendered by non-contracted providers in a hospital setting at the published Nebraska Medicaid fee schedule in effect on the date of service.

17. Family Planning Services

a. Family planning services are a mandatory Medicaid benefit. The MCO must not restrict the member's choice of a contracted or non-contracted provider as specified in 42 CFR § 431.51(b)(2) from which the member chooses to receive family planning services and supplies

b. The MCO must provide, at a minimum, coverage for the following family planning services:

- **i.** Comprehensive medical history and physical exams in a frequency per year that meets or exceeds Nebraska Medicaid FFS limits. This visit includes anticipatory guidance and education related to member's reproductive health care needs;
- **ii.** Contraceptive counseling to assist members in reaching an informed decision (such as natural family planning, follow-up visits, and referrals);
- **iii.** Laboratory tests performed as part of an initial or follow-up exam for family planning purposes and management of sexual health;
- **iv.** Drugs for the treatment of lower genital tract and genital skin infections or disorders, and urinary tract infections, when the infection or disorder is diagnosed during a family planning visit. A follow-up visit for the treatment must also be covered;
- **v.** Male and female sterilization procedures in accordance with 42 CFR Part 441, Subpart F; and
- **vi.** Treatment of major complications from certain family planning procedures such as treatment of:
  - a) A perforated uterus due to intrauterine device insertion;
  - b) Severe menstrual bleeding caused by a Depo-Provera injection requiring dilation and curettage; and
  - c) Surgical or anesthesia-related complications during a sterilization procedure.

c. Services must include diagnostic evaluation, supplies, devices, and related counseling for the purpose of voluntarily preventing or delaying pregnancy, detection and treatment of sexually transmitted infections (STIs), and age-appropriate human papillomavirus infection vaccination. Prior authorization must not be required for treatment of STIs.

d. The MCO must reimburse non-contracted family planning providers at no less than the Nebraska Medicaid FFS rate in effect on the date of service.

e. The MCO may encourage members to receive family planning services through the MCO's network of providers to ensure continuity and coordination of a member's comprehensive care. No additional reimbursements will be made to the MCO for members who elect to receive family planning services outside the MCO's provider network.

f. The MCO should encourage family planning providers to communicate with the member's PCP on any form of treatment provided.

g. The MCO must limit coverage for infertility to the diagnosis and treatment of medical conditions when infertility is a symptom of a suspected medical condition such as thyroid disease, brain tumor, or hormone dysfunction. The MCO must ensure coverage is not available if the sole purpose of the service is attempting to achieve pregnancy, per 471 NAC § 10-006.09.

18. Prenatal and Maternity Care Services

a. The MCO must cover prenatal care, labor and delivery, and six (6) weeks post-partum care.

b. The MCO must cover certified nurse-midwife services that are medically necessary in accordance with the applicable statutes and regulations.

c. Coverage for a hospital stay following a normal vaginal delivery may not be limited to less than forty-eight (48) hours for both the mother and newborn child. Coverage for a hospital stay following a cesarean section may not be limited to less than ninety-six (96) hours for both the mother and newborn child.

19. Hysterectomies and Sterilizations

a. The MCO must cover medically necessary hysterectomies as described in 42 CFR § 441.255.

- **i.** Sterilization by hysterectomy will not be covered if performed solely for the purpose of rendering an individual permanently incapable of reproducing. Coverage will also not be provided if there was more than one purpose for the procedure, but the primary purpose was to render the individual permanently incapable of reproducing.

b. The MCO must provide coverage for sterilizations that are conducted in accordance with 471 NAC 000-109, 10-006.06, and 18-004.06 and Federal regulations at 42 CFR § 441.250-441.259.

20. Limitations on Abortions

a. The MCO must ensure that abortion services are approved in writing by both the MCO Medical Director and the MLTC Medical Director before the service is rendered to ensure compliance with federal and state regulations.

b. The MCO must only provide for abortion services in accordance with 42 CFR § 441.202 and the Consolidated Appropriations Act of 2008, which stipulate that abortions are covered only in instances where pregnancy is the result of either:

i. An act of rape or incest; or

ii. In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

c. For abortion services performed in accordance with this section, a physician must certify in writing that, on the basis of their professional judgment, the life of the pregnant woman would be endangered if the fetus were carried to term. The certification statement must contain the diagnosis or medical condition that makes the pregnancy life endangering. The physician must attach the certification statement to the claim form that must be retained by the MCO.

d. No other abortions, regardless of funding, can be provided as a benefit under this contract. The MCO must not make payment for any core benefit or service under the contract to a network or non-contracted provider if any abortion performed hereunder violates Federal regulations or the Hyde Amendment Codification Act.

21. Speech Pathology and Audiology

The MCO must cover, at a minimum, speech pathology and audiology services when the following criteria are met:

a. The services are ordered by a licensed provider;

b. The services are medically necessary;

c. The services or the condition of the member is so complex that only a licensed speech pathologist or audiologist can safely and effectively perform the service; and

d. The speech pathology or audiology service meets a minimum of one (1) of the conditions listed in 471 NAC § 23-003.01 or 23-003-02.

22. Transplants

The MCO must pay for all covered services associated with transplant care for a member. As required by 471 NAC § 18-004.40, the MCO must cover transplant services, including donor services that are medically necessary and defined by Medicare as non-experimental. If Medicare policy does not exist for a certain type of transplant, the MLTC Medical Director or designee will determine whether the transplant is medically necessary and non-experimental. The MCO must cover at a minimum the following transplants:

a. Heart and lung;

b. Lung only;

c. Heart only;

d. Intestinal and/or multi-visceral;

e. Kidney only;

f. Pancreas only;

g. Kidney and pancreas;

h. Liver only;

i. Bone marrow/stem cell; and

j. Cornea.

23. Medical Services for Special Populations

a. The Special Health Care Needs (SHCN) population is defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care management.

b. The MCO must assess each member for SHCN within ninety (90) calendar days of enrollment. The assessments must be completed by appropriate health care professionals and referrals to care and case management made as indicated.

c. The MCO must utilize historical claims data, if available, to identify members who may need SHCN assessment. MCO must submit the policies and procedures to MLTC for review and approval a minimum of forty-five (45) calendar days prior to the proposed implementation date.

d. The MCO must notify the member's PCP when the member is identified with SHCN.

e. Members may self-identify to either the enrollment broker or the MCO that they have SHCN. The enrollment broker will notify the MCO of these members.

f. As a result of SHCN assessments, individualized treatment plans must be:

- **i.** Developed in collaboration with the member's PCP, the member/caregiver's participation, and any specialists caring for the member;
- **ii.** Approved by the MCO in a timely manner, as defined and required by the MCO;
- **iii.** Compliant with applicable Quality Assurance (QA) and UM standards; and
- **iv.** Reviewed and revised upon reassessment of functional need, at least every twelve (12) months or when the member's circumstances or needs change significantly.

g. The MCO must allow members direct access to a specialist as needed to meet the member's health care needs, e.g., through a standing referral or an approved number of visits.

24. Chiropractic Services

a. Coverage for chiropractic services is limited, as described in 471 NAC § 5-003.02 to:

- **i.** Certain spinal x-rays;
- **ii.** Manual manipulation of the spine;
- **iii.** Certain evaluation and management services;
- **iv.** Traction;
- **v.** Electrical stimulation;
- **vi.** Ultrasound; and
- **vii.** Certain therapeutic procedures, activities, and techniques designed and implemented to improve, develop, or maintain the function of the area treated.

b. Unless provided as a value-added service, the MCO must not cover any other diagnostic or therapeutic service or supply, provided by a chiropractor or on their order including, but not limited to, laboratory tests, orthopedic devices, physiotherapy, nutritional supplements, EKGs, and acupuncture.

25. Dialysis Services

The MCO must follow Medicare guidelines for coverage of dialysis pursuant to 471 NAC § 18-004.24.

26. Durable Medical Equipment

a. The MCO must provide coverage and be financially responsible for medically necessary DME, prosthetics, orthotics, medical supplies, and assistive devices including, but not limited to, hearing aids.

b. The MCO must, at minimum, provide coverage for DME-related covered services as listed in Chapters 7 and 8 of Title 471 of the Nebraska Administrative Code.

c. In-network and out-of-network nursing facilities or intermediate care facilities (for individuals with developmental disabilities) must be reimbursed separately for the following DME:

- **i.** Air fluidized beds;
- **ii.** Non-standard (custom) wheelchairs and wheelchair accessories, options, and components;
- **iii.** Power operated vehicles; and
- **iv.** Negative pressure wound therapy (wound VAC).

27. Home Health Services

The MCO must cover the following home health services:

a. Skilled nursing services provided by:

- **i.** A registered nurse (RN); or
- **ii.** A licensed practical nurse (LPN);

b. Home health aide services;

c. Physical therapy provided by a licensed physical therapist;

d. Speech therapy provided by a licensed speech pathologist; and

e. Occupational therapy provided by a licensed occupational therapist.

28. Hospice Services

a. The MCO must provide comprehensive hospice services to members, including nursing services, physician services, medical social services, counseling services, home health aide/homemaker, medical equipment, medical supplies, drugs and biologicals, physical therapy, occupational therapy, speech language pathology, volunteer services, and pastoral care services.

b. These services must be offered based upon individual needs assessment and the choices of terminally ill members and their families for palliative care and support.

29. Medical Transportation Services

a. The MCO must provide emergency and NEMT for its members.

b. The MCO must establish policies and procedures for emergency transportation and NEMT services that ensures the member's access to care. These policies and procedures must be compliant with Nebraska Medicaid guidelines for emergency transportation and NEMT.

c. The MCO must establish a broker to ensure NEMT access for its members. The broker must be responsible for and perform all administrative functions including, but not limited to:

- **i.** Establishing a transportation network;
- **ii.** Receiving NEMT services requests;
- **iii.** Verifying member program eligibility and MCO enrollment;
- **iv.** Screening members for mobility status and existing transportation resources;
- **v.** Verifying coverage of program services, authorizing, and arranging for transport; and
- **vi.** Validating claims for provider payments.

d. The direct provision of services must be performed by transportation providers who are enrolled in Nebraska Medicaid as NEMT providers.

e. NEMT Covered Services

- **i.** Medicaid covers the most appropriate non-emergency transportation (NET) services necessary to obtain Nebraska Medicaid reimbursed services when one of the following criteria is met:
  - a) Member does not own or does not have access to a working licensed vehicle;
  - b) Member does not have a current valid driver's license;
  - c) Member is unable to drive due to a documented physical, cognitive, or developmental limitation;
  - d) Member is unable to travel or wait by himself or herself due to a documented physical, cognitive, or developmental limitation; or
  - e) Member is unable to secure free transportation as defined in this chapter.

f. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services
All transportation services, with prior authorization, for medically necessary EPSDT covered services will be provided without regard to service limitations defined within this chapter.

g. NEMT Customer Call Center
The MCO must ensure its broker maintains a toll-free telephone number, with access to oral interpretation services free of charge and other toll-free voice and telecommunication devices for deaf clients. Toll-free telephone access for approving NEMT requests is required as follows:

- **i.** Maintain sufficient personnel to perform the functions required herein during the hours of 8 AM through 7 PM Central Time, Monday through Friday;
- **ii.** Maintain voice mail routing and response procedures;
- **iii.** Provide twenty-four (24) hour toll-free access in order to provide information on how to access transportation for an urgent medical condition;
- **iv.** Accept NEMT service requests by telephone and secure online ordering; and
- **v.** Call performance standards, per Section V.F.2.c – Member Services Call Center, apply to the MCO's broker and must be included in the Member/Provider Call Center monthly report.

h. NEMT Service Approval

- **i.** The MCO must ensure its broker is responsible for determining appropriateness for NEMT for its members enrolled in the MCO per Chapter 27 of Title 471 of the Nebraska Administrative Code.
- **ii.** The MCO must ensure its broker receives requests for NEMT, screens each request, and, if approved, assigns the trip to the most appropriate NEMT provider.
- **iii.** The MCO must ensure that its broker requires no more than three (3) business days advance notice from the member, with the exception of urgent care or the availability of an individual NEMT provider, where notice may be sooner than three (3) business days.
- **iv.** The MCO must ensure that its broker establishes procedures regarding NEMT for standing orders so that members are not required to continually make arrangements for repetitive program appointments or services. Standing orders must include, but are not limited to, outpatient therapy services, chemotherapy, dialysis, high-risk pregnancy, prenatal care, and outpatient behavioral health services.
- **v.** The MCO must ensure that its broker make a decision, arrange NEMT, and provide notice to the member within one (1) business day of the request or as expeditiously as the member's health requires for urgent care.

vi. The MCO must ensure its broker arranges the most appropriate and lowest cost available mode of transportation based on each member's mobility status and personal capabilities.

vii. The MCO must ensure its broker maintains documentation supporting medical necessity for approval of a personal attendant/escort.

viii. The MCO must ensure its broker arranges NEMT for hospital discharges (acute, psychiatric, and state hospitals) when such requests are verified by hospital staff.

ix. The MCO must ensure its broker approves NEMT for one (1) legally responsible adult to accompany children under the age of nineteen (19), if requested, or another adult selected by the legally responsible adult. The MCO's broker must ensure children ages twelve (12) and under are not transported by a public or commercial NEMT provider without adult supervision.

x. The MCO must ensure consistent application of criteria for approval decisions and consultation with the member's medical service provider when appropriate.

i. NEMT Provider Service Requirements

The MCO must ensure that any NEMT network providers deliver service that allows members to arrive promptly for appointments, so that there is not an excessive wait for their transportations. The pick-up and wait times should align with the following requirements.

i. The wait time for a pick-up to a scheduled appointment must not exceed sixty (60) minutes prior to the scheduled appointment time.

ii. The member must not wait more than thirty (30) minutes from drop-off time to their scheduled appointment time.

iii. The wait time for a scheduled return trip, after an appointment, must not exceed sixty (60) minutes.

iv. Member's may be picked up on a "will call" basis, which must also not exceed sixty (60) minutes wait time after the NEMT provider is contacted for the return trip.

v. For multiple passenger trips, which are only allowed for commercial providers when the first member approves multi-loading, members should not remain in the vehicle for more than forty-five (45) minutes longer than the average travel time for transport, for an individual client using that mode, from the point of pick-up to the destination.

vi. Exceptions to service delivery times specified herein may be made for trips with pick-up or destinations outside of the member's local area or verified scheduled consecutive trips.

vii. Exceptions may also be made due to unusual situations such as exceptional distances in rural areas or other situations out of the control of the NEMT provider.

viii. During periods of inclement weather conditions, the MCO's broker shall have written procedures in place that at a minimum includes notifying the members of the delay, the alternative schedule, and any alternative pick-up arrangements.

ix. The provider must wait 30 minutes following the scheduled pick-up time before departing without the member.

j. The MCO must ensure its broker authorizes and reimburses a personal attendant/escort when medically necessary.

k. Record of Service Documentation

The MCO must ensure its broker requires NEMT providers to maintain a daily drivers' log. The daily drivers' log is excluded for fixed-route public transit systems and commercial air. The NEMT providers/escorts daily logs shall contain, at a minimum, the following information per transportation leg:

i. Driver/escort's full name;

ii. Driver/escort's signature or approved electronic signature;

iii. Vehicle identification;

iv. Actual pick-up time (clearly designate time using either AM or PM designation or military time) for each approved member;

v. Actual pick-up address;

vi. Name of member transported, and, if applicable, the name of the accompanying adult or escort; and

vii. Member or parent/guardian signature or approved electronic signature and date.

l. The MCO must ensure its broker has an internal system of monitoring, analysis, evaluation, and improvement of the delivery of the NEMT service that:

i. Provides for regular UM and quality assessment reporting to the MCO and MLTC, including profiling of NEMT provider utilization patterns;

ii. Provides for systematic data collection, analysis, and evaluation of performance; and

iii. Provides for timeliness for correction, and assignment of specific personnel to be responsible for ensuring compliance and follow up.

m. NEMT Information Technology Requirements

i. The MCO must ensure its broker has information technology systems that include unique or innovative features including a web-based system that allows remote notification of and access to errors or demonstration of benefits in a live system environment.

ii. The MCO must ensure its broker has information technology systems that accommodate screening, services approval, submission of claims for adjudication, payment, and any other information necessary to ensure that appropriate NEMT is approved and provided.

iii. The MCO must ensure its broker has information technology systems that include a member and provider portal so that members may schedule trips and providers may accept/decline trips, schedule, and dispatch trips in the portal.

iv. The MCO must ensure its broker's information system is designed to automate trip assignment to providers based first on the lowest cost for the appropriate mode of transportation and second on provider performance. The MCO's broker is prohibited from excluding trip assignments to NEMT providers that do not use tablet technology.

v. The MCO must ensure its broker's information system is able to interface with tablet technology already in use by commercial carriers and/or the Nebraska Department of Transportation supplied technology.

vi. The MCO must ensure its broker's information system has claims clearing practices with real-time access to client signature logs and GPS tagged trip verifications.

vii. The MCO must ensure its broker's information system allows for claims to be submitted electronically.

viii. The MCO must ensure that its broker follow all other provisions of Section V.R Systems and Technical Requirements and Section V.S Claims Management.

30. Excluded Services

Excluded services are those services for which the MCO is not financially responsible, but the member may obtain under the Nebraska Medicaid State Plan. The MCO is responsible for informing members about how to access these excluded services, provide all required referrals, and assist in scheduling these services. These services will be paid for by MLTC on a FFS basis. Excluded services include:

a. Intermediate care facility services for individuals with developmental disabilities;

b. Institutional LTC/NF services at a custodial level of care;

c. School-based services;

d. HCBS waiver services; and

e. Nebraska Medicaid Personal Assistance Services.

31. Prohibited Services

a. Prohibited services are those required to treat complications or conditions resulting from non-covered services, services not reasonable and necessary, and services that are experimental and investigational unless approved by the MLTC Director.

b. The MCO is absolutely prohibited from paying for an item or service described in Section 1903(i) of the Social Security Act.

32. Dental Services

a. General Provisions

i. The MCO must provide members, at a minimum, with core dental benefits and services specified in the RFP and as defined in the Nebraska Medicaid State Plan. The MCO must possess the expertise and resources to ensure the delivery of quality dental services to MCO members in accordance with Nebraska Medicaid program standards and the prevailing dental community standards.

ii. The MCO must provide a mechanism to reduce inappropriate and duplicative use of dental services. Services must be furnished in an amount, duration, and scope that is not less than the amount, duration, and scope for the same services furnished to those that are eligible under FFS Medicaid, as specified in 42 CFR § 438.210(a)(1) and (2).

iii. If new dental services are added to the Nebraska Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the contract must be amended and MLTC will make every effort to give the MCO sixty (60) calendar days advance notice of the change. However, the MCO must add, delete, or change any service as may be deemed necessary by MLTC within the timeframe required by MLTC if mandated by federal or state legislation or court order.

b. Amount, Duration, and Scope

i. The MCO must ensure that dental services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.

ii. The MCO must not arbitrarily deny or reduce the amount, duration, or scope of a required dental service because of the member's diagnosis, type of illness, or condition.

iii. The MCO may place appropriate limits on a dental service

iv. On the basis of certain criteria, such as medical necessity; or

v. For the purpose of utilization control.

vi. The MCO must not impose dental service limitations that are more restrictive than those that currently exist under the Nebraska Medicaid State Plan. Upward variances of amount, duration and scope of core covered benefits and services are allowed.

vii. The MCO may limit dental services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care.

viii. The MCO must not portray core dental benefits or services as an expanded health benefit.

c. Medically Necessary Dental Services

i. The MCO must specify and provide to MLTC what constitutes "medically necessary dental 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; and
c) The ability to attain, maintain, or regain functional capacity.

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

d. Second Opinions

When requested by the member, the MCO must provide for a second opinion from a qualified dental professional within the network or arrange for the member to obtain one outside the network, at no cost to the member.

e. Core Medicaid Dental Benefits and Services

The core dental benefits and services are described in 471 NAC § 6-004.02 and are as follows:

i. Diagnostic Services including:

a) Oral Evaluations;
b) Radiographs; and
c) Diagnostic Casts.

ii. Preventive Services including:

a) Prophylaxis;
b) Topical Fluoride;
c) Space Maintainers (Passive Appliances); and
d) Recementation of Space Maintainers.

iii. Restorative Services including:

a) Amalgam or Resin;
b) Crowns – Resin;
c) Crowns – Porcelain;
d) Recement Inlay;
e) Recement Crown;
f) Prefabricated Stainless Steel Crowns;
g) Prefabricated Stainless Steel Crown with Resin Window;
h) Sedative Filling;
i) Core Buildup, including any pins;
j) Pin retention;
k) Prefabricated Post and Core in Addition to Crown;
l) Temporary Crown;
m) Crown Repair;
n) Therapeutic Pulpotomy and Pupal Therapy;
o) Root Canal Therapy and Re-treatment of Previous Root Canals;
p) Apicoectomy;
q) Emergency Treatment to Relieve Endodontic Pain; and
r) Unspecified Restorative Procedure.

iv. Periodontic Services including:
- a) Gingivectomy or Gingivoplasty per tooth or per quadrant;
- b) Periodontal Scaling and Root Planing;
- c) Full Mouth Debridement; and
- d) Periodontal Maintenance Procedure.

v. Prosthodontic Services, including:
- a) Complete Dentures (Maxillary and Mandibular);
- b) Immediate Dentures (Maxillary and Mandibular);
- c) Maxillary Partial Resin Base;
- d) Mandibular Partial Resin Base;
- e) Maxillary Partial Cast Metal Base;
- f) Mandibular Partial Cast Metal Base;
- g) Adjustments – Dentures and Partials;
- h) Repairs to Dentures and Partials;
- i) Rebase of Dentures and Partials;
- j) Reline of Dentures and Partials;
- k) Interim Dentures (Maxillary and Mandibular);
- l) Flipper Partial Dentures (Maxillary and Mandibular);
- m) Tissue Conditioning; and
- n) Recement Fixed Partial Denture.

vi. Oral and Maxillofacial Surgery Services including:
- a) Extractions Routine and Surgical;
- b) Tooth Reimplantation and/or Stabilization of an Accidentally Evulsed or Displaced Tooth and or Alveolus;
- c) Surgical Exposure of Impacted or Unerupted Tooth for Orthodontic Reasons,
- d) Biopsy of Oral Tissue (Hard or Soft);
- e) Alveoloplasty;
- f) Excisions; and
- g) Occlusal Orthotic Device.

vii. Orthodontic Services including:
- a) Orthodontic Treatment;
- b) Removable and Fixed Appliance Therapy (thumb sucking and tongue thrust);
- c) Repair of Orthodontic Appliances;
- d) Orthodontic Retainers (Replacement); and
- e) Repair of Bracket and Standard Fixed Orthodontic Appliances.

viii. Adjunctive General Services including:
- a) Palliative Treatment;
- b) General Anesthesia;
- c) Analgesia, Anxiolysis, Inhalation of Nitrous Oxide;
- d) Intravenous Sedation/Analgesia;
- e) Non-Intravenous Conscious Sedation;
- f) House Call, (Nursing Facility Call), Hospital Call, Ambulatory Surgical Center (ASC) Call;
- g) Office Visit – After Regularly Scheduled Hours; and
- h) Occlusal Guard.

ix. Cosmetic dental procedures are not covered as a core benefit and/or service.

f. EPSDT Services - Dental

i. In accordance with 42 CFR § 441.56(b)(1)(vi) and the American Academy of Pediatric Dentistry's Dental Periodicity Schedule, the MCO must provide dental screening services furnished by direct referral to a dentist for children beginning at three (3) years of age or eruption of the first tooth.

ii. In accordance with 42 CFR § 441.56(c)(2), the MCO must provide dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health.

iii. The MCO must accurately report, via encounter data submissions, all dental screenings and access to preventive services as required for MLTC to comply with federally mandated CMS 416 reporting requirements.

g. Emergency Dental Services

The MCO must make provisions for and advise all members of the provisions governing emergency use pursuant to 42 CFR § 438.114. Emergency-related definitions are in the Glossary of this RFP.

Requirements for the MCO to provide emergency dental services are as follows.

i. Provision of these services in an emergency context broadens the MCO's responsibilities to include payment for these services to out-of-network providers.

ii. The MCO must be responsible for dental related services provided in an emergency context other than those described in this section.

iii. In providing for emergency dental services and care as a covered service, the MCO must not:

a) Require prior authorization for emergency dental services and care;

b) Indicate that emergencies are covered only if care is secured within a certain period of time;

c) Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered; or

d) Deny payment based on the member's failure to notify the MCO in advance or within a certain period of time after the care is given.

iv. The MCO must not deny payment for emergency dental care.

v. The MCO must not deny payment for treatment obtained when a member had an emergency dental condition including cases in which the absence of immediate dental attention would not have had the outcomes specified in 42 CFR § 438.114(a) of the definition of an emergency dental condition.

vi. The hospital-based provider and the dental home may discuss the appropriate care and treatment of the member. Notwithstanding any other state law, a hospital may request and collect insurance or financial information from a patient in accordance with Federal law to determine if the patient is a member of the MCO, if emergency dental services and care are not delayed.

vii. The MCO must not deny emergency dental services claims submitted by a non-contracting provider solely based on the period between the date of service and the date of clean claim submission unless that period exceeds three-hundred-and-sixty-five (365) calendar days.

viii. If third party liability (TPL) exists, payment of claims must be determined in accordance with this RFP.

ix. The MCO must review and approve or disapprove emergency service claims based on the definition of emergency dental services and care specified in the Glossary.

33. Continuity of Care for Members Transitioning Between MCOs.

a. The MCO must establish processes for continuity of care for members newly enrolled in the MCO after the implementation phase has passed, per 42 CFR § 438.208. The MCO must establish an automated process for sharing of previously approved coverage authorizations and care management plans in which a member was enrolled. The previous MCO must respond to the request of the new MCO for this information within three (3) business days.

b. The discharging MCO must provide active assistance to members when transitioning to another MCO or to Medicaid FFS.

c. The receiving MCO must be responsible for the provision of medically necessary services covered under the contract that are required for the member during the transition period (i.e. prenatal care, acute care, etc.) of thirty (30) calendar days for medical, behavioral health, and dental services and ninety (90) calendar days for pharmacy services. During this transition period, the receiving MCO must be responsible for the following, but not limited to:

i. Notification to the new PCP of member's choice;

ii. Notification to the new dental provider of member's choice;

iii. Requesting transfer of the member's care records; and

iv. Arrangement of medically necessary services, if applicable, and other requirements for new members.

d. In the event that a member receives medically necessary covered services before the effective date of this contract, the MCO must authorize the continuation of services without any form or prior approval and regardless of whether the services are being provided by a provider within or outside the MCO's provider network. In order to ensure uninterrupted service delivery, the MCO must accept authorization files from MLTC or its designee as directed to identify enrollees for whom prior approvals were issued prior to the effective date of this contract. The MCO must

accept and honor those prior approvals for the first ninety (90) calendar days of the Contract Start Date.

e. For all transplants, all previous coverage authorizations must be honored, without redetermination during the transition periods unless the end date on the coverage authorization is prior to the expiration of the transition period.

F. MEMBER SERVICES AND EDUCATION

Member Rights and Protections

1. Member Rights

a. The MCO must have written policies regarding members' rights that are specified in this section and in compliance with 482 NAC § 7-001. At a minimum, each MCO member is guaranteed the right to:

- **i.** Be treated with respect and consideration of their dignity and privacy;
- **ii.** Receive information about available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand the information;
- **iii.** Participate in decisions regarding their health care, including the right to refuse treatment. Refusal of treatment is not a reason for which the MCO can request disenrollment of the member from the MCO;
- **iv.** Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- **v.** Request and receive a copy of their medical records, and request that they be amended or corrected as specified in 42 CFR §438.100(b)(2)(vi);
- **vi.** Obtain available and accessible health care services covered under the contract;
- **vii.** Request disenrollment per 42 CFR § 438.56; and
- **viii.** Each member is free to exercise their rights and entitled to a guarantee that the exercise of those rights will not adversely affect the member's treatment by the MCO, its providers, or MLTC.

b. Indian Health Protections

The MCO must adhere to Section 5006(d) of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5 and 42 CFR § 438.14.

- **i.** The MCO must permit any American Indian who is enrolled in the MCO and eligible to receive services from an Indian Health Services/Tribal 638/Urban Indian Health (I/T/U) primary care participating in the MCO's network as a PCP, to choose that I/T/U as their PCP, as long as that provider has the capacity to provide the service.
- **ii.** The MCO must permit any American Indian to obtain services covered under this contract from out of network I/T/U providers from which they are otherwise eligible to receive such services.
- **iii.** The MCO must demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for American Indian members who are eligible to receive services from such providers.
- **iv.** The MCO must permit an out of network I/T/U provider to refer an American Indian member to a network provider.
- **v.** In compliance with Section 5006(a) of the ARRA, the MCO must
  - a) Exempt from premiums any Indian who is eligible to receive or has received an item or service furnished by an I/T/U provider or through referral;
  - b) Exempt from all cost sharing any American Indian who is currently receiving or has ever received an item or service furnished by an American Indian health care provider or through referral; and
  - c) Follow required American Indian health protections included in Section V.Q.5. Provider Reimbursement - Indian Health Protections

c. Notice to Members of Provider Termination

- **i.** The MCO must make a good faith effort to provide affected members with written notice of a provider's termination from the MCO's network. This includes members who receive their primary care from, or were seen on a regular basis by, the terminated provider. The notice to the member must be provided thirty (30) calendar days prior to the effective date of the termination, or within fifteen (15) calendar days of the receipt of the termination notice from the provider.
- **ii.** The MCO must provide notice to a member who receives a prior authorized course of treatment. The written notice must be provided within ten (10) calendar days from the date the MCO becomes aware of the change if the notice is provided in advance.
- **iii.** Failure to provide notice prior to the termination date is allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves

from the service area and fails to notify the MCO, or when the provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under any of these circumstances, notice must be issued immediately upon the MCO becoming aware of the circumstances.

2. Member Services Call Center

a. The MCO must operate a member call center with a toll-free telephone line to respond to questions, concerns, and complaints from members, their families, and their providers. The call center and call center employees must be located in the United States of America.

b. The MCO must develop member call center policies and procedures that address staffing; training; hours of operations; access and resources standards; transfers/referrals, including case management referrals from any source; monitoring of calls via recording or other means; and compliance with standards in this RFP.

c. The MCO must ensure the call center staff can handle calls from members with limited English proficiency and members with disabilities, including but not limited to members with hearing or speech disabilities.

d. The MCO must ensure the call center is staffed adequately to respond to members' questions, at a minimum from 8 AM to 5 PM, Central Time, Monday through Friday.

e. The MCO must ensure the member call center provides an option to speak with qualified nurses, during the call center hours, to triage urgent care and emergency calls from members and to facilitate the transfer of calls to a care manager from or on behalf of a member who requires immediate assistance from a care manager.

f. The MCO must ensure that, during normal business hours, call transfers to case managers be made as warm transfers, e.g. when transferring a call, the call center staff provides the person picking up the call with a brief summary of the member's concern and introduces the member.

g. If a call transfer is not possible, the MCO must ensure that a care manager is notified and returns the member's call within thirty (30) minutes and that the care manager has access to the necessary information to resolve the member's issue. The MCO must implement protocols, approved in advance by MLTC, that describe how member calls to the nurse triage/nurse advice line will be handled.

h. The MCO must ensure that the member call center is adequately staffed with individuals trained to accurately respond to member questions regarding managed care, including but not limited to, covered services, the Medicaid program, EPSDT, and the MCO's provider network.

i. The MCO must measure and monitor the accuracy of responses and telephone etiquette and take corrective action as necessary to ensure that members are being given correct information in a helpful and polite manner.

j. The MCO must install, operate, and monitor an automated call distribution system for business and non-business hours, including weekends and holidays. This automated system must:

- **i.** Effectively manage all calls received and assign incoming calls to available staff in an efficient manner;
- **ii.** Transfer calls to other telephone lines, as necessary;
- **iii.** Provide detailed reports in a format approved by MLTC, including the quantity, length, and types of calls received; the number of calls transferred or referred; abandonment rate; wait time; busy signal rate; response time; and call volume;
- **iv.** Provide a message that notifies callers that calls may be monitored for Quality Improvement (QI) purposes;
- **v.** Provide callers with instructions about what to do in case of an emergency;
- **vi.** Include a voice mailbox with adequate capacity;
- **vii.** Measure the number of calls in the queue;
- **viii.** Measure the length of time callers are on hold;
- **ix.** Measure the total number of calls and average calls handled per day, week, and month;
- **x.** Measure the average hours of use per day;
- **xi.** Assess the busiest times and days by number of calls;
- **xii.** Record calls to assess whether member questions are answered accurately and politely;
- **xiii.** Provide a backup telephone system that would operate in the event of line trouble, emergency situations including natural disasters, or other problems, so that access to the call center is not disrupted; and
- **xiv.** Provide interactive voice response (IVR) options that are user-friendly for members.

k. The MCO must meet the following call center performance standards.

- **i.** The MCO must answer ninety percent (90%) of calls within thirty (30) seconds or direct the call to an automatic call pickup system with IVR options.
- **ii.** The MCO must ensure that no more than one percent (1%) of incoming calls receive a busy signal.

iii. The MCO must maintain an average hold time of three (3) minutes or less. Hold time, or wait time, for the purposes of this RFP includes:

a) The amount of time a caller waits for a member services representative to assist them after the caller has navigated the IVR system and requested a live person; and

b) The amount of time a customer service representative places a caller on hold.

iv. The MCO must maintain an abandonment rate of calls of not more than five percent (5%).

v. The MCO must return all voice-mails no later than the next business day.

l. The MCO must conduct ongoing quality assurance to ensure call center performance standards are met.

m. If MLTC determines that it is necessary to conduct onsite monitoring of the MCO's member call center functions, the MCO is responsible for all reasonable costs incurred by MLTC or its authorized agent(s) related to such monitoring.

3. Oral Interpretation and Written Translation Services

a. In accordance with 42 CFR § 438.10(d), MLTC will provide to the MCOs, and on its website, the prevalent non-English languages spoken by members in the state.

b. The MCO must make culturally, and linguistically appropriate oral interpretation services available free of charge to each Medicaid member enrolled with the MCO. This applies to all non-English languages, not just those that Nebraska specifically requires. The member must not be charged for interpretation services. The MCO must notify its members that oral interpretation is available for any language, written information is available in Spanish, and how they can access these services. Materials that provide this information must be written in English and Spanish.

c. The MCO must ensure that translation services are provided for all written marketing and member materials in any language that is spoken as a primary language for four percent (4%) or more of members, or potential members, of the MCO. Within ninety (90) calendar days of notice from MLTC that an additional language is necessary, materials must be translated and made available. No charge can be assessed for these materials to ensure that all members and potential members understand how to access the MCO and use services appropriately as specified in 42 CFR § 438.10(c)(4) and (5).

4. Requirements for Member Materials

a. The MCO must comply with the following requirements for all written member materials, regardless of the means of distribution (for example, printed, web, advertising, and direct mail).

b. The MCO must write all member materials in a style and reading level that will accommodate the reading skill of MCO members. In general, the writing should be at no higher than a six-point-nine (6.9) grade level, as determined by the Flesch–Kincaid Readability Test.

c. MLTC reserves the right to require the MCO to submit evidence that written member materials were tested against the a six-point-nine (6.9) grade reading-level standard.

d. The MCO must distribute member materials to each new member within thirty (30) calendar days of enrollment. One of these documents must describe the MCO's website, the materials that the members can find on the website, and how to obtain written materials if the member does not have access to the website.

e. The MCO must ensure written materials are available in alternative formats, communication modes, and in an appropriate manner that considers the special needs of those who, for example, have a visual impairment, speech impairment, or is hard of hearing; physical or developmental disability; or limited reading proficiency.

f. All Medicaid members enrolled with the MCO must be informed that information is available in alternative formats and communication modes, as well as how to access them. These alternatives must be provided at no expense to each member.

g. The MCO must make all written materials, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its particular service area. Currently, the prevalent non-English language in the state is Spanish. The MCO must make its written information available in any additional non-English languages identified by MLTC during the duration of the contract.

h. The MCO must ensure all written materials be clearly legible with a minimum font size of twelve-point (12-point), with the exception of member identification (ID) cards, or as otherwise approved by MLTC.

i. The quality of materials used for printed materials must be, at a minimum, equal to the materials used for printed materials for the MCO's commercial plans, if applicable.

j. The MCO's name, mailing address, (physical location, if different), and toll-free telephone number must be prominently displayed on all marketing materials, including the cover of all multi-page materials.

k. The MCO must ensure all multi-page written member materials notify the member that real-time oral interpretation is available for any language at no expense to the member, and how to access those services.

l. The MCO must ensure all written materials related to MCO enrollment and PCP selection educate members on how to verify with their usual providers that they are participating providers in the selected MCO and are available to see the member.

m. The MCO must ensure all marketing materials are made available by the MCO across the state. Materials may be customized for particular locations or populations within the state.

n. The MCO must ensure all marketing activities provide for equitable distribution of materials without bias toward or against any group.

o. The MCO must ensure all marketing materials accurately reflect information that is applicable to an average member of the MCO.

p. In all member materials, the MCO must include the date of issue or revision.

q. The MCO must ensure copies of all member mailings/materials (print and multimedia) be provided contemporaneously to MLTC.

r. The MCO must include taglines in the prevalent non-English languages in the state, and in a conspicuously visible font size, explaining the availability of written translation or oral interpretation to understand the information provided.

s. The MCO must include taglines in the prevalent non-English languages in the state and in a conspicuously visible font size that provide information on how to request auxiliary aids and services.

t. The MCO must include taglines in the prevalent non-English languages in the state and in a conspicuously visible font size that provide the toll-free and Teletypewriter Telephone/Text Telephone (TTY/TDY) telephone number of the MCO's member/customer service unit.

5. Member Handbook

a. The MCO must develop, maintain, and post a member handbook in both English and Spanish to the member portal of its website. In addition to the requirements described in this RFP, the handbook must comply with the requirements in 42 CFR § 438.10(g).

b. The MCO must submit the draft member handbook to MLTC for review and approval a minimum of one-hundred-and-fifty (150) calendar days prior to the Contract Start Date and anytime thereafter when changes are made a minimum of thirty (30) calendar days prior to implementation of the changes.

c. The MCO must also have hard copies available and inform members in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.

d. At a minimum, the MCO must review and update the member handbook annually. The MCO must submit the updated handbook to MLTC for review and approval a minimum of forty-five (45) calendar days before it is to be implemented. If the MCO wishes to make changes to the handbook more frequently than annually, the revised language must still be submitted to MLTC a minimum of forty-five (45) calendar days prior to proposed implementation.

e. The MCO's updated member handbook must be made available to all members on an annual basis, through its website. When there is a significant change in the member handbook, the MCO must provide members written notice of the change and the process for requesting it a minimum of thirty (30) calendar days before the effective date of the change.

f. At a minimum, the member handbook must include:

- **i.** A table of contents;
- **ii.** A general description of basic features of how MCOs operate and information about the MCO in particular;
- **iii.** A description of the Member Services department, what services it can provide, and how member services representatives (MSRs) may be reached for assistance. The member handbook shall provide the toll-free telephone number, fax number, email address, and mailing address of the Member Services department, as well as its hours of operation;
- **iv.** A section that stresses the importance of a member notifying Medicaid Eligibility of any change to its family size, mailing address, living arrangement, income, other health insurance, assets, or other situation that might affect ongoing eligibility;
- **v.** Member rights/protections and responsibilities, as specified in 42 CFR § 438.100 and this RFP;
- **vi.** Appropriate and inappropriate behavior when seeing an MCO provider. This section must include a statement that the member is responsible for protecting their ID cards

and that misuse of the card, including loaning, selling, or giving it to another person, could result in loss of the member's Medicaid eligibility and/or legal action;

vii. Instructions on how to request no-cost multi-lingual interpretation and translation services. This information must be included in all versions of the member handbook;

viii. A description of the PCP selection process and the PCP's role as coordinator of services;

ix. The member's right to select a different MCO or change providers within the MCO;

x. Any restrictions on the member's freedom of choice of MCO providers;

xi. A description of the purpose of the Medicaid and MCO ID cards, why both are necessary, and how to use them;

xii. The amount, duration and scope of benefits available to the member under the contract between the MCO and MLTC in sufficient detail to ensure that members understand the benefits for which they are eligible;

xiii. Procedures for obtaining benefits, including authorization requirements;

xiv. The extent to which, and how, members may obtain benefits, including family planning services, from out-of-network providers;

xv. Information about health education and promotion programs, including chronic care management;

xvi. Appropriate utilization of services including not using the ED for non-emergent conditions;

xvii. How to make, change, and cancel medical appointments and the importance of cancelling or rescheduling an appointment, rather than being a "no-show";

xviii. Information about a member's right to a free second opinion per 42 CFR § 438.206(b)(3) and how to obtain it;

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

a) What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR § 438.114(a) and 42 CFR § 422.113(c),

b) That prior authorization is not required for emergency services,

c) The process and procedures for obtaining emergency services, including use of the 911-telephone system, and

d) That, subject to provisions of 42 CFR Part 438, the member has a right to use any hospital or other setting for emergency care.

xx. The policy about referrals for specialty care and other benefits not furnished by the member's PCP;

xxi. How to obtain emergency and non-emergency medical transportation;

xxii. Information about the EPSDT program and the importance of children obtaining these services;

xxiii. Information about notifying the MCO if a female member becomes pregnant or gives birth, the importance of early and regular prenatal care, and obtaining prenatal and post-partum care;

xxiv. Information about member copayments. The charging of a copayment is at the discretion of the MCO. If the MCO chooses to ask its providers to charge copayments, this cost-sharing must be in compliance with 42 CFR § 447.50 through 447.57 and cannot exceed the amounts specified at 471 NAC § 3-008;

xxv. The importance of notifying the MCO immediately if the member files a workers' compensation claim, has a pending personal injury or medical malpractice lawsuit, or has been involved in an accident of any kind;

xxvi. How and where to access any benefits that are available under the Medicaid State Plan that are not covered under the MCO's contract with MLTC, either because the service is carved out or the MCO will not provide the service because of a moral or religious objection;

xxvii. That the member has the right to refuse to undergo any medical service, diagnosis, or treatment or to accept any health service provided by the MCO if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds;

xxviii. Member grievance, appeal, and State Fair Hearing procedures and timeframes, as described in 42 CFR § 438.400-424 and this RFP, as follows:

a) For grievances and MCO level appeals:

1). Definitions of a grievance and an MCO level appeal;

2). The right to file a grievance or MCO level appeal;

3). The requirements and timeframes for filing a grievance or MCO level appeal;

4). The availability of assistance in the filing process;
5). The toll-free number(s) the member can use to file a grievance or an appeal by telephone; and
6). The fact that, when requested by a member, benefits can continue if the member files an appeal within the timeframes specified for filing at 477 NAC § 10-001. Pursuant to the same regulation, the member should also be notified that the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

b) For State Fair Hearing:
1). Definition of a State Fair Hearing;
2). The right to request a hearing;
3). The requirements and timeframes for requesting a hearing;
4). The availability of assistance to request a fair hearing;
5). The rules on representation at a hearing; and
6). The fact that, when requested by a member, benefits can continue if the member files a request for a State Fair Hearing within the timeframes specified for filing at 477 NAC § 10-001. Pursuant to the same regulation, the member should also be notified that the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

xxix. As set forth in 42 CFR § 438.3(j), 42 CFR § 438.10(g)(2)(xii) and in this section, a description of advance directives that includes:
a) The State's and MCO's policies about advance directives, and
b) Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.

xxx. Information about how members can file a complaint with MLTC or the Division of Public Health about a provider's failure to comply with advance directive requirements;
xxxi. How a member may report suspected provider fraud and abuse including, but not limited to, the MCO's and MLTC's toll-free telephone number and website links created for this purpose; and
xxxii. Any additional information that is available upon request, including but not limited to:
a) The structure and operation of the MCO,
b) The MCO's physician incentive plan (42 CFR § 438.10(f)(3),
c) The MCO's service utilization policies,
d) How to report alleged marketing violations to MLTC, and
e) Reports of transactions between the MCO and parties in interest (as defined in section 1318(b) of the Public Health Service Act) provided to the State.

g. A minimum of once a year, the MCO must notify members of the option to receive the Member Handbook and the provider directory in either electronic or paper format.

6. Other Member Notifications
a. A minimum of annually, the MCO must provide an explanation of a member's disenrollment rights to each member. The notice must be sent no less than sixty (60) calendar days before the start of each enrollment period.
b. A minimum of annually, and in compliance with 42 CFR § 438.10(g), (h), and (2), the MCO must inform all members of their right to request:
i. An updated member handbook, at no cost to the member; and
ii. An updated provider directory, at no cost to the member.

7. Member Newsletter
a. The MCO must develop and distribute, a minimum of twice a year, a member newsletter. This publication must be available on the member portal and mailed to members on request. Topics covered in the newsletter must be timely and relevant to the member population. Suggested topics to discuss include but are not limited to:
i. Educational information on chronic illnesses and ways to self-manage care;
ii. Behavioral health information;
iii. Reminders of flu shots and other prevention measures at appropriate times;
iv. Medicare Part D issues;
v. Cultural competency issues;

vi. Tobacco cessation information and programs;
vii. Human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome(AIDS) testing for pregnant women; and
viii. Other information as required by MLTC.

b. The MCO must submit a draft of the member newsletter to MLTC a minimum of forty-five (45) calendar days prior to its intended publication for review and approval.

8. Provider Directory for Members

a. The MCO must develop and maintain a provider directory for its members in three (3) formats:
i. A hard copy directory, when requested, for members, potential members, and the enrollment broker;
ii. A web-based, searchable, online directory for members, potential members, and the general public; and
iii. An electronic file of the directory to be updated weekly and submitted to MLTC or its designee, and the enrollment broker.

b. The MCO must submit templates of its provider directory to MLTC a minimum of sixty (60) calendar days prior to the Contract Start Date for MLTC's review and approval.

c. At a minimum, the MCO must update the hard copy directory for members on a monthly basis. The MCO must update the web-based version in real time, and no less often than three (3) business days after notification of any change. Daily updates are preferred, if possible.

d. In accordance with 42 CFR § 438.10(h), the provider directory must include, but not be limited to:
i. Names, locations, telephone numbers, specialties, and non-English languages spoken of all current contracted providers (including urgent care clinics, FQHCs, RHCs, labs, radiology providers, behavioral health providers, hospitals, and pharmacies) in the MCO's network. Those PCPs, specialists, and other providers not accepting new patients must be identified; and
ii. Hours of operation, including identification of providers with non-traditional hours (before 8 AM, after 5 PM, Central Time, or any weekend hours).

e. To assist Medicaid enrollees in identifying participating providers for each MCO, the MCO must make the provider directory available on the MCO's website and must provide the provider directory to the enrollment broker in a machine-readable file and format. The MCO must permit the enrollment broker to maintain hard copies of the MCO's directory to share with Medicaid enrollees on request.

9. Member ID Cards

MCO members will be issued one member ID card related to their Medicaid eligibility and their enrollment in the Nebraska Medicaid managed care delivery system. MLTC issues an ID card to all Medicaid-eligible individuals, including MCO members. This card is not proof of eligibility but can be used by providers to access the MLTC's electronic eligibility verification systems. These systems contain the most current information available on members, including MCO enrollment. No MCO-specific information is printed on the card. The MCO member may need to show this card to access Medicaid services not included in the MCO benefits and services.

a. The MCO must issue an ID card to each of its members. At a minimum, the card must include:
i. The member's name;
ii. The member's Medicaid ID number;
iii. The enrollment broker's toll-free telephone number;
iv. The MCO's name and address;
v. Instructions on what the member should do in the event of an emergency;
vi. The member's PCP's name and telephone numbers (including the after-hours number if it is different); and
vii. The MCO's toll-free number(s) for Member Services, filing a grievance, and reporting suspected fraud.

b. The MCO may provide the MCO member ID card in a separate mailing from the welcome packet. However, the ID card must be sent no later than ten (10) business days from the date of receipt of the file from MLTC or the enrollment broker that identifies the new member. As part of the welcome packet information, the MCO must explain the purpose of the card and how to use it in tandem with the MLTC-issued card.

c. The MCO may issue the card without the PCP information if no PCP selection has been made as of the date of the card's mailing. Once PCP selection has been made by the member or through

auto assignment, the MCO must reissue the card within ten (10) business days of the selection or auto-assignment. As part of the mailing of the reissued card, the MCO must explain the purpose of the new card, the changes between the new and previous card, and that the member should destroy the previous card.

d. The MCO must reissue the MCO ID card to a member within ten (10) calendar days of notice that a member has lost their card, had a name or PCP change, or for any other reason that requires a change to the information on the current ID card.

e. If the MCO has knowledge of any MCO member permitting the use of their ID card by any other person, the MCO must immediately report this information to the Special Investigation Unit in the Department of Health and Human Services Division of Public Health at (402) 471-9407 (Lincoln and Greater Nebraska) or (402) 595-3789 (Omaha).

f. The MCO must ensure that its subcontractors can identify members in a manner that will not result in discrimination against the members, to provide or coordinate the provision of all benefits and services, expanded services, and/or out-of-network services.

g. Pharmacy-Related ID Card Requirements

The MCO must provide prescription billing information on the member's ID card that:

i. Complies with the standards set forth in the National Council for Prescription Drug Programs' Health Care Identification Card Pharmacy and/or Combination ID Card Implementation Guide at the time of issuance of the card; and

ii. Includes, at a minimum, the following data elements:

a) The name of the MCO and the prescription benefit manager; and

b) All electronic transaction routing information and any other numbers required by the MCO or its benefit administrator to process a prescription claim electronically.

h. Dental-Related ID Card Requirements

i. The member's Dental Home name and telephone numbers (including after-hours number if it is different);

ii. The card may be issued without the Dental Home information if no Dental Home selection has been made as of the date of the card's mailing. Once the Dental Home selection has been made by the member or through auto-assignment, the MCO must reissue the card within ten (10) business days of the selection or auto-assignment. As part of the mailing of the reissued card, the MCO must explain the purpose of the new card, the changes between the new and previous card, and that the member should destroy the previous card.

10. Member Website

a. The MCO must maintain a website that includes a member portal. The member portal must be interactive and accessible using mobile devices and have the capability for bi-directional communications (i.e., members can submit questions and comments to the MCO and receive responses).

b. The MCO website must include general and up-to-date information about the Nebraska Medicaid program and the MCO. All material to be included on the website must be submitted to and approved by MLTC in advance of its intended posting. MLTC will review and approve or request changes as quickly as practical but within thirty (30) calendar days of receipt.

c. The MCO must remain compliant with applicable privacy and security requirements (including but not limited to HIPAA) when providing member eligibility or member identification information on its website.

d. The MCO website must, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern.

e. The MCO website must follow all written marketing guidelines included in Section V G Member Marketing.

f. Use of proprietary items that would require use of a specific browser or other interface is not allowed.

g. The MCO must provide the following information on its website, and such information must be easy to find, navigate among, and be reasonably understandable to all members:

i. The most recent version of the member handbook;

ii. Telephone contact information for the MCO, including the toll-free customer service number prominently displayed and a telecommunications device for the deaf (TDD) number;

iii. A searchable list of network providers, with a designation of open or closed panels. This directory must be updated in real time for changes to the MCO network;

iv. A link to the enrollment broker's website and the enrollment broker's toll-free number for questions about enrollment;

v. A link to the Medicaid Eligibility website, currently http://accessnebraska.ne.gov, for questions about Medicaid eligibility; and

vi. Information about how to file grievances and appeals.

11. Medical Records

a. A member's medical record is the property of the provider who generates the record. Medical records include those maintained by PCPs or other providers, as well as, but not limited to, those kept in placement settings such as nursing facilities, assisted living facilities, and other home and community-based providers.

b. Each member is entitled to a copy of their medical record at no cost.

c. The MCO must have written policies and procedures to maintain the confidentiality of all medical records in compliance with applicable law. Policies and procedures must be submitted to MLTC for review and approval sixty (60) calendar days prior to their implementation.

d. The MCO must ensure that a medical record (hard copy or electronic) is established when information is received about a member. If the PCP has not yet seen the member, such information may be kept temporarily in an appropriately labeled file, in lieu of establishing a medical record, but must be associated with the member's medical record as soon as one is established.

e. The MCO must ensure the medical record includes, at a minimum, the following:

i. Member-identifying information, including name, member ID number, date of birth, gender, and legal guardianship (if applicable);

ii. Primary language spoken by the member and any translation needs;

iii. Services provided through the MCO, date of service, service site, and name of service provider;

iv. Medical history, diagnoses, treatment prescribed, therapy prescribed, and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the MCO;

v. Referrals including follow-up and outcome of referrals;

vi. Documentation of emergency or after-hours encounters and follow-up;

vii. Signed and dated consent forms (as applicable);

viii. Documentation of immunization status;

ix. Documentation of advance directives, as appropriate;

x. Documentation of each visit must include:

a) Date and begin and end times of service;
b) Chief complaint or purpose of the visit;
c) Diagnoses or medical impression;
d) Objective findings;
e) Patient assessment findings;
f) Studies ordered and results of those studies (e.g., laboratory, x-ray, EKG);
g) Medications prescribed; and
h) Health education provided

xi. Name and credentials of the provider rendering services (e.g., MD, DO, OD) and the signature or initials of the provider. Initials of providers must be identified with correlating signatures; and

xii. Documentation of EPSDT requirements including but not limited to:

a) Comprehensive health history,
b) Developmental history,
c) Unclothed physical exam,
d) Vision, hearing and dental screening,
e) Immunizations,
f) Lab testing including mandatory lead screening, and
g) Health education and anticipatory guidance.

f. The MCO must have written policies and procedures for the maintenance of medical records to ensure that records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information. Medical records shall be maintained in a detailed and comprehensive manner, which conforms to professional standards, permits effective medical review and audit processes, and facilitates an adequate system for follow-up treatment. Policies and procedures must be submitted to MLTC for review and approval sixty (60) calendar days prior to their implementation.

g. The MCO must have written standards for documentation on medical records for legibility, accuracy, and plan of care that comply with applicable law.

h. When a member changes PCPs, the MCO must ensure their medical records or copies of medical records are forwarded to the new PCP within ten (10) business days from receipt of the request for transfer of the medical records.

i. MLTC is not required to obtain written approval from a member before requesting the member's medical record from the PCP or any other organization or agency. The MCO may obtain a copy of a member's medical records without written approval of the member if the reason for such request is directly related to the administration of the Nebraska Medicaid program.

j. The MCO must afford MLTC access to all members' medical records, whether electronic or paper, within twenty (20) business days of receipt of the request or more quickly if necessary in MLTC's sole determination.

k. Information related to fraud and abuse may be released. However, HIV-related information may not be disclosed except as provided in state statute, and substance use disorder information shall only be disclosed consistent with federal and state law including, but not limited to 42 CFR § 2.1 et seq.

12. Advance Directives

a. The MCO must maintain written policies and procedures for advance directives, as described in 42 CFR § 489.100 and 42 CFR § 422.128.

b. The MCO must provide written information to all adult members with respect to:

i. Their rights under applicable law; and

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

c. The MCO is prohibited from conditioning the provision of care or otherwise discriminating against an individual based on whether the individual has executed an advance directive.

d. The MCO must inform individuals that complaints concerning noncompliance with advance directive requirements may be filed with MLTC or the DHHS Division of Public Health.

e. The MCO must update any written information on advance directives to reflect changes in state law as soon as possible, but no later than ninety (90) calendar days after the effective date of a change.

13. Communication with New Members

a. MLTC's enrollment broker is required to send to the MCO a daily electronic transmission file that contains the names, addresses, and telephone numbers of all members newly assigned to the MCO, with an indicator for members who were auto-assigned. The MCO must use this file to identify new members, initiate communication with new members via welcome packet mailings and calls, and assign members to a PCP, if the member has not already chosen one.

b. Welcome Packets

i. The MCO must send a welcome packet to new members within ten (10) business days of receiving the new member file.

ii. The MCO must mail a welcome packet to each new member. When the name of the responsible party for the new member is associated with two or more new members, the MCO is only required to send one welcome packet.

iii. All contents of the welcome packet are considered member materials and, as such, must be submitted for review and approval by MLTC a minimum of one hundred and fifty (150) calendar days prior to the Contract Start Date. The materials must comply with the requirements of this RFP and 42 CFR § 438.10 (g)(2). The welcome packet must include, at a minimum:

a) A welcome letter with MCO contact information. If the MCO ID card is mailed separately, the welcome letter must also state that the member will receive their member ID card separately;

b) Information on how to request a member handbook;

c) The MCO member ID card (if not mailed separately);

d) Notice that the provider directory and Member Handbook are available on the member portal and that the member may request a hard copy if they want one. Directions for how to obtain hard copies must be included in this notice; and

e) Other information that the MCO wishes to include, such as an EPSDT program periodicity schedule, prenatal care materials, guidance regarding emergency services, availability of community services/resources, and any other materials that might be appropriate for the member.

c. Welcome Calls

i. The MCO must make welcome calls to new members within ten (10) business days of the date the MCO sends the welcome packet.

ii. A minimum of one hundred and fifty (150) calendar days prior to the Contract Start Date, the MCO must develop and submit to MLTC for approval a script to be used during the welcome call to discuss the following information with the member:

a) A brief explanation of the program;
b) A discussion of member confidentiality requirements;
c) The availability of oral interpretation and written translation services and how to obtain them free of charge;
d) The concept of patient-centeredness, including the importance of the member making a first appointment with his or her PCP for preventive care before the member requires care due to an illness or condition. If the member did not already select their PCP, the member should be advised that they may select a PCP and the MCO must assist with this process, if needed;
e) A determination of whether the member is pregnant, has a chronic condition, faces barriers to accessing care (e.g., transportation needs, mobility limitations) or any special health care needs. Assistance in making an appointment with the PCP must be offered to all members with any of these issues; and
f) Assistance with any needed referrals, including but not limited to, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program.

iii. The MCO must make three (3) attempts to contact the member. If the MCO discovers that the member has lost or has never received the welcome packet, the MCO must resend it.

iv. The MCO must report to MLTC, monthly, the name, telephone number(s), and Medicaid Recipient ID Number of each member it was unable to contact after three (3) attempts.

v. The MCO may propose to MLTC an alternate method and plan for welcoming members per this section if anticipated to be more effective. MLTC in its sole discretion may approve this alternate method.

14. Member Education

a. In all its written and verbal communications with its members, the MCO must provide ongoing education about how the member can improve their health and wellness. This must include, but not be limited to, the member handbook, the new member welcome packet, the member newsletter, other member mailings, and communication with member services representatives, case managers, and other MCO staff.

b. The MCO is responsible for educating members on the appropriate utilization of ED services, including behavioral health emergencies.

c. The MCO must submit to MLTC for review and approval its proposed member education plan a minimum of one hundred and fifty (150) calendar days prior to the Contract Start Date. This plan must include, but not be limited to:

i. The MCO's plans for new member outreach, including welcome packets and welcome calls, as well as ongoing member education;

ii. How the MCO plans to reach out to members in need of care management services;

iii. The MCO's plan to incorporate patient engagement tools such as smartphone-based support programs, mobile applications, or text messaging innovations. A smartphone-based support program could include the following features:

a) Mobile applications and/or mobile-friendly content that is accessible across a broad range of electronic devices;
b) Consumer-friendly and engaging content that helps keep patients on-track with key health appointments and screenings;
c) Tools to help stratify users by risk profile and direct the higher risk users to state-based or MCO-based resources;
d) Outreach support to educate patients about the mobile tools; and
e) Reporting and analytics to help the State measure the effectiveness of the electronically based support program.

iv. How the MCO plans to meet the informational needs, relative to member education, for the physical and cultural diversity of the state. This may include, but is not limited to, a description of the provisions for non-English speaking members, interpreter services, and alternate communication mechanisms (such as sign language, Braille, or audio tapes); and

v. A list of all subcontractors engaged in marketing or member education activities for the MCO.

d. The MCO may not conduct member education or distribute member education materials in provider offices.

G. MEMBER MARKETING

1. General Guidelines for Marketing

a. Marketing, for the purposes of this RFP, is defined in 42 CFR § 438.104(a) as any communication from a MCO to a Medicaid enrollee, who is not enrolled in that MCO, that can reasonably be interpreted as intended to influence the Medicaid enrollee to 1) enroll in that particular MCO, or 2) either not enroll in, or dis-enroll from, another MCO.

b. Marketing is different than member education. Member education is defined as communication with a MCO member for the purpose of retaining the member as a member and improving their health status.

c. Marketing materials are materials produced and presented in any medium, by or on behalf of the MCO, and can reasonably be interpreted as intended to market the MCO to potential enrollees.

d. Under the Nebraska Medicaid managed care program, all direct marketing to Medicaid enrollees or potentially eligible individuals must be performed in accordance with 42 U.S.C. § 1396u-2(d)(2)(A) and 42 CFR § 438.104.

e. The MCO must ensure that:

- **i.** All marketing materials and activities comply with the requirements in 42 CFR § 438.10 and the MLTC requirements set forth in this RFP;
- **ii.** All marketing activities are conducted in an orderly, non-disruptive manner and do not interfere with the privacy of members, Medicaid enrollees, or the general community;
- **iii.** Marketing materials are not distributed without prior MLTC review and approval;
- **iv.** Media marketing materials are distributed within thirty (30) calendar days of MLTC approval. Thirty (30) calendar days after MLTC approval of these materials the approval for use is no longer valid;
- **v.** Marketing materials are distributed statewide;
- **vi.** The MCO does not seek to influence enrollment in conjunction with the sale or offering of any private insurance; and
- **vii.** The MCO does not, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities as defined in 42 CFR § 438.104(a).

f. The MCO must ensure that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud members/enrollees or MLTC as specified in 42 U.S.C § 1396u-2(d)(2) and 42 CFR § 438.104. Marketing materials must not contain any assertion or statement (whether written or verbal) that:

- **i.** The member must enroll in the MCO to obtain or not to lose benefits; and
- **ii.** That the MCO is endorsed by CMS, the federal or state government, MLTC, or any similar entity.

g. The MCO is responsible for the creation, production, and distribution of its own marketing and member materials. MLTC and its enrollment broker will only be responsible for distributing general material developed and produced by the MCO for inclusion in the enrollment package distributed to Medicaid enrollees. MLTC will determine which materials will be included in the enrollment broker generated packet and which materials will be distributed by the MCO.

h. Activities involving distribution and completion of an MCO enrollment form during the course of enrollment activities is an enrollment function and is the sole responsibility of MLTC's enrollment broker.

i. If a person who provides a testimonial or endorsement for the MCO has a financial interest in the company, this fact must be disclosed in the member/marketing materials.

j. The MCO shall comply with the Office of Minority Health, DHHS' Cultural and Linguistically Appropriate Services Guidelines, which are available at: https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53, and participate in the State's efforts to promote the delivery of services in a culturally competent manner to all Medicaid enrollees.

2. Marketing Plan

a. The MCO must develop and implement a plan detailing the marketing activities it will undertake and materials it will create during the contract period, which must incorporate the requirements of this RFP. The detailed, proposed plan must be submitted to MLTC for review and approval a minimum of one hundred and fifty (150) calendar days prior to the Contract Start Date.

b. The MCO must not begin member marketing activities associated with this contract prior to approval of the marketing plan by MLTC.

c. The plan must include at a minimum:

- **i.** Stated marketing goals and strategies;
- **ii.** A marketing calendar, which begins at the Contract Execution Date, and runs through the first calendar year of providing services to Medicaid members, that addresses all marketing areas including, but not limited to, advertising plans, website development and launch plans, printed materials, material distribution plans (including specific locations), or outreach activities (health fairs, area events, etc.);
- **iii.** A summary of value-added benefits to be used by MLTC to create a plan comparison chart to assist Medicaid enrollees in selecting the MCO that best meets their needs;
- **iv.** Distribution methods and schedules, including media schedules for electronic or print advertising (including date and station or publication);
- **v.** How the MCO plans to meet the informational needs, relative to marketing (for prospective enrollees), of the physical and cultural diversity within the state. This may include but is not limited to: a description of the provisions for non-English speaking prospective enrollees, interpreter services, or alternate communication mechanisms (such as sign language, Braille, audio tapes, etc.);
- **vi.** A list of all subcontractors engaged in marketing activities for the MCO;
- **vii.** A copy of the training curriculum for marketing representatives, both internal and subcontracted staff;
- **viii.** The MCO's procedure for monitoring and enforcing compliance with all marketing guidelines including, but not limited to, the MCO methods for monitoring of prohibited marketing methods among internal staff and subcontractors;
- **ix.** A copy of the instruction given to participating providers regarding provider marketing guidelines described in this section of the RFP;
- **x.** Copies of all marketing materials planned for distribution by the MCO or any of its subcontractors;
- **xi.** Copies of marketing materials that are:
  - a) Currently in concept form, but not yet produced, including a detailed description; or
  - b) Samples from other states that will be duplicated in a similar manner for the Nebraska Medicaid managed care population;
- **xii.** Details of proposed marketing activities and events;
- **xiii.** Details regarding the basis the MCO uses for awarding bonuses or increasing the salary of marketing representatives or any other employees involved in marketing activities;
- **xiv.** Details about the distribution of current materials, as well as plans to remove outdated materials from public areas; and
- **xv.** The MCO's protocols for responding to unsolicited direct contact (verbal or written) from a Medicaid enrollee or potentially eligible individual. This must include circumstances that will:
  - a) Initiate a referral to the enrollment broker;
  - b) Initiate a referral to the Medicaid Eligibility customer service line, and
  - c) Terminate the conversation.

d. The MCO must submit any changes to the marketing plan, including materials or activities to MLTC for review and approval a minimum of one hundred and fifty (150) calendar days before intended implementation of the marketing activity.

e. The MCO must update the marketing plan annually and submit it to MLTC for approval a minimum of one hundred and fifty (150) calendar days before intended implementation.

3. Allowable Marketing Activities

a. The MCO and its subcontractors are permitted to perform the following activities:

- **i.** Distribute general information through mass media (i.e., newspapers, magazines, and other periodicals; radio; television; the internet; public transportation advertising; billboards; and any other media outlets), in compliance with prohibitions to placement detailed in this RFP;

ii. Make telephone calls and home visits to members currently enrolled in the MCO (member education and outreach), for the purpose of educating them about services offered by or available through the MCO;

iii. Respond to verbal or written requests for information made by Medicaid enrollees, in compliance with the marketing plan approved by MLTC;

iv. Provide promotional giveaways that do not exceed $15.00 in value, to current members;

v. Attend or organize activities that benefit the entire community, such as health fairs or other health education and promotion activities. MLTC must be notified no later than thirty (30) calendar days prior to the activity, and details must be provided about the planned marketing activities using the process described in this RFP;

vi. Attend activities at a business, only at the invitation of the entity. The MCO must notify MLTC in advance of the activity and details must be provided;

vii. Attend events at the request of MLTC to disseminate or share information about the MCO, its services, and outcomes;

viii. Conduct telephone marketing, only during incoming calls from Medicaid enrollees. The MCO may return telephone calls to potential members only when requested to do so by the caller. The MCO must utilize the response plan outlined in the marketing plan during these calls, as approved by MLTC; and

ix. Send plan-specific materials to Medicaid enrollees only at their request.

b. If there is any instance in which an MCO-allowable activity conflicts with a prohibited activity, the MCO must follow the prohibited activity guidance.

4. Prohibited Marketing Activities

The MCO and its subcontractors are prohibited from engaging in the following activities:

a. Marketing directly to Medicaid enrollees or potentially Medicaid eligible individuals, including persons currently enrolled in FFS Medicaid or other MCOs. Direct marketing includes direct mail advertising; unsolicited email ("spam"); and door-to-door, telephonic, or other "cold call" marketing techniques;

b. Asserting that the MCO is endorsed by CMS, the federal or state government, MLTC, or any similar entity;

c. Distributing plans and materials or making any statement (written or verbal) that MLTC determines to be inaccurate, false, confusing, misleading, or intended to defraud members or MLTC. This includes statements that mislead or falsely describe covered services, membership or availability of providers, or qualifications or skills of providers;

d. Portraying competitors or potential competitors in a negative manner;

e. Assisting with enrollment or improperly influencing MCO selection;

f. Inducing or accepting a member's enrollment or disenrollment from any Medicaid enrollee or member not currently enrolled with the MCO;

g. Using the seal of the State of Nebraska or MLTC's name, logo, or other identifying marks on any materials produced or issued, without the prior written consent of MLTC;

h. Distributing marketing information (written or verbal) that implies that joining MCOs or a particular MCO is the only means of preserving Medicaid coverage, or that MCOs or a particular MCO is the only provider of Medicaid services and the potential enrollee must enroll in the MCO or MCOs to obtain benefits or not lose benefits;

i. Comparing itself to another organization/MCO by use of the other's name;

j. Sponsoring or attending any marketing or community health activities or events without notifying MLTC within the timeframes specified in Section V.G.3.a.v – Allowable Marketing Activities;

k. Engaging in any marketing activities, including unsolicited personal contact with a Medicaid enrollee or potentially eligible individual, at an employer-sponsored enrollment event when employee participation is mandated by the employer;

l. Marketing or distributing marketing materials, including member handbooks, or soliciting members in any other manner, inside, at the entrance, or within one hundred (100) feet of DHHS local offices without prior approval from MLTC. Medicaid eligibility office staff or approved MLTC agents are the only authorized personnel to distribute such materials;

m. Marketing or distributing marketing materials in hospital EDs, including the ED waiting areas, patient rooms, or treatment areas;

n. Registering or asserting any copyright or releasing any report, graph, chart, picture, or other document relating to services provided under this contract without the prior written consent of MLTC;

o. Purchasing or otherwise acquiring or using mailing lists of Medicaid-eligible individuals from third-party vendors, including providers and state offices;

p. Using raffle tickets, event attendance, or sign-in sheets to develop mailing lists of prospective members;

q. Charging members for goods or services distributed at events;
r. Charging members a fee for accessing the MCO website;
s. Influencing enrollment in conjunction with the sale or offering of any private insurance;
t. Using terms that would influence, mislead, or cause potential members to contact the MCO, rather than the MLTC-designated enrollment broker, for enrollment;
u. Referencing the private insurance component of the MCO, if any, in any of its Medicaid MCO enrollee marketing materials;
v. Using terms in marketing materials such as "choose," "pick," "join," etc., unless the marketing materials include the enrollment broker's contact information;
w. Provide promotional giveaways to persons not currently members; and
x. MCOs must not produce branded materials instructing members about how to change to a different MCO. They must use MLTC-provided or approved materials and refer members directly to the enrollment broker for needed assistance.

5. Media Contacts

The MCO must not provide information to the media or give media interviews without the prior consent of MLTC. The MCO must refer any contacts by the media or other entity or individual not directly related to the program to MLTC within twenty-four (24) hours of contact.

6. Provider Marketing Guidelines

a. When conducting any form of marketing in a provider's office, the MCO must obtain and keep on file the written consent of the provider.
b. The MCO shall not require its providers to distribute MCO-prepared marketing communications to their patients.
c. The MCO shall not provide incentives or giveaways to providers to distribute marketing materials to MCO members or potential MCO members.
d. The MCO shall not allow providers to solicit enrollment or disenrollment in an MCO or distribute MCO-specific materials.
e. The MCO shall not provide printed materials to providers with instructions detailing how to change MCOs to members of other MCOs.
f. The MCO must instruct participating providers regarding the following communication requirements:
  i. Participating providers who wish to let their patients know of their affiliations with one or more MCOs must list each MCO with whom they contract.
  ii. Participating providers may display and distribute health education materials for all contracted MCOs or they may choose not to display and distribute for any contracted MCOs. Health education materials must adhere to the following guidance:
    a) Health education posters cannot be larger than sixteen (16) x twenty-four (24) inches;
    b) Children's books, donated by MCOs, must be in common areas; and
    c) Materials may include the MCO's name, logo, telephone number and website address.
  iii. Providers are not required to distribute and/or display all health education materials provided by each MCO with whom they contract. Providers can choose which items to display as long as they distribute items from each contracted MCO and that the distribution and quantity of items displayed are equitable.
  iv. Providers may display marketing materials for MCOs provided that appropriate notice is conspicuously and equitably posted, in both size of material and type set, for all MCOs with whom/which the provider has a contract.
  v. Providers may display MCO participation stickers, but if they do, they must display stickers for all contracted MCOs or choose not to display stickers for any contracted MCOs.
  vi. MCO stickers indicating that the provider participates with a particular MCO cannot be larger than five (5) x seven (7) inches and cannot indicate anything more than "The MCO is accepted or welcomed here."
  vii. Providers may inform their patients of the benefits, services, and specialty care services offered through the MCOs in which they participate. However, providers may not recommend one MCO over another, offer patients incentives for selecting one MCO over another, or assist the patient in deciding to select a specific MCO in any way, including, but not limited to, using a phone, computer, or fax machine in the office.
  viii. On actual termination of a contract with the MCO, a provider who/that has contracts with other MCOs may notify their patients of the change and the impact of the change on the patient, including the date of the contract termination. Providers must continue to see

current patients enrolled in the MCO through the termination date, according to all terms and conditions specified in the contract between the provider and the MCO.

H. GRIEVANCES AND APPEALS

1. General Requirements

a. The MCO must have a grievance system for members that complies with federal and state regulations, including a grievance process, an appeal process, and access to the State's fair hearing system. The MCO must distinguish between a grievance, grievance system, and grievance process, as defined below:

i. A grievance is a member's expression of dissatisfaction with any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested.

ii. 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.

iii. A grievance process is the procedure for addressing and tracking members' grievances.

b. The MCO must:

i. Give members reasonable assistance in completing forms and other procedural steps, including but not limited to providing interpreter services and toll-free numbers with teletypewriter/telecommunications devices for deaf individuals and interpreter capability;

ii. Acknowledge receipt of each grievance and appeal, in writing, to the member within ten (10) calendar days of receipt;

iii. Ensure that individuals completing the review and making decisions for grievances and appeals are not the same individuals involved in previous levels of review or decision-making, nor the subordinate of any such individual;

iv. Ensure, for the following circumstances, that the decision maker is a health care professional with clinical expertise in treating the member's condition or disease:

a) An appeal of a denial that is based on lack of medical necessity,

b) Because of the member's medical condition, the grievance requires expedited resolution,

c) A grievance regarding denial of expedited resolution of an appeal, and

d) The grievance or appeal involves clinical issues;

v. Consider all comments, documents, records, and any other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit decision;

vi. Provide access to MLTC and/or its designee for any information related to grievances or appeals filed by its members. MLTC will monitor enrollment and termination practices to ensure proper implementation of the MCO's grievance procedures, in compliance with 42 CFR § 438.228; and

vii. Ensure all written notices described in this section meet the requirements of 42 CFR § 438.10 and Section V.F, Member Services and Education, of this contract.

2. Complaint and Grievance Processes

a. A member may file a grievance verbally or in writing. A provider may file a grievance verbally or in writing when acting as the member's authorized representative.

b. A member may file a grievance with the MCO or MLTC at any time.

c. The MCO must address each grievance and provide notice, as expeditiously as the member's health condition requires, and under all circumstances within ninety (90) calendar days from the day on which the MCO receives the grievance.

d. The MCO must provide written notice of grievance resolution.

3. Service Authorizations and Notices of Adverse Benefit Determination

a. Service Authorization

i. The MCO must provide a definition of service authorization that, at a minimum, includes the member's request for the provision of a service.

ii. The MCO must ensure 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 must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

b. Notice of Adverse Benefit Determination

i. The MCO must notify the requesting provider, and give the member 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.

ii. The MCO must give the member written notice of any adverse benefit determination (not just service authorization adverse benefit determinations) within the timeframes required for each type of decision. The notice must explain:

a) The adverse benefit determination the MCO or its subcontractor has taken or intends to take;

b) The reason(s) for the adverse benefit determination;

c) The member's right to receive, on request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's claim for benefits. Such information includes medical-necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits;

d) The member's or the provider's right to file an appeal;

e) The member's right to request a State Fair Hearing;

f) Procedures for exercising a member's rights to appeal or grieve a decision;

g) Circumstances under which expedited resolution is available and how to request it; and

h) The member's rights to have benefits continue pending the resolution of an appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the cost of these services.

c. Timeframes for Notice of Adverse Benefit Determination

i. The MCO must provide notice to the member a minimum of ten (10) business days before the date of action when the adverse benefit determination is a termination, suspension, or reduction of previously authorized Medicaid-covered services.

ii. The period of advanced notice required is shortened to five (5) business days if probable member fraud has been verified.

iii. The MCO must give notice by the date of the action under the following circumstances:

a) The death of a member;

b) A signed written member statement requesting service termination or giving information requiring termination or reduction of services, if the statement reasonably indicates that the member understands the result of the statement will be a termination or reduction of services;

c) The member's admission to an institution where he or she is ineligible for further services;

d) The member's address is unknown and mail directed to him/her has no forwarding address;

e) The member has been accepted for Medicaid services by another state;

f) The member's physician or dentist prescribes the change in the level of medical care;

g) An adverse determination is made regarding the preadmission screening requirements for nursing facility admissions on or after January 1989; or

h) The safety or health of individuals in the facility would be endangered, the member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or a member has not resided in the nursing facility for thirty (30) calendar days (applies only to adverse benefit determinations for nursing facility transfers).

iv. The MCO must provide notice on the date of action when the determination is a denial of payment.

v. Standard Service Authorization Denial

The MCO must give notice as expeditiously as the member's health condition requires, and within MLTC established timeframes, which may not exceed fourteen (14) calendar days following receipt of the request for service. The timeframe may be extended up to fourteen (14) additional calendar days if the member or the provider requests an extension or the MCO justifies a need for additional information and the reason(s) why the extension is in the member's interest. If the MCO extends the timeframe, the member 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 member's health condition requires and, in any event, no later than the date the extension expires.

vi. Expedited Service Authorization Denial
For cases in which a provider indicates or the MCO determines that following the standard timeframe could seriously jeopardize the member'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 member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service. The MCO may extend the time period by up to fourteen (14) calendar days if the member requests an extension or if the MCO justifies a need for additional information and the reason(s) why the extension is in the member's interest.

vii. 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. An untimely service authorization constitutes a denial and therefore constitutes an adverse benefit determination.

4. Appeal Processes

a. A member may file an MCO-level appeal. A provider, acting on behalf of the member and with the member's written consent, may also file an appeal.

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

c. The member or provider may file an appeal either verbally or in writing in accordance with 42 CFR § 438.402(c)(3)(ii).

d. The MCO must:

i. Ensure verbal inquiries seeking to appeal an adverse benefit determination are treated as appeals in accordance with 42 CFR § 438.406(b)(3);

ii. Ensure that there is only one level of appeal for members;

iii. Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing;

iv. Provide the member and his or her representative (free of charge and sufficiently in advance of the resolution timeframe for appeals) the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied on, or generated by the MCO (or at the direction of the MCO) in connection with the appeal of the adverse benefit determination; and

v. Consider the member and their representative (if any), or (if instead applicable) the representative of a deceased member's estate as parties to the appeal.

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

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

ii. Within two (2) calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if they disagree with that decision; and

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

f. The MCO must provide written notice of disposition, which must include:

i. The results and date of the appeal resolution; and

ii. For decisions not wholly in the member's favor:

a) The right to request a State Fair Hearing,
b) How to request a State Fair Hearing,
c) The right to continue to receive benefits pending a hearing,
d) How to request the continuation of benefits, and
e) If the MCO adverse determination is upheld in a hearing, the member may be liable for the cost of any continued benefit received while the appeal was pending.

5. Expedited Appeals Process

a. The MCO must establish and maintain an expedited review process for appeals that the MCO determines (at the request of the member or their provider) that taking the time for a standard resolution could seriously jeopardize the member'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 to the extent that any differences are specifically noted in the regulation for expedited resolution.

b. The member or provider may file an expedited appeal either verbally or in writing. No additional member follow-up is required.

c. The MCO must inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and/or in writing, in the case of an expedited resolution.

d. The MCO must resolve each expedited appeal, and provide notice, as expeditiously as the member's health condition requires, within seventy-two (72) hours after the MCO receives the appeal. The MCO may extend the timeframes by up to five (5) calendar days if the member requests the extension or the MCO shows that there is a need for additional information and the reason(s) why the delay is in the member's interest. For any extension not requested by the member, the MCO must:

- **i.** Make reasonable efforts to give the member prompt verbal notice of the delay;
- **ii.** Within two (2) calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and
- **iii.** Resolve the appeal as expeditiously as the member's health condition requires and no later than the date on which the extension expires.

e. The MCO must make a reasonable effort to provide verbal notice of disposition, along with written notice, which must include:

- **i.** The results and date of the appeal resolution; and
- **ii.** For decisions not wholly in the member's favor:
  - a) The right to request a State Fair Hearing,
  - b) How to request a State Fair Hearing,
  - c) The right to continue to receive benefits pending a hearing,
  - d) How to request the continuation of benefits, and
  - e) If the MCO adverse determination is upheld in a hearing, the member may be liable for the cost of any continued benefit received while the appeal was pending.

f. The MCO must ensure that no punitive action is taken against a provider as a result of the provider's request for an expedited resolution or support of a member's appeal.

g. If the MCO denies a request for expedited resolution of an appeal, it must:

- **i.** Transfer the appeal to the standard timeframe of no longer than thirty (30) calendar days from the day the MCO receives the appeal with a possible extension of fourteen (14) calendar days; and
- **ii.** Make a reasonable effort to give the member prompt verbal notice of the denial and written notice within two (2) calendar days.

6. Continuation of Benefits

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

- **i.** The member files the request for an appeal timely in accordance with 42 CFR § 438.402(c)(1)(ii) and (c)(2)(ii);
- **ii.** The appeal involves the termination, suspension, or reduction of previously authorized services;
- **iii.** The services were ordered by an authorized provider;
- **iv.** The period covered by the original authorization has not expired; and
- **v.** The member timely files for continuation of benefits. For purposes of this section, "timely files" means on or before the later of the following:
  - a) Within ten (10) calendar days of the MCO sending the notice of adverse benefit determination, or
  - b) The intended effective date of the MCO's proposed adverse benefit determination.

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

- **i.** The member withdraws the appeal or request for State Fair Hearing;
- **ii.** The member fails to request a State Fair Hearing and continuation of benefits within ten (10) calendar days after the MCO sends the notice of an adverse resolution to the member's appeal; or
- **iii.** The State Fair Hearing office issues a hearing decision adverse to the member.

c. If the final resolution of the appeal or State Fair Hearing is adverse to the member, that is, upholds the MCO's adverse benefit determination, the MCO may recover the cost of services furnished to the member while the appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

7. Access to State Fair Hearings

a. A member may request a State Fair Hearing. The provider may also request a State Fair Hearing if the provider is acting as the member's authorized representative. A member or their representative may request a State Fair Hearing only after receiving notice that the MCO is upholding the adverse benefit determination.

b. If the MCO takes action and the member requests a State Fair Hearing, the State must grant the member 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 member or the member's representative (if any) by the MCO.

c. Following the date of the MCO's notice of appeal resolution, the member or the member's representative (if any) has one hundred and twenty (120) calendar days in which to file a request for State Fair Hearing.

d. The parties to the State Fair Hearing include the MCO, and the member and their representative (if any), or (if instead applicable) the representative of a deceased member's estate.

8. Reversed Appeals

a. If the MCO or the State Fair Hearing process reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but in no event later than seventy-two (72) hours from the date the MCO receives notice reversing the determination.

b. The MCO must pay for disputed services if the MCO or State Fair Hearing decision reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending.

9. Grievance and Appeal Recordkeeping Requirements

a. The MCO must maintain records of grievances and appeals. The record of each grievance and appeal must contain, at a minimum, all the following information:

i. A general description of the reason for the appeal or grievance;

ii. The date the grievance or appeal was received;

iii. The date of each review or, if applicable, review meeting;

iv. Resolution at each level of the appeal or grievance process, as applicable;

v. Date of resolution at each level of the appeal or grievance process, as applicable; and

vi. Name of the covered person by or for whom the appeal or grievance was filed.

b. The MCO is required to accurately maintain the record in a manner that is accessible to MLTC and available on request to CMS.

10. 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 or renewing a contract:

a. The member's right to a State Fair Hearing and how to obtain a hearing and representation rules at a hearing;

b. The member's right to file grievances and appeals and the requirements and timeframes for filing them;

c. The availability of assistance in filing grievances or appeals, and participating in State Fair Hearings;

d. The toll-free number(s) to use to file verbal grievances and appeals;

e. The member's right to request continuation of benefits during an appeal or State Fair Hearing filing and, if the MCO adverse decision is upheld in a hearing, that the member may be liable for the cost of any continued benefits received while the appeal was pending; and

f. Any State-determined provider appeal rights to challenge the failure of the organization to cover a service.

11. Reporting of Complaints, Grievances, and Appeals

The MCO is required to submit to MLTC monthly data for the first six (6) months after the Contract Start Date, and then submit data quarterly, thereafter, as specified by MLTC, about grievances and appeals. MLTC reserves the right to extend the monthly reporting requirement at its sole discretion. This information will be used by MLTC to measure the MCO's performance.

I. PROVIDER NETWORK REQUIREMENTS

1. General Provider Network Requirements

a. The network must be supported by written contracts between the MCO and its providers. Providers must first be enrolled with Nebraska Medicaid.

b. The MCO must ensure that network providers offer hours of operation that are no shorter in duration than the hours of operation offered to commercial members, or comparable Medicaid members if the provider serves only the Medicaid population.

c. There must be sufficient providers for the provision of medically necessary covered services, including emergency medical care, at any time.

d. The MCO must have available non-emergent after-hours physician or primary care services within its network.

e. Network providers must be available within a reasonable distance to members and accessible within an appropriate timeframe to meet the members' medical needs. Standards for distance and time are fully outlined in Attachment 14 - Access Standards. The MCO must ensure that providers are available within these requirements.

f. The MCO's network providers must comply with all applicable requirements set forth in this contract.

g. The MCO must take corrective action if it, or its providers, fail to comply with the timely access requirements in this section and Attachment 14 – Access Standards.

h. The MCO must make a good faith effort to contract with urgent care centers in Nebraska to maximize availability of urgent care services to its members. In the event that a contract cannot be obtained, the MCO must maintain documentation detailing the efforts it has made.

i. In order to ensure members have access to a broad range of health care providers, and to limit the potential for disenrollment due to lack of access to providers or services, the MCO must not have a contract arrangement with any provider in which the provider agrees that it will not contract with another MCO, or in which the MCO agrees that it will not contract with another provider. The MCO must not advertise or otherwise hold itself out as having an exclusive relationship with any provider.

j. In all its 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.

k. The MCO must require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, and provide for interpreters in accordance with 42 CFR § 438.206(c)(2).

l. The MCO must have adequate capacity within its network to communicate with members in Spanish and other languages, when necessary, as well as with those individuals who are deaf or hearing-impaired.

m. The MCO must consider the ability of providers to ensure physical access, accommodations, and accessible equipment for Medicaid members with physical, developmental, or mental disabilities.

n. Each MCO must establish procedures for changing an existing provider contract with a provider that include the requirements of this section .

i. If an MCO makes any material change to a provider contract, the MCO shall provide the provider with at least 60 (sixty) calendar days' notice of the material change. The notice of a material change required under this section shall include each of the following:

a) The effective date of the material change;

b) A description of the material change;

c) The name, business address, telephone number, and electronic mail address of a representative of the MCO to discuss the material change, if requested by the provider;

d) Notice of the opportunity for a meeting using real-time communication to discuss the proposed changes if requested by the provider, including any mode of telecommunications in which all users can exchange information instantly such as the use of traditional telephone, mobile telephone, teleconferencing, and videoconferencing. If requested by the provider, the opportunity to communicate to discuss the proposed changes may occur via electronic mail instead of real-time communication; and

e) Notice that upon three (3) material changes in a twelve-month (12) period, the provider may request a copy of the provider contract with material changes consolidated into a single document. The provision of the copy of the provider contract with the material changes incorporated by the managed care organization:

1). Shall be for information purposes only,

2). Shall have no effect on the terms and conditions of the provider contract, and

3). Shall not be construed as the creation of a new contract.

ii. Any notice required to be delivered shall be sent to the provider's point of contact as set forth in the provider contract and shall be clearly and conspicuously marked "contract change." If no point of contact is set forth in the provider contract, the MCO must send the requisite notice to the provider's place of business addressed to the provider.

2. Provider Discrimination Prohibition

a. An MCO may not discriminate with respect to provider participation in the Medicaid program, reimbursement, or indemnification of any provider who/that is acting within the scope of their license or certification under applicable state law, solely on the basis of that license or certification.

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

c. 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(b) shall not be construed to:

i. Require the MCO to contract with providers beyond the number necessary to meet the needs of its members;

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

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

3. Mainstreaming of Members

a. To ensure mainstreaming of Nebraska Medicaid members, the MCO must take affirmative action so that members are provided covered services without regard to payer source, race, color, creed, gender, religion, age, national origin (to include those with limited English proficiency), ancestry, marital status, sexual orientation, genetic information, or physical or mental illnesses. The MCO must take into account a member's literacy and culture when addressing members and their concerns, and must take reasonable steps to ensure subcontractors do the same. Examples of prohibited practices include, but are not limited to, the following:

i. Denying or not providing a member any covered service or access to an available facility;

ii. Providing to a member any medically necessary covered service that is different, or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large, except where medically necessary;

iii. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service, or restricting a member in any way in their enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and

iv. Assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, gender, national origin, ancestry, marital status, sexual orientation, income status, Medicaid membership, or physical or mental illnesses of the participants to be served.

b. If the MCO knowingly executes a subcontract with a provider with the intent of allowing or permitting the subcontractor to implement barriers to care (i.e., the terms of the subcontract act to discourage the full utilization of services by some members) the MCO shall be subject to intermediate sanction or contract termination.

c. If the MCO identifies a problem involving discrimination by one of its providers, it must promptly intervene and require a corrective action plan from the provider to come into compliance within 30 (thirty) calendar days and notify MLTC in writing. Failure to take prompt corrective measures shall subject the MCO to intermediate sanction or contract termination.

4. Establishing the Network

a. The MCO must offer an appropriate range of preventive, primary care, and specialty services adequate for the number of its members. The MCO must submit documentation to MLTC, in a format approved by MLTC, to demonstrate it meets this requirement prior to the Contract Start Date and any time there is a significant change (as defined by the State) in the MCO's operations that impacts services.

b. The MCO's network must include a sufficient number/type of providers to meet MLTC access standards for adequate capacity for adult and pediatric primary care providers (PCPs); high-volume specialties (cardiology, neurology, hematology/ oncology, obstetrics and gynecology, and orthopedic physicians); behavioral health; and, urgent care centers, FQHCs, RHCs, dentists,

dental specialists (endodontists, oral surgeons, orthodontists, pedodontists, periodontists, prosthodontists), and pharmacies. The MCO must also contract with additional specialties (allergy, dermatology, endocrinology, gastroenterology, general surgery, neonatology, nephrology, neurosurgery, occupational therapy, ophthalmology, otolaryngology, pathology, physical therapy, pulmonology, psychiatry, radiology, reconstructive surgery, rheumatology, urology, and pediatric specialties); hospitals; and additional provider types to meet its members' needs.

c. The MCO must provide an adequate network of PCPs to ensure that members have access to all primary care services in the benefits package. All members must be allowed the opportunity to select or change their PCP. Provider types that can serve as PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, or obstetrics/gynecology (OB/GYN). Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing within the scope and requirements of their license.

d. The MCO must maintain a network of qualified providers that meets appointment availability and geographic access standards defined in Attachment 14 – Access Standards and all requirements in this section. Attachment 2 – Nebraska Counties Classified by Urban/Rural/Frontier Status provides a map of Nebraska counties classified by urban, rural, and frontier status, as this classification is referenced in the access standards.

e. The MCO's network must include providers that are currently serving Medicaid members and will need to be part of the MCO's network to continue to care for these members.

f. The MCO must provide female members 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 member's designated source of primary care, if that source is not a women's health specialist.

g. For members who meet Special Health Care Needs (SHCN) criteria, the MCO must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.

h. The MCO must ensure that its provider network includes sufficient numbers of network providers with experience and expertise regarding the following behavioral health conditions:

- **i.** Co-occurring mental health and substance use disorders;
- **ii.** Co-occurring mental health and substance use disorders and developmental disabilities;
- **iii.** Serious and persistent mental illness;
- **iv.** Severe emotional disturbance among children and adolescents, including coordinated care for children served by DHHS or other state agencies (e.g., Children and Family Services, Probation, Developmental Disabilities, etc.);
- **v.** Sex-offending behaviors;
- **vi.** Eating disorders; and
- **vii.** Co-occurring Serious Mental Illness and common chronic physical illnesses.

The MCO must contract with providers who/that demonstrate a commitment to the behavioral health principles of care defined in Section V.L Care Management of this RFP, including principles of rehabilitation and recovery from mental illness and substance use disorder; a focus on recovery-oriented, trauma-informed services and trauma-specific treatment (e.g., trauma-focused cognitive behavioral therapy); consumer and family involvement in program management and oversight; a family-driven and strengths-based approach to working with children and their families; cultural and linguistic competency; and training for staff about these principles.

i. The MCO's provider network must be submitted to MLTC, via the provider enrollment file, a minimum of one hundred and twenty (120) calendar days prior to the Contract Start Date. A list of Medicaid eligible providers will be provided by MLTC upon contract award.

j. If any service or provider type is not available to a member within the mileage radius specified in Attachment 14 – Access Standards, the MCO must submit to MLTC, for approval a minimum of sixty (60) calendar days prior to implementation, verification that the covered services are not available within the required distance.

k. The MCO is not precluded from making arrangements with a provider outside Nebraska for members to receive a higher level of skill or specialty than the level that is available within Nebraska.

5. Contracting with FQHCs and RHCs

An MCO must offer to contract with all FQHCs and RHCs in Nebraska. If a contract cannot be reached between the MCO and an FQHC or RHC, the MCO must notify MLTC.

6. Adequate Capacity

When establishing and maintaining the network, the MCO must consider:

- **a.** Its anticipated Medicaid enrollment;
- **b.** The expected utilization of services, as well as the characteristics and health care needs of specific Medicaid populations enrolled in the 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/that are not accepting new Medicaid patients;
- **e.** The geographic location of providers and members, considering distance, travel time, the mode of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities; and
- **f.** Members with SHCN, including individuals with disabilities. The MCO should identify providers with experience and competency providing primary and other specialty care services to individuals with adult-onset and developmental disabilities.

7. Patient-Centeredness/Patient-Centered Medical Homes

- **a.** The MCO must promote and facilitate the capacity of its providers to provide patient-centered care by using systematic, patient-centered medical home (PCMH) management processes and health information technology to deliver improved quality of care, health outcomes, and patient compliance and satisfaction. Members must be active participants in their own health and well-being; they must be cared for by a physician who leads a medical team that coordinates all aspects of the preventive, acute, and chronic needs of members, using the best available evidence and appropriate technology. The MCO's implementation of PCMHs must be inclusive of pediatric practices.
- **b.** Requirements of a PCMH include:
  - **i.** Providing comprehensive, coordinated health care for members and consistent, ongoing contact with members throughout their interactions with the health care system, including but not limited to, electronic contacts and ongoing care coordination and health maintenance tracking;
  - **ii.** Providing primary health care services for members and appropriate referral to other health care professionals or health professionals with structured follow-up;
  - **iii.** Planning and coordinating activities to prevent illness and disease;
  - **iv.** Encouraging active participation by a member and their family, guardian, or authorized representative, when appropriate, in health care decision-making and care plan development;
  - **v.** Facilitating the partnership between members, their PCP, and when appropriate, the member's family;
  - **vi.** Encouraging the use of specialty care services and supports;
  - **vii.** Providing enhanced access to care outside normal business hours of operation; and
  - **viii.** Facilitating open scheduling and same-day appointments where possible.
- **c.** The MCO must strive to improve the ability of its behavioral health provider network to meet all the health needs of members through strengthened collaboration with PCPs, service providers, inpatient hospital providers, and consumer/peer providers.
- **d.** The MCO must manage its behavioral health provider network to integrate with other programs and services members receive to promote their recovery, empowerment, and the use of their and their families' strengths, when appropriate, to achieve members' clinical goals and health outcomes. The MCO must work with its providers to coordinate with the following formal and informal resources and programs:
  - **i.** Rehabilitation programs that promote and provide skill-building, community support, supported employment, and full competitive employment for members;
  - **ii.** Recovery support services;
  - **iii.** Natural community supports for members and their families; and
  - **iv.** Anonymous recovery programs (e.g., 12-step programs) for members and their families.

8. Establishing Dental Homes

- **a.** Dental Home Principles

  The American Academy of Pediatric Dentistry defines Dental Homes as an ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.

  MLTC principles for Dental Homes include:
  - **i.** Care that is comprehensive and includes acute, corrective, and preventative services;
  - **ii.** Care that is individualized to each member based upon a dental exam for tooth decay and gum problems;

iii. Care that is preventative and includes information about proper care for the member's teeth and gums, and correct diet;

iv. For children, care that prepares parents and guardians with guidance about what to expect for their child's age for the growth of teeth and the jaw;

v. For children, care that is educational and helps parents and guardians learn about their child's dental health now and as their child grows; and

vi. Care that is provided in a culturally competent manner.

b. Dental Home Requirements

The MCO must include in its Provider Network Development Management Plan, detailed in this section, a plan for establishing Dental Homes for members. The Dental Home plan must, at a minimum, address the following topics:

i. Outreach to potential Dental Home participating providers;

ii. Policies and procedures for establishing and monitoring the Dental Home program including, but are not limited to:

a) Covered services in the amount, duration, and scope that the MCO recommends should comprise the Dental Home package. This package of services will be finalized with MLTC input and approval prior to contract start;

b) Referrals to dental specialists when care cannot be provided directly within the Dental Home;

c) Education topics to be addressed in the Dental Home setting; and

d) Guidelines for the management of acute dental trauma.

iii. Strategies for encouraging member participation, with a particular focus on parents or guardians of members six (6) to 35 (thirty-five) months of age.

c. Access to Specialty Dental Providers

i. The MCO must ensure the availability of access to specialty providers. The MCO must ensure access standards and guidelines to specialty providers are met as specified in this Section in regard to timeliness and service area.

ii. The MCO must establish and maintain a provider network of dental specialists adequate and reasonable in number, in specialty type, and in geographic distribution to meet the dental needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum:

a) The MCO has signed a contract with providers of the specialty types listed below who accept new members and are available at least on a referral basis.

b) The MCO must ensure, at a minimum, the availability of the following providers:

1). Endodontists,
2). Oral Surgeons,
3). Orthodontists,
4). Pedodontists,
5). Periodontists, and
6). Prosthodontists.

c) The MCO must use specialists with pediatric expertise when the need for pediatric specialty care is significantly different from the need for a general dentist.

d) In accordance with 42 CFR § 438.208(c)(4) for members determined to need a course of treatment, the MCO must have a mechanism in place to allow members to directly access a specialist as appropriate for the member's condition and identified needs.

9. Pharmacy Network

a. The MCO must accept into its network any pharmacy or pharmacist participating in the Medicaid program provided the pharmacy or pharmacist is licensed and in good standing with MLTC and accepts the terms and conditions of the contract offered to them by the MCO.

b. The MCO or its contracted Pharmacy Benefits Manager (PBM) must obtain an active agreement from a participating pharmacy provider prior to the start of services under this contract for that pharmacist to be considered a network provider, even if that pharmacy has an existing relationship for non-Medicaid services with that MCO or its PBM. The pharmacy provider must agree to the terms of the MCO's PBM contract for the Nebraska Medicaid program.

c. The MCO may contract with specialty pharmacies to ensure the adequate availability of specialty drugs. The MCO may limit distribution of specialty drugs to a network of pharmacies that meet reasonable requirements to distribute specialty drugs. The MCO may not exclude a Nebraska pharmacy from participation in its specialty pharmacy network as long as the pharmacy is willing to accept the terms of the MCO's contract with its specialty pharmacies. If the MCO maintains a list of designated specialty drugs, the MCO must submit it to MLTC for review and written approval a minimum of sixty (60) calendar days prior to the Contract Start Date and its intended

implementation. Changes to the specialty drug list must also be reviewed and approved by MLTC. Specialty drugs are defined in the Glossary.

d. The MCO may utilize mail-order pharmacies in its network, but must not require or incentivize members to use a mail-order pharmacy, including through different member copays. Members who opt to use this service must not be charged fees, including postage and handling fees.

e. The MCO must not designate preferred pharmacies within its network or offer incentives to members to use a designated pharmacy. The MCO must not incorporate branding of any pharmacy onto member ID cards.

10. Clinical Laboratory Improvement Amendments Requirements

In compliance with the Clinical Laboratory Improvement Amendments (CLIA) and the requirements of 42 CFR § 493, Subpart A, MLTC requires all clinical laboratories to provide verification of CLIA licensure (including the CLIA identification number) or Certificate of Waiver during the provider registration process. Failure to do so will result in either a termination of an active provider identification number or denial of initial registration. These requirements apply to all clinical laboratories. Pass-through billing or other activities conducted with the intent of avoiding these requirements is prohibited. The MCO may not reimburse providers who do not comply with the above requirements.

11. Appointment Availability and Referral Access Standards

a. Nebraska's appointment availability standards are included in Attachment 14 – Access Standards. MLTC will monitor each MCO's compliance with these standards through regular reporting per Attachment 13 – Reporting Requirements. Additionally, walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with appointment availability standards.

b. Wait times for scheduled appointments should not routinely exceed 45 (forty-five) minutes, including time spent in the waiting room and the examining room, unless the provider is unavailable or delayed because of an emergency. If a provider is delayed, the member should be notified immediately. If a wait of more than 90 (ninety) minutes is anticipated, the member should be offered a new appointment.

c. Follow-up to emergency room visits must be available in accordance with the attending provider's discharge instructions.

d. At any time, direct contact with a qualified MCO clinical staff person must be available to members through a toll-free telephone number. The MCO may not require a PCP referral for appointments with behavioral health providers when the behavioral health providers are in the MCO's network.

e. The MCO is responsible for monitoring and ensuring provider compliance with appointment availability standards and provision of appropriate after-hour coverage.

f. The MCO must have processes to monitor and reduce the appointment "no-show" rate by provider and service type. As best practices are identified, MLTC may require that they be implemented by the MCOs.

g. The MCO must monitor the practice of placing members who seek any covered services on waiting lists. If the MCO determines that a network provider has established a waiting list and the service is available through another network provider, the MCO must stop referrals to the network provider until such time as the network provider has openings, and take action to refer the member to another appropriate provider. In circumstances in which the member requires residential behavioral health services and is placed on a waiting list, the MCO must require its providers to offer interim services until residential services are available.

12. Geographic Access Standards

a. The MCO must comply with maximum travel times and distance requirements per Attachment 14 – Access Standards. Requests for exceptions as a result of prevailing community standards or a lack of available providers must be submitted to MLTC in writing for approval. Such requests should include data on the local provider population available to the non-Medicaid population.

b. If there are gaps in the MCO's provider network, the MCO must develop a provider network availability plan to identify the gaps and describe the remedial action(s) that will be taken to address those gaps. When any gap is identified, the MCO must document its efforts to engage any available providers (three good-faith attempts, for example) and must incorporate the circumstances of, and information to be gained by, this gap into its written plan to ensure adequate provider availability over time.

c. The MCO must establish a program of assertive outreach to rural areas where covered services may be less available than in more urban areas, and must include any gaps in its availability plan. The MCO must monitor utilization across Nebraska to ensure access and availability, consistent with the requirements of the contract and the needs of its members.

13. Provider Outreach and Application Processing

a. The MCO must develop standardized provider application/credentialing forms and provider contracts for use with all providers, and utilize standardized processes.

b. The MCO must notify MLTC, a minimum of 15 (fifteen) calendar days in advance, if it decides no longer to accept provider applications for primary care or a certain specialty because member needs and MLTC access standards are being met otherwise. The MCO must also notify MLTC a minimum of fifteen (15) calendar days in advance of resuming acceptance of those provider applications.

c. The MCO is prohibited from explicitly or implicitly communicating to potential network providers that the provider may face a lower reimbursement rate or any other financial or operational sanction should that provider choose not to sign a letter of intent with the MCO.

14. Provider Enrollment in Medicaid

a. The MCO must only reimburse providers enrolled with Nebraska Medicaid for the dates of service.

b. The MCO must use the provider enumeration established by MLTC that has been enrolled and screened for credentialing, contracting, and reimbursing providers. This includes the National Provider Identifier and taxonomy, and provider type and specialty that the provider has been screened and enrolled as.

c. The MCO may begin its credentialing process concurrently with a provider's Medicaid provider enrollment rather than delaying its credentialing process until MLTC has approved a provider's enrollment in Medicaid.

d. The MCO must use provider information regularly supplied by MLTC to update provider contracts and network participation.

15. Provider Credentialing and Re-Credentialing

a. The MCO is required to establish and implement written policies for the selection and retention of providers, consistent with provider credentialing and re-credentialing requirements of applicable law and to submit these policies to MLTC for approval.

b. The MCO must completely process credentialing applications from all provider types within 30 (thirty) calendar days of receipt of a completed credentialing application. A completed credentialing application includes all necessary documentation and attachments. "Completely process" means that the MCO must:

i. Review, approve, and load approved providers to its provider files in its system and submit the information in the weekly electronic provider file to MLTC or MLTC's designee; or

ii. Deny the application and ensure that the provider is not used by the MCO.

c. A provider whose credentialing/re-credentialing application is denied must receive written notification of the decision, with a description of their appeal rights.

d. The MCO must accept provider credentialing information submitted via the Council for Affordable Quality Healthcare system. The MCO must also adopt any standardized provider credentialing form and/or process for applicable providers within sixty (60) calendar days of its development and/or approval by MLTC.

e. The MCO must utilize the current National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of MCOs for the credentialing and re-credentialing of licensed independent providers and provider groups with whom/which it contracts or employs and who fall within its scope of authority and action.

f. The MCO must re-credential each provider a minimum of every three (3) years, taking into consideration various forms of data, including but not limited to grievances, results of quality reviews, results of member satisfaction surveys, and utilization management information.

g. The MCO must communicate with MLTC, DHHS Division of Behavioral Health, and DHHS Division of Public Health regarding incidents or audits that potentially affect provider licensure for any applicable provider types.

16. Central Credentialing Verification Subcontractor

a. The MCO must work with all other contracted MCOs to jointly procure a Central Credentialing Verification Subcontractor (CCVS). The CCVS must begin its work at full capacity no later than one (1) year from the start of MCO's Contract Start Date.

b. The CCVS will develop and maintain a portal where all Medicaid providers and prospective Medicaid providers will submit applications to enroll with all contracted MCOs, and where the providers will upload all required materials for the credentialing process.

c. Each provider seeking to be credentialed with any of the MCOs will need to submit a single application to the CCVS.

d. The CCVS will verify all providers' credentials on behalf of the MCOs for both initial applications and the re-credentialing process every three (3) years.

e. The CCVS must have applicable NCQA accreditation and perform this work in accordance with NCQA credentialing standards.

f. The MCO must ensure that the CCVS generates reporting for all MCOs' credentialing activities. At a minimum, this reporting must include:

- **i.** A monthly volume of credentialing applications, approvals and denials, and re-credentialing activities;
- **ii.** Turnaround time reports for all applicants and for clean applications; and
- **iii.** An aging distribution.

g. Prior to contracting with a CCVS, the MCOs must obtain MLTC approval of (a) the proposed CCVS and (b) the credentialing process, including components delegated to the MCOs' CCVS. The MCO must require that all licensed medical professionals are credentialed in accordance with MLTC's credentialing requirements. MLTC retains final approval of the credentialing subcontractor and process.

17. Network Provider Database

a. The MCO must maintain and continually update its network provider database that contains, at a minimum, the following information for each network provider:

- **i.** Network provider name as well as any group affiliations;
- **ii.** Contracted services;
- **iii.** Site address(es) (street address, city, zip code, region of the state);
- **iv.** Site telephone numbers;
- **v.** Site hours of operation;
- **vi.** Website URLs, as appropriate;
- **vii.** Emergency/after-hours provisions;
- **viii.** Professional qualifications and licensing;
- **ix.** Areas of specialty, including specialties related to behavioral health conditions;
- **x.** Cultural and linguistic capabilities, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office;
- **xi.** Whether network provider's offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment;
- **xii.** Whether network providers will accept new members;
- **xiii.** Malpractice insurance coverage and malpractice history;
- **xiv.** Availability to accept new members; and
- **xv.** Credentialing status.

b. The MCO must have the capability to produce a list of network providers, sorted by type of service, availability to accept new members, and by providers' capability to communicate with members in their primary languages. This list must be available to the MCO's clinical staff at all times, and available to network providers and other interested parties upon their request and at no charge. As described in the Member Services section of this contract, this list must be available on the MCO's website and updated in real time.

18. Network Development Management Plan

a. This plan should demonstrate the MCO's capability of developing a network within the state. While this contract does not require or promote the solicitation of letters of intent from potential network providers, the MCO shall demonstrate its track record in building networks in the state or other markets, particularly for Medicaid or other public-payer products. The MCO may also describe its efforts to become more familiar and develop relationships with Nebraska providers.

b. From the date of contract award and then every two weeks until the contract effective date, the MCO shall provide updates about its network development activities. This plan must detail the MCO's network status, including GeoAccess reports, and describe any provider network gaps and the MCO's remediation plans.

c. Future network development plans must be submitted by November 1st of each contract year (See Attachment 13 – Reporting Requirements.) This document is an assurance of the adequacy and sufficiency of the MCO's provider network [42 CFR § 438.206], and ensures that the provision of core benefits and services will occur [42 CFR § 438.207(b) and 42 CFR § 438.207(c)]. The MCO must also submit, as needed, an updated plan when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in services, covered benefits, payments, or eligibility of a new population. The updated plan must be submitted to MLTC sixty (60) calendar days prior to implementation of any significant changes.

d. The MCO must include in its stated future plans a narrative and statistical analysis consistent with the MLTC assessment methodology. At a minimum, the analysis must be derived from:

i. Quantitative data, including performance of appointment standards/appointment availability, eligibility/enrollment data, utilization data, network inventory, demographic (age/gender/race/ethnicity) data, and the number of single case contracts by service type;
ii. Qualitative data (including outcomes data), when available, including grievance information; concerns reported by eligible or enrolled members; grievances, appeals, and requests for hearings data; member satisfaction survey results; and, prevalent diagnoses;
iii. Status of provider network issues within the prior year that were significant or required corrective action by the MCO, including findings from the MCO's annual operational review;
iv. A summary of network development efforts conducted during the prior year;
v. Plans to correct any current material network gaps and barriers to network development;
vi. Priority areas for network development activities for the following year, goals, action steps, timelines, performance targets, and measurement methodologies for addressing priorities; and
vii. The participation of members, family members/caretakers, providers, including state-operated providers, and other community stakeholders in the annual network planning process.

e. The MCO's network development plan must be submitted to MLTC for approval. The MCO must submit periodic progress reports as requested by MLTC.

19. Provider Network Policies and Procedures

a. The MCO must have policies about how it will:
i. Communicate with the network regarding contractual or program changes and requirements;
ii. Monitor network compliance with state rules, MLTC policies, and MCO policies, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring a member's care is not compromised during the grievance/appeal processes;
iii. Evaluate the quality of services delivered by the network;
iv. Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;
v. Monitor the adequacy, accessibility, and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English;
vi. Process provisional credentials for behavioral health service providers;
vii. Recruit, select, credential, re-credential, and contract with providers in a manner that incorporates quality management, utilization, office audits, and provider profiling;
viii. Provide training for its providers and maintain records of such training;
ix. Educate its provider network regarding appointment time requirements; and
x. Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate.

b. All policies and procedures must be submitted to MLTC as part of the readiness review for approval. Post-implementation policies and procedures must be submitted to MLTC for review and approval a minimum of forty-five (45) calendar days prior to implementation.

c. The MCO must notify providers and members of impending policy changes a minimum forty-five (45) calendar days prior to implementation.

J. PROVIDER SERVICES

1. Provider Services

The MCO must have a provider services function to provide support and assistance to all its providers. This function must, at a minimum:

a. Be available Monday through Friday from 7:00 AM to 8:00 PM (Central Time) to address non-emergency provider issues and on an anytime basis for non-routine prior authorization requests and emergent provider and pharmacy issues;

b. Have clinical pharmacists available Monday through Friday, 8:00 AM to 8:00 PM (Central Time) for clinical questions and prior authorization processing;

c. Ensure each MCO provider is provided all rights outlined in the MCO's provider handbook;

d. Provide ongoing provider training, respond to provider inquiries, and provide general assistance to providers regarding program operations and requirements; and

e. Make regularly scheduled visits to provider sites, as well as ad-hoc visits as appropriate.

2. Provider Toll-Free Telephone Line

a. The MCO must operate a toll-free telephone line to respond to provider questions, comments, inquiries, and complaints. A separate line or menu option must be dedicated to pharmacy and prescription issues, including member copayments, if applicable.

b. The MCO must ensure that provider calls are acknowledged and resolved within three (3) business days of receipt. If the issue cannot be resolved within three (3) business days, the MCO must notify the provider of the expected resolution timeframe, which shall not exceed thirty (30) business days (including referrals from MLTC).

c. The MCO's call center system must have the capability to track provider call management metrics. Minimum requirements can be found in Attachment 13 – Reporting Requirements.

d. After normal business hours, the provider services toll-free telephone line must include recorded information regarding normal business hours and instructions about how to verify enrollment for any MCO member with an emergent or urgent medical condition. However, a provider does not have to obtain verification before providing ED services and care.

e. The MCO must measure and monitor the accuracy of responses provided by call center staff and report this monthly to MLTC. Corrective action must be taken by the MCO as necessary to ensure the accuracy of responses by staff.

f. Call center staff must have access to electronic documentation from previous calls made by or on behalf of the member to the MCO's information line(s).

3. Provider Handbook

a. The MCO must submit a provider handbook to MLTC for review and approval a minimum of ninety (90) calendar days prior to its implementation. The approved handbook must be available on the MCO website within ten (10) calendar days of its approval by MLTC. The MCO may choose not to distribute the handbook by regular mail as long as it provides written notification to providers that it is available online and includes details about how the provider may request a printed copy at no charge to the provider. The provider handbook must include, but is not limited to, the following:

- **i.** Description of the MCO and its corporate entity;
- **ii.** Services and benefits provided by the MCO, including core services and value-added services;
- **iii.** Emergency service responsibilities;
- **iv.** Confidentiality provisions;
- **v.** Process for verifying a member's enrollment in the MCO;
- **vi.** Medical necessity standards as defined by MLTC and the MCO;
- **vii.** Practice guidelines and protocols;
- **viii.** Network provider credentialing process and criteria;
- **ix.** Medical record standards;
- **x.** MLTC's standards for geographic access and appointment availability;
- **xi.** Mainstreaming requirements;
- **xii.** UM requirements, including procedures for service authorizations, concurrent review, extensions of lengths of stay, and retrospective reviews for all covered services;
- **xiii.** Clinical criteria for admission, continued stay, and discharge for each covered service;
- **xiv.** Reporting requirements for serious reportable events and reportable adverse incidents;
- **xv.** Use of MLTC preferred drug list;
- **xvi.** Pharmacy payer sheet;
- **xvii.** Compound prescription requirements;
- **xviii.** Prospective drug utilization review (DUR) response requirements;
- **xix.** Paper and electronic claims submission protocols and standards, including instructions and all information necessary for a claim, in accordance with 42 CFR § 447.45, along with samples of claims;
- **xx.** Policies and procedures detailing the provider complaint system including, but not limited to, specific instructions about how to contact the MCO to file a provider complaint, the timelines allowed for resolution, and the procedure for escalation of unresolved disputes;
- **xxi.** Policies and procedures for the MCO's Grievance System, including information about how the provider may file a grievance or appeal on a member's behalf with written permission;
- **xxii.** Process for appealing payment and service denial decisions;
- **xxiii.** Procedures for using web-based provider services;
- **xxiv.** Call center number(s) and hours;
- **xxv.** Names and contact information of provider services staff;
- **xxvi.** MCO prompt pay requirements;

xxvii. Information regarding the MCO's chronic care and DM programs, including instruction about making referrals;
xxviii. Quality performance standards and requirements;
xxix. Expectations for PCPs; and
xxx. Provider rights and responsibilities.

b. The MCO must:
i. Modify or supplement the provider handbook by distributing periodic notices to network providers;
ii. Review the handbook a minimum of bi-annually and amend it, if necessary, in consultation with MLTC and (as appropriate) its members, their families, providers, and other stakeholders. Any necessary changes must be submitted to MLTC for approval a minimum of sixty (60) calendar days before its implementation; and
iii. Redistribute the amended portions of the handbook to network providers through a clear change process.

4. Provider Website

a. The MCO must have a provider website. It may be developed within the MCO's existing website (such as a portal) to meet these requirements. The MCO must post up-to-date and accurate information and documents to its provider website. MLTC may request that any information be added, removed, or altered that it determines is inaccurate, misleading, or is in any way contrary to the objectives of this contract.

b. The MCO provider website must include general and up-to-date information about the MCO as it relates to the Nebraska Medicaid program. All information must be searchable, and must include, but need not be limited to:
i. The MCO provider handbook and all MCO policies and procedures;
ii. MCO-relevant MLTC bulletins;
iii. Limitations on provider marketing;
iv. Information on upcoming provider training;
v. Provider training manuals;
vi. Information about the provider and member grievance system;
vii. Information about obtaining prior authorizations and referrals;
viii. The MCO formulary (list of covered medications) and the Nebraska PDL;
ix. MCO pharmacy prior authorization requirements;
x. Updated MCO MAC pricing;
xi. Instructions regarding how and whom to contact for questions about filling prescriptions;
xii. Information about how to contact the MCO's Provider Services staff;
xiii. A link to the MLTC website and other related websites;
xiv. A link to the MCO's corporate website; and
xv. MLTC-approved formulary changes and prior authorization requirements, clinical criteria, and revisions a minimum of thirty (30) calendar days prior to the effective date of the requirement or revision.

c. The MCO must, in collaboration with MLTC, determine which program content shall be published on the website. The MCO's website must provide web-enabled transactional capabilities. These capabilities must include, but are not limited to:
i. Provider/member inquiries;
ii. Submission of initial authorization and other requests; and
iii. Web-based referral search system that will allow MCO and MLTC staff, providers, members, and any other interested persons to locate network providers through an online searchable database. The searchable database must include network providers and facilities with information regarding areas of clinical specialization, race/ethnicity, languages spoken, disciplines, and demographic information.

d. The MCO provider website is considered marketing material and must be submitted to MLTC for review and approval a minimum of one hundred and twenty (120) calendar days prior to the Contract Start Date. After the Contract Start Date, any changes must be submitted to MLTC for review and approval forty-five (45) calendar days prior to its implementation.

e. The MCO must remain compliant with applicable privacy and security requirements (including but not limited to HIPAA) when providing any member eligibility or identification information on the website.

f. The MCO website must, at a minimum, be in compliance with Section 508 of the United States Rehabilitation Act of 1973 and meet all standards the Act sets for people with visual impairments and disabilities that make usability an issue.

g. The MCO must ensure that the website is maintained with accurate and current information and is compliant, at all times.

5. Provider Outreach, Education, and Training

a. The MCO must provide training to all providers and their staff regarding the requirements of the provider contract, including limitations on provider marketing, identification of special needs of members (including the LTSS population), and the appropriate utilization of emergency room services, including for behavioral health emergencies. The MCO must make initial training available within thirty (30) calendar days of contracting with a provider.

b. The MCO must also conduct ongoing training throughout the duration of this contract, as deemed necessary by the MCO or MLTC, to ensure compliance with program standards and this contract. Training sessions must include, but not be limited to:

- **i.** Face-to-Face and tele- or web-conference training sessions;
- **ii.** Recorded provider training sessions on or available from the MCO's website;
- **iii.** Training and education for nursing facilities regarding billing procedures for when a member transitions from a skilled to a custodial level of care; and
- **iv.** Documentation of training sessions and attendance, available to MLTC on request.

c. The MCO must submit a copy of the provider training handbook and training schedule to MLTC for review and approval a minimum of one hundred and twenty (120) calendar days prior to the Contract Start Date. The MCO must submit any changes to the handbook to MLTC a minimum of forty-five (45) calendar days prior to scheduled changes and dissemination of such changes.

d. The MCO must develop and offer specialized initial and ongoing training in billing procedures, service authorization requirements, and other procedures it deems appropriate for network providers who/that have traditionally billed and obtained service authorization primarily from Medicaid or Medicare only or who/that are new to the integrated managed care contracts, including behavioral health providers and pharmacists. The MCO must advise MLTC of these sessions and appropriate staff shall be allowed to attend at their discretion.

e. The MCO must develop, establish, and maintain a provider advisory committee. The committee must have representation from the larger provider organizations in the state, as well as individual providers, including behavioral health and pharmacy providers, as well as providers who primarily serve individuals with disabilities. Whenever feasible, MCO staff shall work collaboratively with the provider advisory committee, as well as established provider organizations, to create network development and management strategies and procedures.

f. The MCO must establish a behavioral health advisory sub-committee to provide input to the provider advisory committee.

g. The MCO must meet with providers and provider associations on a regular basis and at various locations throughout the state. In addition, the MCO must hold a provider forum no less frequently than quarterly, at various locations across the state. The forums must be facilitated by the MCO's Administrator/CEO or designee. The purpose of the forums is to improve communication between the MCO and its providers. The forums must be open to all providers within the MCO's network. The forums must not be the only venue by which the MCO communicates and participates in a discussion and review of the issues affecting its provider network. The MCO must report information discussed during these meetings and forums to the MCO's executive management and MLTC. Provider forum meeting agendas and minutes must be made available to MLTC on request.

6. Collaboration with Network Providers

a. The MCO must promote ongoing and seamless communication between providers and the MCO. To accomplish this task, the MCO must:

- **i.** In addition to establishing and working collaboratively with the provider advisory committee, include provider representatives in the MCO's committee structure, to give providers a direct voice in developing and monitoring clinical policies and operational issues;
- **ii.** Work with providers to improve administrative efficiencies through the use of the MCO's website, information technology, and other strategies identified through provider meetings and on-site visits;
- **iii.** Provide encryption software on request from a provider to allow the exchange of member data via email and
- **iv.** Provide a monthly newsletter that includes articles covering topics of interest for all provider types. This newsletter must be posted to the MCO's website.

b. The MCO must identify a provider network liaison, who will work collaboratively with the provider advisory committee to establish the process for responding to provider concerns; develop provider training in response to identified needs or changes in protocols, processes, and forms; and enhance MCO-provider communication strategies.

c. Throughout the term of the contract, the MCO must alert providers to modifications in the provider handbook and to changes in provider requirements that are not otherwise communicated by MLTC. To accomplish this task the MCO must:

i. Request and obtain from providers an email address, so they can be alerted to access the MCO's website to download updates to the provider handbook and provider requirements;
ii. Email providers and publish on the MCO's website any policy clarification not otherwise communicated by MLTC; and
iii. Post notification of policy and procedural changes on the MCO's website. Advance notification to members and providers of changes that will affect access to or provision of services, or payment of services, is required. The MCO must make a good-faith effort to provide a minimum of forty-five (45) calendar days advance notice of any necessary changes.

7. Provider-Patient Communication/Anti-Gag Clause

a. Subject to the limitations described in 42 CFR § 438.102(a)(2), the MCO must not prohibit or otherwise restrict a health care provider, acting within the lawful scope of their practice, from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the contract, for the following:
i. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
ii. Any information the member needs to decide among relevant treatment options;
iii. The risks, benefits, and consequences of treatment or non-treatment; and
iv. The member's right to participate in decisions regarding their health care, including the right to refuse treatment or to express preferences about future treatment decisions.

b. Any MCO that violates the anti-gag provisions set forth in 42 U.S.C. § 438.102(a)(1) will be subject to intermediate sanctions.

c. The MCO must comply with the provisions of 42 CFR § 438.102(a)(1)(ii) concerning the integrity of professional advice to members, including no interfering with providers' advice to members, and information disclosure requirements related to physician incentive plans.

8. Provider Complaint System

a. A provider complaint is any verbal or written expression, originating from a provider and delivered to any employee of the MCO, voicing dissatisfaction with a policy, procedure, payment, or any other communication or action by the MCO.

b. The MCO must establish a provider complaint system to track the receipt and resolution of provider complaints from in-network and out-of-network providers.

c. This system must be capable of identifying and tracking provider complaints received by telephone, in writing, or in person.

d. As part of the provider complaint system, the MCO must:
i. Have dedicated provider services staff for providers to contact via telephone, electronic mail, regular mail, and in person, to ask questions, file a provider complaint, and resolve problems;
ii. Identify a key staff person specifically designated to receive and process provider complaints;
iii. Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual, and provider subcontract provisions, collecting all pertinent facts from all parties and applying the MCO's and MTLC's written policies and procedures; and
iv. Ensure that MCO executives with the authority to require corrective action are involved in the provider complaint escalation process. The names, telephone numbers, and email addresses of these individuals must be provided to MLTC within fifteen (15) calendar days of contract signing, and within two (2) business days of any changes.

e. The MCO must prepare and implement written policies and procedures that describe its provider complaint system. These policies and procedures must be submitted to MLTC for review and approval a minimum of sixty (60) calendar days prior to the Contract Start Date. The policies and procedures must include, at a minimum:
i. Allowing providers a minimum of thirty (30) calendar days to file a written complaint, a description of the filing process, and the resolution timeframes;
ii. A description of how providers may file a complaint with the MCO for issues that are MCO-related, and under what circumstances they may file a complaint directly with MLTC for those issues that are not a MCO function;
iii. A description of how provider services staff are trained to distinguish between a provider complaint and a member grievance or appeal for which the provider is acting on the member's behalf;
iv. The process by which providers are allowed to consolidate complaints regarding multiple claims that involve the same or similar payment or coverage issues;

v. The process for thoroughly investigating each complaint and for collecting pertinent facts from all parties during the investigation;

vi. A description of the methods used to ensure that MCO executive staff with the authority to require corrective action are involved in the complaint process, as necessary;

vii. A process for giving providers (or their representatives) the opportunity to present their cases in person;

viii. Identification of specific individuals who have authority to administer the provider complaint process; and

ix. A description of the system to capture, track, and report the status and resolution of all provider complaints, including all associated documentation. This system must capture and track all provider complaints, whether received by telephone, in person, or in writing.

f. The MCO must include a description of the provider complaint system in its provider handbook and on its provider website. It must include specific instructions regarding how to contact the MCO's provider services staff and contact information for the MCO staff person who receives and processes provider complaints.

g. The MCO must distribute its policies and procedures to in-network providers at the time of contracting and to out-of-network providers with the remittance advice. The MCO may distribute a summary of these policies and procedures to providers if the summary includes information about how the provider may access the full policies and procedures on the MCO's website. This summary must also detail how the in-network provider can request a hard copy of the policies and procedures from the MCO at no charge to the provider.

K. SUBCONTRACTING REQUIREMENTS

1. General Requirements

In accordance with 42 CFR § 438.230, the MCO must oversee all subcontractors' performance and must be held accountable for any function and responsibility that it delegates to any subcontractor, including, but not limited to:

i. The MCO must evaluate the prospective subcontractor's ability to perform the activities, and determine that ability is sufficient, prior to delegating the activities.

ii. The MCO must have a written contract between the MCO and the subcontractor that specifies the activities and reporting responsibilities delegated to the subcontractor;

iii. The MCO must provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

iv. The MCO must verify the subcontractor is accredited with the appropriate accreditation organization if applicable.

v. The MCO must monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards and state MCO laws.

vi. If necessary, the MCO must identify deficiencies or areas for improvement, and take corrective action.

vii. The MCO must ensure the subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.

viii. The MCO must ensure the subcontractor agrees that the State, the HHS Inspector General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determined of amounts payable under the MCO's or PAHP contract with the State.

ix. The MCO must ensure that the subcontractor will make available, for purposes of an audit, evaluation, or inspection of its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to Medicaid enrollees.

x. The right to audit, under Section V. K. 1. g. – Subcontracting General Requirements, will exist through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

xi. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

2. The MCO must submit all subcontracts, business associate agreements (BAA), and data sharing agreements for the provision of any services under this contract, to MLTC for review and approval, a minimum of one hundred and twenty (120) calendar days prior to their planned implementation. MLTC must have the right to review and approve or disapprove all subcontracts, BAAs, and data sharing agreements entered into for the provision of any services under this RFP, including but not limited to, the MCO's PBM contract.

3. The MCO must not execute a subcontract with any entity that has been excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 of the Social Security Act (42 U.S.C. §1320a-7), or who/which is otherwise barred from participation in the Medicaid or Medicare programs. The MCO must not enter into any relationship with anyone or any entity debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

L. CARE MANAGEMENT

1. General Requirements

a. The MCO must develop a care and case management program that focuses on collaboration between the MCO and the member, the family, guardian or caregiver, providers, and others providing services to the member, including Home and Community Based Services (HCBS) service coordinators. Services furnished to the member by the MCO must be coordinated with the services the member receives from community and social support providers per 42 CFR § 438.208(b)(2)(iv).

b. The MCO must work with its providers to ensure a patient-centered care and case management approach that addresses a member's medical, dental, vision, behavioral health, and social determinant of health care needs. Principles that guide this integrated management approach include:

- **i.** An accessible, comprehensive, fully integrated array of preventive and treatment services for all age groups. The approach is designed to be evidence-based, responsive to changing needs, and built on a foundation of continuous quality improvement;
- **ii.** Mental illness and substance use disorder services that are integrated into a comprehensive physical and behavioral healthcare system delivered in multiple settings, including primary care clinics; and
- **iii.** Availability of relevant clinical information that must be accessible to the member's health care providers, and in compliance with federal and state laws and other applicable standards of medical record confidentiality and protection of patient privacy.

c. The MCO must assist members in the coordination of holistic services using person-centered strategies, manage co-morbidities, and not focus solely on the member's primary condition.

d. The MCO must incorporate care and case management interventions that focus on the whole person and empower the member to participate with their medical home, dental home, specialists, and other care providers, to effectively manage health conditions and prevent complications through:

- **i.** Adherence to medication regimens;
- **ii.** Regular preventive health care;
- **iii.** Healthy lifestyle choices; and
- **iv.** Self-management strategies to improve chronic disease and other health conditions

e. The MCO must stratify their members for care and case management interventions. Patient stratification is based on clinical conditions and/or social circumstances that place the member at higher risk. Proactive care and case management of at-risk and rising risk members helps prevent or minimize the need for higher intensity case management. The MCO must identify, track and trend members who are receiving care and case management.

f. Care and case management must address the social determinants of health and how it impacts the members' health and wellness. Requirements include:

- **i.** Training on the impact of social determinates on a members' health and wellness. Training must include, but not be limited to, issues related to housing, education, food, physical and sexual abuse, violence, healthcare disparities, and cultural diversity;
- **ii.** Ensuring that all covered services, including MH or substance use disorder treatment services, appropriate to a member's level of need, are available to the member;
- **iii.** Ensuring that all care and case management staff are knowledgeable about community resources and make referrals to these resources as needed. Resources include, but are not limited to:
  - a) Housing assistance and shelters,
  - b) Food banks and pantries,
  - c) Educational and job opportunities,
  - d) Organizations that assist with and address physical and/or sexual abuse, and
  - e) Transportation
- **iv.** Developing, subscribing to, or acquiring a community resource tool for care and case management. Information provided by this tool must be current and include Nebraska resources as well as applicable border state community resources. The MCO must have the tool active ninety (90) calendar days prior to the Contract Start Date and provide access to this information to MLTC upon request.

g. The MCO is required to provide care and case management separate from, but integrated with, UM and QI activities. The major components of care and case management include advocacy, communication, problem-solving, collaboration, and member empowerment.

h. The MCO must employ care coordinators and care managers to arrange, assure delivery of, and monitor, preventive and other comprehensive healthcare services for members. See staffing requirements in Section V.D Staffing Requirements.

i. The MCO must submit all care and case management policies and procedures to MLTC for review and approval prior to the Contract Start Date, during the readiness review. This includes a description of program services available at each patient stratification level, member outreach procedures, and flow diagrams.

j. All appropriate staff must be trained in the care and case management policies and procedures. These must also be shared with healthcare providers to promote consistency of care.

2. Care and Case Management Services

a. The MCO must develop and implement a care and case management program consistent with existing state policies and procedures to ensure all eligible members have access to these basic care and case management services.

b. The MCO's care and case management program must promote empowerment of the person and shared decision making. Examples of care and case management services the MCO may provide include, but are not limited to:

- **i.** Assistance with appointment scheduling and identifying participating providers, when necessary;
- **ii.** Assistance with accessing primary care, behavioral health, dental, preventive and specialty care, as needed;
- **iii.** Care coordination of discharge planning with a focus on the seriously mentally ill population, members with special needs, short-term and long-term hospital stays, and other institutions, such as juvenile institutions, per 42 CFR § 438.208(b);
- **iv.** Assistance for dental health care needs, including but not limited to:
  - a) Finding a general and/or specialty dentist,
  - b) Establishing a dental home,
  - c) Transitions of dental care such as between dental clinics and after an emergency/urgent visit,
  - d) Supporting special needs patients unable to care for their mouth properly on their own because of a disabling condition,
  - e) Catastrophic dental conditions (treatment on ten or more teeth at the same time),
  - f) Cleft palate, and
  - g) Dental care while pregnant.
- **v.** Continuity of care that includes collaboration and communication with health care providers involved in a member's transition to another level of care, to optimize outcomes and resources while eliminating care fragmentation. Continuity of care activities must ensure that the appropriate healthcare personnel, including the PCP, are kept informed of the member's treatment progress and treatment needs. The MCO must ensure healthcare provider interactions are effective and meet the needs of the members; and
- **vi.** Member and provider education which may include mailings, newsletters, face-to-face or virtual meetings.

c. The MCO must develop and implement care and case management policies and procedures consistent with existing federal and state regulations. The MCO must review the policies and procedures annually, update as needed, and secure approval of the MCOs Clinical Advisory Committee (CAC). After approval by the CAC, any proposed changes must be submitted to MLTC a minimum of forty-five (45) calendar days prior to the proposed implementation date. Policies and procedures must, at a minimum, address the following:

- **i.** Involvement of the member and/or authorized family members or guardians in care planning, as appropriate;
- **ii.** Engagement of members in care and case management who do not respond to attempts to make contact;
- **iii.** Process to actively engage members who need care and case management if they disengage;
- **iv.** Pharmacy utilization data to tailor care and case management services;
- **v.** Encourage participation in care and case management activities by collaborating with the following providers:
  - a) PCPs, behavioral health, and dental health providers,
  - b) HCBS service coordinators, and

c) Community support providers.

vi. Procedures and criteria for referrals to specialists and sub-specialists to ensure that services can be furnished to members promptly and without compromising care. The MCO must:
- d) Provide the coordination necessary for referral;
- e) Determine the need for services outside the MCO network;
- f) Refer a member to the appropriate service providers; and
- g) Members with serious mental illness must be referred to behavioral health specialist as needed.

vii. Identification and assessment of any member with SHCNs to ensure that services and activities are not duplicated;

viii. Procedures and criteria for maintaining care plans and referral services when a member changes PCPs;

ix. Documentation of emergency and urgent care, medically indicated follow up care, and referral services in each member's MCO health care record;

x. A process that ensures continuity of care that when a provider leaves the MCO network, the MCO allows members, who are undergoing an active course of treatment, to access services from non-contracted providers for an additional ninety (90) calendar days;

xi. Development of talking points and triggers for when a member may need emergency care;

xii. Education of staff about barriers members may experience in making and keeping appointments;

xiii. Facilitation of group visits to encourage self-management of various physical and behavioral health conditions such as pregnancy, diabetes, or tobacco use; and

xiv. Ensure continuity of care for the following high-risk situations:
- a) Members transitioning between MCOs;
- b) Members whose treating providers become unable to continue service delivery for any reason;
- c) Members transitioning from the children's system to the adult system;
- d) Members transitioning to/from IHS or other tribal agencies; and
- e) Member discharges from inpatient and residential treatment levels of care, including state psychiatric hospitals.

3. Care Management

a. MCOs are required to provide care management to all members. Care management must include but is not limited to, a set of processes that arrange, deliver, and monitor the benefit of medical and social services provided to a member.

b. Care management planning must include resources that help identify the care management needs of a member through the following:
- **i.** Homeless identification form;
- **ii.** Self-identification forms provided to the patient in the member benefit packet;
- **iii.** Health Risk Screening (HRS);
- **iv.** MCO specific health risk assessment;
- **v.** Medical records;
- **vi.** Dental records;
- **vii.** Predictive analytic tools which are technology-based patient stratification tools that help identify high-risk and rising risk members;
- **viii.** Historical claims data;
- **ix.** State-wide HIE;
- **x.** State-registries; and
- **xi.** Prescription Drug Monitoring Program (PDMP).

c. The MCO must comply with MLTC requests for any documentation to support periodic audits.

d. Care management plans are:
- **i.** Ongoing and modified as needed, to meet the changing needs of the patient;
- **ii.** Comprehensive;
- **iii.** Evidence-based;
- **iv.** Care coordination with multi-disciplinary care teams, which at a minimum include clinical and behavioral health services, dental services, psychosocial needs, referrals, and care transition management; and
- **v.** Appropriate interventions that reduce health risks and decrease the cost of care.

4. Case Management

a. Case management planning must include resources that help identify the case management needs of a member through the following;
- **i.** Homeless self-identification form;
- **ii.** Self-identification forms provided to the member in the member benefit packet;
- **iii.** HRS;
- **iv.** MCO specific health risk assessment;
- **v.** Medical records;
- **vi.** Dental records;
- **vii.** Predictive analytic tools which are technology-based patient stratification tools that help identify high-risk and rising risk members;
- **viii.** Historical claims data;
- **ix.** Provider referrals;
- **x.** State-wide HIE;
- **xi.** State-registries; and
- **xii.** PDMP.

b. Case management activities that must be performed include, but are not limited to:
- **i.** Assisting members who self-identify as medically complex either in conversation with the MCO staff or through the self-identification form in the member benefit packet;
- **ii.** Administering an HRS which includes, but is not limited to, the MLTC defined and required HRS questions;
- **iii.** Perform the required MCO action(s) based on the member responses to the HRS;
- **iv.** Periodic evaluation of the member's historical claims data, including diagnosis information that is current and verified, within a twelve (12) month look back as defined in the medically complex guidance policy;
- **v.** Ongoing engagement with the member through care and case management;
- **vi.** Provide case management to medically complex members according to the specifications included in the Medically Complex Guidance policy;

c. Examples of members who are appropriate for case management include those with or who are:
- **i.** A disabling mental disorder;
- **ii.** A chronic substance abuse disorder;
- **iii.** A physical, intellectual, or developmental disability with functional impairment that significantly impairs the individual from performing one or more activities of daily living each time the activity occurs, see 471 NAC § 12 for the definition of activities of daily living for adults;
- **iv.** A disability determination based on Social Security criteria;
- **v.** A serious and complex medical condition;
- **vi.** Chronically homeless;
- **vii.** Foster care children and adolescents aging out of the foster care system;
- **viii.** Dual eligible;
- **ix.** Transitioning from a state facility to the community; or
- **x.** Special needs adolescents aging out who will no longer be eligible for EPSDT services.

d. The MCO must comply with MLTC requests for any documentation to support periodic audits.

5. Health Risk Screening and Health Risk Assessment

a. The MCO must provide health risk screening to all members on enrollment to identify members in need of care and case management. The MCO must implement the MLTC defined HRS questions, at a minimum.

b. As part of a health risk assessment, the MCO must use a variety of mechanisms to identify members potentially in need of case management, including those who currently have or are likely to experience catastrophic or other high-cost or high-risk conditions. These mechanisms must include, at a minimum, evaluation of claims data, member self-referral, and physician referral. The MCO must submit the member stratification methodologies it proposes to use to identify potential case management members to MLTC for review and approval a minimum of ninety (90) calendar days prior to the proposed implementation date.

c. Health risk assessments must be developed to collect information such as, but not limited to:
- **i.** Severity of the member's health conditions/disease state;
- **ii.** Co-morbidities, or multiple complex health care conditions;
- **iii.** Recent treatment history and current medications;
- **iv.** Long-term services and supports the member currently receives;
- **v.** Demographic and social determinants of health information (including ethnicity, education, living situation/housing, legal status, employment status, food security);
- **vi.** Activities of daily living (including bathing, dressing, toileting, mobility, and eating);

vii. Instrumental activities of daily living (including medication management, money management, meal preparation, shopping, telephone use, and transportation);
viii. Communication and cognition;
ix. Indirect supports;
x. General health and life goals;
xi. Safety (need for welfare/protection to eliminate harm to self or others);
xii. The member's current treatment providers and care plan, if applicable;
xiii. Behavioral health concerns, including depression, mental illness, suicide risk, and exposure to trauma;
xiv. Substance use, including alcohol;
xv. Interest in receiving care and case management services; and
xvi. Dental health status and need for emergency dental care.

6. Behavioral Health: Principles of Care

a. The MCO's integrated service delivery system must be guided by the following behavioral health principles of care:
i. Services must be part of an overall coordinated system of care that ensures access to MH and SUD treatment services to improve the overall health of each member. To the fullest extent possible, services should be provided in the community where the member lives;
ii. Services must provide recovery-based care;
iii. Services must be trauma-informed;
iv. Services will be patient-centered, family-driven, age and developmentally appropriate;
v. SUD services will be delivered in accordance with the principles of recovery-oriented systems of care;
vi. Members must be able to choose their own provider to the fullest extent possible at all levels of treatment; and
vii. Services must provide a resiliency-based system of care for children and their families.

b. The MCO must ensure that active treatment is being provided to each member when needed. Active treatment includes implementation of a professionally developed and supervised individual plan of care, in which the member participates and shows progress.

7. Disease Management (DM)

a. DM is a structured, coordinated care management program focused on managing chronic disease, reducing acute episodes and disease complications, improving quality of life, and reducing healthcare costs relative to an illness or syndrome.

b. DM programs must:
i. Emphasize prevention and maintenance;
ii. Use evidence-based guidelines to enhance patient care through prevention and proactive interventions;
iii. Support the provider-patient relationship;
iv. Support activities and interventions associated with the treatment plan such as, health-condition monitoring, member adherence to the treatment plan, evaluation of other co-morbidities, and lifestyle;
v. Promote patient self-management and empowerment through education, communication, and disease-specific interventions;
a) Education should include information that increases the member's understanding of their condition(s), the factors that impact their health status e.g., diet and nutrition, smoking, lifestyle, medication compliance, and
b) Empowers the member to be more effective in self-care and management of their health by:
1). Actively and effectively participating in their care;
2). Being compliant and cooperative with the recommended treatment plan;
3). Identifying precipitating factors and appropriate responses before they require more acute intervention;
4). Understanding the appropriate use of resources needed for their care; and
5). Include analysis of performance indicators and outcome measures to ensure the program is achieving desired goals including;
I. Clinical Outcomes and health care utilization;
II. Member satisfaction; and
III. Improved financial outcomes.

c. Health conditions that benefit from DM include, but are not limited to:

i. Asthma;
ii. Bipolar disorder;
iii. Coronary artery disease (CAD);
iv. Congestive heart failure (CHF);
v. Chronic obstructive pulmonary disease (COPD);
vi. Diabetes;
vii. HIV/AIDS;
viii. Hypertension;
ix. Major depressive disorder (MDD);
x. Schizophrenia; and
xi. Substance use disorder (SUD).

8. The MCO Must develop policies and procedures for terminating Care and Case Management

Acceptable reasons for member case closure include:

a. Achievement of established care plan goals including stabilization of the member's condition, successful links to community support and education, and improved member health;
b. Member request to withdraw from either care or case management;
c. Members who complete the post-partum period or are no longer pregnant and have no further needs;
d. Member loss of eligibility or death;
e. Member disenrollment from the health plan; and
f. Lack of member contact with the care or case manager, or lack of member compliance with the care or case management. Lack of member contact must be documented in the care or case management plan. At least three (3) different types of attempts should be made prior to closure for this reason. When appropriate, these should include attempts to contact the member's family or authorized representative. Examples of contact attempts include:
  i. Making phone call attempts before, during, and after regular working hours;
  ii. Visiting the family's home;
  iii. Sending letters with a request for correct address;
  iv. Use of technology resources such as emails and text messages, as applicable; and
  v. Checking with the PCP, Women, Infants, and Children Program (WIC), and other providers.

9. Coordination of Care with Other Case and Care Managers and Care Givers

a. The MCO must attempt to ascertain whether a member has any other care or case manager(s), and, if so, to engage with them.
b. The MCO must attempt to ascertain whether a member has any other authorized caregivers in the member's care planning, and, if so, to engage with them.
c. Members who are aged, blind, or disabled; dual eligible; or who are enrolled in HCBS waiver programs or other state programs are likely to have one or more care or case managers.
d. The MCO is responsible for ensuring coordination between its providers and the WIC program. Coordination includes referral of potentially eligible women, infants, and children and providing appropriate medical and dental information to the WIC program.
e. The MCO must demonstrate an understanding of health care and social service programs offered by MLTC and other state agencies and leverage these programs for members when appropriate. Leveraging of existing programs may take the form of subcontracting or highly collaborative partnering to reduce or eliminate duplication of effort. Highly collaborative partnering must include but is not limited to, crisis response services in coordination with behavioral health system entities.

10. Care and Case Management for Pregnant Members

a. The MCO must ensure that its members who are pregnant begin receiving care within the first trimester, or within seven (7) calendar days after enrolling in the MCO or notification of the member's pregnancy.
b. The MCO must provide information to the pregnant member on an adequate network of available, and accessible, PCPs and OB/GYN physicians who provide prenatal services. A pregnant member must be assured direct access within the MCO's provider network to OB/GYN care. The OB/GYN must be required to notify the PCP of his/her provision of such care and coordinate that care with the PCP.
c. The MCO must develop an outreach program to encourage women to seek prenatal services during their first trimester of pregnancy. This outreach program may utilize community, religious organizations, and other community groups to develop outreach programs or referral networks. This may include distribution of brochures and educational materials that emphasize the importance of prenatal care.

d. The MCO must perform and require its health care providers to perform a risk assessment on all pregnant members including a screen for tobacco, alcohol, and substance use. For high-risk pregnant members, the MCO must have an adequate network of available and, accessible, maternal fetal-medicine specialists for further evaluation, consultation, care, and delivery as recommended by the guidelines of the American College of Obstetricians and Gynecologists. The MCO must provide case management for high-risk pregnant members including, but not limited to, patients with a history of prior preterm birth.

e. The MCO must educate staff of the Priority Populations which include pregnant and injecting drug users, pregnant substance abusers, injecting drug users, and women with dependent children. This may include collaboration with the DBH as appropriate.

f. The MCO must ensure that PCPs and OBGYN physicians provide prenatal and post-partum care in accordance with the guidelines of the American College of Obstetricians and Gynecologists. The MCO must ensure that the PCP or the OBGYN counsels the pregnant member about plans for her newborn child, such as identifying the PCP who is to perform the newborn exam and selecting the PCP who will provide subsequent pediatric care when the child is added to the MCO. This applies to the selection of a dentist and dental home as well.

g. Appropriate referrals must also be made to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program for nutritional assistance and other needed community resources.

h. The MCO must develop and promote patient engagement tools including mobile applications and smartphone-based support to supplement existing pregnancy services. The MCO must submit its Marketing Plan to MLTC for review and approval one hundred and fifty (150) calendar days prior to the implementation date. The goals of patient engagement are to:

- **i.** Improve engagement and assist pregnant women with keeping appointments, and educating them about the necessary health screenings and care needed throughout their prenatal and post-partum stages;
- **ii.** Increase identification and triage of high-risk pregnancies to specialized maternal case managers and other public health resources; and
- **iii.** Improve health decision-making and outcomes such as breastfeeding.

i. The MCO must provide care and case management services to high-risk pregnancies in the postpartum period as well. This includes women who had an adverse pregnancy outcome, or preterm delivery before thirty-seven (37) weeks gestation.

11. Coordination with HCBS Service Coordinators

a. The MCO must collaborate and coordinate with HCBS case managers in a manner that complements but does not duplicate, the member's plan for support and services.

b. The MCO must develop and submit its policies and procedures for coordination of care with HCBS case managers to MLTC for review and approval sixty (60) calendar days prior to the proposed implementation date. These policies and procedures must address the methods the MCO will use to ensure that services are not duplicated.

12. Coordination with Tribal Organizations

The MCO must develop policies and procedures for care and case management for Tribal members, those who are eligible for care through IHS or other Tribally funded health and human service programs, including:

a. Identification and appointment of a Tribal Liaison, to work with IHS and the Tribes;

b. Development of processes and procedures to identify, ensure appropriate access to, and monitor the availability and provision of culturally appropriate care within the MCO's network;

c. Development of processes and procedures to coordinate eligibility and service delivery with IHS, Tribally operated facility/program, and urban Indian clinics (I/T/Us) authorized to provide services pursuant to Public Law 93-638; and

d. Development of methods for regularly coordinating on a minimum of a quarterly basis with IHS, 638 providers, Urban Indian Health Centers, and other involved agencies to coordinate and facilitate health service delivery.

13. Coordination with the Division of Children and Family Services

The MCO must develop policies and procedures for care and case management collaboration with the Division of Children and Family Services for foster care children. This collaboration must include identification and response to a child's health care needs including behavioral and dental health. These policies and procedures must include:

a. A schedule for initial and follow-up health care screenings and evaluations that are evidence-based and age-appropriate;

b. Monitoring and treatment received for identified health care needs;

c. Sharing of current and relevant medical, behavioral and dental health care information in compliance with federal and state regulations;
d. Ensuring comprehensive continuity of care for health care services; and
e. Oversight of prescription medications, with a focus on polypharmacy and psychotropic medications.

M. QUALITY MANAGEMENT

1. The MCO must include Quality Assessment and Performance Improvement (QAPI) processes in its operations to assess, measure, and improve the quality of care provided to and the health outcomes of its members.

a. The MCO QAPI program must include a QAPI Committee for medical and behavioral health, as well as a separate QAPI Committee for dental health.
b. The MCO's QAPI functions must comply with all state and federal regulatory requirements, as well as those requirements identified in this RFP, any other applicable law, and any resulting contract.
c. The MCO must support and comply with MLTC's Quality Strategy, including all reporting requirements in formats and using data definitions provided by MLTC after contract award. The MCO will be provided with the final Quality Strategy after it is approved by CMS.
d. The MCO must support MLTC's Quality Assessment and Performance Improvement Committee (QAPIC) initiatives and attend meetings as requested.
e. The MCO must have a sufficient number of qualified personnel to comply with all QAPIC requirements in a timely manner, including external quality review activities.
f. The MCO's QAPI program must include:
i. Performance improvement projects (PIPs);
ii. Quality performance measurement and evaluation;
iii. Member and provider surveys; and
iv. MCO accreditation requirements, including a comprehensive provider credentialing and re-credentialing program, as described in Sections V.C Business Requirements and V.I Provider Network Requirements of this RFP.
g. The MCO must ensure that the QAPI unit within the organizational structure is separate and distinct from other units, such as UM and CM. The MCO is expected to integrate QM processes, such as tracking and trending of issues, throughout all areas of the organization.

2. QAPI Program

The MCO's QAPI program, at a minimum, must comply with state and federal requirements including 42 CRF § 438.330.The QAPI program must:

a. Ensure continuous evaluation of the MCO's operations. The MCO must be able to incorporate relevant variables as defined by MLTC;
b. At a minimum, assess the quality and clinical appropriateness of care furnished to members;
c. Provide for the maintenance of sufficient encounter data to identify each practitioner providing services to members, specifically including the unique physician identifier for each physician;
d. Maintain a health information system that can support the QAPI program. The MCO's information system must support the QAPI process by collecting, analyzing, integrating, and reporting data required by the State's Quality Strategy. All collected data must be available to the MCO and MLTC;
e. Make available to its members and providers information about the QAPI program and a report on the MCO's progress in meeting its goals annually. This information must be submitted for review and approval by MLTC prior to distribution;
f. Solicit feedback and recommendations from key stakeholders, providers, subcontractors, members, and families/caregivers, and use the feedback and recommendations to improve the quality of care, utilization management policies and procedures, and system performance. The MCO must further develop, operationalize, and implement the outcome and quality performance measures with the QAPIC, with appropriate input from, and the participation of, MLTC, members, family members, providers, and other stakeholders; and
g. Require that the MCO make available records and other documentation, and ensure subcontractors' participation in and cooperation with, the annual on-site operational review of the MCO and any additional QAPI reviews. This may include participation in staff interviews and facilitation of member/family/caregiver, provider, and subcontractor interviews.

3. QAPI Deliverables

The MCO must submit the following QAPI deliverables to MLTC as described in Attachment 13 – Reporting Requirements. Any subsequently revised documents must also be submitted to MLTC for review and approval a minimum of ninety (90) calendar days prior to their planned implementation. QAPI deliverables are as follows:

a. Description and composition of the QAPIC;

b. A written description of the MCO's QM program, including detailed QM goals and objectives, a definition of the scope of the program, accountabilities, and timeframes;

c. A QM work plan and timeline for the coming year that clearly identifies target dates for implementation and completion of all phases of the MCO's QAPI activities, consistent with the clinical quality performance measures and targets set by MLTC, including, but not limited to:

i. Data collection and analysis;

ii. Evaluation and reporting of findings;

iii. Implementation of improvement actions, where applicable; and

iv. Individual accountability for each activity;

a) Procedures for remedial action for deficiencies that are identified;

b) Specific quality of care occurrences that require corrective action; and

c) Procedures for monitoring and evaluating that the corrective actions taken lead to improvement in quality-of-care delivery;

d) Procedures to ensure the providers review of remedial actions and feedback about results is obtained; and

e) Annual QAPI program evaluation that includes:

i. Description of completed and ongoing QAPI activities;

ii. Identified issues, including tracking of issues over time; and

iii. Analysis of and tracking progress about implementation of QAPI goals and the principles of care, as appropriate, and as defined in this RFP. Measurement of and compliance with these principles must be promoted and enforced through the following strategies, at a minimum:

a) Use of QAPI findings to improve practices at the MCO and subcontractor levels;

b) Timely reporting of findings and improvement actions taken and their relative effectiveness;

c) Dissemination of findings and improvement actions taken and their relative effectiveness to key stakeholders, committees, members, families/caregivers (as appropriate), and posting on the MCO's website;

d) Performance measure results from performance improvement efforts and activities planned/taken to improve outcomes compared with expected results and findings. The MCO must use an industry-recognized methodology, such as SIX SIGMA or other appropriate method(s), for analyzing data. The MCO must implement inter-rater reliability testing of evaluation, assessment, and UM decisions, and make available to MLTC upon request;

e) An analysis of whether there have been demonstrated improvements in members' health outcomes, the quality of clinical care, quality of service to members, and overall effectiveness of the QM program; and

f) Procedures assessing the quality and clinical appropriateness of care furnished to members with SHCN. The assessment mechanism must use appropriate health care professionals to determine the quality and appropriateness of care.

4. Quality Assurance and Performance Improvement Committee (QAPIC)

a. The MCO must provide a mechanism for the input and participation of members, families/caretakers, providers, MLTC, and other stakeholders in the monitoring of service quality and determining strategies to improve outcomes.

b. The MCO must form a QAPIC no later than one month following the Contract Start Date. The MCO's Chief Medical Officer or designee must serve as either the chairperson or co-chairperson of the QAPIC.

c. The MCO must include, at a minimum, the following as members of the committee:

i. The MCO's QM Manager;

ii. The MCO's Performance and Quality Improvement Coordinator(s). The MCO's Medical Management Manager, Utilization Management Manager, and the MCO's Member Services Manager;

iii. The MCO's Provider Services Manager;

iv. Family members/guardians of children or youth who are Medicaid members;

v. Adult Medicaid members; and

vi. Network providers, including PCPs, specialists, pharmacists, and providers knowledgeable about disability, mental health, and substance use disorder treatment of children, adolescents, and adults in the state. The provider representatives should have experience caring for the Medicaid population, including a variety of ages and races/ethnicities, and rural and urban populations.

d. Other committees that report to QAPIC

i. All committees must have a representative from the Health Equity Committee.

a) Clinical Advisory Committee: The MCO must create and maintain a Clinical Advisory Committee to facilitate regular consultation with experts who are familiar with standards and practices of treatment, including diseases/chronic conditions common in the Medicaid population, disabilities, and mental health and/or substance use disorder treatment for adults, children, and adolescents in the state.

b) Provider Advisory Committee: The MCO must create and maintain a Provider Advisory Committee to assist with creation of network development and management strategies and procedures. In addition, the MCO may establish a behavioral health advisory committee to provide input to the Provider Advisory Committee. The committee must have representation from the major provider organizations in the state, as well as individual providers, including behavioral health, dental, pharmacy providers, and providers who primarily serve individuals with disabilities.

c) Member Advisory Committee: The Member Advisory Committee promotes a collaborative effort to enhance the MCO's patient-centered service delivery system. Its purpose is to provide input and advice regarding the MCO's program and policies.

d) Provider Credentialing Committee: The Provider Credentialing Committee makes recommendations regarding credentialing decisions and outlines the structure, protocols, and peer-review process for the Credentialing Department and the MCO.

e) Utilization Management Committee: The MCO must establish an internal UM committee that focuses on clinical service delivery trends across its membership, utilization patterns of care, and key utilization indicators.

f) Health Equity Committee: The Health Equity Committee must identify areas of disparity and collaborate with members, providers, and communities to develop policy and care strategies that proactively promote the elimination of health disparities.

ii. The additional required committees must report at least every quarter to the QAPIC. The QAPIC must monitor performance as part of its annual QM work plan and program evaluation.

5. Health Equity Committee

a. The MCO must participate in the MLTC's efforts to reduce health disparities, address social risk factors, and achieve health equity.

b. The MCO must identify disparities in health care access and availability, service provision, member satisfaction, and outcomes. These activities include obtaining data on race, ethnicity, geography, language, and Social Determinants of Health (SDOH) using assessments such as HRS and HRA to determine population with the highest needs.

c. The MCO must ensure the delivery of services in a culturally competent and effective manner to all members by promoting cultural competency at all levels of the MCO and with network providers, including promoting awareness of implicit biases and how they impact policy and processes.

d. The MCO must engage caregivers and families when designing services and interventions that integrate care and address childhood adversity and trauma.

e. The MCO must obtain ongoing input from members within population streams who have disparate outcomes to:

i. Create strategies for reducing health disparities that incorporate the perspective of the member; and

ii. Define metrics, timelines, and milestones that indicate success; and establish credibility and accountability through active member involvement and feedback.

f. The MCO must collaborate and partner with members, other Nebraska-contracted managed care entities, network providers, and internal staff to test, refine, and share successful strategies for reducing disparities.

g. The MCO must connect and engage with individuals and organizations within the communities the MCO serves to understand community needs and resources.

h. The MCO must partner with community-based organizations and contribute to solutions addressing SDOH-related needs, such as:

i. Access to nutritious food (food insecurity, food deserts, and food stamps);

ii. Employment;

iii. Housing stability;

iv. Education;
v. Transportation;
vi. Interpersonal safety; and
vii. Alleviation of toxic stress.

i. The MCO must ensure the active referral to and follow-up on identified needs related to SDOH such as those outlined above by:
i. Providing validated up-to-date community resource lists for member and provider use;
ii. Sharing health risk assessments and other sources identifying SDOH needs, subject to state and federal privacy requirements, with network providers, state agencies and community health workers;
iii. Maintaining documentation of follow up confirming that the member received the services and periodic follow up thereafter to assess short-term and long-term outcomes; and
iv. Staying informed of innovations and research findings that impact the health of populations experiencing disparities.

j. The MCO must track data over time and increase performance targets when milestones are met.

k. The MCO must describe how the MCO meets the requirements for addressing health disparities in the annual QAPI Program evaluation as part of its QAPI submission.

l. The Health Equity Committee must include MCO leadership, care managers, members representing the geographic, cultural, and racial diversity of the MCO's membership, community leaders, provider network manager, and the QAPI Program manager.

m. The Health Equity Committee must meet a minimum of quarterly, and the MCO must keep written minutes of the meetings. The MCO must pay travel costs for committee members who are members or their representatives.

n. MLTC must be copied on all correspondence to the committee, including agendas and committee minutes.

6. Member Advisory Committee

a. The MCO must establish a Member Advisory Committee that is accountable to the MCO's QAPIC.

b. The MCO's Member Advisory Committee must include members, members' representatives, providers, and advocates that reflect the MCO's population and communities served. The Member Advisory Committee must represent the geographic, cultural, and racial diversity of the MCO's membership.

c. At a minimum, the MCO's Member Advisory Committee must provide input into the MCO's planning and delivery of services; QAPI/quality improvement activities; program monitoring and evaluation; and member, family, and provider education.

d. The MCO must provide orientation and ongoing training for Member Advisory Committee members so that they have sufficient information and understanding of the managed care program to fulfill their responsibilities.

e. The MCO must develop and implement a Member Advisory Committee Plan that describes the meeting schedule and the draft goals of the Committee that must include, but is not limited to, members' perspectives about improving quality of care. This plan must be submitted to MLTC for approval a minimum of ninety (90) calendar days before the Contract Start Date and annually thereafter.

f. The MCO's Member Advisory Committee must meet a minimum of quarterly, and the MCO must keep written minutes of the meetings. The MCO must pay travel costs for committee members who are MCO members or their representatives.

g. The MCO must copy MLTC on agendas and committee minutes.

h. The MCO must report on the activities of the MCO's Member Advisory Committee semi-annually. This report must include the membership of the committee (name, address, and organization represented), a description of any orientation and/or ongoing training activities for committee members, and information about committee meetings, including the date, time, location, meeting attendees, and minutes from each meeting. These reports must be submitted to MLTC according to the schedule described in Attachment 13 – Reporting Requirements.

7. Clinical Advisory Committee

a. The MCO must develop, establish, and maintain a Clinical Advisory Committee.

b. The Clinical Advisory Committee must provide input into all policies, procedures, and practices associated with care management and case management, utilization management, including clinical practice guidelines, and utilization management criteria to ensure that they reflect up-to-date standards consistent with research, requirements for evidence-based practices, and community practice standards in the state.

c. The Clinical Advisory Committee must include members who care for children, adolescents, and adults in the state across a variety of ages and races/ethnicities, have an awareness of differences between rural and urban populations, and represent pharmacists, physical health providers, and behavioral health providers.

d. The Clinical Advisory Committee must review and approve initial practice guidelines. Any significant changes in guidelines must also be reviewed and approved by the Clinical Advisory Committee prior to adoption by the MCO.

e. The Clinical Advisory Committee must meet on an as-needed basis, but a minimum of twice a year and preferably quarterly.

f. The MCO must submit to MLTC for approval its plan for development of the Clinical Advisory Committee a minimum of ninety (90) calendar prior to the Contract Start Date and annually thereafter. The MCO must also provide copies of the committee's minutes to MLTC.

8. Dental Health - Quality Assessment and Process Improvement

a. The MCO must establish and implement a dental QAPI program, as described in 42 CFR § 438.330 to:

i. Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities;

ii. Incorporate improvement strategies that include, but are not limited to:

a) Performance improvement projects;
b) Dental record audits;
c) Performance measures; and
d) Surveys;

i. Detect underutilization and overutilization of services; and

ii. Assess the quality and appropriateness of dental care furnished to enrollees with special healthcare needs.

b. The Dental QAPI Program's written policies and procedures must address components of effective healthcare management and define processes for ongoing monitoring and evaluation that will promote quality of care. High-risk and high-volume areas of patient care should receive priority in selection of QAPI activities.

c. The QAPI Program must define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success.

d. The MCO must submit its Dental QAPI Program description to MLTC for written approval within sixty (60) calendar days prior to the Contract Start Date.

e. The MCO's governing body must oversee and evaluate the impact and effectiveness of the Dental QAPI Program. The role of the MCO's governing body must include providing strategic direction to the Dental QAPI Program, as well as ensuring the Dental QAPI Program is incorporated into overarching QAPI Program and operations throughout the MCO.

f. Dental QAPI Committee

i. The MCO must form a Dental QAPI Committee that must, at a minimum include:

a) The MCO Dental Director to serve as either the chairman or co-chairman;
b) MCO staff representing the various departments of the;
c) Member advocate representative;
d) Family members/guardians of children or youth who are Medicaid members;
e) Adult Medicaid members; and
f) Network providers, including general dentists and dental specialists, knowledgeable about the treatment of children, adolescents, and adults. The provider representatives should have experience caring for the Medicaid population, including a variety of ages and races/ethnicities, and rural and urban populations.

g. Dental QAPI Committee Responsibilities

i. The Dental QAPI Committee must:

a) Meet on a quarterly basis;
b) Direct and review quality improvement (QI) activities;
c) Ensure that Dental QAPI activities are implemented throughout the MCO;
d) Review and suggest new and or improved QI activities;
e) Direct task forces and committees to review areas of concern in the provision of dental services to members;
f) Designate evaluation and study design procedures;
g) Conduct individual dental home and dental home practice quality performance measure profiling;

h) Report findings to appropriate executive authority, staff, and departments within the MCO;
i) Direct and analyze periodic reviews of members' service utilization patterns;
j) Maintain minutes of all committee and sub-committee meetings and submit a summary of the meeting minutes to MLTC with other quarterly reports;
k) Report an evaluation of the impact and effectiveness of the Dental QAPI Program to MLTC annually. This report must include, but is not limited to, all dental care management activities;
l) Review and approve the MCO's Dental QAPI Program Description, Work Plan, and Annual Program Evaluation prior to submission to MLTC;
m) Review and approve dental UM clinical practice guidelines annually;
n) Review the Cultural Competency Plan;
o) Study and evaluate issues that MLTC or the Dental QAPIC may identify;
p) Establish annual performance targets;
q) Review and approve all member and provider surveys prior to their submission to MLTC;
r) Define the role, goals, and guidelines for the Dental QAPIC, set agendas, and produce meeting summaries;
s) Provide training; participation stipends; and reimbursement for travel, child-care, or other reasonable participation costs for members or their family members. Participation stipends should only be provided if the individuals have not otherwise paid for their participation, as staff of an advocacy or other organization;
t) The MCO must incorporate recommendations from all staff and MCO committees, the results of PIPs, other studies, improvement goals, and other interventions into the Dental QAPI Program, the Dental QAPI Program Description, the Dental QAPI Work Plan, and the Annual Dental QAPI Program Evaluation; and
u) The Dental QAPIC must perform all duties outlined in this section, in coordination with the overarching MCO QAPIC.

h. Dental QAPI Work Plan

The Dental QAPIC must develop and implement a written Dental QAPI plan which incorporates the strategic direction provided by the governing body and is developed in coordination with the overarching MCO QAPI plan. The Dental QAPI plan must be submitted to MLTC within sixty (60) calendar days prior to the Contract Start Date, by the MCO and annually thereafter, and prior to revisions. The Dental QAPI plan, at a minimum, must:

i. Reflect a coordinated strategy to implement the Dental QAPI Program, including planning, decision making, intervention, and assessment of results;
ii. Include processes to evaluate the impact and effectiveness of the Dental QAPI Program;
iii. Include a description of the MCO staff assigned to the Dental QAPI Program, their specific training, how they are organized, and their responsibilities; and
iv. Describe the role of its providers in giving input to the QAPI Program.

i. Dental QAPI Reporting Requirements

i. The MCO must submit Dental QAPI reports annually to MLTC which, at a minimum, must include:
a) QI activities;
b) Recommended new and/or improved QI activities; and
c) Evaluation of the impact and effectiveness of the Dental QAPI program.

9. Dental QAPI Data Collection

a. The MCO must collect dental performance data and conduct data analysis with the goal of improving members' quality of care. The MCO must document and report to the State its results on dental performance measures chosen by MLTC to improve quality of care and members' health outcomes.

b. Data analysis must consider the MCO's previous year's performance, and reported rates must clearly identify the numerator and denominator used to calculate each rate. The data analysis must provide, at a minimum, information about dental quality of care, service utilization, member and provider satisfaction, and grievances and appeals. Data must be collected from administrative systems, medical records, and member and provider surveys. The MCO must also collect data on member and provider characteristics as specified by MLTC, and about services furnished to members through the MCO's encounter data system. The MCO must ensure that data received from providers is accurate and complete by:

i. Verifying the accuracy and timeliness of reported data;
ii. Screening the data for completeness, objectivity, and consistency; and

iii. Collecting service information using MLTC-developed templates.

c. The MCO's data analysis process must be able to identify and resolve system consistent issues with a continuous quality improvement approach.

d. The MCO is responsible for collecting valid and reliable data and using qualified staff to report it. Data collected for dental performance measures and PIPs must be returned by the MCO in a format specified by MLTC, and by the due date specified. Any extension to collect and report data must be made in writing in advance of the initial due date and is subject to approval by MLTC. Failure to follow the data collection and reporting instructions that accompany the data request may result in a penalty being imposed on the MCO per Section V.V Contract Non-compliance.

10. Quality Performance Measurement and Evaluation

The MCO must report on all CMS Adult Core Set, CMS Child Core Set, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures, and Healthcare Effectiveness Data and Information Set (HEDIS®) measures, as well as additional performance measures as determined by MLTC. Measures may be removed or added at will by MLTC, and MCOs will be given a sixty (60) calendar day period in which to implement additional measure requirements. MCOs will report using the most current version, specification, or manual that is available prior to required reporting deadlines, as is related to the given measure set. MCOs may request exemption from reporting specific measures within respective sets due to inability to report, subject to MLTC approval, within an MLTC designated schedule.

a. MCO may utilize a hybrid or other methodology for collecting and reporting performance measure rates, as allowed by NCQA for HEDIS measures or as allowed by other entities for nationally recognized measures. The MCO must collect data from medical records, dental records, electronic records, or through approved processes, such as those utilizing a health information exchange. The number of records that the MCO collects will be based on HEDIS, external quality review (EQR), or other sampling guidelines. It may also be affected by the MCO's previous performance rate for the measure being collected. The MCO must provide MLTC on request with its methodology for calculating performance measures.

b. The MCO must use QI activities and initiatives to improve population health outcomes, including the creation of new processes and procedures through iterative testing and evaluation that, at a minimum, incorporates insights from data, research, members, and providers. The MCO must use QI activities and initiatives to identify disparities in health care access, service provision, satisfaction, and outcomes. This includes obtaining data on member demographics and social determinants, stratifying MCO data (e.g., claims, Healthcare Effectiveness Data, information set [HEDIS], CAHPS, health risk assessment, member-identified race, ethnicity, geography, language, and SDOH) to determine populations with the highest needs.

c. The MCO must show demonstrable and sustained improvement toward meeting MLTC performance targets. MLTC may impose sanctions on an MCO that does not show statistically significant improvement in a measure rate. MLTC may require the MCO to demonstrate that it is allocating increased administrative resources to improve its rate for a particular measure. MLTC also may require a corrective action plan and may sanction any MCO that shows a statistically significant decrease in its rate, even if it meets or exceeds the minimum standard.

d. The MCO must report results of measuring or assessing outcomes and quality and must incorporate these performance indicators into its PIPs. To the extent possible, results should be posted publicly on the MCO's website immediately after being accepted by the QAPIC and approved by MLTC. The MCO's must notify MLTC of the location of the webpage where the results are posted.

e. Any outcomes and performance measure results that are based on a sample of member, family, or provider populations must demonstrate that the samples are representative and statistically valid. Whenever data are available, outcomes and quality indicators should be reported in comparison to past performance and to national benchmarks.

f. The MCO must report to MLTC on a quarterly basis the minutes and disposition of quality program initiatives that were presented to the QAPIC to ensure that all quality initiatives are reviewed at the frequencies outlined in the QAPI Program Description. The reporting requirements are described in Attachment 13 – Reporting Requirements.

11. Performance Improvement Projects

a. The MCO must conduct one PIP that focuses on clinical indicators and another that focuses on non-clinical indicators. As an alternative the MCO may conduct one PIP consisting of both clinical and non-clinical performance indicator measures. The clinical topic must address a relevant topic to the MCO's population, which is expected to have a favorable effect on health outcomes and the non-clinical measure should address member satisfaction or corresponding process associated with the clinical measure. PIPs must meet all PIP related CMS requirements, 42 CFR § 438.330(d), and be approved by MLTC prior to implementation.

b. The MCO must conduct one dental PIP that focuses on clinical indicators and another that focuses on non-clinical indicators. As an alternative the MCO may conduct one dental PIP consisting of clinical and non-clinical performance indicator measures. The clinical topic must address a relevant topic to the MCO's population, which is expected to have a favorable effect on health outcomes and the non-clinical measure should address member satisfaction or corresponding process associated with the clinical measure. PIPs must meet all PIP related CMS requirements, 42 CFR § 438.330(d), and be approved by MLTC prior to implementation.

c. Medical and Behavioral health PIPs must be addressed in the MCO's medical and behavioral health annual QAPI Program Description, Work Plan, and Program Evaluation. The MCO must report the status and results of each project to MLTC as outlined in the Quality Strategy.

d. Dental PIPs must be addressed in the MCO's dental annual QAPI Program Description, Work Plan, and Program Evaluation. The MCO must report the status and results of each project to MLTC as outlined in the Quality Strategy.

e. All PIPs must comply with CMS requirements, including:

- **i.** A clear PIP topic supported by data and PIP Aim statement(s) as determined or approved by MLTC;
- **ii.** Clear, defined, and measurable objectives that the MCO can achieve in each year of the project;
- **iii.** A well-defined PIP population(s);
- **iv.** Measurements of performance using quality indicators that are objective, measurable, clearly defined, and allow tracking of performance over time. The MCO must use a sound methodology based on accepted research practice and reliable data collection processes. The MCO must use measures that are based on current scientific knowledge and clinical experience. Qualitative or quantitative approaches may be used as appropriate;
- **v.** If sampling is used, the sample size must be generalizable to the eligible PIP population and proper sampling methods used to ensure valid and reliable results;
- **vi.** The data analysis and interpretation of performance indicator results;
- **vii.** Testing and implementation of targeted and actionable interventions that have the potential to achieve improvement in the access to and quality of care;
- **viii.** A methodology for the evaluation of the effectiveness of the chosen interventions. The impact and effectiveness of each intervention should be evaluated individually in addition to evaluating overall performance indicator results. Intervention specific evaluation results should be used to drive next steps for each intervention; and
- **ix.** Planning and initiation of activities for increasing or sustaining improvement.

f. The MCO must submit to MLTC the status or results of its PIPs in its annual QAPI Annual Program Evaluation. Next steps must also be addressed, as appropriate, in the QAPI Program Description and Work Plan.

g. The MCO must implement the PIP recommendations on approval by MLTC and the QAPIC.

h. Each PIP must be completed in a reasonable time to allow the results to guide its quality improvement activities. Information about the success and challenges of PIPs must be also available to MLTC for its annual review of the MCO's quality assessment and performance improvement program 42 CFR § 438.330(d).

i. CMS, in consultation with MLTC and other stakeholders, may specify additional performance measures and PIPs to be undertaken by the MCO.

j. MLTC reserves the right to request additional reports from the MCO. The MCO will be notified of additional reporting requirements no less than sixty (60) calendar days prior to the due date of a report.

12. Medical and Behavioral Health Member Satisfaction Surveys

a. The MCO must contract with a vendor that is certified by NCQA to perform the following CAHPS surveys: Health Plan Medicaid Adult and Health Plan Medicaid Child with the children with chronic conditions (CCC) supplemental items.

b. The MCO must use the most current version of CAHPS for Medicaid members. For the CAHPS Child Surveys with CCC supplemental items, the MCO must separately sample the Title XIX (Medicaid) and Title XXI (CHIP) populations and separate data and results when submitting reports and responses to MLTC to fulfill the CHIPRA requirement.

c. Each survey must be administered to a statistically valid random sample of members who are enrolled in the MCO at the time of the survey. Analyses must include statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards. Survey results, responses, and action plans derived from these results are due September 30th of each year. MLTC reserves the right to make CAHPS member survey results public.

d. Survey results, responses, and descriptions of the survey process must be reported to MLTC separately for each required CAHPS survey. Upon administration of the CAHPS Child surveys, results and responses for Medicaid children and CHIP children must be reported separately.

13. Dental Member Satisfaction Survey

a. The MCO must contract with a vendor that is certified by NCQA to perform the Medicaid adult dental CAHPS survey. The MCO must use the most current version of CAHPS for Medicaid adult members.

b. The CAHPS dental adult survey must be administered to a statistically valid random sample of members who are enrolled in the MCO at the time of the survey. Analyses must include statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.

c. The MCO must conduct an annual survey to assess Medicaid child dental member satisfaction in the following areas: getting needed care, getting care quickly, coordination of care, quality of care, provider communication to members, and MCO customer service.

d. The MCO must work with MLTC and any other MCO to develop the Medicaid child dental member satisfaction survey tool and methodology that will be used by all participating MCOs. This must be finalized and approved by MLTC a minimum of ninety (90) calendar days prior to its intended administration. The methodology used by the MCO must be based on proven survey techniques that ensure an adequate sample size and statistically valid and reliable data collection practices with a confidence interval of a minimum of 95% and scaling that results in a clear positive or negative finding (neutral response categories should be avoided). The MCO must utilize measures that are based on current scientific knowledge and clinical experience.

e. Survey results, responses, and action plans derived from these survey results are due September 30th of each year. MLTC reserves the right to make member survey results public.

14. Medical and Behavioral Health Provider Satisfaction Surveys

a. The MCO must conduct an annual provider survey to assess providers' satisfaction with provider credentialing, service authorization, MCO staff courtesy and professionalism, network management, appeals, referral assistance, coordination, perceived administrative burden, provider communication, provider education, provider complaints, claims reimbursement, and utilization management processes.

b. The MCO must work with MLTC and any other MCO to develop the provider satisfaction survey tool and methodology that will be used by all participating MCOs. This must be finalized and approved by MLTC a minimum of ninety (90) calendar days prior to its intended administration. The methodology used by the MCO must be based on proven survey techniques that ensure an adequate sample size and statistically valid and reliable data collection practices with a confidence interval of a minimum of 95% and scaling that results in a clear positive or negative finding (neutral response categories should be avoided). The MCO must utilize measures that are based on current scientific knowledge and clinical experience.

c. The MCO must submit an annual provider satisfaction survey report that summarizes the survey methods and findings and provides an analysis of opportunities for improvement and action plans derived from survey results. This report is due forty-five (45) calendar days after the end of each calendar year.

15. Dental Provider Satisfaction Surveys

The MCO must conduct an annual provider survey to assess satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing, claims reimbursement, and utilization management processes. The MCO must work with MLTC and any other MCO to develop the Dental Provider Satisfaction survey tool and methodology that will be used by all participating MCOs. This must be finalized and approved by MLTC a minimum of ninety (90) calendar days prior to administration.

N. UTLIZATION MANAGEMENT

1. General Requirements

a. The MCO's UM activities must include the evaluation of medical necessity of health care services according to established criteria and clinical practice guidelines to ensure that medically appropriate services are provided to members when they need them.

b. The MCO's UM program must focus on individual and system outliers to ensure that health care and service goals are met.

c. The MCO's UM program must comply with federal utilization management and control requirements, including the certification of need and recertification of need for continued inpatient settings, including psychiatric residential treatment facilities, and as described in 42 CFR § 438.

d. The MCO must require inpatient hospital providers to comply with federal requirements regarding UM plans, UM committees, plans of care, and medical care evaluation studies, as described in 42 CFR § 456.

e. The MCO must not structure compensation to individuals or entities that conduct UM activities to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member, as described in 42 CFR § 438.210(e).

f. The MCO must actively monitor federal and state Medicaid regulations for updates and changes and must monitor all UM activities for compliance with federal and state Medicaid regulations, and other state documents.

g. The MCO must utilize results from internal audits of its UM activities, such as live monitoring of call center performance and documentation of completed UM reviews, to effect changes in training design, policies and procedures.

2. UM Program Description

The MCO must have a written UM Program description and work plan that outlines its structure and accountability mechanisms. The description must be submitted to MLTC for written approval annually and include, at a minimum:

a. Criteria and procedures for the evaluation of medical necessity;

b. Procedures for utilization management provider and member appeals;

c. Mechanisms to detect and document over- and under-utilization of medical services;

d. Mechanisms to assess the quality and clinical appropriateness of care furnished to members with SHCNs;

e. Availability of UM criteria to providers used in a coverage determination to the requesting provider;

f. Involvement of actively practicing, board-certified physicians with the necessary credentials and experience, and who have appropriate clinical expertise in treating the member's condition or disease in the appeal review for medical appropriateness;

g. Availability of physician reviewers with the necessary credentials and experience to discuss coverage determinations by telephone with the member's physician, if requested;

h. Evaluation of new medical technologies and new applications of existing technologies and the applicable medical necessity criteria;

i. Process and procedures to address disparities in health care;

j. A process for identifying, analyzing, and reporting clinical quality of care concerns to the Quality Assurance and Process Improvement Committee (QAPIC) for further review, and when necessary assist the QAPIC in developing process improvement and corrective action plans to improve health care service;

k. A process for the MCO to include medical consultation when studying UM utilization patterns and population health trends;

l. A description of the MCO's management of prior authorizations, concurrent UR, and retrospective UR. The MCO must submit this description to MLTC for approval no later than sixty (60) calendar days prior to the Contract Start Date, annually thereafter, and prior to any intended revisions. MLTC's approval must be obtained prior to implementation of these policies and procedures;

m. Establishing methods to ensure that the MCO UM decision-making process is as efficient and uncomplicated as possible for the member, the provider and the provider's staff;

n. Reasonable steps to ensure that network providers prescribe pharmaceuticals in accordance with the policies and instructions provided by MLTC and reflected in the MLTC's Preferred Drug List;

o. A description of the MCO's annual evaluation of their UM program. This evaluation must be submitted to MLTC annually, no later than thirty (30) calendar days after the last day of the calendar year; and

p. A process for providing prescribers with members' drug utilization data obtained from MLTC and the Nebraska DUR board to inform prescribing activity. As part of this effort, the MCO must:

- **i.** Work to improve collaboration across prescribers, to reduce conflicting or duplicate prescribing; and
- **ii.** Provide reports to PCPs and other network providers about the patterns of prescription utilization by members, in an effort to increase collaboration and reduce inappropriate prescribing patterns.

3. Clinical Practice Guidelines

a. The MCO must develop clinical practice guidelines, in accordance with 42 CFR § 438.236(b), that:

- **i.** Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
- **ii.** Consider the needs of the MCO's members, including children with serious emotional disorders and adults with serious and persistent mental illness;

iii. Are adopted in consultation with network providers;
iv. Comply with state and federal requirements;
v. Are approved in advance by the MCO Clinical Advisory Committee and MLTC;
vi. Are reviewed and updated by the MCO at least annually, and periodically as appropriate;
vii. Are disseminated, by the MCO, to all affected providers and, on request, to members and as defined in 42 CFR § 438.236(c);
viii. Are posted to the MCO's website; and
ix. Provide a basis for consistent decisions for utilization management, member education, service coverage, and any other areas to which the guidelines apply 42 CFR § 438.236(d).

b. The MCO must provide network providers with technical assistance and other resources to implement the clinical practice guidelines.

c. The MCO must coordinate the development of clinical practice guidelines with other MLTC MCOs to avoid providers receiving conflicting guidelines from various MLTC MCOs.

d. The MCO must monitor the application of the clinical practice guidelines annually through peer review processes and collection of performance measures for review by the MCO's QAPIC.

e. Using information acquired through its Quality Assurance and Process Improvement (QAPI) and UM activities, the MCO must submit to MLTC annually the implementation of the clinical practice guidelines, including compliance and outcomes measures and a process to integrate these practice guidelines into care and case management and UR activities.

4. Authorization of Services

a. 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. The MCO must have processes to ensure consistent application of medical necessity and authorization review criteria for coverage determinations and consultation with the requesting provider, when appropriate.

b. The MCO must ensure that any decision to deny a requested service or to authorize a service in an amount, duration, or scope that is less than requested, be made by a practitioner with the necessary credentials and experience.

c. The MCO must develop service authorization procedures with the input, review, and approval of the QAPIC. These procedures must be submitted to MLTC, for review and approval, a minimum of ninety (90) calendar days prior to the Contract Start Date.

d. The MCO must:
i. Incorporate the definition of medical necessity for covered services, inclusive of service definitions and levels of care, into relevant MCO documents;
ii. Not require prior authorization for emergency services;
iii. Place clinically appropriate limits on service delivery, such as applying criteria, clinical practice guidelines, or medical necessity criteria for utilization control, provided the services that are delivered can be reasonably expected to achieve their purpose within that timeframe;
iv. Not arbitrarily deny a medically appropriate service solely because of the member's diagnosis, type of illness, or condition. This also applies to the MCO's subcontractors;
v. Have in effect mechanisms to ensure consistent application of authorization review criteria for coverage determinations;
vi. Inform network providers of revisions to the formulary and pharmacy prior authorization requirements;
vii. Have written policies and procedures for prescribers to request a peer-to-peer consultation on prior authorization requests. The peer-to-peer consultation must be conducted by a state-licensed physician with the necessary credentials and experience;
viii. Consult with the requesting network provider, when appropriate;
ix. Notify the requesting provider, and give the member written notice, of any decision to deny a requested service, 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;
x. For standard authorization requests, make a coverage determination and provide notice of any denial or decision to authorize services in an amount, duration, or scope that is less than requested as expeditiously as the member's health condition requires and within the timeframes included in Section V.H Grievances and Appeals of this RFP; and
xi. For expedited authorization requests make a decision within the timeframes identified in Section V.H Grievances and Appeals of this RFP, including when the network provider indicates, and the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, or would cause a prudent layperson, possessing an average knowledge of medicine and health, reason to believe that his/her condition is of such a

nature that failure to obtain immediate medical care could result in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

5. Authorization of Pharmacy Services

a. The MCO must submit to MLTC, for review and written approval a minimum of sixty (60) calendar days prior to the Contract Start Date, medical necessity criteria for all drugs requiring prior authorization.

b. Prior authorization may be applied for drugs under the following conditions:

i. When prescribing medically necessary non-preferred or non-formulary (non-PDL) drugs;

ii. When prescribing drugs inconsistent with approved FDA labeling, or when prescribing is inconsistent with nationally accepted guidelines;

iii. When prescribing brand name medications that have A-rated generic equivalents;

iv. To minimize potential drug over-utilization; or

v. To accommodate exceptions to Medicaid drug utilization review standards.

c. The MCO must use a state-licensed child and adolescent psychiatrist to review prior authorization requests for psychotropic medication use in youth as described under Section V.D. Staffing Requirements of this RFP.

d. MLTC may, at its discretion, prohibit prior authorization for selected drug products or devices.

e. The MCO must maintain an electronic automated process, a toll-free telephone number, and a fax line for providers to submit requests for prior authorization of drugs that are non-preferred or subject to clinical edits. If the MCO or its PBM operates a separate call center for prior authorization requests, it will be subject to the same provider call center standards set forth in Section V.J Provider Services of this RFP.

f. The MCO must allow submission of pharmacy prior authorization requests on a common paper form developed and approved by MLTC.

g. The MCO must notify the requesting prescriber and pharmacy, and give the member written notice, of any decision to deny a requested medication, or to authorize a medication in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 CFR § 438.404.

h. The MCO may not penalize or charge the prescriber, pharmacy or member in any way for the authorization process.

i. A member receiving a prescription drug that is subject to new or different prior authorization requirements (e.g., new clinical edits, removal from formulary, or PDL) must be permitted to continue to receive that prescription drug if determined to be medically necessary for a minimum of another ninety (90) calendar days from the date the new or different prior authorization requirements go into effect. The MCO must determine whether this medical necessity is present in consultation with the prescriber.

j. The MCO is allowed to implement step therapy or fail-first protocols to promote utilization of the most cost-effective and clinically appropriate drug therapy. However, if so implemented, the MCO must submit to MLTC for approval a process for a prescriber to request an override of these restrictions. At a minimum, the MCO must grant the override when the prescriber provides evidence that the preferred treatment method has been or is likely to be ineffective in the treatment of the patient's medical condition or will cause or will likely cause an adverse reaction or other physical harm to the patient. MCO must submit to MLTC the step therapy or fail-first protocol prior to implementation.

6. Concurrent Review Inpatient Services

a. The MCO must develop a process for concurrent review of inpatient services to monitor the medical necessity of the need for continued stay. The concurrent review process must include provisions for multiple-day approvals when the episode of care is reasonably expected to last more than one (1) day, based on the medical necessity determination.

b. An important feature of concurrent review is the evaluation of each patient case against established medical necessity criteria, including national clinical practice guidelines. The MCO must use current, evidence-based, published, and commercially available medical necessity criteria.

7. Retrospective Utilization Review

a. The MCO must develop and implement retrospective UR functions to examine trends in utilization, particularly over- and under-utilization. These include but are not limited to:

i. A process to identify utilization patterns of all network providers using data elements and established outlier criteria for both inpatient and outpatient services;

ii. Processes, based on clinical decision support, claims and outcome data, and medical record audits for network providers to monitor and report under-and over-utilization of services at all levels of care and for all patient populations;

iii. Retrospective review of a sample of network providers to ensure that the services furnished to members, were medically necessary, and were authorized and billed in accordance with the MCO's requirements;

iv. Review of a network provider's clinical utilization to establish compliance with Medicaid requirements; and

v. Processes to review all claims denied payment through retrospective review to ensure that claims are denied individually and any denials, both those resulting in repayment and those withheld from a future payment, must be subjected to due process before payment is withheld or repaid. In the absence of a fully denied claim, the provider must be paid in good faith.

b. The MCO must monitor emergency services for inappropriate utilization by network providers and members and have methods in place to address inappropriate utilization. The test for appropriateness of the request for emergency services must be whether a prudent layperson would have requested such services. For the purposes of this RFP, a prudent layperson is one who possesses an average knowledge of health and medicine.

c. The MCO must submit processes and procedures to MLTC for review and approval a minimum of ninety (90)calendar days prior to the Contract Start Date or the intended implementation date. The processes and procedures must be reviewed by the MCO annually and updated by the MCO as needed.

8. Reconsideration, Peer-to-Peer, and Appeal Process

Reconsideration Review and Peer-to-Peer Discussion:

a. The MCO must offer a reconsideration review and peer-to-peer discussion process with reasonable timelines for covered services with a prior authorization requirement or those covered services requiring concurrent review. A reconsideration review involves submission of additional clinical information and/or a peer-to-peer discussion.

b. An appeal or State Fair Hearing request can be made regardless of whether a reconsideration review and/or peer-to-peer discussion is requested. Voluntary participation in a reconsideration review and/or peer-to-peer discussion does not pause the deadlines to request an appeal or State Fair Hearing.

9. Medication Therapy Management

a. The MCO must develop a medication therapy management (MTM) program specific to the needs of its members.

b. The MCO's MTM program must include coordination among the MCO, the member, the pharmacist, and the prescriber using various means of communication. It must assist members in understanding their prescriptions, provide education about their medication, and engage the patient in efforts to improve their compliance with prescribed medication regimens. It must also educate members about how to effectively communicate their preferences and needs with their prescribers to promote shared decision-making.

c. At a minimum, the MCO's MTM program must assess prescribing patterns and treatment plans involving psychotropic medications, opioids, medications at risk of abuse, high-cost medications, and other medications identified by MLTC or the MCO. The MCO must develop a tracking system and submit it to the DUR program for review.

d. The MCO's MTM program must have a process in place to refer high-need patients to care and/or case management.

e. The MCO must submit an annual report to MLTC that describes its MTM program activities, the relative effectiveness of its efforts over the reporting period, and the MCO's activities planned for the next reporting period.

10. Drug Utilization Review Program (DUR)

a. The MCO must develop and maintain DUR programs, including prospective and retrospective DUR programs. The program must adhere to all federal and state requirements for DUR programs. The program must meet all requirements of the CMS Annual DUR Report. The MCO must submit the processes and procedures for these programs to MLTC for review and approval a minimum of ninety (90)calendar days prior to the Contract Start Date or implementation of any changes. The MCO must:

i. Monitor for potential off-label drug usage;

ii. Establish and maintain retrospective DUR exception criteria to include pro-DUR edits and processing edits;

iii. Conduct drug criteria analysis, review member and provider profiles, and generate specific reports, including reports required by federal regulations;

iv. Review and analyze MTM reports tracking systems for case management for patients identified through the DUR program;

v. Design and implement interventional education programs for members, prescribers and pharmacies;

vi. Evaluate effectiveness of the interventional education programs for members, prescribers and pharmacies;

vii. Submit to MLTC an analysis of cost outcomes and the evaluations of the effectiveness of the member, prescriber, and pharmacy educational interventions;

viii. Use results of the above assessments to improve MTM education and interventions;

ix. Perform, at a minimum, one (1) retrospective DUR intervention each quarter of the contract year and submit to MLTC the final analysis and report; and

x. Submit to MLTC the draft CMS Annual Report for review and approval prior to submission to CMS.

b. The MCO must nominate a non-voting staff member to attend the Nebraska Drug Utilization Review Board meetings, which occur at a minimum four (4) times a year, for the term of this contract. The MCO must obtain MLTC's written approval of the nominee.

c. Per section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) consistent with section 1902(oo)(1)(A)(ii) of the Social Security Act, the MCO must operate a DUR program and implement provisions in the DUR program.

The MCO DUR program must have in place:

i. Prospective safety edits and an automated claims review process for subsequent opioid fills (refills) when in excess of any limitation (duplicate fills, early fills, and drug quantity limitations) that may be specified by MLTC and retrospective safety edits and a claims review automated process for any fills in excess of the maximum Morphine Milligram Equivalent dose limitation identified by the state;

ii. A process for retrospective automated claims review as specified by the State that monitors concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics. Permitted exclusions from the above safety edits and claims review requirements apply to members receiving hospice or palliative care; receiving treatment for cancer; residents of a long-term care facility, a facility described in section 1905(d) of the Act, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy; or other individuals the state elects to treat as exempt from such requirements.

iii. A program to monitor and manage appropriate use of antipsychotic medications by children not more than the age of eighteen (18) and children in foster care.

iv. A process as defined by MLTC that identifies potential fraud or abuse of controlled substances by members, health care providers prescribing drugs to members so enrolled, and pharmacies dispensing drugs to members so enrolled. This process may include lock-in programs and prescription drug monitoring programs (PDMP).

d. The MCO must provide to MLTC, detailed reporting on providers who checked the prescription drug history through the qualified PDMP, described in section 1944(b) of the SUPPORT Act before prescribing, to include but is not limited to aggregate trends with respect to prescribing controlled substances and perform audits for documentation of good faith efforts when seeing trends for failure of such PDMP checks.

11. Psychotropic Drug Utilization Management

a. The MCO must require prior authorizations and edits for psychotropic drugs to youth that, at a minimum, meet state and federal regulations.

b. The MCO must manage the prescribing of psychotropic medications to members age twenty (20) and under by:

i. Measuring psychopharmacology usage and prescribing patterns;

ii. Monitoring the use of, and the claims related to, psychopharmacology to identify target populations, such as age subsets, for proposed interventions;

iii. Preparing member-specific profiles of medication use based on pharmacy data to guide the interventions the MCO will use with the prescriber; and

iv. Developing prescriber and pharmacy interventions to reduce clinically inappropriate prescribing of atypical antipsychotic and multiple medications to the same member. The MCO must:

a) Implement these interventions on the approval of MLTC and report to MLTC the results of the intervention;

b) Support MLTC pharmacy initiatives by promoting and communicating the adoption of clinical policy recommendations to PCPs, and other network providers, including behavioral health providers; and

c) Propose new interventions to MLTC which will be reviewed with the DUR Board.

c. The MCO must submit reports to MLTC detailing approvals and denials of requests for psychotropic medications for youth. The report must utilize the eligibility categories provided to the MCO via the enrollment files for each youth for whom a drug request is made by a prescriber. These reports must be submitted as specified in Attachment 13 - Reporting Requirements.

d. If requested by MLTC, the MCO must participate and collaborate with inter-agency workgroups and initiatives.

12. Restricted Services Program

a. The MCO is required, at a minimum, to implement a restricted services program consistent with the provisions of 471 NAC § 1-005.00- 005.05.

b. Restricted services are a mechanism for restricting Medicaid members to a specific hospital, primary care provider, prescribing provider, and/or a specific pharmacy provider in accordance with 471 NAC § 2-004. The restricted services mechanism cannot prohibit the member from receiving services that meet the exceptions contained in 471 NAC § 1-005.00- 005.05.

c. MLTC may request that a member be placed in a restricted services status when it determines that over-utilization, duplication of services, non-compliance, or drug-seeking behavior is suspected.

d. The MCO, through retrospective UR or through the recommendation of a network provider, must also determine that the services available to a member be restricted and communicate these restrictions to MLTC.

e. The MCO must:

i. Be able to implement in its claims system a restricted services status for a member and communicate this status to MLTC and other MCOs in a manner to be specified by MLTC;

ii. Provide the member and providers with advance written notification of the decision to restrict services provided to a member;

iii. Allow members in the restricted services program to change providers for cause;

iv. Establish processes for identification of new members and of members who transfer from another MCO who have existing restricted services; and

v. Conduct the following activities and have in place written policies and procedures, approved by MLTC, for such activities that fall under the care coordination and daily operational aspects of restricted services, including but not limited to:

a) Assigning a care manager to review, document, and manage the clinical or organizational needs of a member enrolled in restricted services;

b) Assigning staff member(s) to communicate and collaborate with MLTC's enrollment broker and Pharmacy Unit on an ongoing basis concerning the coordination and processes for restricted services;

c) Conducting retrospective UR to identify the potential need for restricted services for a member, in addition to requests by network providers for a review of utilization patterns by a member; and

d) Maintaining sufficient documentation for all member restricted service recommendations, including but not limited to documentation of over-utilization or duplication of services and documentation from network providers who requested a review by the MCO of a member because of suspected over-utilization of services or duplication of services.

f. The continued need for restricted services for a member must be evaluated by the MCO a minimum of every two years.

g. If a member is in a restricted services status and is unable to obtain care or services from their restricted services provider(s) due to extenuating circumstances, the MCO must have policies and procedures in place to authorize necessary exceptions.

13. Medical and Behavioral Health Utilization Management Committee

a. The MCO must establish a UM Committee that focuses on clinical service delivery trends across its membership, utilization/patterns of care, and key utilization indicators. The UM Committee must be chaired or co-chaired by the MCO or designee and must report its findings to the Quality Assessment and Performance Improvement Committee (QAPIC). The UM Committee must review, at a minimum:

i. The need for and approval of:

a) Any changes in UM policies, standards, and procedures;

b) The implementation of clinical practice guidelines;

c) The monitoring of the UM program description and work plan; and

ii. Grievances and appeals, including expedited appeals and State Fair Hearings related to UM activities to determine any needed policy changes.

b. MCO must identify system and care gaps through UM operations and seek recommendations for improvement from UM committee. The MCO should assist their network to rectify or improve processes.

14. Dental Health Utilization Management

a. The policies and procedures must include, but not be limited to:
- **i.** The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of dental care services;
- **ii.** The data sources and clinical review criteria used in decision making;
- **iii.** The appropriateness of clinical review must be fully documented;
- **iv.** The process for conducting informal reconsiderations for adverse determinations;
- **v.** Mechanisms to ensure consistent application of review criteria and compatible decisions; and
- **vi.** Data collection processes and analytical methods used in assessing utilization of dental care services.

b. The MCO must disseminate the practice guidelines to all affected providers and, upon request, to members. The MCO must take steps to encourage adoption of the guidelines.

c. The MCO must identify the source of the dental management criteria used for the review of service authorization requests, including but not limited to:
- **i.** The vendor must be identified if the criteria were purchased;
- **ii.** The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state dental care provider association or society;
- **iii.** The guideline source must be identified if the criteria are based on national best practice guidelines; and
- **iv.** The individuals who will make medical necessity determinations must be identified if the criteria are based on the dental/medical training, qualifications, and experience of the MCO Dental Director or other qualified and trained professionals.

d. The MCO must disseminate the UM Program dental management criteria and practice guidelines to all affected providers, and members upon request. Decisions for UM, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.

e. The MCO must have written procedures listing the information required from a member or dental care provider in order to make medical necessity determinations. Such procedures must be given verbally to the member or healthcare provider when requested. The procedures must outline the process to be followed in the event the MCO determines the need for additional information not initially requested.

f. The MCO must have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, the MCO may deny authorization of the requested service(s).

g. The MCO must have sufficient staffing with clinical expertise and training to apply service authorization medical management criteria and practice guidelines

h. The MCO must make medical necessity determinations that are consistent with the parameters in this section.

i. The MCO must submit written policies and processes for MLTC approval, a minimum of sixty (60) calendar days prior to implementation, on how the core dental benefits and services the MCO provides ensure:
- **i.** The prevention, diagnosis, and treatment of health impairments;
- **ii.** The ability to achieve age-appropriate growth and development; and
- **iii.** The ability to attain, maintain, or regain functional capacity.

j. The MCO must identify the qualification of staff who will determine medical necessity.

k. Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.

l. The MCO must ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease must determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.

m. The individual(s) making these determinations must have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.

n. The individual making these determinations is required to attest that they will make no adverse determination regarding any dental procedure or service outside of the scope of such individual's expertise.

o. The MCO must provide a mechanism to reduce inappropriate and duplicative use of healthcare services. Services must be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to Medicaid eligible individuals under the Medicaid State Plan. The MCO must not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member. The MCO may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210.

p. The MCO must ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR §438.6, 42 CFR §422.208, and 42 CFR §422.210.

q. The MCO must report fraud and abuse information identified through the UM program to MLTC's Program Integrity Unit in accordance with 42 CFR §455.1(a)(1).

r. In accordance with 42 CFR §456.111 and §456.211, the MCO Utilization Review plan must provide that each enrollee's record includes information needed for the UR committee to perform UR required under this section. This information must include, but is not limited to the following:

- **i.** Identification of the enrollee;
- **ii.** The name of the enrollee's dentist;
- **iii.** Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission;
- **iv.** The plan of care required under 42 CFR §456.80 and §456.180;
- **v.** Initial and subsequent continued stay review dates described under 42 CFR §456.128, §456.133; §456.233 and §456.234;
- **vi.** Date of operating room reservation, if applicable; and
- **vii.** Justification of emergency admission, if applicable.

15. Dental Utilization Management Committee

a. The UM program must include a Dental Utilization Management (UM) Committee that integrates with other functional units of the MCO as appropriate and supports the QAPI Program (refer to the Quality Assurance and Performance Improvement subsection of the RFP for details regarding the QAPI Program).

b. The Dental UM Committee must provide utilization review and monitoring of UM activities of both the MCO and its providers and is directed by the MCO Dental Director. The Dental UM Committee must convene no less than quarterly and must submit a summary of the meeting minutes to MLTC with other quarterly reports. Dental UM Committee responsibilities include:

- **i.** Monitoring providers' requests for rendering healthcare services to its members;
- **ii.** Monitoring the dental appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling;
- **iii.** Reviewing the effectiveness of the utilization review process and making changes to the process as needed;
- **iv.** Approving policies and procedures for UM that conform to industry standards, including methods, timelines, and individuals responsible for completing each task;
- **v.** Monitoring consistent application of "medical necessity" criteria;
- **vi.** Application of clinical practice guidelines;
- **vii.** Monitoring over- and under-utilization;
- **viii.** Review of outliers; and
- **ix.** Dental Record Reviews.

c. The MCO must conduct Dental record reviews to ensure that Dental Homes provide high quality healthcare that is documented according to established industry standards. The MCO must establish and distribute to providers standards for record reviews that include all dental record documentation requirements addressed in the contract.

d. The MCO must maintain a written strategy for conducting dental record reviews, reporting results, and the corrective action process. The strategy must be provided a minimum of sixty (60) calendar days prior to the Contract Start Date or implementation of any changes for MLTC review and approval. The strategy must include, but is not limited to, the following:

- **i.** Designated staff to perform this duty;
- **ii.** The method of case selection;
- **iii.** The anticipated number of reviews by practice site;
- **iv.** The tool the MCO must use to review each practice site; and
- **v.** How the MCO must link the information compiled during the review to other MCO functions (e.g. QI, credentialing, peer review, etc.)

e. The MCO must conduct reviews at all primary dental services providers that have treated more than 100 unduplicated members in a calendar year, including individual offices and large group facilities. The MCO must review each site at least one (1) time during each Contract year.

f. The MCO must review a reasonable number of records, in a random process, at each site to determine compliance. The MCO must review a minimum of ten records or up to ten percent (10%), per practice site.

g. The MCO must report the results of all record reviews to MLTC quarterly with an annual summary.

16. Utilization Management Reports

a. The MCO must submit reports as specified in Attachment 13 – Reporting Requirements. MLTC reserves the right to request additional reports. MLTC will make every effort to notify the MCO of additional required reports no less than thirty (30) calendar days prior to due date of those reports. However, there may be occasions the MCO will be required to produce ad hoc reports in a shorter time frame.

b. Service Authorization

i. Service authorization includes, but is not limited to, prior authorization.

ii. The MCO Dental UM Program policies and procedures must include service authorization policies and procedures consistent with 42 CFR §438.210, 438.905, 438.910, and state laws and regulations for initial and continuing authorization of services that include, but are not limited to, the following:

a) Written policies and procedures for processing requests for initial and continuing authorizations of services, where a provider does not request a service in a timely manner or refuses a service; and

b) Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate.

iii. The MCO Dental Director is required to make any decision to deny a service authorization request or to authorize service in an amount, duration, or scope that is less than requested.

iv. The MCO must provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process must be included in its member manual and incorporated in the grievance procedures.

v. The MCO's service authorization system must provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers.

vi. The MCO's service authorization system must have capacity to electronically store and report all service authorization requests, decisions made by the MCO regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.

vii. The MCO must not deny continuation of higher level services for failure to meet medical necessity unless the MCO can provide the service through an in-network or out-of-network provider at a lower level of care.

17. Timing of Service Authorization Decisions

a. Standard Service Authorization

i. The MCO must make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate dental information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations must be made no later than fourteen (14) calendar days following receipt of the request for service unless an extension is requested. The MCO must maintain a documentation system to report to MLTC on a monthly basis all service authorizations provided in the format specified by MLTC.

ii. An extension may be granted for an additional fourteen (14) calendar days if the member or the provider or authorized representative requests an extension or if the MCO justifies to MLTC a need for additional information and the extension is in the member's best interest. In no instance must any determination of standard service authorization be made later than twenty-five (25) calendar days from receipt of the request.

b. Expedited Service Authorization

In the event a provider indicates, or the MCO determines, that following the standard service authorization timeframe could seriously jeopardize the member'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 member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.

c. Post Authorization

i. The MCO may extend the seventy-two (72) hour expedited service authorization decision period by up to fourteen (14) calendar days if the member or if the MCO justifies to MLTC a need for additional information and how the extension is in the member's best interest.

ii. The MCO must make retrospective review determinations within thirty (30) calendar days of obtaining the results of any appropriate dental or medical information that may be required, but in no instance later than one hundred and eighty (180) calendar days from the date of service.

iii. The MCO must not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.

d. Timing of Notice

i. Approval

a) For service authorization approval for a non-emergency admission, procedure or service, the MCO must notify the provider as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and must provide documented confirmation of such notification to the provider within two (2) business days of making the initial determination.

b) For service authorization approval for extended stay or additional services, the MCO must notify the provider rendering the service, whether a healthcare professional or facility or both, and the member receiving the service within one (1) business day of the service authorization approval.

ii. Adverse Action

a) The MCO must notify the member, in writing using language that is easily understood, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in this RFP. The notice of action to members must be consistent with requirements in 42 CFR §438.10(c) and (d), 42 CFR §438.404(c), and 42 CFR §438.210(b)(c)(d) and in this RFP for member written materials.

b) The MCO must notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested.

iii. Informal Reconsideration

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

b) In a case involving an initial determination, the MCO must provide the member or a provider acting on behalf of the member and with the member's written consent an opportunity to request an informal reconsideration of an adverse determination by the dentist or clinical peer making the adverse determination.

c) The informal reconsideration should occur within one (1) business day of the receipt of the request and should be conducted between the provider rendering the service and the MCO's dentist authorized to make adverse determinations or a clinical peer designated by the Dental Director if the dentist who made the adverse determination cannot be available within one (1) business day. The Informal Reconsideration will in no way extend the thirty (30) calendar day required timeframe for a Notice of Appeal Resolution.

iv. Exceptions to Requirements

a) The MCO must not require service authorization for emergency dental services as described in this section whether provided by an in-network or out-of-network provider.

b) The MCO must not require service authorization or referral for EPSDT dental screening services.

c) The MCO must not require service authorization for the continuation of covered services of a new member transitioning into the MCO, regardless of whether such services are provided by an in-network or out-of-network provider, however, the MCO may require prior authorization of services beyond thirty (30) calendar days.

O. PROGRAM INTEGRITY

1. General Requirements

a. The MCO must comply with all state and federal laws, regulations, and mandates relating to fraud, waste, and abuse (FWA), and erroneous payments in the Medicaid program including, but not limited to 42 CFR § 438.608.

b. The Nebraska Medicaid Program Integrity Unit (NMPI) is the entity within MLTC charged with identifying and investigating allegations of FWA and erroneous payments.

c. The Medicaid Fraud and Patient Abuse Unit (MFPAU) of the Nebraska Attorney General's office is the primary law enforcement entity responsible for the prosecution of provider fraud for the Nebraska Medicaid program.

d. The MCO must certify that all statements, reports, and claims, financial and otherwise, are true, accurate, and complete. The MCO must not submit for payment purposes those claims, statements, or reports that it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, its contract with MLTC, and MLTC policy.

e. The MCO must immediately report to NMPI any suspicion or allegations of fraud.

f. In accordance with applicable laws and MLTC policies and procedures, the MCO must report in writing overpayments made by MLTC to the MCO as well as overpayments made by the MCO to a provider or subcontractor. Please refer to Section V.O.2. Recovery of Overpayments, below.

g. The MCO, as well as its contractors, subcontractors, and providers, whether contracted or non-contracted, must comply with all federal requirements (42 CFR § 455.100-455.107) about disclosure reporting of owners and managing employees.

h. The MCO must require that all its providers, contractors, and subcontractors take all the necessary actions to permit the MCO to comply with FWA and erroneous payment requirements included in this contract and state and federal regulations. The MCO is ultimately responsible for compliance with the terms of this contract and activities and compliance of all providers, contractors, sub-contractors, and third parties. The MCO agrees to require, via contract or arrangement that those providers comply with regulations and any enforcement actions directly initiated by MLTC under its regulations, including but not limited to, termination and restitution.

i. The MCO must have a FWA and erroneous payments unit within the organization comprised of experienced staff members. As described in Section V.D Staffing Requirements, this unit must include a State-based Program Integrity Officer and a minimum of one (1) full time employee State-based investigator for every fifty-thousand (50,000) or fewer members. The unit's primary purpose is to prevent, detect, investigate, and report suspected FWA and erroneous payments that may be committed by network providers, members, employees, or other third parties with whom/which the MCO contracts or subcontracts.

j. The MCO, its employees, contractors, and subcontractors must cooperate fully with oversight entities responsible for FWA and erroneous payment detection and prosecution activities. This cooperation includes providing access to all necessary case information, computer files, and appropriate staff in the form, manner, and deadline directed by MLTC. This cooperation includes participating in FWA and erroneous payments training sessions, meetings, and joint reviews of network providers or members. The MCO must participate in the Nebraska Health Care Fraud Task force meeting by sending one of its dedicated State-based FWA staff.

k. The MCO, its contractors, and subcontractors must cooperate in any investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. This cooperation includes providing information, access to records, and access to interview the MCO's employees, contractors, and subcontractors, in the form, manner, and deadline directed by MLTC.

l. When NMPI requests access to copies of any records or data maintained by the MCO, employees, contractors, subcontractors, or providers, the response must be in the form, manner, and deadline directed by NMPI.

m. At the readiness review and annually thereafter, the MCO must confirm in writing, by completing and submitting the Annual Program Integrity Confirmation and FWA Plan that the MCO's Compliance Officer(s) understand all requirements related to the MCO's receipt of state and federal funds. The MCO must confirm that its officers understand that they are subject to criminal prosecution, civil action, or administration actions for any intentional false statements or other fraudulent conduct related to their contractual obligations.

n. NMPI will seek all appropriate remedies for fraud, abuse and violation of law if the MCO, a provider, employee, contractor, or subcontractor has committed fraud or abuse as defined in this contract, or has otherwise violated applicable law.

o. The MCO may not contract with or reimburse providers that are excluded by Medicare, any state Medicaid program, or any state CHIP. Federal financial participation (FFP) is not available to pay providers excluded by Medicare, Medicaid, or CHIP. The MCO is responsible for the refund to MLTC of any money paid for services provided by an excluded provider.

p. The MCO may only pay providers that are enrolled in the Nebraska Medicaid program. The MCO must use the provider enumeration and associated information (Medicaid ID, NPI, Taxonomy, Provider Type, Provider Specialty, address, business names, etc.) that has been enrolled and screened by Nebraska Medicaid for credentialing. This enumeration must be included on the provider file submitted to MLTC.

q. The MCO must immediately notify NMPI of any providers that are terminated for cause from the MCO network and any providers that leave the MCO's network to avoid a for-cause termination.

r. NMPI will notify the MCO of payment suspensions or good cause exceptions and the MCO must then suspend payments or otherwise comply with 42 CFR § 455.23 and other applicable laws and regulations. Payment suspensions or good cause exceptions are effective the date of the notification letter. Failure to suspend payments or otherwise comply will result in the recoupment of the payments from the MCO and may lead to sanctions on the MCO.

s. The MCO must develop policies, processes, and procedures which allow providers to self-disclose erroneous payments and return the erroneous payments after approval by NMPI. Provider self-disclosures must be included on reports to NMPI.

2. Recovery of Overpayments

The MCO must pursue the recovery of overpayments identified as FWA after receiving permission from NMPI and reflect the recovery on the encounter record and other reports used for rate setting. In the event that the MCO does not pursue all recoveries, MLTC will pursue them and collect the money.

a. Overpayments must be reported and returned within sixty (60) calendar days of the identification of the overpayments. Information on recoveries is used for the setting of capitation rates.

b. Recoveries as a result of FWA or erroneous payment activity by the MCO may be retained by the MCO when:

- **i.** The amount is not part of a civil or criminal action by the MFPAU or federal government;
- **ii.** NMPI has approved the recovery of the overpayment from the provider;
- **iii.** The recovery is accurately reflected in the encounter data and other reports; and
- **iv.** Documentation of the recovery is maintained by the MCO.

c. Recoveries as a result of an investigation originated by NMPI or associated contractor, may be assessed on the MCO or the provider as determined by NMPI.

- **i.** If assessed on the MCO, the MCO must pay the overpayment to MLTC and may pursue a refund from the provider if the recovery is accurately reflected in the encounter data. Reports and documentation of the recovery must be maintained by the MCO.
- **ii.** If assessed on the provider, the MCO may not collect the overpayment.
  - a) NMPI will follow its standard recovery process and deadlines.
  - b) Documentation of the recovery will be maintained by NMPI.

d. The MFPAU directs the recovery of overpayments due to civil or criminal actions against a provider.

3. MCO FWA Policies, Procedures, and Plan

a. The MCO must have policies, procedures, and a plan that is designed to prevent, reduce, detect, correct, and report known or suspected FWA and erroneous payments.

b. The MCO's FWA Policies and Procedures must include the following components:

- **i.** Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable state and federal requirements;
- **ii.** Agreement to report all allegations of FWA to the NMPI in the form, manner, and deadline directed;
- **iii.** The designation of a Program Integrity Officer that is accountable to senior management and must ensure an adequately staffed program integrity office;
- **iv.** A description of the qualifications of the staff, who must be adequate in number and training, to effectively implement this contract;
- **v.** Effective training and education for the Program Integrity Officer, Program Integrity Staff, MCO employees, contractors, and subcontractors;
- **vi.** A description of the methodology and standard operating procedures used to prevent, identify, and investigate FWA and erroneous payments, and to recover overpayments or otherwise intervene with providers;
- **vii.** Enforcement of standards through well-publicized materials included in member and provider handbooks, training, and newsletters;
- **viii.** A description of the specific proactive controls in place to detect FWA and erroneous payments, including an explanation of the technology used to identify aberrant billing patterns, claims edits, post-processing review of claims, and record reviews;
- **ix.** The MCO understanding of the False Claims Act and the other provisions described in Section 1902(a)(68)(A) of the Social Security Act and Nebraska's Medicaid False Claims

Act, Neb. Rev. Stat. § 68-934 et seq. and how these laws inform the FWA and erroneous payments prevention, detection, and intervention activities;

x. A provision indicating that the MCO's FWA and erroneous payments unit has access to provider records;

xi. Procedures for timely, complete, and consistent exchange of information in the form, manner, and deadline directed, and for collaboration with NMPI and MFPAU regarding FWA and erroneous payments;

xii. Agreement to and the method the MCO will use to suspend all provider payments when notified by NMPI to suspend payments due to a credible allegation of fraud or other efforts;

xiii. The method the MCO will use to comply with requests from NMPI or the MFPAU for access to and copies of any records kept by the MCO, computerized data stored by the MCO, or information maintained by MCO providers to which MLTC is authorized to have access; and

xiv. The method the MCO will use to prevent payments to international accounts.

c. The MCO Program Integrity Compliance Plan must include the following:

i. Procedures for ongoing monitoring and auditing of MCO systems, including but not limited to, claims processing, billing and financial operations, enrollment functions, member services, provider services, and continuous quality improvement; and the MCO's providers, subcontractors, employees, and any others, as appropriate;

ii. Provisions for the confidential reporting of plan violations, such as a hotline to report violations, and a clearly designated individual, such as the Compliance Officer or the Program Integrity Officer, to receive them. Several independent reporting paths must be created for the reporting of fraud so that such reports cannot be diverted by any supervisors or other personnel;

iii. Protections to ensure that no individual who reports program integrity-related violations or suspected FWA is retaliated against by anyone who is employed by or contracts with the MCO. The MCO must ensure that the identity of individuals reporting violations or suspected violations of the compliance plan must be kept confidential to the extent possible. Anyone who thinks that they have been retaliated against may report this violation to MLTC or the Federal DHHS Office of Inspector General;

iv. Provisions for a prompt response to detected offenses and for development of corrective action initiatives related to the contract in accordance with 42 CFR § 438.608(a); and

v. Prior to readiness review, annually, and prior to any material change (per Attachment 13 – Reporting Requirement), the MCO must submit the following for review, revisions directed by MLTC, and approval by NMPI:

a) The MCO FWA Policies, Procedures, and Plan,
b) The MCO Compliance Plan,
c) The name of the Compliance Officer, and
d) The name of the Program Integrity Officer.

4. Prohibited Affiliations

a. In accordance with 42 CFR § 438.610, the MCO may not knowingly have a relationship with and must have a proactive method to prevent the following relationship(s):

i. An individual or entity debarred, suspended, or otherwise excluded from participating in any state or federal programs;

ii. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation, of an individual or entity excluded from participating in state or federal programs including, but not limited to:

a) A director, officer, or partner of the MCO;
b) A person with ownership of five percent (5%) or more of MCO equity; and
c) A person or entity with an employment, consulting, or other arrangement with the MCO under its contract with MLTC;

iii. Any individual or entity excluded from participation in any state Medicaid program or the Medicare program; and

iv. Any individual or entity listed on the Federal System for Award Management, the Office of Inspector General's List of Excluded Individuals and Entities database, or the Nebraska Medicaid Excluded Providers list.

a) The MCO must conduct a search of the then-current version of these lists monthly to capture exclusions and reinstatements that have occurred since the previous search. The MCO must document the results of the search and maintain the documentation;

b) When the MCO identifies a relationship with a debarred or excluded individual or entity, the MCO must initiate efforts to sever the relationship with the debarred or excluded individual or entity immediately and report to NMPI immediately.

c) Medicaid funds cannot be paid or be used to pay, through direct payment or capitation, any individual or entity that employs or contracts with an excluded provider/individual. This includes MCO employees, contractors, and subcontractors.

d) The contract requires that the MCO not contract with providers that the state has determined have been terminated from the Medicare, Medicaid or CHIP programs pursuant to 42 CFR § 455.101. [Section 1932(d)(5) of the Act]. If the MCO employs, contracts, or subcontracts with a debarred or excluded individual or entity, the MCO is subject to liquidated damages and a performance improvement plan.

b. In addition to any other remedy or sanction available to DHHS, the agency may withhold capitation payments until the MCO complies.

5. The MCO and MFPAU

a. The MCO and the MCO's contractors, subcontractors, and providers, whether contracted or non-contracted, must make available to MFPAU without the need for a subpoena or search warrant, in the form, manner, and deadline, any and all administrative, financial, or medical records relating to the delivery of services for which Nebraska Medicaid funds are expended.

b. The MCO must comply in the form, manner, and deadline with the MFPAU requests for data stored or formulated by the MCO or its subcontractors, including but not limited to, claims data, encounter data, eligibility information, and enrollment data.

c. The MCO must certify that the data supplied to MFPAU is true, accurate, and complete. This data must be supplied without charge and in the form, manner, and deadline requested by MFPAU.

d. The MCO must allow MFPAU staff access to its location(s) of business, contractors, subcontractors, and employees whether within or outside of the State. Access to the MCO's places of business must be allowed during normal business hours and at other times under special circumstances when after-hour admission is required. Special circumstances are at the sole discretion of MFPAU.

e. MFPAU has the right to recover inappropriately expended Medicaid funds directly from providers, the MCO, or its contractors and subcontractors, in criminally and civilly prosecuted cases or settlements. The MCO is not entitled to any part of recovered funds.

f. The MCO must subrogate to MFPAU any and all claims it has or may have, related to Nebraska Medicaid, against pharmaceutical companies, retailers, providers, or other subcontractors, medical device makers, or durable medical equipment manufacturers in the marketing or pricing of their products.

g. In the event that the MCO conducts a hearing or review of its decision to institute interventions or sanctions against a provider, the MCO must provide MFPAU adequate notice of the hearing, and furnished copies, at that time, of any and all pleadings and evidence. MFPAU has the right to intervene in these proceedings. If necessary for MFPAU's investigative purposes, MFPAU may suspend these proceedings until MFPAU's investigation is complete.

h. Regardless of any monetary settlement, payment, intervention, sanction, or other agreement between the MCO and any provider suspected of fraud, MFPAU retains the right to pursue any and all appropriate civil or criminal actions against the provider.

i. The MCO and its contractors and subcontractors must supply information and training or orientation to the MFPAU and NMPI on how MCO required activities (provider credentialing, payment adjudication, etc.) are completed at the request of the MFPAU or NMPI.

j. In addition to any other remedy or sanction available to DHHS, the agency may withhold capitation payments until the MCO complies.

6. Employee Education About Fraud, Waste, and Abuse

a. The MCO must comply with federal law to educate employees about FWA, the compliance plan, and false claims recoveries (Deficit Reduction Act of 2005 – Section 6032). This includes:

i. Evidence of completed, effective education (training materials and training plan) for the Program Integrity Officer and the organization's employees, MCO providers, and members about the compliance plan, FWA, and erroneous payments and how to report any allegations regarding any of them;

ii. Effective lines of communication between the Compliance Officer and the MCO employees, MCOs, providers, and MLTC and its designee(s); and

iii. Established written policies for all employees (including management), and any subcontractor or agent of the entity, that include detailed information about the False

Claims Act and the other provisions named in section 1902(a)(68)(A) of the Social Security Act. The MCO must include detailed information about the MCO's policies and procedures for detecting and preventing FWA. The MCO must also include in any employee handbook a specific discussion of the laws described in the written policies, and the whistleblower rights and protections of and for employees.

b. This training must be conducted annually for all employees and within thirty (30) calendar days of employment for new hires.

c. The MCO must require new employees to complete and attest to training within thirty (30) calendar days of hire related to the following in accordance with state and federal laws:

- **i.** MCO code of conduct training;
- **ii.** Privacy and security (including but not limited to HIPAA);
- **iii.** FWA and erroneous payments;
- **iv.** Procedures for the timely, consistent exchange of information and collaboration with MLTC;
- **v.** Organizational chart, including the Program Integrity Officer and program integrity investigator(s); and
- **vi.** Provisions of 42 CFR § 438.610 and all relevant state and federal laws, regulations, policies, procedures and guidance (including CMS' *Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks)* issued by MLTC, DHHS, CMS, the Office of Inspector General, including updates and amendments to these documents or any such standards established by the State.

d. The MCO must maintain a toll-free provider compliance hotline number and ensure that the number and an accompanying explanatory statement are distributed to its members and providers through its member and provider handbooks.

e. The MCO must create and disseminate written materials for educating employees, managers, providers, and subcontractors about health care fraud laws, the MCO's policies and procedures for preventing and detecting FWA and the rights of employees to act as whistleblowers. The MCO's education must comply with all requirements of Section 1902(a) (68) of the Social Security Act.

7. MCO Oversight by Nebraska Medicaid Program Integrity

a. The MCO must submit the following reports to NMPI in the format, reporting period, and timeframe as specified in Attachment 13-Reporting Requirements. The MCO must also have documented policies and processes to collect the information necessary for the following reports:

- **i.** A bi-weekly tips report that identifies patterns of data mining outliers, audit concerns, critical incidents, hotline calls, or other internal and external tips with potential implications about provider billing anomalies and the safety of Nebraska Medicaid members. Along with the bi-weekly tips report, the MCO must take steps to triage or substantiate these tips and provide timely updates to NMPI;
- **ii.** FWA Abuse Interventions Report – A monthly report of the MCO activity to investigate and resolve referrals of potential fraud, waste, abuse, and erroneous payments. The report must be submitted in the form, manner, and deadline directed by MLTC.
  - a) Detailed information about new referrals since the last report of potential FWA and erroneous payments opened by the MCO;
  - b) Summary of new referrals since the last report of potential FWA and erroneous payments opened by the MCO;
  - c) Detailed update of current case investigations of potential FWA and erroneous payments;
  - d) Summary of current case investigations of potential FWA and erroneous payments;
  - e) Case investigations closed since the last report;
  - f) All overpayments identified since the last report;
  - g) All overpayments collected since the last report;
  - h) Detailed information on all erroneous payments that have been resolved since the last report; and
  - i) Summary of erroneous payments that have been resolved since the last report.
- **iii.** Monthly reports of claims adjudicated to finalization by the MCO in the previous calendar month. The report must be submitted in the form, manner, and deadline directed by MLTC;
- **iv.** Monthly report of all providers that have left the MCO provider network, including the provider's name, NPI, Medicaid Provider ID number, provider type, address, and the reason. The report must be submitted in the form, manner, and deadline directed by MLTC;

v. Monthly report of the MCO's efforts to detect and prevent FWA and erroneous payments and must address the elements listed below. The report must be submitted in the form, manner, and deadline directed by MLTC;
  a) Both pre-pay and post pay utilization review activities;
  b) Member and provider hotline complaints;
  c) MCO QA/QI meeting minutes and reports;
  d) All site visit reports; and
  e) All other MCO activity that covers the prevention, reduction, detection, correction, or reporting of potential fraud, waste, abuse, or erroneous payments;

vi. A quarterly report of service verification with clients to confirm that services have been provided. This verification may be conducted by mail, electronic correspondence, or telephone. Sampling criteria may include a representative sample or a targeted sample;

vii. Quarterly reports of audits to identify, report the results to NMPI, and correct payments made for:
  a) Services paid after the recipient's death;
  b) Services paid during a recipient's incarceration; or
  c) Ambulatory services, such as prescription drugs, therapies, or medical supplies, received by the patient while that patient is hospitalized, or living in or treated in a setting reimbursed at an all-inclusive rate; and

viii. Ad Hoc claim listings to fulfill NMPI and MFPAU Requests for Information (RFI). The report must be submitted in the form, manner, and deadline directed by MLTC.

b. Collaboration with NMPI

i. NMPI will hold regular meetings with all MCOs to review and discuss investigations, compliance, prevention, and other Program Integrity related activities. These meetings will be attended by the MCO's Program Integrity Officer and State-based Nebraska-specific investigators.

ii. The MCO's Program Integrity Officer will serve as the primary point of contact for all issues related to FWA and erroneous payments.

c. Investigations

i. The MCO must cooperate with all appropriate state and federal agencies, including the MFPAU and the DHHS Office of Inspector General, in investigating allegations of FWA and erroneous payment.

ii. When the MCO identifies an allegation of FWA or erroneous payments it must promptly perform an investigation for the entire contract period preceding the allegation. The MCO must promptly provide the results of any preliminary investigations to NMPI.

iii. After an investigation is referred to the MFPAU by NMPI, the MCO must cease all investigative efforts, refunds or recoupments, or civil actions unless otherwise advised by NMPI or MFPAU. The MCO must not notify the provider of the referral of an investigation.

iv. The MCO must cooperate and assist MLTC and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected FWA or erroneous payments. At any time during normal business hours, MLTC, MFPAU, the State Auditor's Office, Nebraska Office of the Attorney General, General Accounting Office (GAO), Comptroller General, Federal DHHS, or any of their designees, and as often as they deem necessary during the contract period and for a period of ten (10) years from the expiration date of the contract (including any contract extensions/renewals), have the right, power, and authority to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the contract or any other applicable laws.

v. The MCO and its contractors and subcontractors must make all program and financial records and service delivery sites open to the representative or any designees listed immediately above. The entities listed above must have timely and reasonable access and have the right, power, and authority to examine and make copies, excerpts, or transcripts from any books, documents, papers, or records that are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts, and transcripts; contact and conduct private interviews with MCO clients, employees, and contractors; and complete on-site reviews of all matters relating to service delivery as specified by the contract. The rights of access in this subsection are not limited to the required retention period but will last as long as records are retained. The MCO must provide originals or copies (at no charge) of all records and information requested. Requests for information must be compiled in the form, manner, and deadline directed by NMPI.

vi. The MCO's employees and its contractors and subcontractors and their employees must cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process.

vii. The MCO must comply with all the requirements of Neb. Rev. Stat. § 68-974 as directed by NMPI.

P. MCO REIMBURSEMENT

1. General Requirements

a. This contract is a full-risk arrangement, except for any risk mitigation terms set forth explicitly elsewhere in this section.

b. MLTC will make monthly capitation payments to the MCO to cover all services in the contract, except for any mother's costs of obstetrical deliveries, for which MLTC will pay the MCO a supplemental payment, in addition to the monthly capitation payment. Capitation payments will be made prospectively for prospective enrollment and retrospectively to the first day of the member's enrollment and based on the MCO's electronic enrollment file.

c. The MCO must agree to accept, as payment in full, the capitation rate and supplemental payments established by MLTC pursuant to the contract and must not seek additional payment from a member or MLTC for any unpaid cost.

d. The MCO must assume one hundred percent (100%) liability for any expenditures above the monthly capitation rate.

e. Payment for items or services provided under this contract may not be made to any entity located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

f. The MCO must have written policies and procedures for receiving and processing payments and adjustments. Any charges or expenses imposed by financial institutions for transfers or related actions must be borne by the MCO.

2. Capitation Rate Determination Process

a. MLTC will develop cost-effective and actuarially sound rates in accordance with generally accepted actuarial principles and CMS rules, regulations, and guidance (currently available at: https://www.medicaid.gov/medicaid/managed-care/guidance/rate-review-and-rate-guides/index.html) appropriate for the populations covered and the services provided, as described in this contract.

b. Capitation rates will be in effect for the initial year, or twelve (12) month contract period beginning with the Contract Start Date.

c. Monthly capitation rates will be established separately for two (2) regions, shown in the map in Attachment 4 – Rating Regions:

i. Rating Region One (1) consists of forty-one (41) counties: Antelope, Boone, Burt, Butler, Cass, Cedar, Clay, Colfax, Cuming, Dakota, Dixon, Dodge, Douglas, Fillmore, Gage, Hamilton, Jefferson, Johnson, Knox, Lancaster, Madison, Merrick, Nance, Nemaha, Seward, Otoe, Pawnee, Pierce, Platte, Polk, Richardson, Saline, Sarpy, Saunders, Seward, Stanton, Thayer, Thurston, Washington, Wayne, and York.

ii. Rating Region Two (2) consists of fifty-two (52) counties: Adams, Arthur, Banner, Blaine, Box, Butte, Boyd, Brown, Buffalo, Chase, Cherry, Cheyenne, Custer, Dawes, Dawson, Deuel, Dundy, Franklin, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Greeley, Hall, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Kearney, Keith, Keya Paha, Kimball, Lincoln, Logan, Loup, McPherson, Morrill, Perkins, Phelps, Red Willow, Rock, Scottsbluff, Sheridan, Sherman, Sioux, Thomas, Valley, Webster, and Wheeler.

d. The categories of aid (COA) are:

i. Aged, Blind, Disabled 0-20 M&F (Including State Disability Program);

ii. Aged, Blind, Disabled 21+ M&F (including State Disability Program);

iii. 21-64 F – Women With Cancer (WWC) (Breast & Cervical Cancer Program);

iv. Children's Health Insurance Program (CHIP) M&F;

v. Family under 1, M&F*;

vi. Family 1-5 years, M&F;

vii. Family 6-20 years, F;

viii. Family 6-20 years, M;

ix. Family 21 years+, M&F;

x. Foster Care/State Wards/Subsidized Adoption & Guardianship M&F;

xi. Healthy Dual;

xii. Dual – Long-Term Care;

xiii. Non-Dual Long-Term Care;

xiv. Dual - (HCBS) Waiver;

xv. Non-Dual – (HCBS) Waiver;
xvi. Katie Beckett 0-18 years, M&F;
xvii. 599 CHIP – Regular Monthly Cohort;
xviii. 599 CHIP – Maternity Supplemental;
xix. Maternity Supplemental;
xx. Refugee Medical ;
xxi. Expansion 19-44, M;
xxii. Expansion 19-44, F;
xxiii. Expansion 45-64, M& F;
xxiv. Health Insurance Premium Payment (HIPP) – Expansion;
xxv. HIPP – Disabled/Non-Dual Waiver;
xxvi. HIPP – Katie Becket; and
xxvii. HIPP – All other.

* Family Category of Aid - Section 1931 of the Social Security Act, Children and related populations and Section 1931 of the Social Security Act, Adults, and related populations.

e. Capitation rates are developed using encounter data, fee-for-service data, and supplementary financial information, from each MCO under contract at the time of this RFP's release, for the eligible populations from calendar years 2019, 2020, and 2021. Following is a list of adjustments considered in the rate development:
i. Utilization trend;
ii. Unit cost trend;
iii. Medicaid program changes;
iv. Coordinated care savings; and
v. MCO administrative allowance.

f. The MCO must provide any and all information requested by MLTC to assist in the determination of MCO rates. MLTC will give the MCO reasonable time to respond to the request, and the MCO must fully cooperate. MLTC will make the final determination as to what is considered reasonable.

g. No less frequently than annually, MLTC and its actuary will jointly review the information necessary to develop actuarially-sound capitation rates. This review will include an analysis of any anticipated fee schedule changes or other programmatic changes to the Heritage Health, claims experience cost reporting information collected from the MCO, Department of Insurance annual statements, various trend data sources, and administrative experience.

h. Adjusted rates will require an amendment to the contract, mutually agreeable by both parties.

i. MLTC reserves the right to adjust the capitation rate more frequently than annually as program changes dictate. Circumstances precipitating a rate change include and are not limited to:
i. Changes to benefits and services included in the monthly capitation rates;
ii. Changes in federal law, federal regulations, state law, state regulations, state policies, or the Medicaid State Plan;
iii. Changes to Medicaid population groups eligible to enroll; and
iv. Legislative appropriations and budgetary constraints.

j. MLTC's actuary will provide, as part of its certification of capitation rates, a narrative that identifies the specific data, assumptions, and methodologies behind the specific payment rates for each rating region. This narrative will address any MCO-specific factors that influence provision of services to Medicaid members, including but not limited to, reserve contributions and capital costs.

3. Capitation Rates and Payment

a. MLTC will pay the MCO in accordance with monthly capitation rates.

b. The monthly capitation payment is based on member enrollment for the month. This is determined by the total number of Medicaid members assigned to the MCO as of the last working day of the previous month. For age group assignment purposes, age is determined at the beginning of the month for which the payment is intended. The MCO will receive additional payments to cover the cost of services retroactive to the first day of the month of the member's enrollment.

c. The entire monthly capitation payment will be paid during the month of birth, the month of death, and the first month of any incarceration.

4. Supplemental Delivery Payments

a. In addition to the monthly capitation rate, MLTC will pay MCOs a one-time supplemental lump-sum payment for deliveries.

b. The MCO must pay for all covered services associated with maternity care of a pregnant member.

c. The supplemental delivery payment is intended to cover the care of the pregnant member, not the new born.

d. When a member is enrolled in the MCO on her date of delivery and the delivery results in a live birth, MLTC will pay the MCO one supplemental maternity payment. The payment will not be prorated.

e. When a member is enrolled in the MCO for part of the pregnancy but was not enrolled on the date of the delivery, the MCO will not receive the supplemental maternity payment, or any portion thereof.

f. For maternity cases that result in termination of the pregnancy or miscarriage, the MCO is reimbursed through the monthly capitation rate for the member. The MCO will not receive the supplemental delivery payment.

g. Supplemental payment for deliveries will be to reimburse the MCO for the expenses incurred between the date of admission and the date of discharge of a delivery event.

h. The supplemental payment is generated after documentation of a live birth. A live birth is defined as any birth not resulting in miscarriage, still birth, or any other birth not resulting in life.

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

j. The MCO must request payment for the supplemental delivery payment no later than twelve months following the date of service for the delivery. Failure to have supporting records, when audited, may result in recoupment of the supplemental delivery payment.

5. Payment Adjustments

a. In the event an erroneous payment is made to the MCO, MLTC will reconcile the error by adjusting the MCO's next monthly capitation payment or future capitation payments on a schedule determined by MLTC.

b. MLTC will pay the current CMS-approved capitation rate and as applicable will adjust prior month capitation payments upon CMS approval of updated rates.

c. In cases of a retroactive effective date for Medicare enrollment of a member, the MCO must recoup payments made to its providers. The MCO must initiate recoupments within sixty (60) calendar days of the date the MCO becomes aware of Medicare enrollment. The MCO must instruct the provider to resubmit the claim(s) to Medicare.

d. The MCO must refund payments received from MLTC for a deceased member after the month of death and an incarcerated member the month after entering involuntary custody. MLTC will recoup the payment within thirty (30) calendar days of the date MLTC notifies the MCO of death or incarceration. The MCO must notify MLTC should the MCO become aware of a member's death or incarceration.

6. Risk Adjustment

a. Risk-adjusted rates will not be paid in the first year of this contract. For subsequent years of the contract, each MCO's base capitation rates may be risk-adjusted based on the MCO's risk score, reflecting the expected health care expenditures associated with its enrolled members relative to the applicable total Medicaid population.

b. To establish risk-adjusted rates, MLTC's actuary may analyze the risk profile of members enrolled in each MCO using a national risk-adjustment model specified by MLTC.

c. Each member may be assigned to risk categories based on their age, gender, and disease conditions. This information and the relative cost associated with each risk category will reflect the anticipated utilization of health care services relative to the overall population.

d. The relative costs may be developed using MLTC historical data from Medicaid FFS claims and MCO encounter data, as determined appropriate by MLTC's actuary.

e. Risk adjustment will be evaluated annually by MLTC, or more frequently as MLTC determines is warranted.

f. MLTC will provide the MCO with three (3) months advance notice of any major revision to the risk-adjustment methodology. The MCO will be provided the opportunity to provide input regarding any proposed changes. MLTC will consider the feedback from the MCOs when making changes to the risk adjustment methodology.

7. Risk Corridor

a. Annual MCO profits or losses must not exceed two and one half percent (2.5%) in the first contract year. Annual MCO profits must not exceed two percent (2%) in the second and subsequent contract years. In the second and subsequent contract years, there is no limit on MCO losses. MLTC reserves the right to change the structure and percentages of the risk corridor in advance of a contract year.

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

c. This calculation must be completed within twelve (12) months of the end of the contract year. The risk corridor will be calculated first, and any payments/receipts under the risk corridor will be incorporated in the Medical Loss Ratio (MLR) calculation. This methodology is consistent with the Final Rule published by CMS, 42 CFR § 438.8.

d. If the calculation produces a profit above the indicated amount, the MCO must return the excess profit to MLTC as directed by the department's written notification of the final amount to the MCO.

e. The MCO must provide full financial statements and additional requested data to MLTC and its actuary to support the calculation. MLTC must reimburse the federal share of the forfeited funds to CMS and retain the state share for reinvestment pursuant to Neb. Rev. Stat. § 68-995.

f. Regardless of the risk corridor calculation, the MCO is eligible to receive its earned hold-back.

g. All risk corridor, MLR, and end of year calculations are subject to CMS review prior to execution.

8. MLTC Quality Performance Program

a. The MCO must participate in the MLTC quality performance program (QPP), effective as of Contract Start Date. The MLTC QPP must be implemented in accordance with Neb. Rev. Stat. § 68-995 and any successor statutes.

b. The MCO must hold-back one and a half percent (1.5%) of at-risk capitation revenue received by the MCO and related parties under the contract in a separate account. The hold-back constitutes the maximum amount available to the MCO to earn back via the quality performance program.

c. QPP measures for which the MCO is eligible to earn hold-back funds are included in Attachment 6 – QPPs.

d. The MCO must report its performance measures that affect the MCO's eligibility to earn hold-back funds upon the request of MLTC.

e. Each year of the contract constitutes a performance year, beginning on the Contract Start Date. MLTC will assess the MCO's performance based on the measures annually and notify the MCO of the amount of the earned hold-back and unearned (forfeited) hold-back. MLTC will make this determination within twelve (12) months after the end of each contract year.

f. All earned hold-back funds become the property of the MCO.

g. The MCO must return unearned (forfeited) hold-back funds to MLTC as directed, upon written notification.

h. No interest will be due to either party on hold-back funds retained by the MCO or returned to MLTC.

i. MLTC reserves the right to modify the measures and criteria for earning the hold-back funds. In the event MLTC modifies the measures or criteria, MLTC will provide the MCO sixty (60) calendar days advance written notice. These measures will include operational or administrative measures that reflect MCO business processes and may lead to improved access to and quality of care, CMS Medicaid Adult and Child Core Measure sets, HEDIS measures, and MLTC-identified measures that represent opportunities for improvement as indicated by MCOs historical performance.

9. Expressed Compensatory Damages

a. Pursuant to Neb. Rev. Stat. § 68-995, one quarter of one percent (0.25%) of the aggregate of all income and revenue earned by the MCO and related parties under the contract must be at risk for damages if the MCO fails to meet minimum performance metrics. MLTC will provide minimum performance metrics to the MCO prior to year two (2) of the Contract Start Date.

b. The MCO must report its performance on the minimum performance metrics as requested by MLTC.

c. Each year of the contract constitutes a performance year, beginning on the Contract Start Date. MLTC will assess annually the MCO's performance compared with the minimum performance metrics and notify the MCO of the amount of liquidated damages due to MLTC. MLTC will make this determination within six (6) months after the end of each contract year. More information on liquidated damages may be found in Section V. V. Liquidated Damages.

d. MLTC reserves the right to annually modify the minimum performance metrics and criteria for assessing liquidated damages. In the event MLTC modifies the metrics or criteria, MLTC will provide the MCO sixty (60) calendar days advance written notice.

10. Administrative Cap

a. Per Neb. Rev. Stat. § 68-995, the MCO's administrative spending must not exceed 12% (twelve percent). MLTC will not include more than twelve percent (12%) in administrative load during capitation rate development. In the event the MCO administrative spending exceeds twelve percent (12%) the amount in excess will not be considered within the calculation of the risk corridor.

b. Administrative spending shall only include expenses that improve the health status of the population to be served and does not include contractor incentives.

c. Administrative expenditures do not include profit.

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

e. To ensure compliance with state law, MLTC will calculate the administrative expense rate within twelve (12) months after the end of the prior contract year.

f. Unearned hold-back funds are not included as revenue in the administrative cap calculation.

11. Medical Loss Ratio

The MCO must provide quarterly financial reports and information in the format required by MLTC for the purposes of MLTC to calculate and monitor the MCO's Medical Loss Ratio (MLR). MLTC will calculate the MLR within twelve (12) months of the end of each contract year. If the MLR is less than eighty-five percent (85%), the MCO must refund MLTC the difference within the timeframes established by MLTC upon written notice. All risk corridor, MLR, and end of year calculations are subject to CMS review prior to execution. (See Attachment 7 – Medical Loss Ratio Requirements for the MLR calculation methodology and classification of costs.)

12. Hold-back Accounts

a. Pursuant to Neb. Rev. Stat. § 68-995, the MCO must establish and manage a hold-back account, for the purpose of holding funds as required in Section P.8 MLTC Quality Performance Program. The hold-back account must:

i. Be separate from other accounts required by the contract, or that may be required by state or federal law;

ii. Have no risk-bearing investments; and

iii. Be created and operated in full compliance with the Nebraska Uniform Trust Code (Neb. Rev. Stat. § 30-3801 through 30-38110).

b. The MCO is responsible for the necessary fiduciary duties and functions required to administer the holding account. Oversight of the financial accounting will be in accordance with the financial management reporting requirements outlined in Section V. T. Reporting and Deliverables of this contract. MCO will be required to provide monthly account balance statements for MCO-established holdback accounts.

13. Return of Funds

a. All amounts owed by the MCO to MLTC, as identified through routine or investigative reviews of records or audits conducted by MLTC or other state or federal agencies, are due no later than thirty (30) calendar days following MCO notification unless otherwise authorized in writing by MLTC. MLTC reserves the right to collect amounts due by withholding and applying all balances due to MLTC from future capitation or other payments. MLTC reserves the right to collect interest on unpaid balances beginning thirty (30) calendar days from the date of initial notification. Any unpaid balances after the refund is due are subject to interest at the current Federal Reserve Board lending rate or an annualized rate of ten percent (10%), whichever is higher.

b. The MCO must reimburse MLTC for any federal disallowances or sanctions imposed on MLTC as a result of any failure by the MCO to abide by the terms of the contract. The MCO is subject to any additional conditions or restrictions placed on MLTC by the HHS as a result of the disallowance. Instructions for the return of funds would be provided by written notice.

14. High-Cost Drug Pool Risk Corridor

MLTC has established a High-Cost Drug Pool Risk Corridor. The purpose of this pool is to develop a mechanism that will retrospectively re-allocate funding between MCOs should there be a disproportionate share of high-cost drug experience for any MCO(s). As a result of continued uncertainty regarding emerging high-cost drugs coming into the market, MLTC is implementing a risk corridor around the high-cost drug pool as set forth in Attachment 15 – High-Cost Drug Pool Risk Corridor.

15. Expansion Adult - MLR-Based Risk Corridor

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

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

16. HIPP Specific Risk Corridor

This risk corridor will be an MLR-based risk corridor applicable only to the non-HHA HIPP population since the HHA HIPP members are part of the broader HHA risk corridor. This corridor is developed such that the target MLR will be calculated as one hundred percent (100%) minus the rating administrative load (exclusive of margin for profit/risk/contingency). Since the non-HHA HIPP population comprises three different rating cohorts with differing NML amounts built into the capitation rates, a blended MLR target will be determined. Based on each MCO's enrollment distribution between the Disabled/Non-Dual Waiver, Katie Beckett, and All Other non-HHA HIPP cohorts, an aggregate MLR target will be determined for each MCO. The Katie Beckett population will carry a target of ninety-eight and three quarters of one percent (98.75%) (one to one and one quarter percent (1 – 1.25%) admin target) while the other two cohorts will carry a target of ninety-one and three quarters of one percent (91.75%) (one to eight and one quarter percent (1 – 8.25%) admin target). Once the aggregate MLR target is determined based on actual enrollment experience, the risk corridor recoupments/payouts will be calculated based on an adjustment to revenue, consistent with the method used for the HHA risk corridor.

The numerator for the MLR calculation for the HIPP risk corridor will consist of medical expenditures only and will not include the additional expenditures allowable within the federal MLR guidelines (such as Quality Improvement expenditures), nor any expenditures related to HIPP premiums. Any payouts or recoupments under the HIPP-specific risk corridor will be incorporated into the MCO revenue prior to the calculation of the program-wide risk corridor and MLR.

Q. PROVIDER REIMBURSEMENT

1. Reimbursement to In-Network Providers

The MCO must reimburse in-network providers for covered services provided to its members.

2. Provider Payment Changes and Noticing

The MCO must follow all applicable federal and state laws when changing provider payments and or payment provisions.

3. Provider Rate Increases

The MCO must ensure that any rate increases for providers of services under the State Medical Assistance Act required by legislative appropriation are passed on in their entirety to participating providers.

4. Enhanced Payments for Primary Care Services

The MCO must have mechanisms in place to reimburse providers for certain evaluation and management services and immunization administration services furnished by a physician with a specialty in family medicine, general internal medicine, or pediatric medicine. These services must be reimbursed at a rate not less than one hundred percent (100%) of the Medicare fee schedule rate for the year or the Nebraska Medicaid FFS fee schedule rate for the year, whichever is greater.

5. Indian Health Protections

a. In accordance with 42 CFR § 438.14, the MCO must provide I/T/U providers, whether participating in or out of network, payment for covered services provided to American Indian members who are eligible to receive services from I/T/U providers as follow:

i. At a rate negotiated between the MCO and the I/T/U provider; or

ii. In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the MCO would make to a participating provider that is not an I/T/U provider; and

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

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

6. Psychiatric Residential Treatment Facilities

The MCO's rate of reimbursement for psychiatric residential treatment facilities must be no less than the published Medicaid FFS rate on the date of service. MCOs must also perform annual cost settlements with state owned and operated PRTFs as directed by DHHS.

7. Value-Based Contracting

a. It is the policy of MLTC that Heritage Health should promote added value for members and providers. Value is captured through programs that improve outcomes and lower costs. Contracted providers shall be engaged in the pursuit of improved value. A key mechanism to achieve this is through value-based contracting arrangements. For purposes of this contract, value-based contracts are defined as payment and contractual arrangements with providers that include two components:

i. Provisions that introduce contractual accountabilities for improvements in defined service, outcome, cost or quality metrics; and

ii. Payment methodologies that align their financial and contractual incentives with those of the MCO through mechanisms that include, but are not limited to, performance bonuses, capitation, shared savings arrangements, etc.

b. By the end of the first year of the contract and annually thereafter, the MCO must submit to MLTC for its review and approval its plan for implementing value-based purchasing (VBP) agreements. MCO's shall include in their VBP plans strategies for localizing care management, addressing SDOH gaps, and addressing health equity for the Medicaid population. MCO's must include plans for VBP for Medical and Behavioral health services and providers. MLTC reserves the right to establish benchmarks for the percentage of covered lives and paid dollars included in VBP arrangements.

c. The MCO must notify MLTC of any risk-sharing agreements it has negotiated with a provider within fifteen (15) calendar days of any contract signing with the provider containing this provision. Any provider contract that includes capitation payments must require the submission of encounter data within ninety (90) calendar days of the date of service. As applicable, the provider contracts must comply with the requirements set forth in Section V.I Provider Network Requirements of this contract and in compliance with 42 CFR § 434.6. The MCO must maintain all provider contracts in compliance with the provisions specified in 42 CFR § 438.12 and 42 CFR § 438.214, as well as this contract. MLTC reserves the right to direct the MCO to terminate or modify any provider contract if MLTC determines that the modification or termination is in the best interest of the State.

8. Provider Incentive Plans

a. The MCO's provider incentive plans must meet the requirements of 42 CFR §422.208 and 422.210.

b. A provider incentive plan cannot make a payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to a member.

c. The MCO must submit any contract templates that include an incentive plan to MLTC for review and approval a minimum of sixty (60) calendar days prior to their intended use. Any provider incentive plan must receive prior MLTC approval. The MCO must disclose the following information in advance to MLTC:

i. Services furnished by provider/groups that are covered by any incentive plan;

ii. Type of incentive arrangement (e.g., withhold, bonus, or capitation);

iii. Percent of withhold or bonus (if applicable);

iv. Panel size, if patients are pooled, the method used; and

v. If the provider/group is at substantial financial risk, documentation that the physician/group has adequate stop-loss coverage, including the amount and type of stop-loss.

d. If the provider/group is put at substantial financial risk for services not provided by the provider/group, the MCO must ensure adequate stop-loss protection for individual providers and conduct annual member and provider satisfaction surveys.

e. The MCO must provide the information specified in 42 CFR §422.210(b) regarding its provider incentive plan to any Medicaid member on request.

f. If required to conduct member and provider satisfaction surveys (as described in Sections V.F Member Services and Education and V.J Provider Services), survey results must be disclosed to MLTC and, on request, to members.

9. Payments to Out-of-Network Providers

a. If the MCO is unable to provide necessary services to a member within its network, the MCO must adequately and timely arrange for the provision of these services out-of-network. In these circumstances, the MCO must ensure that any prior authorization and payment issues are resolved expeditiously.

b. The MCO must ensure that, if applicable, the cost for the services is no greater than it would have been if the services were furnished within the network and that member copays are no greater than if the services were furnished within the network.

c. The MCO must pay for covered emergency and post-stabilization services that are furnished by providers that have no arrangements with the MCO for the provision of these services. The MCO must reimburse emergency service providers one hundred percent (100%) of the Medicaid rate in effect on the date of service. In compliance with Section 6085 of the Deficit Reduction Act of 2005, this requirement also applies to out-of-network providers.

d. During the initial one hundred and eighty (180) calendar days of the contract, the MCO must pay out-of-network providers at one hundred percent (100%) of the Medicaid FFS rate, to support member continuity of care. The MCO must also continue to pay for services for members for the duration of a prior-authorized service.

e. The MCO may require prior authorization for out-of-network services unless those services are required to treat an emergency medical condition.

f. MCO members have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the MCO's provider network without any restrictions. The out-of-network provider must bill the MCO and be reimbursed at no less than the Medicaid rate in effect on the date of service.

g. MCO members shall be encouraged by the MCO to receive family planning services through the MCO's network of providers to ensure continuity and coordination of a member's total care. No additional reimbursements will be made to the MCO by MLTC for MCO members who elect to receive family planning services outside the MCO's provider network.

10. Reimbursement to FQHCs and RHCs

a. The MCO must reimburse FQHCs and RHCs in accordance with 471 NAC Chapters 29 and 34.

b. The MCO must not enter into alternative reimbursement arrangements with FQHCs or RHCs without prior approval from MLTC.

c. The MCO must provide payment that is not less than the level and amount of payment, which the MCO would make for the services if the services were furnished by a non FQHC or RHC provider.

11. Acute Care Hospital Reimbursement

The MCO may reimburse Acute Care Hospitals using nationally recognized, standardized payment methodologies such as All Patient Refined Diagnosis Related Groups (APR-DRG) for Inpatient services and Enhanced Ambulatory Patient Groups (EAPG) for outpatient services.

12. Critical Access Hospital Contracting and Reimbursement

The MCO must make all critical access hospital (CAH) inpatient payments utilizing in the amount no less than the per-diem rates calculated by MLTC with an annual year-end cost settlement. The annual year-end cost settlement occurs at the end of each CAH's fiscal year. Outpatient rates are calculated by MLTC on a cost-to-charge basis with an annual year-end settlement. Critical access hospitals are listed in Attachment 8 – Critical Access Hospitals.

13. University of Nebraska Medical Center (UNMC) Physician/Practitioner Payments

In compliance with 471 NAC §18.006.02, the MCO must pass on directed payments for services provided by practitioners acting in the capacity of an employee or contractor of the University of Nebraska Medical Center or its affiliated medical practices, UNMC Physicians, and Nebraska Pediatric

Practice, Inc. These payments are calculated into the capitation rate on a quarterly basis and the MCO is at risk. In accordance with 42 CFR §438.6(d)(1), a directed payment will be made for covered services provided by practitioners who are acting in the capacity of an employee or contractor of the public academic medical institutions. The payment amount will be the difference between payments otherwise made to these practitioners. The MCO will be required to adopt the State-directed uniform percentage increase directed payment arrangement for the providers identified as members of this specific class.

14. Medicare Crossover Claims for Duals

a. The MCO must pay, at a minimum, using the following methodology for crossover claims for Medicare/Medicaid eligible duals. Payment must be the lesser of:

i. The patient responsibility amount (copay/coinsurance/deductible); or

ii. The difference (not less than zero) between the Medicaid allowed amount posted on Medicaid FFS fee schedules and what Medicare paid for the service.

a) For RHCs, the MCOs must use the RHC encounter rate as the Medicaid allowed amount in the methodology, not the underlying service code allowed amount.

b) For Tribal facilities, the MCOs must use the IHS encounter rate as the Medicaid allowed amount in the Methodology.

b. The MCO must ensure that Medicaid enrolled providers are reimbursed no less than the Medicaid rate for a Medicaid covered services provided to Medicaid recipients who are eligible for full Medicaid benefits

15. Provider-Preventable Conditions, Including Health Care 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 provider-preventable conditions (PPCs) in compliance with 42 CFR §447.26(b). See Attachment 9 – 2022 Health Care Acquired Conditions for a listing of HACs that apply to this provision.

16. Effective Date of Payment for New Members

The MCO is responsible for benefits and services in the core benefits package from and including the effective date of a member's Medicaid eligibility, for any month the member is enrolled with the MCO. If the member's length of stay for an inpatient admission includes any dates in which the member is enrolled with the MCO, the MCO is responsible for the costs associated with the inpatient stay.

17. Inappropriate Payment Denials

If the MCO demonstrates a pattern of inappropriately denying or delaying provider payments for covered services, the MCO may be subject to suspension of new enrollments, sanctions, contract cancellation, or refusal to contract in a future time period. This applies not only to situations in which MLTC has ordered payment after appeal but also to situations in which no appeal has been made (i.e., MLTC learns of the documented abuse from other sources.)

18. Payment for Emergency Services

The MCO must pay a provider for emergency services (as defined in 42 CFR §438.114(a)) provided to a member, including by a provider that does not have a contract with the MCO. Please refer to Section V.Q.9.d – Payments to Out-of-Network Providers.

19. Pharmacy Reimbursement

a. The MCO and the PBM may not charge pharmacy providers transaction-based or claims-processing fees. The MCO may be subject to sanctions in the event it charges these fees. This applies not only to situations in which MLTC has investigated an appeal, but also to situations in which no appeal has been made (i.e., MLTC learns of the fee from other sources).

b. The MCO must calculate dispensing fees, administration fees, and any other fee payment amounts as approved by MLTC. The MCO must maintain in each paid claim record which methodology was used to determine final payment amounts, i.e. state maximum allowable cost, national average drug acquisition cost, or the submitted usual and customary charge.

c. The MCO's dispensing fee reimbursement must be, at a minimum, the Medicaid FFS rate at the time of contract start for independent pharmacies (defined as those with ownership of six (6) or fewer pharmacies), unless otherwise agreed between the MCO and the pharmacy provider.

20. Maximum Allowable Cost Program

a. The MCO must establish an extensive MAC program in order to promote cost containment when generics are utilized.

b. The MCO must provide a description of its MAC program for review and written approval by MLTC during Readiness Review, prior to the Contract Start Date.

c. The MCO must establish a process for timely notification of the MAC pricing updates to network pharmacies. It must also provide this information on the MCO's website. The information must be reviewed and updated weekly.

d. Policies and procedures about MAC pricing must be submitted to MLTC for review and approval a minimum of one hundred and twenty (120) calendar days prior to the Contract Start Date.

e. The MCO must eliminate products from the MAC list or modify MAC rates in a timely fashion, consistent with pricing changes in the marketplace. MAC pricing must be reviewed and updated based on market changes a minimum of weekly for both price increases and decreases.

f. The MCO must have a process in place to ensure that MAC pricing is appropriate and not routinely below the wholesale price available to State pharmacists. The MCO must provide a reasonable administrative appeals process to allow a dispensing provider to contest a listed MAC rate, which includes the following requirements:

- **i.** The MCO or its PBM must respond to a provider who has contested a MAC rate through this procedure within seven (7) calendar days.
- **ii.** The MCO or its PBM must take steps to determine if the MAC price is appropriate given current state market conditions.
- **iii.** If an update is warranted, the MCO must make the change retroactive to the date of service and make the adjustment effective for all pharmacy providers in the network.

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

h. The MCO must override the MAC on PDL products when the name-brand product is preferred over the generic product.

i. The MCO must have a written policy and procedure that meets state and federal requirements for providing brand-name products when the prescriber appropriately determines and documents that the brand-name product is medically necessary.

R. SYSTEMS AND TECHNICAL REQUIREMENTS

1. General Requirements

a. 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, enrollment, care management, utilization, claims adjudication and payment, grievances and appeals, and disenrollments for reasons other than loss of Medicaid eligibility. Reporting formats and other requirements will be determined by MLTC after contract award.

b. The MCO must provide System Documentation about its health information system that ensures data received from providers is accurate and complete by:

- **i.** Verifying the accuracy and timeliness of reported data;
- **ii.** Screening the data for completeness, logicalness, and consistency; and
- **iii.** Collecting service information in standardized formats to the extent feasible and appropriate.

c. The MCO must provide MLTC with live access to all its systems at any time.

2. HIPAA Standards and Code Sets

The MCO must be able to perform the following functions electronically, including electronic claims management capabilities:

a. Receive enrollment verification via a HIPAA-compliant 834 format;
b. Receive electronic premium payments remittance advice via a HIPAA-compliant 820 format;
c. Provide enrollment verification in a HIPAA-compliant 270/271 format;
d. Allow claims inquiry and response in a HIPAA-compliant 276/277 format;
e. Accept electronic claims transactions in a HIPAA-compliant 837 format;
f. Generate HIPAA-compliant electronic remittance advice in the 835 format;
g. Submit encounter data via the HIPAA-compliant 837 formats;
h. Submit pharmacy encounter data via NCPDP formats; and
i. Transmit and receive the pharmacy transactions in the NCPDP formats.

3. Resource Availability and Systems Changes

a. Resource Availability

- **i.** The MCO must provide systems help desk (SHD) services for all MCO, MLTC, and other state agency staff who may have direct access to MCO systems.
- **ii.** The MCO's SHD must be available via local and toll-free telephone service and via e-mail from 7:00 AM to 7:00 PM, Central Time, Monday through Friday. If requested by MLTC, the MCO must staff the SHD on a Saturday or Sunday.
- **iii.** The MCO's SHD staff must be able to answer user questions regarding MCO system functions and capabilities; report any recurring programmatic and operational problems to appropriate MCO or MLTC staff for follow-up; redirect problems or queries that are not

supported by the SHD, as appropriate, via a telephone transfer or other agreed-upon methodology; and redirect problems or queries specific to data access authorization to the appropriate MLTC login account administrator.

iv. The MCO must ensure that individuals who place calls to the SHD between the hours of 7:00 pm to 7:00 am, central time, Monday through Friday, are able to leave a message. The SHD must respond to messages by noon, central time, of the following business day.

v. The MCO must ensure that recurring problems, not specific to system unavailability, identified by the SHD are documented and reported to MCO management within one (1) business day of recognition so that deficiencies are promptly corrected.

vi. The MCO must have an information systems (IS) service management system that provides an automated method to record, track, and report all questions or problems reported to the SHD.

b. Systems Policies and Procedures

i. The MCO must have in place written systems policies and procedures that document all manual and automated processes for its IS, including the safeguarding of all its information.

ii. The MCO must maintain and distribute to all users (including MLTC) distinct systems design and management manuals, user manuals, and quick reference guides.

iii. The MCO must ensure that the systems user manuals contain information about, and instructions for, using applicable systems functions and accessing applicable system data.

iv. The MCO must ensure that all manuals and reference guides are available in printed form and on the MCO's website.

v. The MCO must update the electronic version of these manuals immediately upon taking effect, and make printed versions available within ten (10) business days of the update taking effect.

c. System Changes

i. The MCO's systems must conform to future federal and/or MLTC-specific standards for encounter data exchange a minimum of ninety (90) calendar days prior to the standard's effective date, as directed by CMS or MLTC.

ii. If a system update or changes are necessary, the MCO must draft the appropriate revisions to the System Documentation, and forward them to MLTC for review and approval a minimum of forty-five (45) calendar days prior to intended implementation. Upon MLTC approval, the MCO must prepare revisions to the appropriate manuals before implementing the system changes, and must have printed manual revisions made within ten (10) business days of the system revision.

iii. The MCO must notify MLTC of changes to its system a minimum of 90 (ninety) calendar days prior to the projected date of the change. These changes include major upgrades, modifications, or updates to application or operating software associated with the following core production systems:

a) Claims processing;
b) Eligibility and enrollment processing;
c) Service authorization management;
d) Provider enrollment and data management; and
e) Conversions of core transaction management systems.

iv. The MCO must respond to notification from MLTC of IS problems, excluding IS unavailability, in the following timeframes:

a) Within five (5) calendar days of notification from MLTC, the MCO must respond in writing regarding system problems;
b) Within fifteen (15) calendar days, the correction must be made or a requirements analysis and specifications document must be provided to MLTC;
c) The MCO must correct the deficiency by an effective date to be determined by MLTC; and
d) The MCO's systems must have a system-inherent mechanism for recording any change to a software module or subsystem.

v. Unless otherwise agreed to in advance by MLTC, the MCO must not schedule systems unavailability to perform system maintenance, repair, or upgrade activities to take place during hours that could compromise or prevent critical business operations.

vi. The MCO must work with MLTC on any testing initiative required by MLTC and must provide sufficient system access to allow MLTC staff to participate in the testing activities.

4. Systems Refresh Plan

The MCO must provide to MLTC an annual systems refresh plan. This plan must outline how IS within the MCO's control will be systematically assessed to determine the need to modify, upgrade, or replace application software, operating hardware and software, telecommunications capabilities, or information management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover, or any other relevant issues. The systems refresh plan must also indicate how the MCO will ensure that the version and/or release level of all IS components (application software, operating hardware, and operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM or SDF to support the IS component.

5. Eligibility and Enrollment Data Exchange

The MCO must:

- **a.** Receive, process, and update enrollment files sent in the frequency provided (daily, hourly, or real-time) by MLTC or the enrollment broker;
- **b.** Update its eligibility and enrollment databases for all enrolled services within four (4) hours for most recipients and in no case later than 24 (twenty-four) hours of receipt of these files;
- **c.** Transmit to MLTC, in the formats and methods specified by MLTC, member address and telephone number changes;
- **d.** Transmit and receive the Managed Care Entity (MCE) Member Data File;
- **e.** Transmit and receive data related to nursing facility stays in MLTC-specified formats;
- **f.** Use the member's Medicaid ID number to identify each member across multiple populations and systems within its control; and
- **g.** Be able to identify potential duplicate records for a single member and, upon confirmation of this duplicate record by MLTC, resolve the duplication so that the enrollment, service utilization, and member interaction histories of the duplicate records are linked or merged.

6. Other Electronic Data Exchange

- **a.** The MCO's system must scan, house, and retain indexed electronic images of documents used by members and providers to interact with the MCO. These documents must be housed in appropriate database(s) and document management systems to maintain the logical relationships to certain key data such as member identification numbers, provider identification numbers, and claim identification numbers. The MCO must ensure that records associated with a common event, transaction, or member service issue have a common index that will facilitate the search, retrieval, and analysis of related activities, such as interactions with a particular member about a reported problem.
- **b.** The MCO must implement optical character recognition technology that minimizes manual indexing and automates the retrieval of scanned documents.
- **c.** The MCO must be able to receive drug reference data and utilize this data to adjudicate pharmacy and provider administered drug claims and transmit utilization data.
- **d.** The MCO must have the capability to support both file based data exchange and API-based data exchange for all interfaces with MLTC systems.
- **e.** The MCO must be able to make claims payments via EFT.
- **f.** The MCO must make data available via APIs under the technical standards specified by CMS Interoperability rules, including FHIR, SMART/OATH 2, and Open ID Connect.
- **g.** The MCO systems must support CORE CAQH Operating rules which were mandated per Section 1104 of the Patient Protection and Affordable Care Act (ACA).
- **h.** The MCO must support exchange of electronic prior authorizations via FHIR or latest standards.

7. Electronic Messaging

- **a.** The MCO must provide a continuously available electronic mail communication link (email system) to facilitate communication with MLTC. This email system must be capable of attaching and sending documents created using software compatible with MLTC's installed version of Microsoft Office and any subsequent upgrades as adopted.
- **b.** As needed, the MCO must be able to communicate with MLTC using encrypted email over a secure transport layer. MCO must comply with the national standards for submitting protected health information electronically. The MCO's must avoid transmitting PHI information by email and use secure portals and secure file sharing services. If email is used, the emails must be encrypted, password protected, and have the necessary disclosure statements at minimum for sending and receiving PHI data.

8. Provider Enrollment

On the Contract Execution Date of the MCO contract and daily thereafter, MLTC will furnish to the MCO a list of MLTC provider types and specialty codes. In order to coordinate provider enrollment records, the MCO must utilize these codes in all provider data communications with MLTC and the enrollment broker. The MCO must provide the following:

- **a.** Daily, a provider file that includes provider name, address, licensing information, Tax ID, NPI, taxonomy, contract information, and any other data as required by MLTC and in a format specified by MLTC;
- **b.** All relevant provider ownership information as prescribed by MLTC, federal, or state laws;
- **c.** Performance of all federal or state-mandated exclusion background checks on providers (owners and managers). The providers must perform the same checks on all their employees a minimum of annually; and
- **d.** Provider enrollment systems must include, at a minimum, the following functionality:
  - **i.** Audit trail and history of changes made to the provider file;
  - **ii.** Automated interfaces with all state licensing and medical boards;
  - **iii.** Automated alerts when provider licenses are nearing expiration;
  - **iv.** Retention of NPI requirements;
  - **v.** System-generated letters to providers when their licenses are nearing expiration;
  - **vi.** Linkages of individual providers to groups;
  - **vii.** Credentialing information;
  - **viii.** Provider office hours;
  - **ix.** Availability for accepting new members;
  - **x.** Provider languages spoken; and
  - **xi.** Provider disability accommodations.

9. Information Security and Access Management

- **a.** The MCO's systems must utilize an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function must:
  - **i.** Restrict access to information on a "least privilege basis" (e.g. users who are permitted inquiry privileges only will not be permitted to modify information);
  - **ii.** Restrict access to specific system functions and information based on an individual user profile, including inquiry-only capabilities. Global access to all functions must be restricted to specified staff, who must be approved by MLTC; and DHHS' Information Systems and Technology.
  - **iii.** Restrict unsuccessful attempts to access system functions to three attempts, with a system function that automatically prevents further access attempts and records those occurrences.
- **b.** The MCO must make system information available to duly authorized representatives of MLTC and other state or federal agencies to evaluate, through inspections or other means, the quality, appropriateness, and timeliness of services performed.
- **c.** The MCO's systems must contain controls to maintain information integrity. These controls must be in place at all appropriate points of processing. The controls must be tested in periodic and spot audits using a methodology to be developed jointly by MLTC and the MCO.
- **d.** Audit trails must be incorporated into all systems to allow information about source data files and documents to be traced through the processing stages to the point at which the information is finally recorded. The audit trails must:
  - **i.** Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that affected the action;
  - **ii.** Have the date and identification stamp displayed on any online inquiry;
  - **iii.** Have the ability to trace data from the final place of recording back to its source data file or document;
  - **iv.** Be supported by listings, transaction reports, update reports, transaction logs, or error logs;
  - **v.** Facilitate auditing of individual records, as well as batch audits; and
  - **vi.** Be maintained online for no less than two (2) years and be retrievable within forty-eight (48) hours.
- **e.** The MCO's systems must have inherent functionality that prevents the alteration of finalized records.
- **f.** The MCO must provide for the physical safeguarding of its data processing facilities and the systems and information housed within those facilities. The MCO must provide MLTC with access to data facilities on request.

g. The MCO must restrict perimeter access to equipment sites, processing areas, and storage areas through a key card or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.

h. The MCO must include physical security features designed to safeguard processor site(s) including fire-retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

i. The MCO must put in place procedures, measures, and technical security to prohibit unauthorized access to the regions of the data communications network inside the MCO's control. This includes but is not limited to ensuring that no provider or member services applications can be directly accessible over the internet and must be appropriately isolated to ensure appropriate access.

j. MCO must ensure that remote access to their IT systems meets all the applicable security standards including but not limited to remote access encryption and strong authentication(use of multi-factor authentication or MFA). The remote access process and protocol(s) must be approved in writing and in advance by MLTC.

k. The MCO must comply with recognized industry standards governing security of state and federal automated data processing systems and information processing. At a minimum, the MCO must conduct a security risk assessment and penetration test and communicate the results in an IS security plan provided prior to the Contract Start Date. This risk assessment must also be made available to appropriate federal agencies. The security risk assessment and penetration test must be completed annually and summary results provided to DHHS.

l. The MCO must scan updates to its software before each release for security and remediate any issues before releasing the updates.

m. The MCO must adhere to the following Data Protection Requirements:

- **i.** Except as provided in Section R. 9. M. (ii) and (iii) below, Medicaid data must be maintained and stored solely by the servicing MCO, a related party or a subcontractor approved under Section V.K - Subcontracting or other "business associate" as defined by 45 CFR § 160.103 subject to a business associate agreement fully compliant with Health Insurance Portability and Accountability Act of 1996 ("HIPAA'), the Health Information for Economic and Clinical Health Act ("HITECH"), and all of their implementing regulations (collectively, the "HIPAA Rules) and federal and state Medicaid laws and regulations. For the avoidance of doubt, except as provided in Section R. 9. M. (ii) and (iii) below the MCO may not continue to use the prior owner of the MCO to store, maintain, utilize, share, or access any of the MCO's Medicaid data.
- **ii.** During a transition period, as defined by Section V.X. Transition and Implementation, resulting from a merger, reorganization, or change of ownership as defined by Section V.C.11 Business Requirements – Written Policies and Procedures, the MCO must submit a Data Use Agreement to MLTC no later than thirty (30) calendar days prior to the start of the transition regarding temporary dual maintenance and usage of data during the transition.
- **iii.** Within ninety (90) calendar days following the expiration of the transition period, the MCO's competitively sensitive Medicaid data must be destroyed or rendered completely and totally inaccessible to users within the prior owner's systems (other than the prior owner's data security personnel) through archival or similar industry standard processes, except to the extent otherwise required by law or other compliance purposes, including but not limited to the records retention requirements under the HIPAA Rules.

10. Systems Availability, Performance, and Problem Management Requirements

a. MCO must notify DHHS of any system outages or degradation that impacts the DHHS customers, report distribution or operations within fifteen (15) minutes of its discovery. This notification will allow the applicable work activities to be rescheduled or handled based on IS unavailability protocols.

b. The MCO must ensure that critical member and provider Internet or telephone-based functions and information, including but not limited to confirmation of MCO enrollment (CME), electronic claims management (ECM), and self-service member and provider services functions are available to the applicable IS users at any time, except during periods of scheduled system unavailability agreed to by MLTC and the MCO. Unavailability caused by events outside of an MCO's control is outside the scope of this requirement.

c. The MCO must ensure that, at a minimum, all other system functions and information are available to the appropriate system users between the hours of 7:00 am and 7:00 pm, central time, Monday through Friday.

d. The MCO must ensure that the systems and processes within its control associated with its data exchanges with MLTC are available and operational according to specifications and the data exchange schedule.

e. In the event of a declared major failure or disaster, the MCO's eligibility/enrollment and claims processing systems must be back online within seventy-two (72) hours of the failure or disaster.

f. In its notification the MCO must explain to the extent known, the impact to critical path processes, such as enrollment management and encounter submission processes.

g. The MCO must provide a minimum of hourly updates to MLTC on IS unavailability events, including problem resolution. At a minimum, these updates must be provided via email or telephone.

h. The MCO must resolve unscheduled IS unavailability and restore services of CME and ECM functions, caused by a failure of systems and telecommunications technologies within the MCO's control, within sixty (60) minutes of determining the system unavailability. Unscheduled system unavailability to any other MCO IS functions caused by system and telecommunications technologies within the MCO's control must be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of IS unavailability.

i. Cumulative system unavailability caused by systems or infrastructure technologies within the MCO's control must not be below ninety-nine point nine percent (99.9%) during any continuous twenty (20) business day period.

j. The MCO is not responsible for the availability and performance of systems and infrastructure technologies outside of its control unless the MCO provides those services as part of its bid.

k. Within five (5) business days of the occurrence of a system availability problem, the MCO must provide MLTC with full written documentation that includes a detailed report and corrective action plan describing how the MCO will prevent the problem from occurring again.

11. Contingency Plan

a. The MCO, regardless of the architecture of its systems, must develop and be continually ready to implement, a contingency plan to protect the availability, integrity, and security of data during unexpected failures or disasters (either natural or man-made), to continue essential application or IS functions during or immediately following the failure or disaster.

b. Contingency plans must include a disaster recovery plan (DRP) and a business continuity plan (BCP). A DRP is designed to recover systems, networks, workstations, applications, etc., in the event of a disaster. A BCP must focus on restoring the operational function of the organization in the event of a disaster and includes items related to IT, as well as operational items, such as employee notification processes and the procurement of office space, equipment, and supplies needed to do business in an emergency.

c. The MCO must submit a contingency plan to MLTC for review and approval no later than 45 (forty-five) calendar days before the Contract Start Date.

d. At a minimum, the contingency plan must address the following scenarios:

- **i.** Any security breach whether data is compromised, stolen or viewed;
- **ii.** The central computer installation and resident software are destroyed or damaged;
- **iii.** System interruption or failures that result from network, operating hardware, software, or operations errors that compromise the integrity of transactions that are active in a live system at the time of the outage;
- **iv.** System interruption or failure that result from network, operating hardware, software, or operations errors that compromise the integrity of data maintained in a live or archival system;
- **v.** System interruption or failure that result from network, operating hardware, software, or operational errors that do not compromise the integrity of transactions or data maintained in a live or archival system, but prevents access to the system, such as causing unscheduled system unavailability; and
- **vi.** The plan must specify projected recovery times and data loss for mission-critical systems in the event of a declared disaster.

e. The MCO must, annually, test its plan through simulated disasters and lower level failures in order to demonstrate to MLTC that it can restore systems functions on a timely basis. In the event the MCO fails to demonstrate through these tests that it can restore systems functions, the MCO must submit a corrective action plan to MLTC, within 10 (ten) business days of the conclusion of the test, describing how the failure will be corrected.

12. Off-site Storage and Remote Back-up

a. The MCO must provide for off-site storage and a remote back-up of all DHHS data, operating instructions, procedures, reference files, System Documentation, and operational files.

b. The data back-up policy and procedures must include, but not be limited to:

- **i.** Descriptions of the controls for back-up processing, including how frequently back-ups occur; retention periods for backup; full or incremental data backups with overwrite or purge timeframes;

ii. Confirmation of real time data backup or replication including details on timing of when data is replicated and any potential data loss scenarios;
iii. Documented back-up procedures;
iv. The location of data that has been backed up (off-site or on-site, as applicable);
v. Identification and description of what is being backed up as part of the back-up plan; and
vi. Any change in back-up procedures in relation to the MCO's technology changes.

c. MLTC must be provided with a list of all back-up files to be stored at remote locations and the frequency by which these files are updated.

13. Records Retention

a. The MCO must have online retrieval and access to documents and files for six (6) years in live systems and ten (10) years in archival systems, for audit and reporting purposes. The claims for services that have a once-in-a-life-time indicator (i.e., appendix removal, hysterectomy) must remain in the current/active claims history for claims editing and are not to be archived or purged. Online access to claims processing data must be possible by Medicaid ID number, provider ID number, and/or internal control number). The MCO must provide forty-eight (48) hour turnaround or shorter for requests for access to information that is six (6) years old, and seventy-two (72) hour turnaround or shorter for requests for access to information in machine readable form, that is between six (6) and ten (10) years old. If an audit or administrative, civil, public records request, or criminal investigation or prosecution is in progress; or audit findings or administrative, civil, or criminal investigations, public records request, or prosecutions are unresolved; then, information must be kept in electronic form until all tasks or proceedings are completed.

b. The historical encounter data submission must be retained for a period not less than six (6) years.

S. CLAIMS MANAGEMENT

1. General Requirements

The MCO must develop and maintain claims processes that ensure the correct collection and processing of claims, as well as the analysis, integration, and reporting of data. These processes must result in information about service utilization, claims disputes, and appeals that can be used for process and program improvement. Medicaid is the payer of last resort and MCOs must require other payers such as Medicare and private insurance to process claims prior to Medicaid.

2. Functionality

a. The MCO must maintain an electronic claims management (ECM) system that will:
i. Uniquely identify the billing, ordering, rendering, and prescribing provider of each service;
ii. Use Nebraska Medicaid Provider Number on claims;
iii. Identify the date of receipt of the claim (the date the MCO receives the claim as indicated by the date stamp on the claim);
iv. Identify real-time accurate history with dates of adjudication, results of each claim, such as paid, denied, pended, adjusted, voided, appealed, etc., and follow-up information about disputed claims;
v. Identify the date of payment, (the date of the check or other form of payment), and the number of the check or electronic funds transfer EFT;
vi. Identify all data elements as required by MLTC for encounter data submission, as described in this contract;
vii. Have the ability to integrate member claim and diagnosis history for use when adjudicating claims to override edit checks (such as prior authorization), based on the existence of a diagnosis or prior claim history;
viii. Accept submission of paper-based claims and electronic claims by participating providers, and non-participating providers according to the MCO policies as approved by MLTC;
ix. Accept submission of electronic and paper adjustment and void transactions;
x. Comply with industry standard electronic claim transactions, including but not limited to X-12 transactions, CMS 1500, CMS 1450, etc.;
xi. Have the capability to adjudicate claims at $0.00; and
xii. For the purpose of this section, identify means to capture, edit, and retain.

b. The ECM capability must function in compliance with the systems and data management requirements specified in Section V.R Systems and Technical Requirements of this contract.

c. The MCO must support an automated clearinghouse mechanism that allows providers to request and receive EFTs for claims payment.

d. The MCO must support a Council for Affordable Quality Healthcare (CAQH)/Committee on Operating Rules for an Information Exchange compliant interface to the automated clearinghouse that allows providers to request and receive EFTs of claims payments.

e. The MCO's claims processing system must be available at any time, except for scheduled dow ntime as agreed to by MLTC.

f. The MCO must adhere to national standards and standardized instructions and definitions that are consistent w ith industry norms. These must include, but are not limited to, HIPAA-based standards and federally-required safeguards, including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR § 455.18 and 455.19.

g. The MCO must include nationally-recognized methodologies to correctly pay claims, including but not limited to:

- **i.** Current published National Correct Coding Initiative (NCCI) for practitioner, outpatient, and Durable Medical Equipment (DME) services. MLTC w ill provide the current published edits to the MCO.
- **ii.** Multiple procedure/surgical reductions. Multiple procedure payment reductions shall not be implemented under the Medical Assistance Act as it applies to therapy services provided by physical therapy, occupational therapy, or speech-language pathology.
- **iii.** Global day evaluation and management bundling standards.
- **iv.** EAPG and APR-DRG payment methodologies.

h. The MCO must provide online and telephone-based capabilities to obtain claim processing status information.

i. The MCO must comply at all times w ith standardized paper billing forms/formats and all future updates.

j. The MCO must not employ off-system or gross adjustments w hen processing corrections for payment errors, unless the MCO requests and receives prior w ritten approval from MLTC.

k. The MCO agrees that if MLTC presents recommendations concerning claims billing and processing that are consistent w ith industry norms, the MCO must comply w ith these recommendations w ithin ninety (90) calendar days.

l. The MCO must not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the MCO or a third party.

m. The MCO must assume all costs associated w ith claims processing, including costs for reprocessing encounters due to errors.

n. The MCO must have the ability to update current procedural terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases, Tenth Revision (ICD-10-CM), and other codes based on HIPAA standards and move to future versions as required.

o. In addition to CPT, ICD-10-CM, ICD-10-PCS, and any other national coding standards, the use of applicable HCPCS Level II and Category II CPT codes are mandatory, aiding both the MCO's and MLTC's evaluation of performance measures.

3. Claims Processing

a. Except for claims from pharmacy providers, the MCO must ensure that all provider claims are processed according to the follow ing timeframes:

- **i.** Within five (5) business days of receipt of a claim, the MCO must provide an initial screening and either reject the claim or assign a unique control number and enter it into the system for processing and adjudication.
- **ii.** In accordance w ith 42 CFR § 447.45, the MCO must adjudicate a minimum of ninety percent (90%) of all claims for services billed to the MCO w ithin fifteen (15) business days of the date of receipt. The date of receipt is the date the MCO receives the claim.
- **iii.** In accordance w ith 42 CFR § 447.45, the MCO must adjudicate a minimum of ninety-nine (99%) of all claims for services billed to the MCO w ithin sixty (60) calendar days of the date of receipt.
- **iv.** The MCO must fully adjudicate (pay or deny) all other claims w ithin six (6) months of the date of receipt.

b. For pharmacy providers, in accordance w ith 42 CFR § 447.45, the MCO must establish, at a minimum, a w eekly payment cycle so that a minimum of 90% of all claims from pharmacy providers for covered services are adjudicated w ithin seven (7) calendar days of receipt and ninety-nine (99%) of all claims are adjudicated w ithin fourteen (14) calendar days of receipt, except to the extent providers have agreed to an alternative payment schedule set forth in the provider contract. Any alternative payment schedules must be reported to MLTC w ithin three (3) business days of their implementation.

c. Rejected Claims

- **i.** The MCO may reject claims due to standardized compliance edits and edits required by MLTC. In those circumstances, the original claim must be returned to the provider accompanied by a standardized response report.

ii. The standardized rejection error report must indicate why the claim is being returned, including all defects or reasons known at the time the determination is made. The letter must contain, at a minimum, the following information:
- a) Member name and Medicaid ID number;
- b) Provider ID number;
- c) Date of service;
- d) Total billed charges;
- e) A list of known defects or reasons for rejection;
- f) MCO's name; and
- g) The date the letter was generated.

d. Pended Claims

In accordance with 42 CFR § 447.45, if a claim is received, but additional information is required for adjudication, the MCO may pend the claim and request in writing (notification via e-mail, website/provider portal, or an interim explanation of benefits (EOB) satisfies this requirement) all necessary information so the claim can be adjudicated within established timeframes.

b. Adjustments and Voids
- **i.** Providers must be able to adjust or void claims as appropriate;
- **ii.** Providers may only adjust or void an adjudicated claim; and
- **iii.** Incorrect provider numbers or member Medicaid ID numbers cannot be adjusted. The claim must be voided and then resubmitted.

e. Timely Filing Guidelines
- **i.** The MCO must not deny provider claims on the basis of untimely filing for claims that involve coordination of services or subrogation (when the provider is pursuing payment from a third party). In situations of third party benefits, the timeframes for filing a claim must begin on the date that the third party completes resolution of the claim.
- **ii.** The MCO must not deny claims solely for failure to meet timely filing guidelines due to an error by MLTC or its subcontractors. If a provider files erroneously with another MCO but produces documentation verifying that the initial filing of the claim occurred timely, the MCO must process the provider's claim and not deny for failure to meet timely filing guidelines.
- **iii.** For purposes of MCO reporting on payments to providers, an adjustment to a paid claim must not be counted as a claim and electronic claims must be treated as identical to paper claims.

f. Claim System Edits
- **i.** The MCO must perform system edits, including but not limited to:
  - a) Validating member eligibility and MCO enrollment for each member;
  - b) Validating covered benefits;
  - c) Identifying invalid, missing, and/or mismatched NPIs and/or tax identification numbers that could result in improper payments. MCOs must use the MLTC determined identifiers for provider identification and editing. The MCO must ensure that the system approves only those claims received from providers enrolled with Medicaid and eligible to render services for which the claims were submitted and that the provider has not been excluded from receiving Medicaid payments;
  - d) Performing system edits for valid dates of service, including ensuring that the dates of services are not in the future or outside the member's Medicaid eligibility span;
  - e) Ensuring that timeliness standards are met;
  - f) Ensuring data accuracy;
  - g) Determining medical necessity, as defined by qualified, medically trained, and appropriately licensed personnel, consistent with NCQA or equivalent accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity;
  - h) Determining whether a covered service requires prior authorization and if so, whether the MCO gave its approval;
  - i) Flagging, in an automated manner, a claim as being an actual or possible duplicate and either denying or pending the claim as necessary;
  - j) Ensuring that the service is covered and eligible for payment; and
  - k) Ensuring that the system evaluates claims for services provided to members to ensure that any applicable benefit limits are applied and that over-utilization standards are considered.

4. Drug Claims Processing

a. Use of a Pharmacy Benefits Manager (PBM)

i. The MCO must use a PBM to process prescription claims. The PBM must pay claims in accordance with the requirements of this contract.

ii. The MCO must identify the proposed PBM and the ownership of the proposed PBM in its proposal. Before entering into a subcontract with a PBM, the MCO must obtain MLTC approval. If the PBM is owned wholly or in part by a retail pharmacy provider, chain drug store, or pharmaceutical manufacturer, the MCO must submit a written description of the assurances it would require and procedures it would put in place contractually, such as an independent audit, to prevent patient steering, ensure no conflicts of interest exist, and ensure the confidentiality of proprietary information. The MCO must provide these assurances and procedures to MLTC for review and approval a minimum of sixty (60) calendar days prior to the date pharmacy services begin under the contract.

iii. The MCO must submit a plan for oversight of the PBM's performance prior to the start of the MCO's PBM. The plan must be submitted a minimum of ninety (90)calendar days prior to the PBM's intended Contract Start Date for review and approval by MLTC. The MCO must ensure the approved PBM complies with this contract and all MLTC requirements.

iv. The MCO must not allow its owned or contracted PBM to charge transaction fees to pharmacy network providers.

v. The MCO must oversee, monitor, and assist with the management of PBM activities, related to the use of mental health drugs for children, including the establishment of prior authorization criteria, clinical appropriateness of use, and step therapy requirements for the use of stimulants and antipsychotics for all enrolled members under age eighteen (18).

vi. MLTC prohibits "spread pricing" defined as any amount charged or claimed by a PBM to an MCO that is in excess of the amount paid to the pharmacy for a prescription, including the ingredient cost, provider fee, and dispensing fee.

b. The MCO must develop and implement a master set of pricing rules and algorithms that will be applied to all pharmacy claims based on business area, and state and federal requirements and policies. The MCO must submit these policies and procedures to MLTC for review and approval a minimum of one hundred and twenty (120) calendar days prior to the Contract Start Date.

c. The MCO must allow pharmacies to fill prescriptions for covered drugs ordered by any Nebraska Medicaid prescriber regardless of the prescriber's managed care network participation.

d. The claims processing system must edit and validate claim transaction submissions for completeness and accuracy in accordance with National Council for Prescription Drug Programs (NCPDP) standards. The system must have the ability to accommodate existing and future NCPDP standards, including, but not limited to, electronic and paper submission of multiple ingredient compound prescriptions, and partial fills.

e. The MCO claims processing system must, at a minimum, update its NDC file weekly, including all product, packaging, prescription, and pricing information, and provide online access to reference file information.

f. The MCO's claims processing system must maintain a history of the pricing schedules and other significant reference data.

g. The MCO's drug claims processing system must be available at any time, except for scheduled downtime as agreed to by MLTC.

h. Provider Identifier

i. The MCO's claims processing system must use prescriber and pharmacy National Provider Identifiers (NPI) for claims processing. All prescribing participating providers must have an individual NPI number. This/these must be the same NPI number(s) used for enrollment in the Nebraska Medicaid program.

ii. The MCO must deny prescriptions written by prescribers who are not enrolled with Nebraska Medicaid.

i. Prospective Drug Utilization Review

i. The claims processing system must, at a minimum, establish a central electronic repository for capturing, storing, and updating prospective DUR data.

ii. The claims processing system must assess each active drug regimen of members in terms of active ingredient duplication, therapeutic duplication, drug/drug interactions, drug/age contraindications, drug/gender limitations, drug/pregnancy contraindications, drug/disease contraindications, over and under-utilization, incorrect dosage or duration of drug treatment, clinical abuse or misuse, and other clinically appropriate evaluations.

j. The MCO will send the encounter in NCPDP format and must send files from the preceding month no later than the eighth (8th) day of the following month.

k. The MCO must report rejected claims detail in a format, frequency, and level of detail required by MLTC.

l. The MCO must not pay more than one dispensing fee per month per client for individuals residing in a Nursing Facility.

m. The MCO must follow the preferred drug list (PDL) when processing drug claims unless medical necessity has been established for patient specific situations.

5. Payments to Providers

a. The MCO must have procedures, approved by MLTC, available to providers in written and electronic form for the acceptance of claim submissions that include:

- **i.** The process for documenting the date of actual receipt of non-electronic claims and the date and time of electronic claims;
- **ii.** The process for reviewing claims for accuracy and acceptability;
- **iii.** The process for preventing the loss of claims; and
- **iv.** The process for reviewing claims to determine if they are complete, correct, and payable.

b. At a minimum, the MCO must run one (1) provider payment cycle weekly.

c. The MCO must encourage its providers, as an alternative to the filing of paper claims, to submit and receive claims information through electronic data interchange.

d. The MCO must notify all contracted providers to file claims associated with covered services directly to the MCO or its subcontractors (as applicable), on behalf of Nebraska Medicaid members.

e. The MCO must pay providers interest at an annualized rate of twelve percent (12%), calculated daily for the full period in which a payable claim, in accordance with 42 CFR § 447.45, remains unpaid beyond the sixty (60) day claims processing deadline. Interest owed to the provider must be paid the same day that the claim is adjudicated. Additionally, the payment must be reported on the encounter submission to MLTC or its designee.

6. Remittance Advice

a. The MCO must produce a remittance advice that reflects the MCO's payments or denials to providers. Each remittance advice generated by the MCO to a provider must clearly identify for each claim:

- **i.** Name of the member;
- **ii.** Unique member Medicaid identification number;
- **iii.** Patient claim number or patient account number;
- **iv.** Date of service;
- **v.** Total provider charges;
- **vi.** Member liability, specifying any coinsurance, deductible, copayment, or non-covered amount;
- **vii.** Amount paid by the MCO and/or the amount denied and the HIPAA-compliant reasons for denial;
- **viii.** An attachment to the remittance advice (RA) if the claim was denied due to a TPL, including but not be limited to, TPL carrier information such as carrier code, policy number, and mailing address; and
- **ix.** A description of provider rights for claims disputes.

b. The MCO must use industry-standard transactions and codes and report them to the department via the encounter submission process.

c. Adjustments and voids must appear on the RA under "Adjusted or Voided Claims" as either approved or denied.

d. The related remittance advice must be sent with the payment, unless the payment is made by electronic funds transfer (EFT). Any remittance advice related to an EFT must be sent to the provider no later than the date of the EFT.

e. If a claim is partially or totally denied because the provider did not submit required information or documentation with the claim, then the remittance advice must include industry-standard remark codes. Resubmission of a claim with the necessary information/documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.

f. In compliance with 42 CFR § 455.19, the following statement must be included on each remittance advice sent to providers: "I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of material fact, may be prosecuted under applicable federal and/or state laws."

7. Paid Claims Sampling

a. On a monthly basis, the MCO must conduct service verification surveys, including providing individual EOB notices or information to a sample group of members in a manner that complies with 42 CFR § 455.20 and 433.116(e). In easily understood language, the required notice must specify:

i. The description of the service furnished;
ii. The name of the provider furnishing the service;
iii. The date on which the service was furnished; and
iv. The amount of payment made for the service.

b. The MCO must stratify the sample group by dollar figure amounts in a representative manner. To the extent that the MCO or MLTC considers a particular pool to warrant closer scrutiny, the MCO may oversample this group. The paid claims sample should be a minimum of two percent (2%) of claims per month. The results must be reported to MLTC on a quarterly basis, per the requirements in Attachment 13 –Reporting Requirements. The MCO must stratify the groups by the following dollar amounts: $0 - $999.99, $1,000 - $9,999.99, $10,000 - $49,999.99, $50,000 or greater.

c. The service verification surveys may be conducted at any point after a claim has been paid, but must not be more than forty-five (45) calendar days after the date of payment. This sampling may be performed by mail, telephonically, or in person (e.g., during case management on-site visits). A concurrent review will be allowed when tied back to a successfully adjudicated claim.

d. The MCO must track any complaints received from members and resolve the complaints according to its established policies and procedures. The resolution may be member education, provider education, or referral to MLTC. The MCO must use the feedback received through this process to modify or enhance the verification of receipt of paid services sampling methodology.

e. Within three (3) business days, the MCO must refer results indicating that paid services may not have been received by the member to MLTC and the MCO's fraud and abuse department for review.

f. The MCO must report the total number of service verification surveys sent out to members, the total number of surveys completed, the total number of services requested for validation, the number of services validated, and an analysis of interventions related to complaints or other issues, all according to the interval listed in Attachment 13 – Reporting Requirements.

8. Claims Dispute Management

a. The MCO must develop an internal claims dispute process for those claims or group of claims that have been denied or underpaid. The written process must be submitted to MLTC for approval a minimum of ninety (90)calendar days prior to the Contract Start Date.

b. The claims dispute process must give providers the option to request binding arbitration for claims that have been denied, underpaid, or bundled, by a private arbitrator who is certified by a nationally-recognized association that provides training and certification in alternative dispute resolution. If the MCO and the provider are unable to agree on an association, the rules of the American Arbitration Association apply. The arbitrator must have experience and expertise in the health care field and must be selected according to the rules of their certifying association. Arbitration conducted pursuant to this section shall be binding on all parties. The arbitrator must conduct a hearing and issue a final ruling within ninety (90) calendar days of being selected, unless the MCO and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorneys' fees, must be shared equally by the parties. Each party shall bear its own attorneys' fees, if any.

c. The MCO must systematically capture the status and resolution of all claim disputes, as well as all associated documentation.

d. Within thirty (30) business days of receiving notice of a dispute resolution, the MCO must adjudicate each disputed claim to a paid or denied status.

9. Claims Payment Accuracy

a. On a quarterly basis, the MCO must submit claims payment accuracy reports to MLTC, in a format determined by MLTC.

b. The report must be based on an audit conducted by the MCO. The audit must be conducted by an entity or staff independent of claims management. Responsibilities and job requirements for the internal audit staff are outlined in Section V.D Staffing Requirements of this contract.

c. The audit must utilize a random sample of all adjudicated claims on initial submission in each quarter. A statistically-valid sample, with provider type and financial stratification, must be selected from the entire population of electronic and paper claims adjudicated on initial submission.

d. The minimum attributes to be tested for each claim selected must include:

i. Claim data is correctly entered into the claims processing system;

ii. The claim is associated with the correct provider;
iii. Proper authorization was obtained for the service;
iv. Member eligibility on the processing date was correctly applied;
v. The allowed payment amount agrees with the contracted rate and the terms of the provider agreement between the MCO and the provider;
vi. Duplicate payment of the same claim did not occur;
vii. The denial reason, if applicable, was applied appropriately;
viii. Copayments were considered and applied if applicable;
ix. Patient liability was correctly identified and applied;
x. Modifier codes were correctly applied;
xi. Other insurance was properly considered and applied if present;
xii. Proper benefit limits were applied; and
xiii. Proper coding including bundling and unbundling was applied.

e. The results of testing should be documented, at a minimum, to include:
i. Results of each attribute tested for each claim selected;
ii. The amount of any overpayment or underpayment for claims processed or paid in error;
iii. An explanation of the erroneous processing for each claim processed or paid in error;
iv. A determination of whether any error is the result of keying errors or errors in the configuration or table maintenance of the claims processing system; and
v. Documentation that any claims processed or paid in error have been corrected.

f. If the MCO subcontracts for the provision of any covered services and the subcontractor is responsible for processing claims, the MCO must submit a claims payment accuracy report for the claims processed by the subcontractor. The report must be based on an audit conducted in compliance with the requirements of this section of the contract.

10. Encounter Data

a. The MCO must submit encounter data that meets established MLTC data quality standards. These standards are defined by MLTC to ensure receipt of complete and accurate data for program administration and capitation rate setting and will be closely monitored and strictly enforced. MLTC will revise and amend these standards as necessary to ensure continuous quality improvement. The MCO must submit accurate encounter data consistent with all encounter data requirements outlined in 42 CFR § 438.242.

b. The MCO must submit encounter data accurately and timely, meeting the standard of 95% correct encounters. The MCO must make an adjustment to encounter claims when the MCO discovers the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed.

c. The MCO must make changes or corrections to any systems, processes, or data transmission formats as needed to comply with MLTC data quality standards as originally defined or subsequently amended. The MCO must comply with industry-accepted claim standards, in accordance with 42 CFR § 447.45, for all encounter data, including submission of complete and accurate data for all fields required on standard billing forms or electronic claim formats to support proper adjudication of a claim.

d. In the event that the MCO denies provider claims for reimbursement due to lack of sufficient or accurate data required for proper adjudication, the MCO must submit all available claims data to MLTC without alteration or omission.

e. When the MCO has entered into capitated reimbursement arrangements with providers, the MCO must require submission of all utilization or encounter data to the same standards of completeness and accuracy, including pricing information, as required for proper adjudication of FFS claims. The MCO must require this submission from providers as a condition of the capitation payment and must enforce this contractual provision to ensure timely receipt of complete and accurate data.

f. The MCO must submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by MLTC, in order to support comprehensive financial reporting and utilization analysis.

g. The MCO must submit encounter data according to standards and formats as defined by MLTC, complying with standard code sets and maintaining integrity with all reference data sources, including provider and member data.

h. All encounter data submissions are subject to systematic data quality edits and audits on submission to verify not only the data content but also the accuracy of claims processing. Any batch submission that contains fatal errors that prevent processing or that does not satisfy defined threshold error rates will be rejected and returned to the MCO for immediate correction. Re-submittals of rejected files, or notification of when the file will be resubmitted, must be completed within one business day of receipt.

i. MLTC will reject or report individual claims or encounters failing certain edits, as deemed appropriate and necessary by MLTC, to ensure accurate processing or encounter data quality, and will return these transactions to the MCO for research and resolution. MLTC will require expeditious action on the part of the MCO to resolve errors or problems associated with these claims or the adjudication of these claims, including any necessary changes or corrections to any systems, processes, or data transmission formats. Generally the MCO must, unless otherwise directed by MLTC, address 90% of reported errors within thirty (30) calendar days and address ninety-nine (99%) of reported errors within sixty (60) calendar days. These errors will be considered acceptably addressed when the MCO has either confirmed and corrected the reported issue or disputed the reported issue with supporting information or documentation that substantiates the dispute.

j. MLTC may require resubmission of the transaction with reference to the original in order to document resolution. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable corrective action plan as required, may result in damages and sanctions as described in Section V.V Contract Non-Compliance.

k. The MCO must collect and submit to MLTC complete and accurate data on member characteristics, provider characteristics, and services furnished to members through an encounter data system, per the State's specifications.

l. The MCO must submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by MLTC, to support comprehensive financial reporting and utilization analysis.

m. The MCO must adhere to applicable federal and MLTC payment rules in the definition and treatment of certain data elements, such as units of service.

n. The NPI is required on all claims and encounter submissions from providers. The MCO must assist providers to obtain an NPI, if necessary.

o. The MCO must ensure that encounter files contain settled claims, adjustments, denials, and voids, including but not limited to, adjustments necessitated by payment errors, processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom/which the MCO has a capitation arrangement. The MCO must ensure that the level of detail associated with encounters from providers with whom/which the MCO has a capitation arrangement are equivalent to the level of detail associated with encounters for which the MCO receives and settles as a FFS claim.

p. The MCO CEO, CFO, or their designee, accepted by MLTC, must attest to the truthfulness, accuracy, and completeness of all encounter data submitted.

q. All institutional and professional encounters must be submitted electronically in the standard HIPAA transaction formats, specifically the American National Standards Institute X12N 837. Compliance with all applicable federal (including but not limited to HIPAA) and state requirements, as amended, is required. MLTC and the MCOs will coordinate the timing of the transition to future HIPAA standard transaction formats, as appropriate.

r. Pharmacy encounter claims must be submitted in the standard NCPDP transaction format.

s. The MCO must have the capability to convert all information that enters its claims system via hard copy paper claims to electronic encounter data, for submission into the appropriate HIPAA compliant formats.

t. Encounter records must be submitted so that payment for discrete services that may have been submitted in a single claim can be ascertained.

u. Encounter data must be submitted a minimum of monthly on a date designated by MLTC and include all claims, in accordance with 42 CFR § 447.45, adjudicated and/or adjusted by the MCO.

v. Within two (2) business days of the end of a payment cycle, the MCO must generate encounter data files for that payment cycle from its claims management system(s) and/or other sources. If the MCO has more than one (1) payment cycle within the same calendar week, the encounter data files may be merged and submitted within two (2) business days of the end of the last payment cycle during the calendar week.

w. The MCO must submit a weekly claim-level detail file of pharmacy encounters to MLTC that includes individual claim level detail information on each pharmacy claim dispensed to a Medicaid patient including, but not limited to, the total number of metric units; dosage form, strength, and package size, and NDC for each covered outpatient drug dispensed to Medicaid enrollees.

x. The MCO must institute processes to ensure the validity and completeness of the data it submits to MLTC. At its sole discretion, MLTC will conduct general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include, but are not limited to: member ID, date of service, provider ID (including NPI number and Medicaid ID number), category and sub-category (if applicable) of service, diagnoses codes, procedure codes and modifiers, revenue codes, adherence to hard benefit limits, date of claim processing, and date of claim payment. Control totals will also be reviewed and verified by the MCO. Additionally, the MCO must reconcile all encounter data submitted to MLTC to control

totals and to the MCO's MLR reports and supply this reconciliation to MLTC with each MLR report submission as specified in Attachment 13 – Reporting Requirements.

y. MLTC intends to use encounter data for the purposes of setting future capitation rates, and the MCO will be subject to compensatory damages in the event the state incurs additional time and costs associated with collecting encounter claim data that was not submitted in accordance with the requirements of this section.

z. The MCO must ensure encounter submissions comply with requirements set forth in 42 CFR § 438.242, 42 CFR § 438.818, 42 CFR § 438.604, and 42 CFR § 438.606.

11. Drug Rebates

a. Nebraska Medicaid is required to and submits the following claims for rebate per Section 1927 of the Social Security Act:

- **i.** Outpatient pharmacy drugs;
- **ii.** Outpatient hospital drugs; and
- **iii.** Practitioner-administered drugs.

b. Section 1903(m)(2)(A) of the Social Security Act states that any outpatient drugs provided by MCOs are eligible for the rebates authorized under Section 1927 of the Act.

c. The MCO must incorporate the following requirements into its appropriate day-to-day systems and business activities.

- **i.** The MCO must include the National Drug Code (NDC) and the date of payment for all encounter data for provider-administered drugs.
- **ii.** The MCO must ensure that the NDC is appropriate for the Healthcare Common Procedure Coding System HCPCS/CPT code based on the drug description, strength, and date of service.
- **iii.** The MCO must ensure that the HCPCS/CPT and NDC units reported represent a medically-appropriate dosing.
- **iv.** The MCO must ensure that the date of service of the claim is not past the manufacturer obsolete/termination date or CMS-determined termination date of the drug.
- **v.** The MCO must ensure the NDC is from a rebate-eligible manufacturer and drug product on the date of service of the claim.

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

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

f. The MCO must disclose all financial terms and arrangements for remuneration of any kind that apply to the MCO and any prescription drug manufacturer or labeler, including, without limitation, formulary management, drug-switch programs, educational support, claims processing, pharmacy network fees, data sales fees, and any other fees. MLTC has the right to audit this information at any time. MLTC agrees to maintain the confidentiality of information disclosed by the MCO pursuant to this section, to the extent that the information is confidential under applicable law.

g. The MCO is not authorized to negotiate rebates with drug companies for PDL products. MLTC or its designee will negotiate rebate agreements. If the MCO or its PBM has an existing rebate agreement with a manufacturer, all Medicaid outpatient drug claims, including drugs administered by medical professionals, must be exempt from these agreements.

h. The MCO must provide all necessary information to timely support MLTC's Medicaid rebate dispute resolution processes. The MCO must assign a single point of contact to research any encounters that are denied on submission to MLTC or identified as a dispute by the manufacturer within thirty (30) calendar days. The MCO must provide an explanation of these disputes to MLTC at the encounter level in a spreadsheet. If claim information is found to be in error, the encounter must be voided within five (5) business days of the determination.

i. The MCO must submit all drug encounters, including retail pharmacy prescription encounters and medical claim encounters for drugs administered by medical professionals, with the exception of inpatient hospital drug encounters, to MLTC. MLTC or its vendor will submit these encounters for federal supplemental pharmacy rebates from manufacturers under the authority of the MLTC Director pursuant to Section 2501 of the ACA.

12. Disputed Drug Encounter Submissions

a. MLTC may review the MCO's drug encounter claims and send a file back to the MCO of disputed encounters that were identified through the drug rebate invoicing process, if any.

b. Within sixty (60) calendar days of receipt of a disputed encounter file from MLTC, the MCO must, if needed, correct and resubmit any disputed encounters and send a response file that includes

(1) corrected and resubmitted encounters, or (2) a detailed explanation of why the disputed encounters could not be corrected, including documentation of all attempts to correct the disputed encounters at an encounter claim level.

c. In addition to the administrative sanctions in Section V.V Contract Non-Compliance, failure by the MCO to submit weekly drug encounter claims files and/or a response file to the disputed encounters file within sixty (60) calendar days as detailed immediately above may result in a quarterly offset to the MCO's capitation payment. This offset will equal the value of the rebate assessed for the disputed encounters.

13. Audit Requirements

a. The MCO must ensure that its systems facilitate the auditing of individual claims. Adequate audit trails must be provided throughout the systems. To facilitate claims auditing, the MCO must ensure that the systems follow, at a minimum, the guidelines and objectives of the American Institute of Certified Public Accountants Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization. The MCO will provide MLTC with a SOC 1 audit annually, including management response letters and user controls.

i. State Audits

a) The MCO must provide to any state auditor (including the Auditor of Public Accounts), or their designee, on written request, files for any specified accounting period for which a valid contract exists, in a file format or audit-defined media required by the auditor. The MCO must provide information necessary to assist the auditor in processing or using the files.

b) If the auditor's findings point to discrepancies or errors, the MCO must provide a written corrective action plan to MLTC within ten (10) business days of receipt of the audit report.

ii. Audit Coordination and Claims Reviews

c) The MCO must coordinate audits with MLTC or its designee and respond within 30 calendar days of a request by MLTC regarding the MCO's review of a specific provider and/or claim(s), and the issue reviewed.

d) In the event MLTC or its designee identifies a mispayment, the MCO has thirty (30) calendar days from the date of notification of the mispayment to determine if the claim(s) were corrected or adjusted prior to the date of MLTC notification. On receipt of this notification, the MCO must not correct the claims, unless directed to do so by MLTC.

e) MLTC reserves the right to review any claim paid by the MCO or its subcontractor. The MCO has the right to collect or recoup any overpayments identified by the MCO from providers of service in accordance with existing laws or regulations. However, if an overpayment is identified by the State or its designee one year or later from the date of payment, the MCO will remit the overpayment to MLTC. Failure by the MCO to collect an overpayment from a provider does not relieve the MCO from remitting the identified overpayment to MLTC.

b. If the MCO performs pharmacy services audits, it must submit to MLTC the policies and procedures of this process for review and written approval. The MCO must not utilize contingency-fee-based pharmacy audits. The MCO must correct any previously submitted encounters to account for any updated payments related to audits.

14. Claims Processing Reports

The MCO will report to MLTC, on a monthly basis, summary data on claims payment activity and reasons for claims denials using standardized RARC and CARC codes. See Attachment 13 – Reporting Requirements.

15. Third-Party Liability

a. General TPL Information

i. Pursuant to applicable law, the Medicaid program is the payer of last resort. All other available TPL resources must meet their legal obligation to pay claims before the MCO pays for the care of a Medicaid member.

ii. The MCO must exercise full assignment rights as applicable; must make every reasonable effort to determine any TPL to pay for services rendered to members under this contract; and cost avoid or recover this liability from the third party(ies).

iii. The MCO must demonstrate that reasonable effort has been made to seek, collect, and report TPL, and the MCO's cost avoidance and recovery efforts.

iv. The MCO must pursue any third party resources for all claim(s) and/or tort action(s). If a client receives the third party resource or settlement directly, then the MCO should

pursue reimbursement from client. If the client fails to cooperate, then a sanction should be applied pursuant to 477 NAC § 12-000.

v. MLTC has the sole responsibility for determining whether or not reasonable efforts have been demonstrated. This determination will consider reasonable industry standards and practices.

vi. The MCO must coordinate benefits in accordance with 42 CFR § 433.135, et seq., and 471 NAC § 3-004 in order to avoid costs and recover payments from liable parties as appropriate. The term "state" means "MCO" for purposes of complying with the federal regulations referenced in the immediately preceding sentence. However, the MCO must pay and chase claims for which third-party liability is derived from an absent parent whose obligation to pay support is being enforced by the DHHS Division of Children and Family Services.

vii. The MCO may utilize subcontractors to comply with coordination-of-benefit efforts for services provided under this contract. The two methods for coordinating benefits are cost avoidance and post-payment recovery.

viii. TPL is established when the MCO receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a health care item or service delivered to a member.

ix. If the probable existence of TPL cannot be established, the MCO must adjudicate the claim. The MCO must recover payments if TPL is later determined to exist.

x. The MCO must identify the existence of potential TPL to pay for covered services through the use of diagnosis and trauma code editing in accordance with 42 CFR § 433.138(e).

xi. If a TPL insurer requires the member to pay any co-payments, coinsurance, or deductibles, the MCO is responsible for making these payments even if the services are provided outside of the MCO network.

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

xiii. MLTC may require a MLTC-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 encounter data.

xiv. MLTC is solely responsible for estate recovery activities and will retain any and all funds recovered through these activities.

b. Cost Avoidance

i. The MCO must cost-avoid a claim if it establishes the probable existence of TPL at the time the claim is filed.

ii. All claims should be cost avoided unless probable existence of TPL was unknown at the time of services rendered or payment of claims by the MCO or if otherwise directed by CMS for specific claim types.

c. Post-Payment Recovery

i. Post-payment recovery is necessary in cases in which the MCO has not established the probable existence of TPL at the time services were rendered or paid for, or was unable to cost avoid.

ii. The MCO must seek recovery within sixty (60) calendar days after the end of the month it learns of the existence of a liable third party after a claim is paid.

iii. The MCO must have established procedures for recovering post-payments for MLTC's review and approval during the readiness review.

iv. The MCO must void encounters for claims that are recouped in full. For recoupments that are not recouped in full, the MCO must submit adjusted encounters in a timely fashion per the standards established in the encounter section of this contract.

v. The MCO must seek reimbursement in accident/trauma-related cases when claims in aggregate equal or exceed $250 for a client in a contract year.

vi. The amount of any recoveries collected by the MCO outside of the claims processing system must be treated by the MCO as offsets to medical expenses for the purposes of reporting.

d. Distribution of TPL Recoveries

i. The MCO may retain up to 100% of its TPL collections if all of the following conditions exist:

a) Total collections received do not exceed the total amount of the MCO financial liability for the member per claim or tort case;

b) Collections do not include payments made by MLTC related to FFS claims, reinsurance, or administrative costs (i.e., lien filing, etc.); and

c) Such recovery is not prohibited by applicable law.

ii. MLTC will utilize TPL data in calculating future capitation rates.

e. TPL Reporting Requirements

i. The MCO must report any money recovered monthly to MLTC.

ii. The MCO must post all third-party payments to claim level detail. The MCO must include the collections and claims information in the encounter data submitted to MLTC, including any retrospective findings via encounter adjustments.

iii. At the request of MLTC, the MCO must provide information not included in encounter data submissions that may be necessary for the administration of TPL activity. This information must be provided in the format and frequency required by MLTC. This information may include, but is not limited to, individual medical records to determine liability for the services rendered.

iv. The MCO must report members with third party coverage to MLTC on a monthly basis, reporting additions and updates of TPL information in a format and medium specified by MLTC. The MCO must cooperate in any manner necessary with MLTC or its cost recovery vendor.

f. Right to Conduct Identification and Pursuit of TPL

i. MLTC may pursue recovery if the MCO fails to recover reimbursement from the third party, to the limit of legal liability, three hundred and sixty five (365) days from the date of loss of the tort claim(s).

ii. The MCO must seek subrogation amounts regardless of the amount believed to be available as required by federal law. The amount of any subrogation recoveries collected by the MCO outside of the claims processing system must be treated by the MCO as offsets to medical expenses for the purposes of reporting.

iii. MLTC retains the right to request tort claims prior to three hundred and sixty five (365) days from the date of loss, if deemed necessary by MLTC.

16. Coordination of Benefits Data

a. MLTC or its designee will provide the MCO with a list of known third party resources for its members via the enrollment file, based on information made available to MLTC at the time of eligibility determination or re-determination. If the MCO operates or administers any non-Medicaid HMO, health plan, or other lines of business, the MCO must assist MLTC with the identification of members with access to other insurance.

b. The MCO must provide, to MLTC, any third party resource information, in a format requested by MLTC and must cooperate with MLTC or its cost-recovery vendor.

17. Coordination of Benefits for Dual Eligible Members

a. The MCO is responsible for providing medically necessary covered services to members who are also eligible for Medicare if the service is not covered by Medicare. The MCO must ensure that services covered and provided under this contract are delivered without charge to members who are dually eligible for Medicare and Medicaid. The MCO must coordinate with Medicare payers, Medicare Advantage Plans, and Medicare providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare.

b. The MCO must pay crossover claims in accordance with the Nebraska dual eligible crossover claim payment methodology published in the Nebraska Medicaid State Plan. The MCO must sign a Coordination of Benefits Agreement and participate in the automated crossover process administered by Medicare. Under this crossover process, The MCO must pay the crossover claim regardless of network status. The MCO can only pay Nebraska enrolled providers and must refer any non-enrolled provider to MLTC prior to payment.

c. The MCO must include provisions to ensure continuation of benefits in all of its contracts. In addition, the provider agreement must specify the provider's responsibility regarding TPL, including:

i. Identifying TPL coverage, including Medicare and long-term care insurance; and

ii. Seeking TPL payments before submitting claims to the MCO.

T. REPORTING AND DELIVERABLES

1. General Requirements

a. This section describes the MCO's state and federal reporting requirements. Program and financial reporting requirements are discussed throughout the RFP and summarized in Attachment 13 – Reporting Requirements. The MCO must comply with all reporting requirements.

b. All deliverables are subject to review by MLTC and will not be considered complete until approved by MLTC. The format and content of each deliverable must be defined and agreed upon prior to the onset of work. MLTC will not review a deliverable unless the format and content has been approved in advance.

c. MLTC may grant approval, reject all or some part of the deliverable, or request that revisions be made by the MCO. Additional review periods are required whenever MLTC requests revisions or rejects a deliverable. Each deliverable must be consistent with previously approved deliverables. The State reserves the right to require the MCO to revise deliverables previously approved or to reject current deliverables based on inconsistencies with previously-approved deliverables.

2. Ownership Disclosure

Federal law requires full disclosure of ownership, management, and control of an MCO (42 CFR § 455.100-455.106). This information must be provided during the readiness review, annually thereafter for each contract year, and within 30 (thirty) calendar days of any change in the MCO's management, ownership or control.

3. Information Related to Business Transactions

a. The MCO must furnish, to MLTC and the United States Department of Health and Human Services, information related to significant business transactions as set forth in 42 CFR § 455.105. Failure to comply with this requirement may result in termination of this contract.

b. The MCO must submit, within 30 (thirty) calendar days of a request made by MLTC, full and complete information regarding:

i. The ownership of any subcontractor with whom/which the MCO has had business transactions totaling more than $25,000 (twenty-five thousand dollars) during the 12-month (twelve) period preceding the date of the request; and

ii. Any Significant Business Transactions between the MCO and any wholly owned supplier, or between the MCO and any subcontractor, during the five (5) year period preceding the date of the request.

4. Encounter Data

a. The MCO must comply with the required format and timelines provided by MLTC for the submission of encounter data. Encounter data includes claims paid or denied by the MCO or the MCO's subcontractors for services delivered to members through the MCO during a specified reporting period. MLTC collects and uses this data for many purposes such as federal reporting, rate setting, risk adjustment, service verification, managed care quality improvement, utilization patterns, access to care determinations, and various research studies.

b. MLTC may change the encounter data transaction requirements with ninety (90) calendar days written notice to the MCO. The MCO must, on notice from MLTC, make the necessary changes to its systems to comply with MLTC requirements, and provide notice of the changes to its subcontractors. The MCO must ensure that its subcontractors comply with MLTC requirements within the specified timeframes.

5. Financial Reporting

a. The MCO must submit quarterly and annual financial reporting to MLTC. The details and timing of the reports will be developed with MCO input. Examples of required reports include, but are not limited to:

i. Certification statement;
ii. Balance sheet;
iii. Income statement;
iv. Lag (incurred but not reported) report;
v. Medical loss ratio calculation;
vi. Profit/risk corridor calculation report;
vii. Related-party statements;
viii. Auditor's report and report on internal controls;
ix. Performance measure calculation reports;
x. Annual disclosure report; and
xi. Enrollment/revenue reconciliation.

b. The MCO must also electronically provide detailed claims and membership data that tie to the income statement. The MCO's response to a MLTC data request shall include, at a minimum, the following data fields:

i. Rating category;
ii. Category of service;
iii. Utilizers;
iv. Paid dollars;
v. Paid units;
vi. Units measure;
vii. Paid days;
viii. Cost per unit;

ix. Cost per day;
x. Per member per month (PMPM) cost;
xi. Member months;
xii. Month of service; and
xiii. Month of payment.

c. The MCO must obtain an annual financial audit acceptable to MLTC for any expenditure of state-awarded funds made by the MCO. The audit must include management letters and audit recommendations.

6. Information on Persons Convicted of Crimes

The MCO must furnish to MLTC information about any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as set forth in 42 CFR § 455.106.

7. Vetting Reports

The MCO must provide information requested in vetting reports from the MLTC Program Integrity department. Report description and frequency are listed in Attachment 13 – Reporting Requirements.

8. Submission Process and Timeframes

a. The MCO must ensure that all required deliverables, which may include documents, manuals, files, plans, or reports, as stated in this RFP or required at a future date, are submitted to MLTC in a timely manner for review and approval. The MCO's failure to submit the deliverables as specified may result in the assessment of liquidated damages, as stated in Section V.V Contract Non-Compliance of this contract.

b. MLTC may, at its discretion, require the MCO to submit additional deliverables both ad hoc and recurring. If MLTC requests any revisions to the deliverables already submitted, the MCO must make the changes and re-submit the deliverables, according to the time period and format required by MLTC. MLTC will provide at least a sixty (60) calendar day notice to the MCO on changes to any reports.

c. Unless otherwise specified in Attachment 13 – Reporting Requirements, deadlines for submitting deliverables are as follows:

i. The MCO must submit monthly deliverables no later than the fifteenth (15^{th}) calendar day of the following month.

ii. The MCO must submit quarterly deliverables within forty-five (45) calendar days of the last day of the calendar quarter immediately preceding the due date.

iii. The MCO must submit annual reports and files, and other deliverables due annually, within thirty (30) calendar days following the twelfth (12^{th}) month of the contract year; except, those annual reports that are specifically exempted from this thirty (30) calendar day deadline by this RFP or by written agreement between MLTC and the MCO.

iv. If a due date falls on a weekend or state holiday, deliverables are due the next business day.

9. Ad Hoc Reports

a. The MCO must prepare and submit any other reports required and requested by MLTC, any of MLTC's designees, the state legislature, or CMS, which are related to the MCO's duties and obligations under this contract. Information considered to be proprietary must be clearly identified by the MCO at the time of submission.

b. The MCO must submit ad-hoc reports within five (5) business days from the date of request, unless otherwise specified by MLTC.

10. Errors

a. The MCO must prepare complete and accurate reports for submission to MLTC. If after preparation and submission, a MCO error is discovered, either by the MCO or MLTC, the MCO must correct the error(s) and resubmit the report within the following timeframes:

i. For encounters, in accordance with the timeframes specified in the Section V.S Claims Management of this RFP; and

ii. For all other reports, fifteen (15) calendar days from the date of discovery by the MCO or date of written notification by MLTC (whichever is earlier). MLTC may at its discretion extend the due date if an acceptable plan of correction has been submitted and the MCO can demonstrate to MLTC's satisfaction that the problem cannot be corrected in fifteen (15) calendar days.

b. Failure of the MCO to respond within these timeframes may result in penalties per Section V. V. Contract Non-Compliance.

11. Reporting Dashboard

a. The purpose of this dashboard is to provide MCO and MLTC leadership with easily accessible MCO results related to access to and quality of care, as well as program cost effectiveness. Access to this dashboard will be determined in consultation with MLTC. The dashboard will augment, but not replace, other reporting templates required by MLTC. At its sole discretion, MLTC may determine that reports generated by this dashboard are sufficient and may no longer require the MCO to complete similar or other reports. Dashboards must be updated within the timelines specified by MLTC. The reporting dashboard must include, at a minimum, statistics related to:

i. Member enrollment;
ii. Call center statistics;
iii. Performance measures;
iv. Care management;
v. Grievances and Appeals;
vi. Pending claims;
vii. Financial status; and
viii. Any other items as identified by MLTC.

b. MLTC reserves the right to require MCO participation in an alternative reporting and dashboard system, at its discretion.

12. MLTC reserves the right to request additional ongoing reports. MLTC will notify the MCO of additional required reports no less than sixty (60) calendar days prior to due date of those reports.

U. CONTRACT MONITORING

1. Operational Reviews

a. In accordance with 42 CFR § 438.66, MLTC, or its designee, will conduct periodic operational reviews to ensure program compliance and identify best practices. The reviews will identify and make recommendations for areas of improvement, monitor the MCO's progress towards implementing mandated programs or operational enhancements, and provide the MCO with technical assistance when necessary. The type and duration of the review will be solely at MLTC's discretion.

b. This monitoring by MLTC does not relieve the MCO of its responsibility to continuously monitor its providers' and subcontractors' performance to ensure compliance with contract provisions.

c. Except in cases in which advance notice is not possible or advance notice may render the review less useful, MLTC will give the MCO a minimum of twenty-one (21) calendar days advance notice of the date of a review. MLTC reserves the right to conduct reviews without notice to monitor contractual requirements and performance.

d. MLTC, or its designee, will coordinate with the MCO to establish the scope of any review, the review site (if on-site), relevant time frames for obtaining information, and the review criteria.

e. MLTC may request, at the expense of the MCO, to conduct on-site reviews of functions performed at out-of-state locations and will coordinate travel arrangements and accommodations with the MCO.

f. The review may include an inspection of the MCO's facilities, as well as auditing or review of any records including, but not limited to, medical records, grievances, enrollments, disenrollments, utilization and medical management, finance, management systems, policies and procedures, or any other areas or materials relevant to this contract.

g. In preparation for a review, the MCO must cooperate with MLTC, by forwarding, in advance, MLTC-requested policies, procedures, job descriptions, contracts, records, logs, or any other materials. Documents not requested in advance must be made available upon request during the course of a review. MCO staff must be available at all times during a review. The MCO must provide an appropriate private workspace and internet access to the review team.

h. The MCO will be provided a copy of the draft review report and given the opportunity to comment on any review finding prior to MLTC issuing the final report, unless the review concerns potential fraudulent or criminal action. Once MLTC finalizes the findings, the MCO must comply with all recommendations that result from the review. The MCO must develop corrective action plans, as outlined in V.V. Contract Non-Compliance, based on the recommendations, if necessary. Failure to comply with recommendations for improvement may result in monetary penalties, sanctions, and/or enrollment restrictions.

i. Corrective action plans and any modifications must be approved by MLTC and DHHS Contracts Administrator. Unannounced follow-up reviews may be conducted at any time after the initial operational review, to determine the MCO's progress in implementing the recommendations and achieving compliance.

2. Business Reviews

a. MLTC will schedule business reviews with each MCO, which will be held on a monthly basis or at a frequency as determined by MLTC. Business reviews are regular meetings with MLTC staff and MLTC leadership to review ongoing business operations of the MCO, performance metrics, quality outcomes, and other topics determined by MLTC.

b. The MCO must participate in MLTC-organized business reviews.

c. The MCO's CEO must participate in the business reviews. MLTC will identify key MCO staff members who must also participate in the review. The MCO must be prepared to participate pursuant to an MLTC-developed agenda and/or presentation template.

3. Ongoing Contract Monitoring

MLTC will:

a. Monitor compliance with the terms of the contract;

b. Receive and respond to all inquiries and requests made by the MCO under this contract, within five (5) business days;

c. Meet with the MCO's representatives on a periodic or as needed basis to address issues that arise;

d. Make best efforts to resolve any issues identified either by the MCO or MLTC that may arise that are applicable to the contract; and

e. Review and approve in writing:

i. Key personnel and staffing plan;
ii. Subcontracts;
iii. Policies and procedures;
iv. Material change in provider network;
v. Provider handbook;
vi. Provider training materials and schedule;
vii. Member handbook;
viii. All member facing materials (print or web-based);
ix. Press or media events/activities or activities that include sponsorship;
x. Call center quality criteria and protocols;
xi. Requests for exemptions to requirements as allowed by this contract; and
xii. Member and Provider Websites.

V. CONTRACT NON-COMPLIANCE

1. Administrative Actions

If the MCO fails to perform any obligation under the contract, at the sole discretion of MLTC, the MCO may be subject to the Administrative Actions detailed below. MLTC will provide written notice to the MCO of non-compliance.

Administrative Actions include:

a. A warning, provided by MLTC in writing; which may include consultation;

b. Education about program policies and billing procedures; and

i. A requirement that the MCO participate in a provider education program. MCO education programs may include attendance at quarterly meetings, at which issues and topics may include, but are not be limited to:

a) The use of procedure codes;
b) The review of key provisions of the Medicaid program;
c) Instruction about reimbursement rates;
d) Instruction about how to inquire about coding problems; and
e) Quality/medical issues.

***Liquidated damages, intermediate sanctions, and termination are not Administrative Actions under this contract.**

c. Submission of a Corrective Action Plan (CAP).

i. *Corrective Action Plan.* If the MCO fails to perform any obligation under the contract, MLTC may require the MCO to complete a Corrective Action Plan (hereinafter "CAP").

a) MLTC shall provide notice of the deadline for the submission of a required CAP to be prepared by MCO and provided to MLTC. In its notice, MLTC shall identify the issue to be resolved and provide any supporting information to allow the MCO to provide an adequate response.

b) MLTC will establish the deadline(s) required for CAP response. The MCO must either respond to the CAP, or request, within said time period, that the CAP be rescinded based on information provided to MLTC. The MCO may also request additional time upon showing of good cause. While MLTC is reviewing the request to rescind or the request for additional time, the time period for response shall be tolled.

c) The proposed CAP must include, but is not limited to, a written response noting the tasks proposed to resolve the issues, individuals responsible for each task to resolve the issues, and a date that each task will be resolved.

d) DHHS will approve or amend the proposed CAP within five (5) business days of receipt. The CAP begins on the date of approval by MLTC.

e) Failure of the MCO to complete the actions set forth in an approved CAP within the deadline(s) set forth in such CAP may be considered a breach of contract.

2. Liquidated Damages

a. MLTC may impose liquidated damages if the terms of a CAP are not met. If imposed, liquidated damages will continue until satisfactory correction of the issue has occurred, as determined by MLTC.

b. In the event the MCO fails to comply with a contract obligation under this contract, including but not limited to items listed in Attachment 10 – Liquidated Damages may be assessed at the sole discretion of MLTC. If assessed, the damages will be used to reduce MLTC's payments to the MCO. If the damages exceed amounts due from MLTC, the MCO will be required to make cash payment to MLTC for the amount in excess.

c. The assessment of Liquidated Damages shall be without prejudice to other remedies or the recovery of other damages.

d. Other Liquidated Damages may be assessed as otherwise permitted by law..

e. MLTC will provide written notice and factual basis for the assessment of liquidated damages to the MCO. Within ten (10) business days of receipt of the written notice, the MCO may appeal the assessment of liquidated damages in writing to the Deputy Director of Policy & Plan Management of MLTC. A written decision will be issued within ten (10) business days. Within five (5) business days of receipt of the written decision, the MCO may request reconsideration of the decision in writing to the Director of MLTC. The Director shall issue a written opinion within thirty (30) calendar days. No further appeals shall be allowed.

3. Failure to Provide Benefits and Services

If MLTC determines that the MCO has failed to provide one or more benefits or services, MLTC will direct the MCO to provide the benefit(s) or service(s). If the MCO continues to fail to provide the benefit(s) or service(s), MLTC will authorize the member(s) to obtain the services from another source and will charge the MCO the actual cost of the services. MLTC will provide written notification of said charge. In this event, funds equivalent to the expense(s) will be deducted from the next monthly capitation payment or a future payment as determined by MLTC. MLTC will provide a list of the affected member(s) concerning which payments to the MCO have been deducted, the nature of the benefit(s) or service(s) denied, and payments MLTC made or will make to provide the medically necessary covered benefit(s) or service(s).

4. Payment Hold-Back

a. In the event the MCO fails to comply with an obligation under this contract, MLTC may hold-back payments to the MCO in an amount determined in the sole discretion of MLTC. This right to withhold is subject to the requirements of 42 CFR §§ 438.4(b), 438.6(a), 438.8, and other governing laws and regulations.

b. MLTC will provide written notice and factual basis for the assessment of the hold-back amount to the MCO. Within ten (10) business days of receipt of the written notice, the MCO may appeal the assessment of the hold-back amount in writing to the Deputy Director of Policy & Plan Management of MLTC. A written decision will be issued within ten (10) business days. Within five (5) business days of receipt of the written decision, the MCO may request reconsideration of the decision in writing to the Director of MLTC. The Director shall issue a written opinion within 30 calendar days. No further appeals shall be allowed.

5. Remedies Non-Exclusive

The rights and remedies provided in this section shall not be exclusive and are in addition to any other rights and remedies provided by law or under this contract.

W. INTERMEDIATE SANCTIONS

1. Acts or Failures to Act Subject to Intermediate Sanctions

The following violations are grounds for intermediate sanctions that may be imposed in the sole discretion of MLTC when the MCO acts or fails to act:

a. The MCO fails substantially to provide medically necessary services that the MCO is required to provide, under law or under its contract with MLTC, to a member covered under the contract.

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

c. The MCO discriminates against members 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 MLTC.
e. The MCO misrepresents or falsifies information that it furnishes to a member, enrollee, or health care provider.
f. The MCO fails to comply with the requirements for physician incentive plans, if applicable.
g. The MCO distributes, directly or indirectly through any agent, marketing materials that were either not approved in advance by MLTC, or that contain false or materially misleading information.
h. The MCO violates 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 MLTC deems a violation and that merits a sanction.

2. Other Misconduct Subject to Intermediate Sanctions

MLTC, in its sole discretion, also may impose sanctions against the MCO if it finds any of the following actions or occurrences:

a. The MCO failed to correct deficiencies in its delivery of service after having received written notice of these deficiencies from MLTC.
b. The MCO was excluded from participation in Medicare for any reason, pursuant to Public Law 95-142.
c. The MCO or any of its owners, officers, or directors committed a criminal offense relating to performance of the contract with MLTC, committed a fraudulent billing practice, or committed a negligent practice resulting in death or injury to an MCO member.
d. The MCO presented, or caused to be presented, any false or fraudulent claim for services, or submitted or caused to be submitted false information to MLTC or CMS.
e. The MCO engaged in a practice of charging and accepting payment (in whole or in part) from members for services for which a Per Member Per Month (PMPM) payment was made to the MCO by MLTC.
f. The MCO rebated or accepted a fee or portion of a fee or charge for a member referral.
g. The MCO failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments.
h. The MCO failed to keep, or make available for inspection, audit, or copying, the records regarding payments claimed for providing services.
i. The MCO failed to furnish any information requested by MLTC regarding payments for providing goods or services.
j. The MCO furnished goods or services to a member, which at the sole discretion of MLTC, and based on competent medical judgment and evaluation, are determined to be insufficient for the member's needs, harmful to the member, or of grossly inferior quality.

3. Sanction Types

a. MLTC may impose the following intermediate sanctions at its sole discretion:
  i. Civil monetary penalties as specified in Attachment 10 – Liquidated Damages;
  ii. Appointment of temporary management as described in this section;
  iii. Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll;
  iv. Suspension of all new enrollments into the MCO, including auto-assignments, as of the effective date of the sanction;
  v. Suspension of payment for members enrolled after the effective date of the sanction, unless and until CMS or MLTC is satisfied that the reason for the imposition of the sanction no longer exists and is not likely to recur;
  vi. Retention of capitation payment(s); and/or
  vii. Any other remedy, right, or sanction allowed under the contract or applicable law.
b. Payments under the contract will be denied for new members when, and for as long as, payment for those members is denied by CMS in accordance with the requirements of 42 CFR § 438.730.

4. Notice of Sanction to MCO and CMS

a. Prior to imposing any intermediate sanction, MLTC will 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 an administrative hearing.
b. MLTC will give the CMS Regional Office written notice whenever it imposes or lifts an intermediate sanction for one of the violations listed in 42 CFR § 438.700, specifying the affected MCO, the type of sanction, and the reason for MLTC's decision to lift a sanction (if applicable). Notice will be given no later than 30 (thirty) calendar days after MLTC imposes or lifts the sanction.

5. Payment of Liquidated Damages and Sanctions

a. The purpose of establishing and imposing liquidated damages is to provide a means for MLTC to obtain the services and level of performance required for successful operation of the contract. MLTC's failure to assess liquidated damages in one or more of the particular instances described herein will in no event waive the right, power, or authority of MLTC to assess additional liquidated damages or actual damages at that time or in the future.

b. The decision to impose liquidated damages (including intermediate sanctions) will include consideration of some or all of the following factors:

i. The duration of the violation;

ii. Whether the violation (or one that is substantially similar) has previously occurred;

iii. The MCO's compliance history;

iv. The severity of the violation and whether it imposes an immediate threat to the health or safety of the MCO's members; and

v. The good faith exercised by the MCO in attempting to achieve or remain in compliance.

c. The violations described in Attachment 10 – Liquidated Damages are examples of the grounds, but not an exclusive list of grounds, on which MLTC may impose liquidated damages.

d. Any liquidated damages assessed by MLTC that cannot be collected through withholding from future capitation payments will be due and payable to MLTC within 30 (thirty) calendar days after the MCO's receipt of the notice of liquidated damages. However, in the event an appeal by the MCO results in a decision in favor of the MCO, any funds withheld by MLTC will be returned to the MCO as consistent with the appeal decision.

6. Special Rules for Temporary Management

a. MLTC may install 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 § 438.706, or that is contrary to any requirements of Sections 1903(m) and 1932 of the Social Security Act.

b. MLTC will impose temporary management if it finds that an MCO has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. In this circumstance, MLTC must also notify members of the MCO of their right to select another MCO, and allow them to do so. MLTC may not delay imposition of temporary management to provide a hearing regarding the sanction. In addition, MLTC will not terminate temporary management until it determines that the sanctioned behavior will not recur.

7. Payment of Outstanding Monies or Collections from MCO

The MCO will be paid for any outstanding monies due less any assessed liquidated damages or sanctions. If liquidated damages exceed monies due, collection will be made from the MCO performance bond or any insurance policy or policies required under this contract, as appropriate. The rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this contract.

8. Provider Sanctions

Nothing contained in this contract shall prohibit MLTC, pursuant to applicable law, from imposing legally available sanctions, and Medicaid termination, on a health care provider for its violations of applicable law.

9. Right and Remedies Non-Exclusive

The rights and remedies provided in this section shall not be exclusive and are in addition to any other rights and remedies provided by law or under this contract.

X. TRANSITION AND IMPLEMENTATION

1. Transition Period

a. The transition period for the contract begins on Contract Execution Date and ends ninety (90) calendar days after the Contract Start Date for any successor contract. The transition period for a contract resulting from a merger, reorganization, or change in ownership of an existing contract begins at the date of close of said the merger, reorganization, or change of ownership, and ends one hundred eighty (180) calendar days thereafter, with optional extension periods available upon request, in writing, by the MCO no less than 10 (ten) calendar days prior to the end of each period, and upon approval by MLTC. During the transition period the MCO must implement the requirements of the contract and work closely with MLTC to facilitate a seamless transition between MCOs, providers, and programs in order to prevent an interruption of services and to ensure continuity of care for members.

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

i. Ninety (90) calendar days from Contract Start Date;
ii. The end date on the authorization from the previous entity; or
iii. A new decision by the MCO with consultation from the provider is determined on the medical necessity of the service.

b. On Contract Execution Date, the MCO must immediately begin collaborating with MLTC to review the contract, its proposal, and preliminary implementation plan. The MCO must provide to MLTC implementation plan updates on a weekly basis, and collaborate with MLTC to address the following:
i. Defining project management and reporting standards;
ii. Establishing communication protocols between the MCO, MLTC, and existing providers;
iii. Defining expectations for the content and format of contract deliverables; and
iv. Resolving transition and implementation issues to MLTC's satisfaction.

c. At a minimum, the MCO must have the following key staff in place to participate in the transition coordination/collaboration process:
i. Chief Executive Officer;
ii. Chief Operating Officer;
iii. Medical Director/Chief Medical Officer;
iv. Behavioral Health Clinical Director;
v. Dental Director;
vi. Member Services Manager;
vii. Provider Services Manager;
viii. Information Management and Systems Director;
ix. Quality Management Manager; and
x. Case Management Administrator.

2. Comprehensive Implementation Plan

a. After Contract Execution Date and before Contract Start Date, the MCO must develop a detailed and comprehensive implementation plan to monitor progress throughout the transition/implementation period.

b. The MCO must include in its implementation plan a detailed description of its implementation tasks, methods, staff accountable for completing tasks, and timelines, at a minimum for the following areas/issues:
i. Staffing;
ii. Data systems including system readiness testing, acceptance testing, transfer of electronic data and records, and a data conversion plan to include, at a minimum, intake, closure, eligibility, demographics, encounters, and other file data;
iii. Network adequacy and development;
iv. Clinical transition;
v. Utilization Management;
vi. Care Management;
vii. Quality Management;
viii. Member services;
ix. Member outreach/communications;
x. Member Handbook and Provider Manual completion;
xi. Member and Provider Websites;
xii. Subcontracting/Vendor services (e.g. vision, dental, pharmacy);
xiii. Security, business continuity, disaster recovery, and contingency planning;
xiv. Claims and eligibility interface development;
xv. Compliance plan;
xvi. Program Integrity plan;
xvii. Financial reporting plan;
xviii. Member and staff orientation and training plans; and
xix. Post-implementation deliverables.

3. Personnel

All key staff, as detailed in Section V.D Staffing Requirements must be hired prior to the Readiness Review. A minimum of two (2) weeks prior to the readiness review, the MCO must submit to MLTC the resumes of any key staff member (that was not submitted with the MCO's proposal) for MLTC review and approval. At that time, the MCO must submit updated organizational charts. The MCO must have sufficient personnel working and operating in the state during the transition and implementation period in order to be fully compliant with the terms of the contract.

4. Transitioning of Managed Care Members and Operations

a. When applicable, the MCO must transition members receiving services so care is not disrupted.

b. The incumbent MCO must collaborate with the successor MCOs and providers to develop and implement care plans for members who require them during the transition and deliver all services contained in the plans.

c. At a minimum, the incumbent MCO must provide service information, emergency telephone numbers, and instructions on how to obtain additional services to each member affected by the transition.

d. If applicable and as necessary, the incumbent MCO must transition to the successor MCO pending grievances, appeals, and member/provider service issues to ensure timely resolution.

e. The incumbent MCO must have a sufficient number of qualified staff to meet filing deadlines and attend all court or administrative proceedings.

5. Readiness Review

a. On or about six (6) months before the Contract Start Date, MLTC will conduct an operational and financial readiness review of the MCO, and will provide needed technical assistance. The MCO must cooperate with MLTC's review process to assess the MCO's operational readiness and ability to provide covered services to members as of the Contract Start Date. The MCO will be permitted to commence operations, and Medicaid enrollees will be enrolled with the MCO, only if the readiness review factors are met to MLTC's satisfaction.

b. Based on the results of the review, MLTC will issue a letter of findings and, if necessary, request a CAP from the MCO.

c. The readiness review will cover all provisions of the contract with a particular focus on assessing the following areas:

- **i.** Network adequacy;
- **ii.** Staffing adequacy;
- **iii.** Subcontracts;
- **iv.** Provider services;
- **v.** Member services;
- **vi.** Quality management;
- **vii.** Care management;
- **viii.** Utilization management;
- **ix.** Financial management;
- **x.** Information processing and system testing;
- **xi.** Continuity of care; and
- **xii.** Grievance and appeal process.

d. During the readiness review, the MCO must provide to MLTC staff access to MCO staff, operational documentation (including a demonstration of computer systems), private workspace, and the internet.

e. As part of the readiness review, the MCO must submit all policies and procedures detailed in this RFP and resulting contract to MLTC for review and approval.

f. If the MCO is unable to demonstrate its ability to meet the requirements of this contract, as determined by MLTC, within the time frames specified by MLTC, MLTC may terminate this contract and have no liability for payment to the MCO.

Y. TERMINATION OF MCO CONTRACT

If the contract is terminated, or the contract expires, the following provisions apply.

1. The MCO must provide services through the end of the contract term and pay for all covered services for all members prior to the date of contract termination.

2. The MCO must submit a written, detailed plan for the transition of its members to another MCO for approval by MLTC. This plan must include the schedule for key activities and milestones.

3. The MCO must make provisions for continuing all management and administrative services and the delivery of direct services to members until the transition of all members is completed and all other requirements of the contract are satisfied.

4. The MCO must designate a person with the appropriate training to act as the transition coordinator. The transition coordinator must interact closely with MLTC and staff from the successor MCO to ensure a safe and orderly transition.

5. The MCO must provide all reports necessary for the transition process. The MCO must provide all reports until MLTC is satisfied that the MCO has completed all outstanding obligations. If the contract is being terminated, the first report shall be due on the fifth day of the month following the notice of termination. If the contract is set for expiration, the reports shall be due starting six (6) months prior to the expiration. The following reports shall be due on the fifth day of each succeeding month, and shall cover activities for the prior month. These reports include, but are not limited to:

a. Monthly claims aging report by provider/creditor including incurred-but-not-reported amounts;

b. Monthly summary of cash disbursements; and
c. A list of all outstanding obligations necessary to complete the contract.

6. The MCO must notify subcontractors of contract termination or expiration as directed by MLTC.

7. The MCO must notify all its members a minimum of forty-five (45) calendar days in advance of the termination or expiration that the MCO will no longer serve as their MCO. The MCO shall be financially responsible for all costs associated with this notification. The notification must be approved in advance by MLTC.

8. The MCO must notify each participating provider, in writing, a minimum of forty-five (45) calendar days in advance of the termination or expiration. The written notice must include the contract end date and must explain to the participating provider how the provider can continue participating in the Medicaid program. The MCO shall be financially responsible for all costs associated with this notification. The notification must be approved in advance by MLTC.

9. The MCO must pay all outstanding obligations for covered services provided to members. The MCO must cover continuation of services for members for the period for which payment is made, as well as for inpatient admissions up until the member's discharge.

10. The MCO must cooperate with other MCOs during the transition period including, but not limited to, sharing and transferring member information and records as outlined in Section V. X. Transitions and Implementation, section 6. MLTC will notify the MCO with specific instructions at the time of transfer. The MCO must comply with these instructions.

11. Upon written notice and instructions from MLTC, the MCO must return any funds advanced to the MCO for coverage of members for periods after the contract end date within thirty (30) calendar days of the contract end date.

12. The MCO must supply all information necessary for reimbursement of outstanding claims.

13. The MCO must return to MLTC or otherwise destroy any confidential information in its possession after the retention period required by law or contract, unless otherwise required by law to retain the information.

14. The MCO must provide the following to MLTC, in a format approved by MLTC:
a. A list of all network providers;
b. A list of members who are receiving care management services;
c. A list of all services requiring MCO prior authorization; and
d. A list of all members receiving prior authorized services with an approved duration that extends beyond the contract end date.

Z. Electronic Visit Verification (EVV) for Home Health Care Services (HHCS)

1. General Requirements

a. MCOs must collectively contract with a single EVV-HHCS solution provider for the provision of EVV services.

b. The EVV-HHCS solution provider must implement, support, and maintain a EVV solution that:
i. Is comprehensive, scalable, and secure;
ii. Supports the reporting and analytical needs of MLTC;
iii. Meets the requirements of the EVV-HHCS Technical Guidance; and
iv. Incorporates claims adjudication.

c. The EVV-HHCS solution provider must have a minimum of five (5) years' experience in health-related IT consulting services, with at least one EVV-related project in the public governmental environment within the last five years.

2. General Functional Requirements

a. The EVV-HHCS solution provider must provide a modern solution that provides a comprehensive, scalable, and secure information solution containing large data sets, dashboard(s), standard reports, and ad hoc reporting tool(s) that support MLTC's aggregation of data and reporting.

b. The EVV-HHCS solution must be designed to provide benefits as defined by the Centers for Medicare and Medicaid Services (CMS). High-level objectives to assist MLTC with realizing EVV benefits must include the following:
i. Facilitate compliance with CMS requirements regarding an EVV-HHCS solution under Medicaid through design of a vendor-neutral EVV solution to take in data from multiple systems and compile such data into a consistent format;
ii. Improve services to members by providing the ability to monitor the delivery of care and services by provider, type of service, and location of service participant;
iii. Target and reduce Fraud, Waste, and Abuse (FWA) through identification of duplicated or unauthorized services;
iv. Allow for more robust data collection and analysis; and
v. Facilitate efficient data exchange between EVV vendors and a vendor-neutral EVV solution.

c. The MCOs must provide a Requirements Analysis Document (RAD) that defines the business, functional, and technical requirements of the shared MCO's EVV solution and establishes the baseline, testing activities, workflow, and process changes for such requirements. The state shall have final approval of the MCO's RAD. The MCO's RAD shall include the following:
- **i.** Business use case and examples;
- **ii.** Required workflow and process modifications;
- **iii.** Solution integration and interface requirements;
- **iv.** Solution architecture requirements;
- **v.** Hardware and software requirements; and
- **vi.** Verification that any relevant requirements have been validated against MITA business processes and CMS certification requirements.

d. The MCOs must provide, implement, operate, and maintain all necessary technology for the EVV-HHCS solution to meet all requirements, business objectives, solution functionality, and necessary software licenses to allow for a sufficient number of users and locations.

e. The EVV-HHCS solution must align with industry and accessibility standards established under section 508 of the Rehabilitation Act, providing greater accessibility for individuals with disabilities, and compliance with federal civil rights law, standards adopted by the Secretary under section 1104 of the Affordable Care Act, and standards and protocols adopted by the Secretary under section 1561 of the Affordable Care Act.

f. MCOs must ensure the EVV-HHCS solution complies with MLTC and enterprise policies and standards, including technology standards, MLTC accessibility and data security standards, and procedures.

g. MCOs must ensure the EVV-HHCS solution allows for MCO program integrity staff and Nebraska Medicaid Program Integrity (NMPI) oversight and investigative functions including:
- **i.** Audit trail capabilities that identify, track, and aggregate changes to visit information, claims information, and other transactions as specified by MLTC.
- **ii.** Establishing user profiles within the solution system that allows MLTC Program Integrity personnel to directly access provider information, transaction information, and audit tools established for purposes of Fraud, Waste, and Abuse monitoring and investigation.
- **iii.** Inclusion in the MCO FWA policies, procedures, and plan.
- **iv.** Inclusion in the MCO compliance plan.

3. CMS Certification Requirements

a. The EVV-HHCS solution must meet all federal requirements for EVV systems including one hundred percent (100%) of the federal certification requirements including delivering and implementing a fully CMS compliant EVV solution, which must achieve full CMS certification.

b. In the event the MCO contracted EVV-HHCS solution provider fails to:
- **i.** Successfully achieve CMS certification within one (1) calendar year of the EVV solution implementation date resulting from any failure of the EVV solution to meet CMS certification requirements; or
- **ii.** Successfully implement an EVV solution that results in MLTC being subject to federal financial participation penalties.

c. MCOs will be required to remit any affected federal financial participation payments to MLTC upon notice from the MLTC.

d. The MCOs must deliver a solution that produces reports and information supporting the MLTC-established and CMS-approved reports including key performance indicators (KPIs.)

e. The MCOs must deliver an EVV-HHCS solution that complies with any checklists that CMS identifies as applicable to an EVV Aggregator Solution (i.e. the 2016 Medicaid Enterprise Certification Toolkit (MECT) published by CMS which may be viewed at the following link: https://www.medicaid.gov/medicaid/data-systems/medicaid-enterprise-certification-toolkit/index.html.)

f. The MCOs shall provide all necessary documentation and shall participate in the outcomes-based certification (OBC) process including the operational readiness review (ORR) conducted before the EVV solution's go-live date. This shall include any "post go-live" certification activities during EVV Solution Operations in addition to other updates such as key performance indicators (KPI) quarterly reporting.

g. Within thirty (30) calendar days of notification from MLTC to proceed with contract activities, the MCOs must develop and submit to MLTC for approval, a Certification Readiness Plan that describes the MCO's approach to CMS certification including any materials required by CMS. The MCOs will be responsible to updating and maintain the Certification Readiness Plan.

h. The MCOs will be responsible for identifying, producing, providing, and satisfying all certifiable criteria, documents, data, reports, and other information required during the certification process in addition to providing reports and solution functionality necessary to meet certification requirements.

i. The MCOs must assist MLTC personnel as necessary during certification presentations.

j. The MCOs and the EVV-HHCS solution provider must participate as needed during federal CMS off-site and on-site certification review activities and shall facilitate review activities and visits to the contractor's operational facilities.

k. The MCOs and the EVV-HHCS solution provider must provide any necessary continuity and availability of personnel after completion of solution implementation through the completion of all certification activities to ensure successful completion of the certification process.

4. Quality Management and Performance Monitoring Requirements

a. The EVV-HHCS solution must support the collection of data requirements for quality improvement organizations established under 42 CFR § 475.100.

b. The MCOs and EVV-HHCS solution provider must support the monitoring of customer satisfaction to include, at a minimum, surveys to identify areas of dissatisfaction and failure to meet business needs requiring improvement or corrective action. The EVV-HHCS solution provider's performance must be at a level to receive customer satisfaction results in at least an average rating of "Satisfied."

c. The MCOs and EVV-HHCS solution provider must collaborate with MLTC in the identification and definition of quality metrics, measure, monitoring, and success to establish standards for project processes, product functionality, regulatory and contractual compliance, project deliverables, project management, documentation, and testing;

i. Identification of quality standards and expectations for key stakeholders, the project, and MLTC to incorporate federal and state mandates and initiatives including Medicaid Information Technology Architecture (MITA) and CMS's Seven Conditions and Standards;

ii. Definition of data collection methods, archiving, and measurement and metrics reporting timeframes; and

iii. Identification of tools and techniques available that the contractor will use in the quality planning and review process.

d. The EVV-HHCS solution provider's quality assurance process shall, at a minimum, do the following:

i. Audit the solution provider's quality requirements and quality measurement initiative results;

ii. Provide consistent and systematic measurement comparison with the solution provider's established quality metrics and standards;

iii. Monitor processes and feedback loops that confer problem prevention; and

iv. Analyze quality data, document opportunities for improvement, and apply what was learned from quality analysis to eliminate gaps between current and desired levels of performance.

5. Training Requirements

a. The EVV-HHCS solution provider must provide training for all provider entities accessing the EVV solution. Training shall cover, at a minimum, how to access the EVV solution and how to view and run reports relating to EVV data. The MLTC anticipates the most common training topics will be compliance, data capturing and reporting, and software usage.

b. The EVV-HHCS solution provider must provide training to identified MLTC staff.

c. The EVV-HHCS solution provider must provide training in multiple delivery methods including, at a minimum, the following:

i. In person through instructor-led classes;

ii. Virtual;

iii. One-on-one;

iv. Training documentation; and

v. Train the trainer.

d. The EVV-HHCS solution provider must provide a Training Plan for the EVV solution that describes the training documentation and methods to be provided to end users including the MLTC, EVV vendors, providers, MCO program integrity staff, NMPI, Medicaid Fraud Patient Abuse Unit (MFPAU), and MCOs on the EVV solution's defined uses including, at a minimum, reporting functions. The Training Plan shall specify training necessary for EVV vendors related to data transformation, conversion, and transmission.

e. The EVV-HHCS solution provider must train end users in all EVV solution functionality including solution administration, solution dashboards, solution screens, standard report usage, and ad hoc reporting.

f. The EVV-HHCS solution provider must develop training materials, presentations, and training scenarios for use during training. These materials must be reviewed and approved by the MLTC prior to use.

g. The EVV-HHCS solution provider must maintain an updated Training Plan. All updates must be approved by the MLTC.

6. Reporting and Data Retention Requirements

a. The contractor's EVV solution shall provide standard, pre-defined reports.

b. The EVV-HHCS solution provider must collaborate with the MLTC to produce data, reports, and performance information that contribute to program evaluation, continuous business operations improvement, transparency, and accountability.

c. The EVV-HHCS solution provider must work with the MLTC to identify future, pre-defined reports and data analysis/functions.

d. The EVV-HHCS solution provider must conduct requirements sessions with the MLTC to develop EVV-HHCS solution dashboards. The EVV-HHCS solution provider must develop dashboards for each group of end users, including MCOs, providers, EVV vendors, and state agencies. Dashboard features must include flags, summary data, links to pre-defined reports, and end user dashboard configuration. Dashboards must contain relevant information for each pre-defined report herein.

e. The EVV-HHCS solution provider must collaborate with the MLTC to produce dashboard information that contributes to program evaluation, continuous business operations improvement, transparency, and accountability.

7. EVV-HHCS Solution Implementation Requirements

The contractor shall implement all technical and functional requirements herein for a fully functioning EVV solution in accordance with Attachment 13 – Reporting Requirements.

AA. FEE FOR SERVICE CLAIMS MANAGEMENT AND PROCESSING – OPTIONAL SERVICES

1. Claims Broker Services

MLTC is currently in the process of replacing its aged Medicaid Management Information System (MMIS). As part of this transition, MLTC is moving toward a model of contracting with risk-bearing entities for the provision of services for nearly all Medicaid members and services. As this transition continues, MLTC will be responsible for processing fewer FFS claims for fewer members. Rather than procure a standalone claims processing system for these remaining needs, MLTC intends to enter into a services agreement with an MCO.

In addition to the MCO responsibilities outlined in this RFP, MLTC will award the processing of the remaining Nebraska Medicaid FFS claims, excluding long-term services and supports claims, hereafter referred to as "claims broker services," to a single MCO. Any reference to claims in this section is also inclusive of FFS adjustments, recoupments, voids, and financial transactions. Payment for claims broker services will be paid separately from managed care capitation payments. MLTC will pay the claims broker an administrative processing fee for each unique adjudicated FFS claim or adjustment on a monthly basis. MLTC will provide the per unique claim initial rate.

MLTC will reimburse the MCO for claims broker services, on a monthly basis, based on a per claim or per authorization request administrative fee.

MLTC will pay for a claim to be processed multiple times if the resubmission is due to provider error. If a claim is denied multiple times due to a claims broker error, MLTC will only pay to process the claim once. The claims broker must provide detailed reports to MLTC for validation of FFS payments and recoveries. The claims broker is responsible for all servicing aspects of FFS claims unless otherwise expressly identified as an exception by MLTC..

The MCO chosen as the claims broker must develop and maintain claims handling and payment policies and procedures in accordance with Nebraska Medicaid policy, CMS's National Correct Coding Initiative (NCCI) guidelines and Medicaid service limits. The claims broker must ensure accurate collection, processing, payment, and reporting of all FFS claims.

2. Reimbursement for Claims Broker FFS Payments

The claims broker must make payments for all FFS claims to providers. The claims broker must submit to MLTC a reconciliation report of all funds expended and received with remaining balance to be reimbursed for FFS payments. The claims broker may submit a funding request on a weekly basis to MLTC to cover the cost of FFS claims payments. The report must be submitted with each funding request to justify the request.

3. Implementation Time Frame

The implementation of the claims broker functionality must occur by the Contract Start Date.

4. Functionality

The claims broker must maintain the same functionality for FFS claims that is required for managed care claims as described in Section V.S Claims Management of this RFP. FFS claims must be processed even if the billing provider is not contracted with the MCO who is performing claims broker services. The claims broker processing system must handle retroactive member eligibility and process claims accordingly.

The MCO must make system or operational changes for FFS claims processing within 60 calendar days of notification by MLTC. The claims broker must correct all processing errors identified by MLTC immediately on notification. Recoupment of erroneous payments made to providers is the sole responsibility of the claims broker. MLTC will not reimburse the claims broker for uncollected recoupments for claims paid in error.

The claims broker processing system must maintain functionality to process claims for services that require unique provider and member reimbursement methodologies that differ from standard processing protocol.

The claims broker must give MLTC inquiry access to its FFS claims processing system to view claims and all information related to FFS claims processing. The claims broker must provide system user training to MLTC staff who support this scope of work.

5. Claims Processing

The claims broker must maintain the same claims processing standards for all non-drug FFS claims that is required for managed care claims, as described in Section V.S Claims Management of this RFP. Requirements for rejected claims, pended claims, adjustments, voids, and timely filing guidelines must mirror managed care requirements. Claim system edits for FFS claims must be maintained in the same manner as required for managed care claims. The claims broker should expect that FFS claims will have different editing and payment methodologies than managed care claims, and must maintain these edits and payment processes separately. The claims broker claims processing system must post all applicable edits to denied FFS claims during a single processing cycle.

6. Drug Claims Processing

The claims broker must use a PBM to process all FFS drug claims. The PBM must pay FFS claims in accordance with the same requirements for managed care pharmacy claims in this RFP.

7. Service Authorization Procedures

The claims broker must develop and administer prior authorization procedures for services paid as FFS in accordance with Nebraska Medicaid policy and the requirements of Section V.N Utilization Management of this RFP. FFS claims must be paid or denied in accordance with FFS authorization policies.

8. Payments to Providers

The claims broker must pay FFS claims at fee schedule rates set by MLTC and in accordance with requirements in Section V.S Claims Management of this RFP.

9. Remittance Advice

The claims broker must adhere to the same remittance requirements for FFS claims as required for managed care claims as outlined in Section V.S Claims Management of this RFP.

10. Third Party Liability

In accordance with Section V.S Claims Management, the claims broker must develop and maintain a process to identify and capture information regarding other insurance sources (TPL) for FFS members. Information regarding TPL must be maintained on the member file and utilized during claims payment to ensure that Medicaid is the payer of last resort. The claims broker will also perform recovery activities for claims that have been paid by Medicaid where third-party coverage was applicable. These payment recoveries will be returned to MLTC in full immediately upon receipt. The claims broker must expend the same level of effort on the recovery and cost avoidance of casualty claims for FFS claims as is expended on managed care claims. Denial of FFS claims for TPL coverage must comply with all MLTC policies and applicable law. MLTC will retain responsibility for all estate recovery activities.

11. Member Services

The claims broker must provide a member services call center activities to all eligible FFS members in the same manner as required for managed care members as outlined in Section V.F Member Services and Education of this RFP. MLTC will provide the claims broker with an interface that provides FFS member eligibility.

12. Provider Services

The claims broker must provide a toll-free telephone line to all providers who render services to FFS members, according to the requirements of Section V.J Provider Services of this RFP. These services must be available to providers even if they are not contracted with the MCO providing claims broker services. These activities include the management of electronic data interchange and trading partner agreements, as well as call center support for provider inquiries such as member eligibility and benefit limits, claims processing issues, or other program clarifications. The claims broker must make provider notifications, bulletins, newsletters, FAQs, and other pertinent information available on its website to providers participating in the FFS programs.

13. Paid Claims Sampling

The claims broker must adhere to the same paid claims sampling requirements for FFS claims as required for managed care claims outlined in Section V.S Claims Management of this RFP.

14. Claims Dispute Management

The claims broker must adhere to the same claims dispute management requirements for FFS claims as required for managed care claims outlined in Section V.S Claims Management of this RFP. FFS claims must be disputed through the State Fair Hearing process. The claims broker must support MLTC in claims disputes by providing all required documentation and subject matter representation in the manner specified by MLTC.

15. Claims Payment Accuracy

The claims broker must adhere to the same claims payment accuracy requirements for FFS claims as required for managed care claims as outlined in Section V.S Claims Management of this RFP.

16. Claims Data

The claims broker must submit all data relevant to the adjudication and payment of FFS claims to MLTC as required by MLTC. All claims data must be submitted to MLTC in standard HIPAA formats, as applicable. FFS claims data (including adjustments and recoupments) must be submitted a minimum of monthly on a date designated by MLTC. Claim data must be identified as FFS and must have the appropriate account code on the claim. The claims broker must work with MLTC to determine the appropriate data for reporting and MLTC will approve any proposed report.

17. Drug Rebates

In accordance with Section V.S Claim Management, the claims broker must provide pharmacy claims information to MLTC so MLTC may perform all drug rebate activities (including disputed drug rebates) for FFS drug claims.

18. Audit Requirements

The claims broker must adhere to all audit requirements for managing FFS claims as required for managed care claims, as outlined in Section V.S Claims Management of this RFP. The claims broker must support MLTC by providing claims payment explanations, as requested.

VI. PROPOSAL INSTRUCTIONS

This section documents the requirements that should be met by bidders in preparing the Technical and Cost Proposal. Bidders should identify the subdivisions of Section V. Project Description and Scope of Work clearly in their proposals; failure to do so may result in disqualification. Failure to respond to a specific requirement may be the basis for elimination from consideration during the State's evaluation.

Proposals are due by the date and time shown in the Schedule of Events. Content requirements for the Technical and Cost Proposal are presented separately in the following subdivisions; format and order:

A. CORPORATE OVERVIEW

The Corporate Overview section of the Technical Proposal should consist of the following subdivisions:

1. BIDDER IDENTIFICATION AND INFORMATION

The bidder should provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized.

2. FINANCIAL STATEMENTS

The bidder should provide financial statements applicable to the firm. If publicly held, the bidder should provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, should be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm should provide a banking reference.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

The State may elect to use a third party to conduct credit checks as part of the corporate overview evaluation.

3. CHANGE OF OWNERSHIP

If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder should describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded bidder(s) will require notification to the State.

4. OFFICE LOCATION

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska should be identified.

5. RELATIONSHIPS WITH THE STATE

The bidder should describe any dealings with the State over the previous five (5) years. If the organization, its predecessor, or any Party named in the bidder's proposal response has contracted with the State, the bidder should identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

6. BIDDER'S EMPLOYEE RELATIONS TO STATE

If any Party named in the bidder's proposal response is or was an employee of the State within the past twelve (12) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a subcontractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

7. CONTRACT PERFORMANCE, AND CRIMINAL OR REGULATORY INVESTIGATIONS OR SANCTIONS

If the bidder or any proposed subcontractor has had a contract terminated for default during the past two (2) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past two (2) years, including the other Party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past two (2) years, so declare.

If at any time during the past two (2) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting Party.

If the Bidder is currently, or has been, during the past five (5) years, the subject of a criminal or civil investigation by a state or federal agency, bidder must provide an explanation with relevant details and the outcome. If the outcome was against the Bidder, provide the corrective action plan or measures taken to prevent such future offenses.

The bidder must identify and describe any regulatory action or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against the Bidder's organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued, as well as any corrective actions required by any federal or state regulatory entity during the last five (5) years that relate to Medicaid and CHIP contracts.

For all of the above in (7), the bidder must include the organization's parent company, affiliates, and subsidiaries in the response.

8. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

The bidder should provide a summary matrix listing the bidder's previous projects similar to this solicitation in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.

The bidder should address the following:

a. Provide narrative descriptions to highlight the similarities between the bidder's experience and this solicitation. These descriptions should include:

- **i.** The time period of the project;
- **ii.** The scheduled and actual completion dates;
- **iii.** The bidder's responsibilities;
- **iv.** For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and
- **v.** Each project description should identify whether the work was performed as the prime contractor or as a subcontractor. If a bidder performed as the prime contractor, the description should provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.
- **vi.** Contractor and subcontractor(s) experience should be listed separately. Narrative descriptions submitted for subcontractors should be specifically identified as subcontractor projects.
- **vii.** If the work was performed as a subcontractor, the narrative description should identify the same information as requested for the contractors above. In addition, subcontractors should identify what share of contract costs, project responsibilities, and time period were performed as a subcontractor.

b. Bidder should provide at least three (3) customer references. For each reference, Bidder should provide the customer's name, contact information (including current telephone number, address, and email address.

9. SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

The bidder should present a detailed description of its proposed approach to the management of the project.

The bidder should identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this solicitation. The names and titles of the team proposed for assignment to the State project should be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

The bidder should provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the solicitation in addition to assessing the experience of specific individuals.

Resumes should not be longer than three (3) pages. Resumes should include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

10. SUBCONTRACTORS

If the bidder intends to subcontract any part of its performance hereunder, the bidder should provide:

a. name, address, and telephone number of the subcontractor(s);
b. specific tasks for each subcontractor(s);
c. percentage of performance hours intended for each subcontract; and
d. total percentage of subcontractor(s) performance hours.

B. TECHNICAL APPROACH

Bidders should respond to Proposal Response Instructions to describe their approach to providing managed care services for the State.

Form A
Bidder Proposal Point of Contact
Request for Proposal Number 112209 O3

Form A should be completed and submitted with each response to this solicitation. This is intended to provide the State with information on the bidder's name and address, and the specific person(s) who are responsible for preparation of the bidder's response.

Preparation of Response Contact Information	
Bidder Name:	
Bidder Address:	
Contact Person & Title:	
E-mail Address:	
Telephone Number (Office):	
Telephone Number (Mobile):	

Each bidder should also designate a specific contact person who will be responsible for responding to the State if any clarifications of the bidder's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Bidder Name:	
Bidder Address:	
Contact Person & Title:	
E-mail Address:	
Telephone Number (Office):	
Telephone Number (Mobile):	

Form B
Notification of Intent to Attend Pre-Proposal Conference
Request for Proposal Number 112209 O3

Bidder Name:	
Bidder Address:	
Contact Person:	
E-mail Address:	
Telephone Number:	
Number of Attendees:	

The "Notification of Intent to Attend Pre-Proposal Conference" form should be submitted to the DHHS via e-mail (DHHS.Procurement@nebraska.gov, hand delivered or US Mail by the date shown in the Schedule of Events.

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the bidder guarantees compliance with the procedures stated in this Solicitation, and agrees to the terms and conditions unless otherwise indicated in writing and certifies that bidder maintains a drug free work place.

_____ I hereby certify that I am a Resident disabled veteran or business located in a designated enterprise zone in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

_____ I hereby certify that I am a blind person licensed by the Commission for the Blind & Visually Impaired in accordance with Neb. Rev. Stat. §71-8611 and wish to have preference considered in the award of this contract.

FORM MUST BE SIGNED USING INK OR VIA DOCUSIGN

CONTRACTOR:	
COMPLETE ADDRESS:	
TELEPHONE NUMBER:	
EMAIL ADDRESS:	
DATE:	
SIGNATURE:	
TYPED NAME & TITLE OF SIGNER:	