State of Nebraska (State Purchasing Bureau)

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

RETURN TO:
State Purchasing Bureau
301 Centennial Mall South, 1st Fl
Lincoln, Nebraska 68508
OR
P.O. Box 94847
Lincoln, Nebraska 68509-4847
Phone: 402-471-2401
Fax: 402-471-2089

SOLICITATION NUMBER	RELEASE DATE
RFP 4166Z1	**October 24, 2012**
OPENING DATE AND TIME	PROCUREMENT CONTACT
January 7, 2013 2:00 p.m. Central Time	**Ruth Gray**

This form is part of the specification package and must be signed and returned, along with proposal documents, by the opening date and time specified.

PLEASE READ CAREFULLY!

SCOPE OF SERVICE

The State of Nebraska, Administrative Services (AS), Materiel Division, Purchasing Bureau, is issuing this Request for Proposal, RFP Number 4166Z1 for the purpose of selecting a qualified contractor to provide a full-risk capitated rate Medicaid Managed Care program for Mental Health and Substance Use Disorder services with the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care.

First round written questions are due no later than November 6, 2012, and should be submitted via e-mail to matpurch.dasmat@nebraska.gov. Written questions may also be sent by facsimile to (402) 471-2089.

Bidder should submit one (1) original and seven (7) copies of the entire proposal. In the event of any inconsistencies among the proposals, the language contained in the original proposal shall govern. Proposals must be submitted by the proposal due date and time.

PROPOSALS MUST MEET THE REQUIREMENTS OUTLINED IN THIS REQUEST FOR PROPOSAL TO BE CONSIDERED VALID. PROPOSALS WILL BE REJECTED IF NOT IN COMPLIANCE WITH THESE REQUIREMENTS.

1. Sealed proposals must be received in State Purchasing by the date and time of proposal opening indicated above. No late proposals will be accepted. No electronic, e-mail, fax, voice, or telephone proposals will be accepted.
2. This form "REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES" MUST be manually signed, in ink, and returned by the proposal opening date and time along with bidder's proposal and any other requirements as specified in the Request for Proposal in order to be considered for an award.
3. It is the responsibility of the bidder to check the website for all information relevant to this solicitation to include addenda and/or amendments issued prior to the opening date. Website address is as follows: http://www.das.state.ne.us/materiel/purchasing/
4. It is understood by the parties that in the State of Nebraska's opinion, any limitation on the contractor's liability is unconstitutional under the Nebraska State Constitution, Article XIII, Section 3, and that any limitation of liability shall not be binding on the State of Nebraska despite inclusion of such language in documents supplied with the contractor's bid or in the final contract.

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request For Proposal For Contractual Services form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the terms and conditions (see Section III) and certifies bidder maintains a drug free work place environment.

FIRM: _____

COMPLETE ADDRESS: _____

TELEPHONE NUMBER: _____ FAX NUMBER: _____

SIGNATURE: _____ DATE: _____

TYPED NAME & TITLE OF SIGNER: _____

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GLOSSARY OF TERMS

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

Action: is defined in the contract as the:

1. Denial or limited authorization of a requested service, including the type or level of service;
2. Reduction, suspension, or termination of a previously authorized service;
3. Denial, in whole or in part, of payment for a service;
4. Failure to provide services in a timely manner, as defined by the State;
5. Failure of the Contractor to act within the timeframes; or
6. For a rural area resident with only one MCO to choose from, the denial of a Medicaid enrollee's request to obtain services outside the network:

    a. From any other provider (in terms of training, experience, and specialization) not available within the network;
    b. From a provider not part of the network who is the main source of a service to the recipient - provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the enrollee is given a choice of participating providers and is transitioned to a participating provider within 60 days;
    c. Because the only plan or provider available does not provide the service because of moral or religious objections;
    d. Because the recipient's provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network; and
    e. The State determines that other circumstances warrant out-of-network treatment.

Addendum: Something added or deleted.

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

Agent: A person authorized by a superior or organization to act on their behalf.

Amend: To alter or change by adding, subtracting, or substituting. A contract can be amended only by the parties participating in the contract. A written contract can only be amended in writing.

Amendment: Written correction or alteration.

Appeal: As defined in 42 CFR 438.400(b). A request for review of an "action". Action means, in the case of an MCO or PIHP:

1. The denial or limited authorization of a requested service, including the type or level of service;

2. The reduction, suspension, or termination of a previously authorized and covered service;
3. The denial, in whole or part, of a payment for a properly authorized and covered service;
4. The failure to provide services in a timely manner, as defined by the State;
5. The failure of a Managed Care Contractor to act within the established timeframes for grievance and appeal disposition; and
6. For a resident of a rural area with only one Medicaid health plan, the denial of a Medicaid enrollee's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network.

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

Award: All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the Request for Proposal. The State reserves the right to reject any or all proposals, wholly or in part, or to award to multiple bidders in whole or in part. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State.

Behavioral Health - Managed Care Organization (BH-MCO): An organization that provides behavioral health services using managed care techniques.

Best and Final Offer (BAFO): A second-stage bid in a public procurement for services.

Bid: The executed document submitted by a bidder in response to a Request for Proposal.

Bid Bond: A bond given by a surety on behalf of the bidder to ensure that the bidder will enter into the contract as bid and is retained by the State from the date of the bid opening to the date of contract signing.

Bidder: Any person or entity submitting a competitive bid response to a solicitation.

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

Business Day: Any weekday, excepting public holidays.

Calendar Day: Every day shown on the calendar; Saturdays, Sundays and State/Federal holidays included. Not to be confused with "Work Day".

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

Children's Health Insurance Program (CHIP): Nebraska is currently a combination Medicaid CHIP state with a Medicaid CHIP (MCHIP) 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 (FPL). The separate CHIP (SCHIP) program established July 19, 2012 provides Medicaid coverage for the unborn children of pregnant women that are otherwise not Medicaid eligible.

Claims Incurred: Amounts paid for claims incurred by the BH-MCO in the contract year. Amounts paid for claims should be net of any and all patient liabilities (e.g. copays), Third Party Liabilities (e.g. coordination of benefits or subrogation), and any rebates received from any party that reduces the BH-MCO's claims expense. Only claims paid for benefits under the Nebraska Medicaid Managed Care Program (NMMCP) shall be included.

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

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

Cold Call Marketing: Any unsolicited personal contact by the Contractor with a potential enrollee for the purpose of marketing.

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

Competition: The process by which two or more vendors vie to secure the business of a purchaser by offering the most favorable terms as to price, quality, delivery and/or service.

Complaint: A written or verbal expression of dissatisfaction from a member about an action taken by the Contractor or service provider other than an adverse action. The Contractor shall not treat anything as a complaint that falls within the definition of action.

Comprehensive Risk Contract: A risk contract that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services:

1. Outpatient hospital services;
2. Rural health clinic services;
3. FQHC services;
4. Other laboratory and X-ray services;
5. Nursing facility (NF) services;
6. Early and periodic screening, diagnosis, and treatment (EPSDT) services;
7. Family planning services;
8. Physician services; and
9. Home health services.

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 provide.

Contract: An agreement between two or more persons to perform a specific act or acts.

Contract Administration: The Management of various facets of contracts to assure that the contractor's total performance is in accordance with the contractual commitments and obligations to the purchaser are fulfilled.

Contract Management: Includes reviewing and approving of changes, executing renewals, handling disciplinary actions, adding additional users, and any other form of action that could change the contract.

Contractor: Any person or entity that supplies goods and/or services.
Conversion Period: A period of time not to exceed six (6) months, during which the State converts to a new Operating System under "Conversion" as per this RFP.

Coordinated Care Management: The overall system of medical and psychosocial management of care encompassing, but not limited to, utilization management, care coordination, discharge planning following restrictive levels of care, continuity of care, care transition, and quality management.

Copyright: A grant to a writer/artist that recognizes sole authorship/creation of a work and protects the creator's interest(s) therein.

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

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

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

Deviation: Any proposed change(s) or alteration(s) to either the contractual language or deliverables within the scope of this Request for Proposal.

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

Earned Revenue: All capitation (gross of all MLTC withholds, reinsurance premiums, or any ceded revenue paid by MLTC related to members eligible for NE Medicaid services during the contract year less federal and state premium taxes. Excludes any capitation received in the contract year related to members eligible for services not in the contract year. This includes any revenue reserves for capitation related to members eligible for services in the contract year but not received in the contract year.

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

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

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

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

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

Evaluation Committee: A committee (or committees) appointed by the requesting agency that advises and assists the procuring office in the evaluation of proposals.

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

Extension: A provision, or exercise of a provision, of a contract that allows a continuance of the contract (at the option of the State of Nebraska) for an additional time according to contract conditions. Not to be confused with "Renewals."

Federally Qualified HMO: An HMO that CMS has determined is a qualified HMO under section 1310(d) of the PHS Act.

F.O.B. Destination: Free on Board. The delivery charges have been included in the quoted price and prepaid by the vendor. Vendor is responsible for all claims associated with damages during delivery of product.

Foreign Corporation: A foreign corporation is a corporation that was formed (i.e. incorporated) in another state but transacting business in Nebraska pursuant to a certificate of authority issued by the Nebraska Secretary of State.

Generally Accepted Accounting Principles (GAAP): The common set of accounting principles, standards and procedures that companies use to compile their financial statements. GAAP are a combination of authoritative standards (set by policy boards) and the commonly accepted means of recording and reporting accounting information.

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

Healthcare Effectiveness Data and Information Set (HEDIS): The most widely used set of standardized performance measures used in the managed care industry, designed to allow reliable comparison of the performance of managed health care plans. HEDIS is sponsored, supported, and maintained by the National committee of Quality Assurance (NCQA).

Health Care Practitioner: As defined at §71 NAC 6215.

Health Care Professional: A physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician 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 certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

HIO: Health insuring organization. A county-operated entity that in exchange for capitation payments, covers services for recipients:

1. Through payments to, or arrangements with, providers;
2. Under a comprehensive risk contract with the State; and
3. Meets the following criteria – (i) First became operational prior to January 1, 1986; or (ii) Is described in section 9517(e)(3) of the Omnibus Budget Reconciliation Act of 1985 (as amended by section 4734 of the Omnibus Budget Reconciliation Act of 1990).

Incentive Withhold: In accordance with Nebraska law, is defined as funds that are withheld from payment in order to incentivize achievement of agreed upon terms. In addition to potential profit, the withhold amount will be at least one and one-half percent of the Earned Revenue. This amount shall be withheld from monthly capitation payments.

Incurred But Not Paid (IBNP): An estimate by a credentialed actuary of claims Incurred But Not Paid (IBNP). This estimate should include no implicit or explicit margin and be developed in accordance with actuarial standards of practice.

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 which 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 and/or facilitating a business process or related transaction.

Installation Date: The date when the procedures described in "Installation by Contractor, and Installation by State", as found in the RFP, are completed.

Late Proposal: A proposal received at the place specified in the solicitation after the date and time designated for all proposals to be received.

Licensing: Bidders must acquire appropriate Nebraska licensure and provide proof-of-licensure with the proposal. If the Bidder is not licensed as required by the Nebraska Department of Insurance (DOI) at the time of proposal submittal, the Bidder shall attest that the appropriate licensure shall be obtained prior to a executing a contract with MLTC. The Bidder shall provide verification that the licensure is not suspended, revoked, denied or found to be noncompliant by Nebraska DOI at the time of contracting.

Licensed Software: Any and all software and documentation by which the State acquires or is granted any rights under the contract.

Lock-In: A method used by the State to limit the medical services and pharmaceuticals provided to NE Medicaid members who have been determined to be abusing or inappropriately utilizing services provided by NE Medicaid. In some complex health conditions, a second treating provider may be added to the member's "locked-in" profile for medication prescription. This usually occurs with psychiatry or pain management once confirmation is received from both providers.

Managed Care Organization (MCO): An organization that is, or is seeking to, qualify for a comprehensive risk contract to provide services to Medicaid managed care enrollees. An entity that has, or is seeking to qualify for, a comprehensive risk contract , and that is – (1) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of Chapter 438 of the Code of Federal Regulations Title 42; or (2) Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: (i) Makes the

services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served by the entity; and (ii) Meets the solvency standards of 42 CFR 438.116.

Mandatory: Required, compulsory or obligatory.

Marketing: Any communication, from the Contractor to a Medicaid recipient who is not enrolled in the BH MCO and can reasonably be interpreted as intended to influence the recipient to enroll in the Contractor's BH program, or either to not enroll in, or to disenroll from, another BH MCO's Medicaid product.

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

May: Denotes discretion.

Medicaid Abuse: Abuse is defined by Federal law (42 CFR 455.2) as "provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program."

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."

Medicaid Waste: Excessive or improper use of services or actions that is inconsistent with acceptable business or medical practice. Medicaid Waste refers to incidents that, although not fraudulent, may directly or indirectly cause financial loss.

Medical Incentive Bonuses: Arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to share savings with contracted providers (that are not related parties).

Medical Loss Ratio (MLR): MLR shall be defined as Medical Expenses divided by Earned Revenue as they relate to eligible members and services under this contract. Nebraska law requires all contracts and agreements relating to the medical assistance program governing at-risk managed care service delivery for behavioral health service shall provide for a minimum medical loss ratio of eighty five percent of the aggregate of all income and revenue earned by the Contractor and related parties under the contract.

Medical Necessity: As defined in 471 NAC 1-002.02A.

Member: An individual entitled to benefits under Title XIX or Title XXI of the Social Security Act and under the rules for participation in NE Medicaid. This term is used interchangeably with enrollee.

Module: A collection of routines and data structures that perform a specific function of the Licensed Software.

Must: Denotes the imperative, required, compulsory or obligatory.

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

Nebraska (NE) 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 MCHIP and SCHIP programs, non-institutional home and community-based services for individuals qualified for Medicaid waivers, the aged, adults and children with disabilities and infants and toddlers with special needs. NE Medicaid is administered by the Medicaid and Long Term Care (MLTC) division of the Department of Health and Human Services (DHHS).

Net Qualified Medical Expense: The amount of medical expenses that is allowed for purposes of calculating the Medical Loss Ratio and Risk Corridor. This amount is defined as the summation of the following items:

1. Claims Incurred;
2. IBNP (plus PAD, and LAE);
3. Medical Incentive Bonuses; and
4. Less "Related-Party" Medical margin.

NMES: (The Nebraska Medicaid Eligibility System.) An automated eligibility verification system for use by Medicaid service providers.

Non-Quality Improvement (QI) Administrative Rate: Non-QI Administrative Expenses are Total Administrative Expenses less QI Administrative Expenses. The Non-QI Administrative Rate equals Non-QI Expenses divided by Earned Revenue. The Allowed Non-QI Administrative Rate equals the rate allowed by MLTC for Risk Corridor calculations.

Opening Date: Specified date and time for the public opening of received, labeled and sealed formal proposals. Not to be confused with "Release Date".

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

Outsourcing: Acquiring computing or related services from a source outside of the State of Nebraska which may include programming and/or executing the State's Licensed Software on the State's CPU's, programming, and/or executing the State's programs and Licensed Software on the contractor's CPU's or any mix thereof.

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

Performance Bond: A bond given by a surety on behalf of the contractor to ensure the timely and proper (in sole estimation of the State) performance of a contract.

Performance Withhold: In accordance with Nebraska law, is defined as funds that are withheld from payment and are at risk as a penalty if the Contractor fails to meet the minimum performance metrics. The withhold amount at risk will be at least a minimum of one-quarter percent of the Earned Revenue. This amount shall be withheld from the monthly capitation payments.

PAHP: Prepaid ambulatory health plan. An entity that:

1. Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;

2. Does not provide or arrange for, or is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and
3. Does not have a comprehensive risk contract.

PCCM: Primary care case manager. A physician, a physician group practice, an entity that employs or arranges with physicians to furnish primary care case management services or, at State option, any of the following:

1. A physician assistant;
2. A nurse practitioner; and
3. A certified nurse-midwife.

PIHP (Prepaid Inpatient Health Plan): As defined by 44 NAC Sections 4701 to 4727, and 42 CFR 438.2, is an entity that

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

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

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

Potential Enrollee: A Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP, PAHP, HIO or PCCM. (Potential enrollee definition is applicable to the Information Requirements - 438.10, not to the Marketing section - 438.104.)

Pre-Proposal Conference: A meeting scheduled for the purpose of providing clarification regarding a Request for Proposal and related expectations.

Primary Care Case Management: A system under which a PCCM contracts with the State to furnish case management services (which include the locations, coordination and monitoring of primary health care services) to Medicaid recipients.

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

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

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

Prior Authorization: The act of authorizing specific services or activities before they are rendered or occur.

Product: A module, a system, or any other software-related item provided by the contractor to the State.

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

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

Project: The total of all software, documentation, and services to be provided under this contract.

Proposal: The executed document submitted by a bidder in response to a Request for Proposal.

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

Protest: A complaint about a governmental action or decision related to a Request for Proposal or the resultant contract, brought by a prospective bidder, a bidder, a contractor, or other interested party to AS Materiel Division or another designated agency with the intention of achieving a remedial result.

Provider: Either of the following:

1. For the fee-for-service program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; and
2. For the managed care program, any individual or entity 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.

Provision for Adverse Deviation (PAD): This is an explicit margin that is allowed to be reserved in addition to the IBNP to account for deviations assuming moderately adverse conditions. This amount shall be developed in accordance with actuarial standards of practice and shall not exceed 7.5% of the IBNP.

Public Proposal Opening: The process of opening proposals, conducted at the time and place specified in the Request for Proposal, and in the presence of anyone who wishes to attend.

Quality Improvement (QI) Expenses: These are expenses for the direct interaction of the insurer, providers and the enrollee or the enrollee's representatives (e.g., face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes as defined below. This category can include costs for associated activities such as:

1. Effective case management, Care coordination, and Chronic Disease Management, including:

- **a.** Patient centered intervention such as:
  - **i.** Making/verifying appointments;
  - **ii.** Medication and care compliance initiatives;
  - **iii.** Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center);
  - **iv.** Programs to support shared decision making with patients, their families and the patient's representatives;
  - **v.** Reminding insured of provider appointment, lab tests or other appropriate contact with specific providers;
  - **vi.** Incorporating feedback from the insured to effectively monitor compliance;
  - **vii.** Providing coaching or other support to encourage compliance with evidence based medicine;
  - **viii.** Activities to identify and encourage evidence based medicine;
  - **ix.** Activities to prevent avoidable hospital admissions;
  - **x.** Education and participation in self-management programs; and
  - **xi.** Medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the insured in the management program to effectively monitor compliance.
- **b.** Improve patient safety;
- **c.** Wellness and health promotion activities;
- **d.** Health Information Technology (HIT) expenses related to Quality Improvement Activities:
  - **i.** Data extraction, analysis and transmission in support of the activities described above; and
  - **ii.** Activities designed to promote sharing of medical records to ensure that all clinical providers and accurate records from all participants in a patient's care.

2. The following items are broadly excluded as not meeting the definitions above:

- **a.** All retrospective and concurrent Utilization Review;
- **b.** Fraud Prevention activities;
- **c.** The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network;
- **d.** Provider Credentialing;
- **e.** Marketing expenses;
- **f.** All Accreditation Fees;

g. Costs associated with establishing or maintaining a claims adjudication system;
h. Costs associated with calculating and administering individual enrollee or employee incentives; and
i. Any function or activity not expressly listed as approved.

Quality Improvement (QI) Administrative Rate: Equals the QI Expenses divided by the Earned Revenue.

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.

Related-Party: Parties are considered to be related if the BH-MCO, or its parent company, partially or wholly owns another entity or subsidiary that receives any revenue from the BH-MCO for Medicaid contracted services. The BH-MCO's parent company is also considered a related party. An example of "Related Party" includes the BH-MCO or its parent company owning (wholly or partially) a clinic which provides NE Medicaid services. Another example would include the BH-MCO sub-contracting services to be provided by the BH-MCO's parent company or subsidiary.

Reinsurance: Also known as stop-loss insurance, risk control, or excess insurance, is a product that provides protection against catastrophic or unpredictable losses. Specifically, this is insurance that a MCO purchases to protect itself against part or all of the losses incurred in the process of honoring the claims of members.

"Related-Party" Administrative Margin: BH-MCO contract year administrative expenses must reflect the costs that would have been incurred in the contract year in the absence of any related-party relationship. Any difference is considered "Related-Party" Administrative Margin for contract year. "Related-Party" administrative expenses are fees paid by the BH-MCO, or any of its subsidiaries, to a related party such as a parent organization.

"Related-Party" Administrative Margin equals "Related Party" Administration divided by Earned Revenue.

"Related-Party" Medical Margin: Medicaid Medical expenses must reflect the costs that would have been incurred in the absence of any related-party relationship. Any difference is considered "Related-Party" Medical Margin. An example of "Related Party" includes the BH-MCO owning (wholly or partially) a clinic which provides Medicaid services. Income statements for Medicaid services performed in the contract year shall be provided to MLTC of any "Related Party" contract that exists. The BH-MCO shall disclose and provide a written description of the related party agreement in conjunction with the related party income statements. MLTC will use these "related party income statements to verify the BH-MCO's "Related-Party" Medical Margin. MLTC reserves the right to discount any amounts in these "Related Party" contracts that it deems excessive (e.g. salaries, parent fees, overhead, etc.).

Reinsurance: Also known as stop-loss insurance, risk control, or excess insurance, is a product that provides protection against catastrophic or unpredictable losses. Specifically, this is insurance that a MCO purchases to protect itself against part or all of the losses incurred in the process of honoring the claims of members.

Release Date: Date of release of the Request for Proposal to the public for submission of proposal responses. Not to be confused with "Opening Date".

Renewal: Continuance of a contract for an additional term after a formal signing by the parties.

Representative: Includes an agent, an officer of a corporation or association, a trustee, executor or administrator of an estate, or any other person legally empowered to act for another.

Request for Proposal (RFP): All documents, whether attached or incorporated by reference, utilized for soliciting competitive proposals.

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

Responsive Bidder: A bidder who has submitted a bid which conforms in all respects to the solicitation document.

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

Shall: Denotes the imperative, required, compulsory or obligatory.

Should: Indicates an expectation.

Solicitation: The process of notifying prospective bidders or offerors that the State of Nebraska wishes to receive proposals for furnishing services. The process may consist of public advertising, posting notices, or mailing Request for Proposals and/or Request for Proposal announcement letter to prospective bidders, or all of these.

Solicitation Document: Request for Proposal.

Specifications: The information provided by or on behalf of the contractor that fully describes the capabilities and functionality of the Licensed Software as set forth in any material provided by the contractor, including the documentation and User's Manuals described herein.

Statutory Accounting Principles (STAT): A set of accounting regulations prescribed by the National Association of Insurance Commissioners for the preparation of an insuring firm's financial statements.

Subcontractor: Any organization or person who provides a function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations under the terms of the Agreement. Subcontractor does not include provider unless the provider is responsible for services other than those that could be covered in a provider agreement.

System: 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. All obligations which are still executory on both sides are discharged but any right based on prior breach or performance survives.

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

Total Administration 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 one (CY1). 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.; and
3. Net Cost of Reinsurance: Reinsurance Premium less projected reinsurance recoveries. Net Cost of Related party reinsurance will be excluded.

Trademark: A distinguishing sign, symbol, mark, word, or arrangement of words in the form of a label or other indication, that is adopted and used by a manufacturer or distributor to designate its particular goods and which no other person has the legal right to use.

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, 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)).

Upgrade: Any improvement or change in the Software that improves or alters its basic function.

Value-Added Health Services: Those services a BH-MCO supply as a replacement for a service covered under this Contract because the BH-MCO has determined that the health status and quality of life for the enrollee is expected to be the same or better using the Value-Added Health Service as it would be using the Covered Service.

Vendor: An actual or potential contractor; a contractor.

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: Denotes the imperative, required, compulsory or obligatory.

GLOSSARY OF ACRONYMS

ACT: Assertive Community Treatment

ASO: Administrative Services Organization

BH-MCO: Behavioral Health Managed Care Organization

CAFCON: Children and Families Coalition of Nebraska

CAP: Client Assistant Program

CCAA: Comprehensive Child and Adolescent Assessment

CFR: Code of Federal Regulations

CLAS: Culturally and Linguistically Appropriate Services

CHIP: Nebraska Children's Health Insurance Program

CMHS: Center for Mental Health Services

CQI: Continuous Quality Improvement

CTA: Community Treatment Aide

CY: Calendar Year

DBH: Division of Behavioral Health

DCFS: Division of Children and Family Services

DDD: Division of Developmental Disabilities

DHHS: Nebraska Department of Health and Human Services

DOI: Department of Insurance

DUR: Drug Utilization Review

ECT: Electroconvulsive Therapy

ED: Emergency Department

EPSDT: Early and Periodic Screening, Diagnosis and Treatment

EQR: External Quality Review

EQRO: External Quality Review Organization

FQHC: Federally Qualified Health Center

FTE: Full Time Employee

FY: Fiscal Year

HIT: Health Information Technology

HMO: Health Maintenance Organization

IBNR: Incurred But Not Reported

ICM: Intensive Case Manager

IHS: Indian Health Service

IOP: Intensive Outpatient Program

LEIE: List of Excluded Individual Entities

MCO: Managed Care Organization

MED: Medicare Exclusion Database

MFCU: Medicaid Fraud Control Unit

MLR: Medical Loss Ratio

MLTC: Nebraska DHHS, Division of Medicaid and Long-Term Care

MRO: Medicaid Rehabilitation Option

NAADAC: The Association for Addiction Professionals (National Association of Alcoholism Counselors and Trainers)

NABHO: Nebraska Association of Behavioral Health Organizations

NAC: Nebraska Administrative Code

NCAAPN: Nebraska Chapter of the American Association of Psychiatric Nurses

NCNASW: Nebraska Chapter of the National Association of Social Workers

NCQA: National Committee for Quality Assurance

NE PACE: Nebraska Medicaid Program of All-inclusive Care for the Elderly

NHA: Nebraska Hospital Association

NMA: Nebraska Medical Association

NMMPH: Nebraska Medicaid Managed Physical Health

NPA: Nebraska Psychiatric Society
NPS: Nebraska Psychological Association

OOH: Out of Home

OIG: Office of the Inspector General

PH-MCO: Physical Health Managed Care Organization

PRFC: Professional Resource Family Care

PTRF: Psychiatric Residential Treatment Facilities

QAPI: Quality Assurance and Performance Improvement

QI: Quality Improvement

QM: Quality Management

QOC: Quality of Care

RBHA: Regional Behavioral Health Authority

RHC: Rural Health Clinic

SAMHSA: Substance use disorder and Mental Health Services Administration

SAPT: Substance use disorder Prevention and Treatment

SED: Serious Emotional Disorder

ThGH: Therapy Group Home

TPR: Third Party Resources

TPL: Third Party Liability

UM: Utilization Management

I. SCOPE OF THE REQUEST FOR PROPOSAL

The State of Nebraska, Administrative Services (AS), Materiel Division, Purchasing Bureau (hereafter known as State Purchasing Bureau), is issuing this Request for Proposal, RFP Number 4166Z1 for the purpose of selecting a qualified contractor to provide a full-risk capitated rate Medicaid Managed Care program for Mental Health and Substance Use Disorder services with the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care.

A contract resulting from this Request for Proposal will be issued for a period of three (3) years effective from date of contract award through June 30, 2016, with the option to renew for two (2) additional one (1) year periods as mutually agreed upon by all parties.

ALL INFORMATION PERTINENT TO THIS REQUEST FOR PROPOSAL CAN BE FOUND ON THE INTERNET AT: http://www.das.state.ne.us/materiel/purchasing/rfp.htm

A. SCHEDULE OF EVENTS

The State expects to adhere to the tentative procurement schedule shown below. It should be noted, however, that some dates are approximate and subject to change.

	ACTIVITY	DATE/TIME
1.	Release Request for Proposal	October 24, 2012
2.	Last day to submit first round written questions.	November 6, 2012
3.	State responds to first round written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://www.das.state.ne.us/materiel/purchasing/rfp.htm	November 20, 2012
4.	Last day to submit second round written questions.	November 27, 2012
5.	State responds to second round written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://www.das.state.ne.us/materiel/purchasing/rfp.htm	December 11, 2012
6.	Proposal opening Location: Nebraska State Office Building State Purchasing Bureau 301 Centennial Mall South, Mall Level Lincoln, NE 68508	January 7, 2013 2:00 PM Central Time
7.	Review for conformance of mandatory requirements	January 7, 2013
8.	Evaluation period	January 7 to January 24, 2013
9.	"Oral Interviews/Presentations and/or Demonstrations" (if required)	To Be Determined
10.	Post "Letter of Intent to Contract" to Internet at: http://www.das.state.ne.us/materiel/purchasing/rfp.htm	To Be Determined
11.	Performance bond submission	February 15, 2013
12.	Contract award	April 15, 2013
13.	Contractor start date	September 1, 2013

II. PROCUREMENT PROCEDURES

A. PROCURING OFFICE AND CONTACT PERSON

Procurement responsibilities related to this Request for Proposal reside with the State Purchasing Bureau. The point of contact for the procurement is as follows:

Name: Ruth Gray
Agency: State Purchasing Bureau
Address: 301 Centennial Mall South, Mall Level
Lincoln, NE 68508

OR

Address: P.O. Box 94847
Lincoln, NE 68509
Telephone: 402-471-2401
Facsimile: 402-471-2089
E-Mail: matpurch.dasmat@nebraska.gov

B. GENERAL INFORMATION

The Request for Proposal is designed to solicit proposals from qualified vendors who will be responsible for providing a full-risk capitated rate Medicaid Managed Care program for Mental Health and Substance Use Disorder services with the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care, hereafter referred to as "MLTC", at a competitive and reasonable cost.

Proposals that do not conform to the mandatory items as indicated in the Request for Proposal will not be considered.

Proposals shall conform to all instructions, conditions, and requirements included in the Request for Proposal. Prospective bidders are expected to carefully examine all documentation, schedules and requirements stipulated in this Request for Proposal, and respond to each requirement in the format prescribed.

A fixed-price contract will be awarded as a result of this proposal. In addition to the provisions of this Request for Proposal and the awarded proposal, which shall be incorporated by reference in the contract, any additional clauses or provisions required by the terms and conditions will be included as an amendment to the contract.

C. COMMUNICATION WITH STATE STAFF

From the date the Request for Proposal is issued until a determination is announced regarding the selection of the contractor, contact regarding this project between potential contractors and individuals employed by the State is restricted to only written communication with the staff designated above as the point of contact for this Request for Proposal.

Once a contractor is preliminarily selected, as documented in the intent to contract, that contractor is restricted from communicating with State staff until a contract is signed. Violation of this condition may be considered sufficient cause to reject a contractor's proposal and/or selection irrespective of any other condition.

The following exceptions to these restrictions are permitted:

1. Written communication with the person(s) designated as the point(s) of contact for this Request for Proposal or procurement;

2. Contacts made pursuant to any pre-existing contracts or obligations; and
3. State staff and/or contractor staff present at the Pre-Proposal Conference when recognized by the State Purchasing Bureau staff facilitating the meeting for the purpose of addressing questions; and
4. State-requested presentations, key personnel interviews, clarification sessions or discussions to finalize a contract.

Violations of these conditions may be considered sufficient cause to reject a bidder's proposal and/or selection irrespective of any other condition. No individual member of the State, employee of the State, or member of the Evaluation Committee is empowered to make binding statements regarding this Request for Proposal. The buyer will issue any clarifications or opinions regarding this Request for Proposal in writing.

D. WRITTEN QUESTIONS AND ANSWERS

Any explanation desired by a bidder regarding the meaning or interpretation of any Request for Proposal provision must be submitted in writing to the State Purchasing Bureau and clearly marked "RFP Number 4166Z1; A full-risk capitated rate Medicaid Managed Care Program Questions". It is preferred that questions be sent via e-mail to matpurch.dasmat@nebraska.gov. Questions may also be sent by facsimile to 402-471-2089, but must include a cover sheet clearly indicating that the transmission is to the attention of Ruth Gray, showing the total number of pages transmitted, and clearly marked "RFP Number 4166Z1; A full-risk capitated rate Medicaid Managed Care Program Questions".

Written answers will be provided through an addendum to be posted on the Internet at http://www.das.state.ne.us/materiel/purchasing/rfp.htm on or before the date shown in the Schedule of Events.

E. ORAL INTERVIEWS/PRESENTATIONS AND/OR DEMONSTRATIONS

The Evaluation Committee(s) may conclude after the completion of the Technical Proposal evaluation that oral interviews/presentations and/or demonstrations are required in order to determine the successful bidder. All bidders may not have an opportunity to interview/present and/or give demonstrations; the State reserves the right to select only the top scoring bidders to present/give oral interviews in its sole discretion. The scores from the oral interviews/presentations and/or demonstrations will be added to the scores from the Technical 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 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. Bidders shall not be allowed to alter or amend their proposals. Only representatives of the State and the presenting bidders will be permitted to attend the oral interviews/presentations and/or demonstrations.

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

Detailed notes of oral interviews/presentations and/or demonstrations may be recorded and supplemental information (such as briefing charts, et cetera) may be accepted; however, such supplemental information shall not be considered an amendment to a bidders' proposal. Additional written information gathered in this manner shall not constitute replacement of proposal contents.

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.

F. SUBMISSION OF PROPOSALS

The following describes the requirements related to proposal submission, proposal handling and review by the State.

To facilitate the proposal evaluation process, one (1) original, clearly identified as such, and seven (7) copies of the entire proposal should be submitted. The copy marked “original” shall take precedence over any other copies, should there be a discrepancy. Proposals must be submitted by the proposal due date and time. A separate sheet must be provided that clearly states which sections have been submitted as proprietary or have copyrighted materials. All proprietary information the bidder wishes the State to withhold must be submitted in accordance with the instructions outlined in Section III, Proprietary Information. Proposal responses should include the completed Form A, Bidder Contact Sheet. Proposals must reference the request for proposal number and be sent to the specified address. Container(s) utilized for original documents should be clearly marked “ORIGINAL DOCUMENTS”. Please note that the address label should appear as specified in Section II part A on the face of each container or bidder’s bid response packet. Rejected late proposals will be returned to the bidder unopened, if requested, at bidder's expense. If a recipient phone number is required for delivery purposes, 402-471-2401 should be used. The request for proposal number must be included in all correspondence.

Emphasis should be concentrated on conformance to the Request for Proposal 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, it is likely that points will be lost in the evaluation process. Elaborate and lengthy proposals are neither necessary nor desired.

The Technical Proposal should be packaged separately (loose-leaf binders are preferred) on standard 8 ½” by 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 must 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 must not contain any reference to dollar amounts. 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 Technical Proposal instructions.

G. PROPOSAL OPENING

The sealed proposals will be publicly opened and the bidding entities announced on the date, time and location shown in the Schedule of Events. Proposals will be available for viewing by those present after the proposal opening. Vendors may also contact the State to schedule an appointment for viewing proposals after the opening date.

H. LATE PROPOSALS

Proposals received after the time and date of the proposal opening will be considered late proposals. Rejected late proposals will be returned to the bidder unopened, if requested, at bidder's expense. The State is not responsible for proposals that are late or lost due to mail service inadequacies, traffic or any other reason(s).

I. REJECTION OF PROPOSALS

The State reserves the right to reject any or all proposals, wholly or in part, or to award to multiple bidders in whole or in part. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State.

J. EVALUATION OF PROPOSALS

All responses to this Request for Proposal which fulfill all mandatory requirements will be evaluated. Each category will have a maximum possible point potential. The State will conduct a fair, impartial and comprehensive evaluation of all proposals in accordance with the criteria set forth below. Areas that will be addressed and scored during the evaluation include:

1. Executive Summary;

2. Corporate Overview shall 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 Request for Proposal;
- **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 bidder performance on prior contracts;
- **e.** Such other information that may be secured and that has a bearing on the decision to award the contract, including but not limited to:
  - **i.** Proof of financial stability in the form of audited financial statements, Dunn & Bradstreet reports, or, if these are not available, unaudited or pro-forma statements; and
  - **ii.** Corporate Resolution, Certificate of Good Standing Certificate, together with any and all amendments thereto; Partnership Agreement; or other relevant business organizational documents, as applicable.

3. Technical Approach.

Evaluation criteria will become public information at the time of the Request for Proposal opening. Evaluation criteria and a list of respondents will be posted to the State Purchasing Bureau website at http://www.das.state.ne.us/materiel/purchasing/rfp.htm Evaluation criteria will not be released prior to the proposal opening.

K. EVALUATION COMMITTEE

Proposals will be independently evaluated by members of the Evaluation Committee(s). The committee(s) will consist of staff with the appropriate expertise to conduct such proposal evaluations. Names of the members of the Evaluation Committee(s) will not become public information.

Prior to award, Bidders are advised that only the point of contact indicated on the front cover of this Request For Proposal For Contractual Services Form can clarify issues or render any opinion regarding this Request for Proposal. No individual member of the State, employee of the State or member of the Evaluation Committee(s) is empowered to make binding statements regarding this Request for Proposal.

L. MANDATORY REQUIREMENTS

The proposals will first be examined to determine if all mandatory requirements listed below have been addressed to warrant further evaluation. Proposals not meeting mandatory requirements will be excluded from further evaluation. The mandatory requirement items are as follows:

1. Signed, in ink, Request For Proposal For Contractual Services form;
2. Executive Summary;
3. Corporate Overview:

- **a.** Proof of financial stability in the form of audited financial statements, Dunn & Bradstreet reports, or, if these are not available, unaudited or pro-forma statements; and
- **b.** Corporate Resolution, Certificate of Good Standing Certificate, together with any and all amendments thereto; Partnership Agreement; or other relevant business organizational documents, as applicable.

4. Technical Approach; and
5. The applicant's Prepaid Limited Health Service Organization Act certificate of authority, pursuant to Nebraska Revised Statute 44-4701 et.seq.

M. REFERENCE CHECKS

The State reserves the right to check any reference(s), regardless of the source of the reference information, including but not limited to, those that are identified by the company in the proposal, those indicated through the explicitly specified contacts, those that are identified during the review of the proposal, or those that result from communication with other entities involved with similar projects.

Information to be requested and evaluated from references may include, but is not limited to, some or all of the following: project description and background, job performed, functional and technical abilities, communication skills and timeliness, cost and schedule estimates and accuracy, problems (poor quality deliverables, contract disputes, work stoppages, et cetera), overall performance, and whether or not the reference would rehire the firm or individual. Only top scoring bidders may receive reference checks and negative references may eliminate bidders from consideration for award.

N. SECRETARY OF STATE/TAX COMMISSIONER REGISTRATION REQUIREMENTS

All bidders are expected to comply with any statutory registration requirements. It is the responsibility of the bidder who is the recipient of an Intent to Award to comply with any statutory registration requirements pertaining to types of business entities (e.g. a foreign or Nebraska corporation, non-resident contractor, limited partnership, or other type of business entity). The bidder who is the recipient of Intent to Award will be required to certify that it has so complied and produce a true and exact copy of its registration certificate, or, in the case registration is not required, to provide the reason as to why none is required. This must be accomplished prior to the award of contract.

O. VIOLATION OF TERMS AND CONDITIONS

Violation of the terms and conditions contained in this Request for Proposal 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; and

2. 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.

III. TERMS AND CONDITIONS

By signing the "Request For Proposal For Contractual Services" form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the terms and conditions and certifies bidder maintains a drug free work place environment.

Bidders are expected to closely read the Terms and Conditions and provide a binding signature of intent to comply with the Terms and Conditions; provided, however, a bidder may indicate any exceptions to the Terms and Conditions by (1) clearly identifying the term or condition by subsection, (2) including an explanation for the bidder's inability to comply with such term or condition which includes a statement recommending terms and conditions the bidder would find acceptable. Rejection in whole or in part of the Terms and Conditions may be cause for rejection of a bidder's proposal.

A. GENERAL

_____ Accept & Initial

The contract resulting from this Request for Proposal shall incorporate the following documents:

1. The signed Request For Proposal form;
2. The original Request for Proposal document;
3. Any Request for Proposal addenda and/or amendments to include questions and answers;
4. The contractor's proposal;
5. Any contract amendments, in order of significance; and
6. Contract award.

Unless otherwise specifically stated in a 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) the contract award, 2) contract amendments with the latest dated amendment having the highest priority, 3) Request for Proposal addenda and/or amendments with the latest dated amendment having the highest priority, 4) the original Request for Proposal, 5) the signed Request For Proposal form, 6) the contractor's proposal.

Any ambiguity in any provision of this contract which shall be discovered after its execution shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

Once proposals are opened they become the property of the State of Nebraska and will not be returned.

B. AWARD

_____ Accept & Initial

All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the Request for Proposal. The State reserves the right to reject any or all proposals, wholly or in part, or to award to multiple bidders in whole or in part, and at its discretion, may withdraw or amend the Request for Proposal at any time. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State. The Request for Proposal does not commit the State to award a contract. If, in the opinion of the State, revisions or amendments will require substantive changes in proposals, the due date may be extended.

By submitting a proposal in response to this Request for Proposal, 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.

Once an intent to award decision has been determined, it will be posted to the Internet at: http://www.das.state.ne.us/materiel/purchasing/rfp.htm

Grievance and protest procedure is available on the Internet at: http://www.das.state.ne.us/materiel/purchasing/agencyservicesprocurementmanual/ProtestGrievanceProcedureForServices.doc

Any protests must be filed by a vendor within ten (10) calendar days after the intent to award decision is posted to the Internet.

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

_____ Accept & Initial

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 or privileges of employment because of race, color, religion, sex, disability, 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 services to be covered by any contract resulting from this Request for Proposal.

D. PERMITS, REGULATIONS, LAWS

_____ Accept & Initial

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

E. OWNERSHIP OF INFORMATION AND DATA

_____ Accept & Initial

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

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

F. INSURANCE REQUIREMENTS

_____ Accept & Initial

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

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

1. WORKERS' COMPENSATION INSURANCE

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

2. COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE

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

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

3. INSURANCE COVERAGE AMOUNTS REQUIRED

a. WORKERS' COMPENSATION AND EMPLOYER'S LIABILITY

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

b. COMMERCIAL GENERAL LIABILITY

General Aggregate	$10,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 any one person
Bodily Injury/Property Damage	$1,000,000 per occurrence
Fire Damage	$50,000 any one fire
Medical Payments	$5,000 any one person

c. COMMERCIAL AUTOMOBILE LIABILITY

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

d. UMBRELLA/EXCESS LIABILITY

Over Primary Insurance	$1,000,000 per occurrence

4. EVIDENCE OF COVERAGE

The contractor should furnish the State, with their proposal response, a certificate of insurance coverage complying with the above requirements to the attention of the Buyer, Administrative Services, State Purchasing Bureau, 301 Centennial Mall S, 1st Fl, Lincoln, NE 68508 (facsimile 402-471-2089). 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.

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

G. COOPERATION WITH OTHER CONTRACTORS

_____ Accept & Initial

The State may already have in place or choose to award supplemental contracts for work related to this Request for Proposal, or any portion thereof.

1. The State reserves the right to award the contract jointly between two or more potential contractors, if such an arrangement is in the best interest of the State.

2. The contractor shall agree to cooperate with such other contractors, and shall not commit or permit any act which may interfere with the performance of work by any other contractor.

H. INDEPENDENT CONTRACTOR

_____ Accept & Initial

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

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

I. CONTRACTOR RESPONSIBILITY

_____ Accept & Initial

The contractor is solely responsible for fulfilling the contract, with responsibility for all services offered and products to be delivered as stated in the Request for Proposal, the contractor's proposal, and the resulting contract. The contractor shall be the sole point of contact regarding all contractual matters.

If the contractor intends to utilize any subcontractors' services, the subcontractors' level of effort, tasks and time allocation must 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. Following execution of the contract, the contractor shall proceed diligently with all services and shall perform such services with qualified personnel in accordance with the contract.

J. CONTRACTOR PERSONNEL

Accept & Initial

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

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

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

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

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

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

K. STATE OF NEBRASKA PERSONNEL RECRUITMENT PROHIBITION

Accept & Initial

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

L. CONFLICT OF INTEREST

Accept & Initial

By submitting a proposal, bidder certifies that there does not now exist any relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this Request for Proposal or project.

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

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

M. PROPOSAL PREPARATION COSTS

_____ Accept & Initial

The State shall not incur any liability for any costs incurred by bidders in replying to this Request for Proposal, in the demonstrations, or oral presentations, or in any other activity related to bidding on this Request for Proposal.

N. ERRORS AND OMISSIONS

_____ Accept & Initial

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

O. BEGINNING OF WORK

_____ Accept & Initial

The 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.

P. ASSIGNMENT BY THE STATE

_____ Accept & Initial

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

Q. ASSIGNMENT BY THE CONTRACTOR

_____ Accept & Initial

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

R. DEVIATIONS FROM THE REQUEST FOR PROPOSAL

_____ Accept & Initial

The requirements contained in the Request for Proposal become a part of the terms and conditions of the contract resulting from this Request for Proposal. Any deviations from the Request for Proposal 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 Request for Proposal or mandatory requirements. “Deviation”, for the purposes of this RFP, means any proposed changes or alterations to either the contractual language or deliverables within the scope of this RFP. The State discourages deviations and reserves the right to reject proposed deviations.

S. GOVERNING LAW

_____ Accept & Initial

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

T. ATTORNEY'S FEES

_____ Accept & Initial

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

U. ADVERTISING

_____ Accept & Initial

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

V. STATE PROPERTY

Accept & Initial

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

W. SITE RULES AND REGULATIONS

Accept & Initial

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

X. NOTIFICATION

Accept & Initial

During the bid process, all communication between the State and a bidder shall be between the bidder's representative clearly noted in its proposal and the buyer noted in Section II, A. Procuring Office and Contact Person of this RFP. After the award of the contract, all notices under the contract shall be deemed duly given upon delivery to the staff designated as the point of contact for this Request for Proposal, in person, or upon delivery by U.S. Mail, facsimile, or e-mail. Each bidder should provide in its proposal the name, title and complete address of its designee to receive notices.

1. Except as otherwise expressly specified herein, all notices, requests or other communications shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth above, 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 three (3) days following deposit in the mail.

2. Whenever the contractor encounters any difficulty which is delaying or threatens to delay its timely performance under the contract, the contractor shall immediately give notice thereof in writing to the State reciting all relevant information with respect thereto. Such notice shall not in any way constitute a basis for an extension of the delivery schedule or be construed as a waiver by the State of any of its rights or remedies to which it is entitled by law or equity or pursuant to the provisions of the contract. Failure to give such notice, however, may be grounds for denial of any request for an extension of the delivery schedule because of such delay.

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.

For the duration of the contract, all communication between contractor and the State regarding the contract shall take place between the contractor and individuals specified by the State in writing. Communication about the contract between contractor and individuals not designated as points of contact by the State is strictly forbidden.

Y. EARLY TERMINATION

_____
Accept & Initial

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) days written notice to the contractor. Such termination shall not relieve the contractor of warranty or other service obligations incurred under the terms of the contract. In the event of cancellation the contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.

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

- **a.** If directed to do so by statute;
- **b.** Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;
- **c.** A trustee or receiver of the contractor or of any substantial part of the contractor's assets has been appointed by a court;
- **d.** Fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its contractor, its employees, officers, directors or shareholders;
- **e.** An involuntary proceeding has been commenced by any party against the contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) days; or (ii) the contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the contractor has been decreed or adjudged a debtor;
- **f.** A voluntary petition has been filed by the contractor under any of the chapters of Title 11 of the United States Code;
- **g.** Contractor intentionally discloses confidential information;
- **h.** Second or subsequent documented "vendor performance report" form deemed acceptable by the State Purchasing Bureau; or

Z. FUNDING OUT CLAUSE OR LOSS OF APPROPRIATIONS

_____
Accept & Initial

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

AA. BREACH BY CONTRACTOR

_____ Accept & Initial

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

BB. ASSURANCES BEFORE BREACH

_____ Accept & Initial

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

CC. ADMINISTRATIVE SPENDING CAP

_____ Accept & Initial

The State shall place a contractual cap on administrative spending by an MCO of seven percent (7%) The Contractor is required to track such expenditures and provide a detailed report of Administrative expenditures on a quarterly basis. Administrative expenditures do not include additional profit and any necessary administrative spending used to improve the health status of members served should not at any time exceed ten percent (10%).

DD. PROFIT/LOSS CAP AND REINVESTMENT

_____ Accept & Initial

Total profit by an MCO shall not exceed three percent (3%) per year and losses shall not exceed three percent (3%) per year as an aggregate of all income and revenue earned by the Contractor and related parties, including parent and subsidy companies and risk-bearing partners, under contract. The MCO must provide for reinvestment of any profits in excess of the contracted amount, performance contingencies imposed by the MLTC, and any unearned incentive funds to fund additional behavioral health services for children, families and adults according to a plan developed with input from stakeholders, consumers and their family members, the office of consumer affairs within MLTC, and the Regional Behavioral Health Authority. Such plan must be approved by MLTC. The Reinvestment Plan must address the behavioral health needs of adults and children, including filling service gaps and providing system improvements, provide for a minimum medical loss ratio of eighty-five percent (85%) of the aggregate of all income and revenue earned by the Contractor and related parties under the contract and provide that Contractor incentives, in addition to potential profit, be at least one and one-half percent (1 ½%) of the aggregate of all income and revenue earned by the Contractor and related parties under contract.

EE. PENALTY

_____ Accept & Initial

In the event that the contractor fails to perform any substantial obligation under the contract, the State may withhold all monies due and payable to the contractor, without penalty, until such failure is cured or otherwise adjudicated. Failure to meet the dates stipulated in the contract for the deliverables may result in an assessment of penalty due the State of $1,000.00 dollars per day, until the deliverables are approved. Contractor will be notified in writing when penalty will commence.

FF. PERFORMANCE BOND

Accept & Initial

The Contractor shall obtain and maintain a performance bond, rated at least A by A.M. Best Company, of a standard commercial scope from a surety company or companies holding a certificate of authority to transact surety business in the state. The Contractor shall not leverage the bond as collateral for debt or create other creditors using the bond as security. The Contractor shall be in breach of this contract if it fails to maintain or renew the performance bond as required by this contract.

1. The Contractor shall obtain a certified check or performance bond in an amount equal to ten million dollars ($10,000,000.00). The check or bond will guarantee that the selected contractor will faithfully perform all requirements, terms and conditions of the contract. Failure to comply shall be grounds for forfeiture of the check or bond as liquidated damages. Amount of forfeiture will be determined by the agency based on loss to the State. The bond or certified check will be returned when the service has been satisfactorily completed as solely determined by the State, after termination or expiration of the contract.

2. The Contractor agrees that if it is declared to be in default of any term of this contract, MLTC may elect to, in addition to any other remedies it may have under this contract, obtain payment under the performance bond for the following:

- **a.** Making funds available through a consensus proceeding in the appropriate court for payment to subcontracted providers and non-contracted health care providers for reimbursement due to nonpayment of claims by Contractor, in the event of a breach of Contractor's obligation under this contract;
- **b.** Reimbursing MLTC for any payments made by MLTC on behalf of the Contractor;
- **c.** Reimbursing MLTC for any extraordinary administrative expenses incurred by a breach of Contractor's obligations under this contract, including, expenses incurred after termination of this contract by MLTC;
- **d.** Making any payments or expenditures deemed necessary to MLTC, in its sole discretion, incurred by MLTC in the direct operation of the contract pursuant to the terms of this contract and to reimburse MLTC for any extraordinary administrative expenses incurred in connection with the direct operation of the Contractor; and
- **e.** The Contractor shall reimburse MLTC for expenses exceeding the performance bond amount.

GG. FORCE MAJEURE

Accept & Initial

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

HH. PAYMENT

_____ Accept & Initial

State will render payment to contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the contractor as solely determined by the State. Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408). The State 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 services provided by the contractor prior to the Effective Date, and the contractor hereby waives any claim or cause of action for any such services.

II. INVOICES

_____ Accept & Initial

Invoices for payments must be submitted by the contractor to the agency requesting the services with sufficient detail to support payment. The terms and conditions included in the contractor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract.

JJ. AUDIT REQUIREMENTS

_____ Accept & Initial

All contractor books, records and documents relating to work performed or monies received under the contract shall be subject to audit at any reasonable time upon the provision of reasonable notice by the State. These records shall be maintained for a period of five (5) full years from the date of final payment, or until all issues related to an audit, litigation or other action are resolved, whichever is longer. All records shall be maintained in accordance with generally accepted accounting principles.

In addition to, and in no way in limitation of any obligation in the contract, the contractor shall agree that it will be held liable for any State audit exceptions, and shall return to the State all payments made under the contract for which an exception has been taken or which has been disallowed because of such an exception. The contractor agrees to correct immediately any material weakness or condition reported to the State in the course of an audit.

KK. TAXES

_____ Accept & Initial

The State is not required to pay taxes of any kind and assumes no such liability as a result of this solicitation. Any property tax payable on the contractor's equipment which may be installed in a state-owned facility is the responsibility of the contractor.

LL. INSPECTION AND APPROVAL

_____ Accept & Initial

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.

MM. CHANGES IN SCOPE/CHANGE ORDERS

_____ Accept & Initial

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

The State may, at any time work is in progress, by written order, make alterations in the terms of work as shown in the specifications, require the performance of extra work, decrease the quantity of work, or make such other changes as the State may find necessary or desirable. The contractor shall not claim forfeiture of contract by reasons of such changes by the State. Changes in work and the amount of compensation to be paid to the contractor for any extra work so ordered shall be determined in accordance with the applicable unit prices of the contractor's proposal.

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

NN. SEVERABILITY

Accept & Initial

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

OO. CONFIDENTIALITY

Accept & Initial

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

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

PP. PROPRIETARY INFORMATION

Accept & Initial

Data contained in the proposal and all documentation provided therein, become the property of the State of Nebraska and the data becomes public information upon opening the proposal. If the bidder wishes to have any information withheld from the public, such information must fall within the definition of proprietary information contained within Nebraska's public record statutes. All proprietary information the bidder wishes the State to withhold must be submitted in a sealed package, which is separate from the remainder of the proposal. The separate package must be clearly marked PROPRIETARY on the outside of the package. Bidders may not mark their entire Request for Proposal as proprietary. Bidder's cost proposals may not be marked as proprietary information. Failure of the bidder to follow the instructions for submitting proprietary and copyrighted information may result in the information being viewed by other bidders and the public. Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, bidders submitting information as proprietary may be required to prove specific, named competitor(s) who would be advantaged by release of the information and the specific

advantage the competitor(s) would receive. Although every effort will be made to withhold information that is properly submitted as proprietary and meets the State's definition of proprietary information, the State is under no obligation to maintain the confidentiality of proprietary information and accepts no liability for the release of such information.

QQ. CERTIFICATION OF INDEPENDENT PRICE DETERMINATION/COLLUSIVE BIDDING

_____ Accept & Initial

By submission of this proposal, the bidder certifies, that he or she is the party making the foregoing proposal that the proposal is not made in the interest of, or on behalf of, any undisclosed person, partnership, company, association, organization, or corporation; that the proposal is genuine and not collusive or sham; that the bidder has not directly or indirectly induced or solicited any other bidder to put in a false or sham proposal, and has not directly or indirectly colluded, conspired, connived, or agreed with any bidder or anyone else to put in a sham proposal, or that anyone shall refrain from bidding; that the bidder has not in any manner, directly or indirectly, sought by agreement, communication, or conference with anyone to fix the proposal price of the bidder or any other bidder, or to fix any overhead, profit, or cost element of the proposal price, or of that of any other bidder, or to secure any advantage against the public body awarding the contract of anyone interested in the proposed contract; that all statements contained in the proposal are true; and further that the bidder has not, directly or indirectly, submitted his or her proposal price or any breakdown thereof, or the contents thereof, or divulged information or data relative thereto, or paid, and will not pay, any fee to any corporation, partnership, company association, organization, proposal depository, or to any member or agent thereof to effectuate a collusive or sham proposal.

RR. PRICES

_____ Accept & Initial

All prices, costs, terms and conditions outlined in the proposal shall remain fixed and valid commencing on the opening date of the proposal until an award is made (and for bidder receiving award prices shall remain as bid for the duration of the contract unless otherwise so stated in the contract) or the Request for Proposal is cancelled.

SS. BEST AND FINAL OFFER

_____ Accept & Initial

The State will compile the final scores for all parts of each proposal. The award may be granted to the highest scoring responsive and responsible bidder. Alternatively, the highest scoring bidder or bidders may be requested to submit best and final offers. If best and final offers are requested by the State and submitted by the bidder, they will be evaluated (using the stated criteria), scored and ranked by the Evaluation Committee. 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.

TT. ETHICS IN PUBLIC CONTRACTING

_____ Accept & Initial

No bidder shall pay or offer to pay, either directly or indirectly, any fee, commission compensation, gift, gratuity, or anything of value to any State officer, legislator or employee based on the understanding that the receiving person's vote, actions or judgment will be influenced thereby. No bidder shall give any item of value to any employee of the State Purchasing Bureau.

Bidders shall be prohibited from utilizing the services of lobbyists, attorneys, political activists, or consultants to secure the contract. It is the intent of this provision to assure that the prohibition of state contact during the procurement process is not subverted through the use of lobbyists, attorneys, political activists, or consultants. It is the intent of the State that the process of evaluation of proposals and award of the contract be completed without external influence. It is not the intent of this section to prohibit bidders from seeking professional advice, for example consulting legal counsel, regarding terms and conditions of this Request for Proposal or the format or content of their proposal.

If the bidder is found to be in non-compliance with this section of the Request for Proposal, they may forfeit the contract if awarded to them or be disqualified from the selection process.

UU. INDEMNIFICATION

Accept & Initial

1. GENERAL

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

2. INTELLECTUAL PROPERTY

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

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

3. PERSONNEL

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

VV. NEBRASKA TECHNOLOGY ACCESS STANDARDS

Accept & Initial

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

WW. ANTITRUST

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

_____ Accept & Initial

XX. DISASTER RECOVERY/BACK UP PLAN

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

_____ Accept & Initial

YY. TIME IS OF THE ESSENCE

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

_____ Accept & Initial

ZZ. RECYCLING

Preference will be given to items which are manufactured or produced from recycled material or which can be readily reused or recycled after their normal use as per state statute (Neb. Rev. Stat. §81-15, 159).

_____ Accept & Initial

AAA. DRUG POLICY

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

_____ Accept & Initial

BBB. NEW EMPLOYEE WORK ELIGIBILITY STATUS

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of new 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 a newly hired employee.

_____ Accept & Initial

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 www.das.state.ne.us.

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

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

CCC. CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND INELIGIBILITY

_____
Accept
& Initial

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

IV. PROJECT DESCRIPTION AND SCOPE OF WORK

The bidder must provide the following requested information in response to this Request for Proposal.

A. PROJECT OVERVIEW

The State of Nebraska's Medicaid program, administered through the Department of Health and Human Services, Division of Medicaid & Long-Term Care (MLTC) is seeking proposals to develop a unique and visionary plan for a full-risk capitated Mental Health and Substance Use Disorder Managed Care program for Medicaid and Children's Health Insurance Program (CHIP) members. The program must be integrated and coordinated for multiple Medicaid/CHIP populations within the managed care structure, including but not limited to the developmental disabilities population, state wards, dually Medicare and Medicaid eligible population, and those with severe mental illness and substance abuse.

The purpose of this Request for Proposal (RFP) is to select, through a competitive procurement process, a qualified bidder to operate a pre-paid inpatient health plan (PIHP), as defined in 42 CFR 438.2. The PIHP will provide Mental Health and Substance Use Disorder services to children, youth, and adults enrolled in the Nebraska Medicaid/CHIP programs. The program will be referred to as the Nebraska Behavioral Health (BH) Managed Care program. A qualified vendor will meet the requirements for experience and expertise to perform the services as described throughout this document. MLTC will select one vendor for a statewide program that meets these requirements.

B. PRINCIPLES OF CARE

The following principles will guide the service delivery system to be developed for the Nebraska BH Managed Care program:

1. Services will be part of an overall coordinated System of Care that ensures access to Mental Health and Substance Use Disorder treatment services to improve the overall health of every person served. To the fullest extent possible, services should be provided in the community where the client lives;
2. Services will provide recovery-based care;
3. Services will be trauma informed;
4. Services will be responsive to linguistic, cultural and other unique needs of any client of a cultural, racial, sexual, gender, or linguistic minority, or other special populations;
5. Services will be person-centered, consumer and family driven, age and developmentally appropriate;
6. Medicaid substance use disorder services will be delivered in accord with the principles of recovery-oriented systems of care;
7. Clients will be able to choose their own provider to the fullest extent possible at all levels of treatment;
8. Services will provide a resiliency-based system of care for children and their families; and
9. Services will promote a service array consistent with the current SAMHSA "Guiding Principles or Recovery" http://www.samhsa.gov/newsroom/advisories/1112223420.aspx and the National Wraparound Initiative's "10 Principles of Wraparound." http://www.rtc.pdx.edu/PDF/TenPrincWAProcess.pdf

C. CONTRACTOR PRIMARY RESPONSIBILITIES

The Contractor shall:

1. Apply managed care practices in a manner that results in Medicaid/CHIP members having access to Mental Health and Substance Use Disorder services that:

- **a.** Are recovery oriented and are part of an overall coordinated system of care;
- **b.** Ensure provision of services that are person and family-centered, timely, developmentally appropriate, culturally relevant and evidence-based;
- **c.** Establish an extensive, accessible provider network that offers a choice of providers and a comprehensive array of services; and
- **d.** Are proactive in organizing and administering a delivery system that meets the behavioral health needs of Medicaid/CHIP members, adjusting operations as needed.

D. INCLUDED POPULATIONS

The following categories are eligible for this program:

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

E. EXCLUDED POPULATIONS

The following categories are excluded from this program:

1. Medicaid members for any period of retroactive eligibility;
2. Aliens who are eligible for Medicaid for an emergency condition only;
3. Members who have excess income or who are designated to have a Premium Due;
4. Members eligible during the period of presumptive eligibility;
5. Participants in an approved DHHS PACE program; and
6. Clients with Medicare coverage where Medicaid only pays co-insurance and deductibles.

F. COVERED SERVICES

The Contractor, through its network of qualified service providers shall deliver the following covered Medicaid/CHIP Mental Health and Substance Use Disorder services as described in Attachment A, Medicaid/CHIP Covered Services, in sufficient amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are delivered and to achieve the goals in the individualized treatment plan. The categories of Medicaid Covered Services are:

1. Crisis Stabilization Services;
2. Inpatient Services (Acute and Sub-Acute);
3. Residential Services;

4. Outpatient Assessment and Treatment;
5. Rehabilitation Services;
6. Support Services; and
7. Service Coverage.

The Contractor must provide the above services that are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition; The Contractor may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

G. SUBSTITUTE OR VALUE-ADDED BEHAVIORAL HEALTH SERVICES

As permitted under 42 CFR 438.6e and to the extent consistent with provisions of State law, the Contractor shall, in its discretion, offer expanded substitute services and benefits to members in addition to those covered services specified above if such services are, in the judgment of the Contractor, medically appropriate and cost-effective. These expanded services may include behavioral health services which are currently non-covered services by the Nebraska Medicaid/CHIP State Plans and/or which are in excess of the amount, duration, and scope in the Nebraska Medicaid/CHIP State Plans.

These services/benefits shall be specifically defined by the Contractor in regard to amount, duration and scope. MLTC will not provide any additional reimbursement for these services /benefits. All substitute or value added services must support the principles of this initiative. Value added services or programs must align with other programs and services to complement and integrate formal and informal resources.

The Contractor shall provide MLTC a description of the expanded or modifications to Substitute Health or value added services/benefits to be offered by the Contractor for approval. Additions, deletions or modifications to Substitute Health or value added services made during the contract period must be submitted to MLTC for prior approval.

H. CONTRACTOR REQUIREMENTS

Contractor must have a minimum of five years' experience and demonstrated success in:

1. Provision of BH-MCO services with complex, publicly-funded Behavioral Health programs; and
2. PIHP, as defined in 42 CFR 438.2, for Mental Health and Substance Use Disorder services provided to children, youth, and adults.

I. THE CONTRACTOR SHALL DEMONSTRATE:

1. Substantial managed care experience and demonstrated success in operating or contracting with complex, publicly-funded behavioral health programs;
2. A proven track record in providing superior services to other governmental clients and covered populations similar to MLTC and its covered populations, as demonstrated by a/an:

a. Flexible, responsive customer service approach that is highly ingrained in the organization;

b. Cohesive, integrated management structure that allows for timely decisions, within a corporate framework that provides access to industry-leading tools, technology, expertise and oversight;

c. Responsive and reliable decision-making based on values consistent with the system delivery principles defined in this RFP;

d. Experience in establishing successful collaborative relationships with governmental customers in the delivery of an integrated system of care;

e. Resource management support necessary to recruit and retain highly-qualified staff;

f. Commitment to provide reinvestment and value added services to enhance behavioral health services;

g. Responsiveness to community needs and soliciting input from stakeholders;

h. Innovative approaches to improve outcomes for members;

i. Experience and success in service delivery to individuals with serious mental illnesses;

j. Experience in successful service delivery to children whose care is provided by multiple, integrated child-serving agencies, specifically experience with children who are Medicaid/CHIP eligible state wards;

k. Experience and successful development, support and monitoring of vertically integrated networks for behavioral health services provided to children, youth, families and adults; and

l. Experience and success in creative approaches to implementing the principles of recovery and resiliency, including evidence of an organizational culture that addresses the following elements:

- **i.** The design of services and supports;
- **ii.** Facilitates the development of consumer-operated programs and use of peer support;
- **iii.** Facilitates the development and use of natural supports;
- **iv.** Facilitates the use of self-management and relapse prevention skills,
- **v.** Supports stable housing;
- **vi.** Supports the development of healthy social networks and skills, employment or school performance;
- **vii.** Demonstrated success in implementing Practice Guidelines that promote an evidence-based culture through provider training, fidelity monitoring and best practices; and
- **viii.** Experience and demonstrated success in implementing program innovations that result in improved clinical outcomes including but not limited to, community tenure, physical/behavioral health integration and service delivery for co-occurring mental illness and substance use disorders and co-occurring mental health disorders and developmental disabilities.

m. A focus on continuous quality improvement with strategies that:

- **i.** Drive accountability and performance;
- **ii.** Contain valid, reliable metrics for outcome measurement;
- **iii.** Monitor the impact of clinical and other service decisions on the member;
- **iv.** Monitor member and provider satisfaction; and
- **v.** Provide adequate oversight of staff through initial orientation, ongoing training and formal clinical supervision to ensure that the skills of staff are consistent with best practices;

vi. Administrative efficiency through technology, including:

a) A supportive and responsive Information Technology (IT) department;
b) Automated systems for detection of suspected fraud and abuse;
c) Data-driven approaches to operationalizing Contract requirements;
d) Experience and demonstrated success in automated linkages to client information for transmission of large data files, such as timely , accurate transmission of encounter files;
e) Safeguards to protect the confidentiality of protected health information;
f) Technology supports that drive accurate, timely claims administration; and
g) Industry-leading reporting capabilities.

n. A proven track record of successful accountability for performance requirements under large, complex contracts, including:

i. Examples of successful achievement of performance thresholds on guarantees that embody the system principles outlined in this RFP; and
ii. The capability to update performance measures as industry standards and program requirements evolve.

J. BUSINESS REQUIREMENTS

1. REGULATION AND GUIDANCE

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

2. MANAGED CARE ORGANIZATION LICENSURE

The Prepaid Inpatient Health Plan (PIHP) must be licensed or certified by the State as a risk-bearing entity (i.e., Certificate of Authority for this behavioral health line of business approved by the Nebraska Department of Insurance for a HMO or Organized Delivery System) or meet the solvency standards established by the State for private health maintenance organizations per Nebraska Revised Statute 44-4701 et seq. The PIHP must make provisions, satisfactory to the Department of Health and Human Services and Department of Insurance, against the risk of insolvency pursuant to 42 CFR 438.116, assure that Medicaid/CHIP enrollees will not be liable for any of the PIHP’s debts if it does become insolvent and agree to comply with the requirements outlined in 42 CFR 438.214.

Bidders who submit a proposal with a partnership of risk-bearing must provide a detailed description of how both entities meet the Managed Care Organization Licensure requirements. Bidders must also provide specifics of the relationship including designated functions of each entity, and how delegated functions will be overseen.

3. ACCREDITATION

The State requires the Contractor to have NCQA or another national certification (including URAC accreditation) at the time of proposal submission or become accredited by the end of contract year two. The national certification must be related to the specific functions of Managed Care entities. Bidders shall include specific information related to which national certification they possess including the time period for the current certification.

If the bidder is in the process of becoming accredited, specific information, including the work plan, timeline and critical milestones for plan accreditation must be submitted to MLTC at the time of proposal submission. The successful bidder that is not accredited at the time of contract award must show significant progress during the first and second years of the contract that results in full NCQA accreditation or another national certification by July 30, 2015.

4. REINSURANCE

The Contractor shall hold a Certificate of Authority from the Department of Insurance and file all contracts of reinsurance, or a summary of the plan of self-insurance as required.

All reinsurance agreements or summaries of plans of self-insurance shall be filed and shall remain in full force and effect for at least ninety (90) calendar days following written notice by registered mail of cancellation to either party to MLTC.

The Contractor shall maintain reinsurance agreements throughout the Contract period, including any extension(s) and/or renewal(s). The Contractor shall provide prior notification to MLTC of its intent to purchase or modify reinsurance protection for certain members.

The Contractor shall provide to MLTC the risk analysis, assumptions, cost estimates and rationale supporting its proposed reinsurance agreements for prior approval. If any reinsurance is provided through related parties, disclosure of the entities and details causing the related party relationship shall be specifically disclosed.

5. ACCESS TO RECORDS

a. INSPECTION AND AUDIT OF FINANCIAL RECORDS

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

b. FEDERAL ACCESS TO RECORDS

The Contractor must allow federal agencies to require changes, remedies, changed conditions, access and records retention, suspension of work, and other clauses approved by the Office of Federal Procurement Policy. In addition, HHS-awarding agencies, the HHS Inspector General, the US Comptroller General, or any of their duly authorized representatives, have the right to timely and unrestricted access to any books, documents, papers, or other records of Contractor that are pertinent to the awards, in order to make audits, examinations, excerpts, transcripts and copies of such documents.

6. ADVANCE DIRECTIVES

a. The Contractor must comply with the requirements of 422.128 for maintaining written policies and procedures for advance directives; and

b. In addition, the Contractor must provide adult enrollees with written information on advance directives policies and include a description of applicable NE law.

7. NOTICE OF PROVIDER TERMINATION

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

8. PROVIDER - ENROLLEE COMMUNICATION

a. ANTI-GAG CLAUSE

The Contractor shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient:

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

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

iii. For the risks, benefits, and consequences of treatment or non-treatment; and

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

b. MORAL OR RELIGIOUS OBJECTIONS

A Contractor 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 Contractor objects to the service on moral or religious grounds.

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

i. To the State;

ii. With its application for a Medicaid contract;

iii. Whenever it adopts the policy during the term of the contract;

iv. Consistent with the provisions of 42 CFR 438.10;

v. To potential enrollees before and during enrollment; and

vi. To enrollees within 90 days after adopting the policy with respect to any particular service.

c. MARKETING ACTIVITIES

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

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

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

iii. Marketing Requirements Include the following:

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

9. ADMINISTRATION/STAFFING
The Contractor is responsible for maintaining a significant local (within the State of Nebraska) presence. Key positions that must be located in Nebraska are the following:

i. Administrator/CEO/COO;
ii. Chief Financial Officer (CFO);
iii. Medical Director/CMO;
iv. Corporate Compliance Officer;
v. Clinical Director/Manager;
vi. Operations Director/Manager;
vii. Grievance and Appeals System Director/Manager;
viii. Care Management/Utilization Review Director/Manager;
ix. Quality Management Director/Manager;
x. Network Services Director/Manager;
xi. Tribal Network Liaison; and
xii. Provider Network Liaison.

a. PROVIDER NETWORK LIAISON
The Contractor shall identify a Provider Network Liaison, who will be responsible for working collaboratively with the Provider Advisory Committee to establish methodologies for processing and responding to provider concerns; developing provider trainings in response to identified needs or changes in protocols, processes, and forms; and enhancing Contractor-provider communication strategies.

b. SUPPORTING STAFF

In addition to the Required Administrative Personnel, the Contractor shall have sufficient number of qualified supporting staff to meet the responsibilities of the Contract, including sufficient experience and expertise in working with the eligible Members served under the Contract to include but is not limited by the following:1) all children and youth, including those served by multiple child-serving agencies (child-welfare, office of juvenile services, schools, behavioral health) in, or at risk of, out of home placements; 2) adults with serious mental illness, addictive disorders and co-occurring disorders of serious mental illness and addictions.

c. HUMAN RESOURCES/STAFFING PLAN

The Contractor shall provide a Human Resources and Staffing Plan that describes how the Contractor will maintain the staffing level to ensure the successful accomplishment of all duties outlined in the contract. The Key Personnel and Required Personnel listed in the RFP are required. The Contractor may propose a staffing plan that combines positions and functions outlined in the RFP for other positions as long as the Contractor describes how the Table of Organization and staff roles delineated in the RFP will be addressed.

All personnel necessary to carry out the terms, conditions, and obligations of the contract are the responsibility of the Contractor. The Contractor shall recruit, hire, train, supervise and, if necessary, terminate such professional, paraprofessional and support personnel as are necessary to carry out the terms of the contract.

10. ADEQUATE CAPACITY

The Contractor shall submit documentation - upon entry into contract, when a change in operations occurs, change in services, benefits, service area or payment or enrollment of a new State population - to the State to demonstrate, in a format specified by the State, that it offers and maintains a/an:

a. Appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of enrollees for the service area; and

b. Network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

11. COMPLIANCE

The Contractor shall be responsible for compliance with all Contract requirements, regardless of whether the Contractor enters into a subcontract to delegate performance of the Contract requirements. Prior to selecting a subcontractor, the Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated. The Contractor shall monitor and formally review a subcontractor's performance on an ongoing basis.

12. CLINICAL LABORATORY IMPROVEMENT AMENDMENT

In compliance with the Clinical Laboratory Improvement Amendment (CLIA) of 1988 and the requirements of 42 CFR §493, Subpart A., MLTC requires all clinical laboratories to provide verification of CLIA Licensure or Certificate of Waiver during the provider registration process. Failure to do so shall result in either a termination of an active provider ID number or denial of initial registration. These requirements apply to all clinical laboratories. Pass-through billing or other similar activities with the intent of

avoiding the above requirements are prohibited. The Subcontractor may not reimburse providers who do not comply with the above requirements.

13. FRAUD, ABUSE AND WASTE

a. The Contractor must report fraud and abuse information to MLTC;

b. The Contractor shall confirm that its officers understand that the Contract includes the receipt by the Contractor of State and Federal funds. Further, the Contractor shall confirm that its officers understand that they are subject to criminal prosecution, civil action, or administrative actions for any intentional false statements or other fraudulent conduct related to their obligations under the Contract; and

c. The Contractor shall submit its written Fraud and Abuse Compliance Plan to MLTC during the implementation period process for approval and annually thereafter by June 30 each year. Requests for revision(s) to the Plan shall be submitted in writing to and approved in writing by MLTC at least thirty (30) days prior to implementation of such revision(s). The Fraud and Abuse Compliance Plan shall include, but not limited to, the following:

- **i.** A description of the methodology and standard operating procedures used to identify and investigate Fraud and Abuse, and to recover overpayments or otherwise sanction Providers;
- **ii.** A description of specific controls in place for Fraud and Abuse detection, including an explanation of the technology used to identify aberrant billing patterns, Claims edits, post processing review of Claims, and record reviews;
- **iii.** A Fraud and Abuse unit within the organization comprised of experienced Fraud and Abuse reviewers. This unit shall have the primary purpose of preventing, detecting, investigating, and reporting suspected Fraud and Abuse that may be committed by Network Providers, Members, employees, or other third parties with whom the Contractor contracts;
- **iv.** The designation of a Compliance Officer and a Compliance Committee that is accountable to senior management and for requirements for an adequately staffed compliance office;
- **v.** Evidence of completed, effective education for the Compliance Officer and the organization's employees; Contractor providers and Members about fraud and abuse and how to report it;
- **vi.** Effective lines of communication between the compliance officer and the Contractor employees, Contractors, providers and MLTC and/or its designee; and
- **vii.** The Contractor shall maintain a toll-free Provider Compliance Hotline number and ensure that the number and an accompanying explanatory statement for use are distributed to its Members and Providers through its Member and Provider handbooks.

d. The Contractor shall have administrative and management policies and procedures that are designed to prevent, reduce, detect, correct and report known or suspected fraud, abuse, and waste in accordance with the requirements specified in the contract. These written policies, procedures and standards of conduct shall articulate the Contractor's commitment to comply with all applicable federal and state standards and regulations to include the following:

i. Enforcement of standards through well-publicized disciplinary guidelines (e.g., Member/provider manuals, trainings, or newsletters, bulletins);

ii. Provisions for internal monitoring and auditing of the Contractor's providers, Subcontractors, employees, and others;

iii. Provision for prompt response to detected offenses and for development of corrective action initiatives relating to the Contract; and

iv. Procedures for timely and consistent exchange of information and collaboration with MLTC-Program Integrity , Attorney General Medicaid Fraud Control Unit (MFCU), and contracted EQRO regarding suspected fraud and abuse occurrences.

e. The Contractor shall establish 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). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers.

f. The Contractor shall establish a policy for referral of suspected Fraud and Abuse to the MLTC Program Integrity. A standardized referral process will be developed to expedite information for appropriate disposition. At a minimum, the Contractor shall report the number of complaints of fraud and abuse made to the State that warrant preliminary investigation. For each complaint which warrants investigation, supply the name and identification number, source of the complaint, type of provider, nature of complaint, approximate dollars involved, and legal and administrative disposition of the case.

g. The Contractor's Fraud and Abuse policies and procedures shall provide and certify that the Contractor's Fraud and Abuse unit has access to records of providers. These policies along with the designation of the compliance officer and committee shall be submitted to MLTC for approval during the implementation period and then thirty (30) days prior to whenever material changes occur. The Contractor's submission of new or revised policies and procedures for review and approval by MLTC shall not act to void any existing policies and procedures which have been prior approved by MLTC for operation. Unless otherwise required by law, the Contractor may continue to operate under such existing policies and procedures until such time as MLTC approves the new or revised version thereof. The Contractor shall develop a certification process that demonstrates the policies and procedures were reviewed and approved by the Contractor's senior management. The Contractor shall, in order to remain in compliance with the Agreement, comply with its Fraud and Abuse policies and procedures.

h. The Contractor shall create and disseminate written materials for the purpose of educating employees, managers, providers, subcontracts and subcontracts' employees about health care Fraud laws, the Contractor's policies and procedures for preventing and detecting Fraud and Abuse and the rights of employees to act as whistleblowers. The Contractor's education shall comply with all requirements of 1902(a) (68) Employee Education About False Claims Recovery.

i. The Contractor will require that all providers and all subcontracts take such actions as are necessary to permit the Contractor to comply with the Fraud and Abuse requirements listed in the Contract, as well as all Federal and State

requirements. To the extent that the Contractor delegates oversight responsibilities to a third party, the Contractor shall require that such third party complies with provisions above, of the Contract relating to Fraud and Abuse. Although all providers with whom the Contractor subcontracts are enrolled in the program and subject to regulations, the Contractor agrees to require, via contract, that such providers comply with regulations and any enforcement actions directly initiated by MLTC under its regulations, including but not limited to, termination and restitution.

j. The Contractor and its employees shall cooperate fully with centralized oversight agencies responsible for Fraud and Abuse detection and prosecution activities. Such cooperation shall include providing access to all necessary case information, computer files, and appropriate staff. In addition, such cooperation may include participating in periodic Fraud and Abuse training sessions, meetings, and joint reviews of subcontracted Providers or Members.

k. The Contractor shall immediately report to MLTC any suspicion or knowledge of fraud and abuse including, but not limited to, the false or fraudulent filings of claims and the acceptance of or failure to return reimbursement for claims known to be fraudulent.

l. The Contractor must report the following to the State:

- **i.** Number of complaints of fraud and abuse made to State that warrant preliminary investigation
- **ii.** For each which warrants investigation, supply the:
  - **a)** Name.ID number;
  - **b)** Source of complaint;
  - **c)** Type of provider;
  - **d)** Nature of complaint;
  - **e)** Approximate dollars involved; and
  - **f)** Legal & administrative disposition of the case.

m. MLTC will seek all appropriate remedies for fraud, abuse and violation of law if it determines that a Contractor, provider, employee, or subcontractor has committed “Fraud” or “Abuse” as defined in this Agreement or has otherwise violated applicable law.

n. Prohibited affiliations with Individuals Debarred by Federal Agencies. General requirement. The Contractor may not knowingly have a relationship with the following:

- **i.** An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549.; or
- **ii.** An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1).

K. MEMBER RIGHTS AND RESPONSIBILITIES

1. MEMBER SERVICES

a. MEMBER RIGHTS

The Contractor shall fully inform behavioral health recipients and family members about their rights and responsibilities and how to exercise them upon enrollment. The Contractor shall comply with any applicable Federal and State requirements that relate to member rights and require its staff and contracted providers to comply with the above requirements when delivering services to NE BH recipients and their families. The Contractor shall comply with all other applicable Federal and State laws such as: Title VI of the Civil Rights Act of 1964, 42 CFR 438.100; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act and other laws regarding privacy and confidentiality.

The Contractor must comply with any applicable Federal and State laws that pertain to enrollee rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees.

b. WRITTEN POLICIES

The Contractor shall develop and implement written policies to protect and enforce member rights.

c. MEMBER COMMUNICATION

The Contractor must have in place a mechanism to assist members to understand the requirements and benefits of the plan. All notices, informational materials, and instructional materials relating to members must be provided in a manner and format that is easily understood. Notices, informational materials, and instructional materials relating to members must be provided at the 6th grade level. This would include a score of up to 6.9 on the Flesh-Kincaid reading level.

d. LANGUAGE REQUIREMENTS

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

In addition, written material must use easily understood language and format. Written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.

e. INTERPRETER SERVICES

The Contractor must make oral interpretation services available free of charge to each member. This applies to all non-English languages not just those that the State identifies as prevalent. The Contractor must notify its members that oral interpretation is available for any language, that written information is available in prevalent non-English languages, and how to access those services.

f. REQUIRED INFORMATION TO MEMBERS

The Contractor shall furnish the information as specified in this section to each of its members or member households within a reasonable time but no more than 30 calendar days after the Contractor receives notice of the member's enrollment. The Contractor shall also provide each member or member household written notice of any change (that the State defines as "significant") in the information specified in this section at least 30 days before the intended effective date of the change.

i. A Provider Directory containing names, locations, telephone numbers, and non-English languages spoken by current contracted providers in the member's service area. This must include identification of providers that are not accepting new patients. The Provider Directory must be available on-line as well as in paper format. The on-line Directory must be updated monthly and the paper formats no less than quarterly.

ii. Any restrictions on the member's freedom of choice among network providers.

iii. Member rights and protections including grievances, appeals and State Fair Hearing procedures and timeframes.

iv. The amount, duration and scope of benefits available under the contract to ensure that members understand the benefits to which they are entitled as required in 42 CFR 438.10(b)(3) and 42 CFR 438.10(f – h).

v. Procedures for obtaining benefits, including authorization requirements.

vi. How after-hours and emergency coverage are provided, including what constitutes an emergency behavioral health medical condition, services, and post stabilization services, with reference to the definitions contained herein and the following:

a) The fact that prior authorization is not required for emergency services;

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

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

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

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

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

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

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

g. MEMBER HANDBOOK

i. The Contractor shall comply with the following requirements:

a) The Contractor shall develop and distribute a Member Handbook in both English and Spanish;

b) The Contractor shall provide the Member Handbook for MLTC review prior to publishing;

c) The Contractor shall distribute the Member Handbook to each new enrollee within thirty (30) days of enrollment;

d) The Contractor shall publish the Member Handbook on the Contractor's website;

e) Unless otherwise instructed by MLTC, the Contractor shall distribute the Member Handbook to enrollees in care at least thirty (30) days prior to the Contract Start Date; and

f) At a minimum, the Contractor shall review and update the Member Handbook annually. The Contractor shall submit the updated Member Handbook to MLTC within 30 days of receiving changes made to the Member Handbook Template. The Contractor's updated Member Handbook must be made available to all enrollees on an annual basis. If the Contractor makes changes to the Member Handbook at a time other than the annual update, the Contractor shall timely distribute the updated Member Handbook to each enrollee and include documentation of the Handbook's distribution in the enrollee's medical record.

h. NOTICE OF PROVIDER TERMINATION

i. The Contractor shall make a good faith effort to provide written notice to any member who is actively receiving services from a provider that has been terminated from the network 15 days after issuance of the provider termination notice.

i. GRIEVANCE, COMPLAINTS AND APPEALS

i. Service Authorizations and Notices of Action

a) Service Authorization
The Contractor must provide a definition of service authorization that, at least, includes the member's request for the provision of a service.

b) Service Authorization Process
The Contractor must assure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

c) Notice of Adverse Action for Service Authorizations
The Contractor 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.

d) Notice of Adverse Action
The Contractor must give the member written notice of any action (not just service authorization actions) within the timeframes for each type of action.

e) Notice of Adverse Action – Content
The notice must explain:

1). The action the Contractor or its Contractor has taken or intends to take;
2). The reasons for the action;
3). The member's or the provider's right to file an appeal;
4). The member's right to request a State Fair Hearing;
5). Procedures for exercising member's rights to appeal or grieve;
6). Circumstances under which expedited resolution is available and how to request it; and
7). The member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.

f) Notice of Adverse Action – Language and Format
The notice must be in writing and must meet the language and format requirements described in the contract.

ii. Timeframes for Notice of Action

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

1). In the death of a member;

2). A signed written member statement requesting service termination or giving information requiring termination or reduction of services (where he or she understands that this must be the result of supplying that information);

3). The member's admission to an institution where he or she is ineligible for further services; and

4). The member's address is unknown and mail directed to him or she has no forwarding address.

b) Timeframes for Notice of Action – Denial of Payment
The Contractor must provide notice on the date of action when the action is a denial of payment.

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

If the Contractor 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 Contractor must issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

d) Timeframes for Notice of Action – Expedited Service Authorization Denial
For cases in which a provider indicates or the Contractor 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 Contractor must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three (3) working days after receipt of the request for service. The Contractor may extend the time period by up to 14 calendar days if the member requests an extension or if the Contractor justifies a need for additional information and how the extension is in the member's interest.

e) Timeframes for Notice of Action – Untimely Service Authorization Decisions
The Contractor must provide notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited

service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions.

iii. General Requirements of Grievance Systems

a) The Contractor must have a grievance system for members that meet all regulation requirements, including a grievance process, an appeal process, and access to the State's fair hearing system. The Contractor must distinguish between grievance system, grievance process, and a grievance:

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

2). 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; and

3). A grievance process is the procedure for addressing member's grievances.

b) The Contractor must:

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

2). Acknowledge receipt of each grievance and appeal; and

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

i) A denial appeal based on lack of medical necessity;
ii) A grievance regarding denial of expedited resolutions of an appeal; and/or
iii) Any grievance or appeal involving clinical issues.

iv. Information to Providers and Subcontractors

The Contractor must provide the following grievance, appeal, and fair hearing procedures and timeframes to all providers and Subcontractors at the time of entering into a contract:

a) The member's right to a State Fair Hearing, 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;

c) The availability of assistance in filing grievances and appeals;

d) The toll-free numbers to file oral grievances and appeals;

e) The member's right to request continuation of benefits during an appeal or State Fair Hearing filing and, if the Contractor action is upheld in a hearing, that the member may be liable for the cost of any continued benefits; and

f) Any State-determined provider appeal rights to challenge the failure of the organization to cover a service.

v. Grievance System – Record Keeping and Reporting
The Contractor must:

a) Maintain records of grievances and appeals; and

b) Submit to the State quarterly data, specified by the State, on grievances and appeals which enables the State to measure the Contractor's performance.

vi. Appeal Process

a) Appeal Process – Authority to File
A member may file a Contractor-level appeal. A provider, acting on behalf of the member and with the member's written consent, may file an appeal.

b) Appeal Process – Timing
The member or provider may file an appeal within 90 days from the date on the Contractor's Notice of Action.

c) Appeal Process – Authority to File
The member or provider may file an appeal either orally or in writing and must follow an oral filing with a written, signed, appeal.

d) Appeal Process – Procedures
The Contractor must:

1). Ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the member or the provider requests expedited resolution;

2). Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing;

3). Allow the member and representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records; and

4). Consider the member, representative, or estate representative of a deceased member as parties to the appeal.

e) Appeal Process – Resolution and Notification

1). The Contractor must:

i) Resolve each appeal;
ii) Provide notice, as expeditiously as the member's health condition requires, within 45 days from the day the Contractor receives the appeal;
iii) The Contractor may extend the timeframes by up to fourteen (14) calendar days if the member requests the extension or the Contractor shows that there is need for additional information and how the delay is in the member's interest; and
iv) For any extension not requested by the member, the Contractor must give the member written notice of the reason for the delay.

f) Appeal Process – Format and Content of Resolution Notice
The Contractor must provide written notice of disposition. The written resolution notice must include:

1). The results and date of the appeal resolution for decisions not wholly in the member's favor;
2). The right to request a State Fair Hearing;
3). How to request a State Fair Hearing;
4). The right to continue to receive benefits pending a hearing;
5). How to request the continuation of benefits; and
6). If the Contractor action is upheld in a hearing, that the member may be liable for the cost of any continued benefits.

vii. State Fair Hearing

a) Requirements for State Fair Hearings
The Contractor shall comply with all requirements as outlined in the contract and by MLTC.

1). Availability. If the Member has exhausted the Contractor level appeal procedures, the Member may request a State Fair Hearing within ninety (90) days from the date of the Contractor's notice of resolution;
2). Parties. The parties to the State Fair Hearing include the Contractor, as well as the Member and his or her representative or the representative of a deceased Member's estate;
3). Notification of the right to State Fair Hearing. The Contractor shall inform the Member of their right to seek a State Fair Hearing if the Member is not satisfied with the Contractor's decision in response to an appeal;

4). Authority to File. A member may request a State Fair Hearing. The provider may request a State Fair Hearing if the provider is acting as the member's authorized representative. A member or provider may request a State Fair Hearing at the same time a Contractor appeal is filed.

5). A Member may file a grievance and a Contractor level appeal, and may request a State Fair Hearing, once the Contractor's appeals process has been exhausted;

6). A network provider, acting on behalf of the Member and with the Member's written consent, may file an appeal. A network provider may file a grievance or request a State Fair Hearing on behalf of a Member; and

7). The Contractor shall not create barriers to timely due process. The Contractor shall be subject to sanctions if it is determined by the State that the Contractor has created barriers to timely due process, and/or, if 10% or more of appeals decisions appealed to a State Fair Hearing level within a twelve (12) month period have been reversed, or otherwise resolved, in favor of the Member. Examples of creating barriers shall include, but not be limited to:

i) Including binding arbitration clauses in Contractor Member choice forms;
ii) Labeling appeals as inquiries or complaints and funneling into an informal review;
iii) Failing to inform Members of their due process rights;
iv) Failing to log and process grievances and appeals;
v) Failure to issue a proper notice, including vague or illegible notices;
vi) Failure to inform of continuation of benefits; or
vii) Failure to inform of right to State Fair Hearing.

viii. Appeal and State Fair Hearing Process – Continuation of Benefits

a) The Contractor must continue the member's benefits if: The appeal is filed timely, meaning on or before the later of the following:

1). Within ten (10) days of the Contractor mailing the Notice of Action; and

2). The intended effective date of the Contractor proposed action.

i) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
ii) The services were ordered by an authorized provider;
iii) The authorization period has not expired; and
iv) The member requests extension of benefits.

ix. Appeal and State Fair Hearing Process – Duration of Continued or Reinstated Benefits must be continued until one of the following occurs:

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

x. Appeal and State Fair Hearing Process – Member Responsibility for Services Furnished While the Appeal is Pending
The Contractor may recover the cost of the continuation of services furnished to the member while the appeal was pending if the final resolution of the appeal upholds the Contractor action.

xi. Appeal and State Fair Hearing Process – Effectuation When Services Were Not Furnished While Appeal was Pending
The Contractor must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires if the services were not furnished while the appeal is pending and the Contractor or the hearing decision reverses a decision to deny, limit, or delay services.

xii. Appeal and State Fair Hearing Process – Effectuation When Services Were Furnished While Appeal Was Pending
The Contractor must pay for disputed services if the Contractor 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.

xiii. Expedited Appeals Process

a) Expedited Appeals Process – General
The Contractor must establish and maintain an expedited review process for appeals when the Contractor determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) 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 where differences are specifically noted in the regulation for expedited resolution.

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

c) Expedited Appeals Process – Procedures
The Contractor must inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

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

e) Requirements Following Extension
For any extension not requested by the member, the Contractor must give the member written notice of the reason for the delay.

f) Expedited Appeal Process – Format of Resolution Notice
In addition to written notice, the Contractor must also make reasonable efforts to provide oral notice of resolution.

g) Expedited Appeal Process – Punitive Action
The Contractor must ensure that no punitive action is taken against a provider who either requests an expedited resolution or supports a member's appeal.

h) Expedited Appeal Process – Action Following Denial of a Request for Expedited Resolution
If the Contractor denies a request for expedited resolution of an appeal, it must:

1). Transfer the appeal to the standard timeframe of no longer than forty-five (45) days from the day the Contractor receives the appeal with a possible fourteen (14) day extension; and

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

xiv. Access to State Fair Hearing

a) State Fair Hearing Process – Contractor Notification of State Procedures
If the Contractor takes action and the member requests a State Fair Hearing, the State (not the Contractor) 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 and provider by the Contractor.

b) State Fair Hearing Process – Authority to File
A member may request a State Fair Hearing. The provider may request a State Fair Hearing if the provider is acting as the member's authorized representative. A member or provider may request a State Fair Hearing at the same time a Contractor appeal is filed.

c) State Fair Hearing - Timing
The member or provider may request a State Fair Hearing within 90 days from the date on the Contractor Notice of Action.

d) State Fair Hearing – Resolution
The State must reach its decisions within the specified timeframes:

1). Standard resolution: within ninety (90) days of the date the member filed the appeal with the Contractor if the member filed initially with the Contractor (excluding the days the member took to subsequently file for a State Fair Hearing) or the date the member filed for direct access to a State Fair Hearing; and

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

i) Meets the criteria for an expedited appeal process, but was not resolved using the Contractor expedited appeal timeframes;
ii) Was resolved wholly or partially adversely to the member using the Contractor expedited appeal timeframes; and
iii) Expedited resolution (if the appeal was made directly to the State Fair Hearing process without accessing the Contractor appeal process) within three (3) working days from agency receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.

e) State Fair Hearing – Parties
The parties to the State Fair Hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate.

f) State Fair Hearing – Disenrollment Requests
The State ensures that any member dissatisfied with a State agency determination denying a member's request to transfer plans/disenroll is given access to a State Fair Hearing.

xv. Grievance Process

a) Grievance Process – Procedures
The member is allowed to file a grievance (complaint) with the Contractor or with the State. The Contractor shall notify MLTC of all member and provider grievances and complaints within one working day of receipt. The Contractor shall notify MLTC on the findings regarding the complaint and the proposed resolution prior to notifying the member or provider. The Contractor shall track the types of grievances and complaints and report quarterly to MLTC.

b) Grievance Process – Authority to File
A member may file a grievance either orally or in writing. A provider may file a grievance when acting as the member's authorized representative.

c) Grievance Process – Disposition and Notification
The Contractor must dispose of each grievance and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes, not to exceed ninety (90) days from the day the Contractor receives the grievance.

d) Grievance Process – Format of Disposition Notice
The State will establish the method the Contractor will use to notify a member of the disposition of a grievance.

L. PROVIDER NETWORK DEVELOPMENT AND MANAGEMENT

The Contractor shall establish, operate and manage a behavioral health Provider Network to deliver Covered Services and meet the behavioral health needs of Members. The Contractor shall assure timely access for all Members to the full range of Covered Services. The Contractor shall have a sufficient number of network management staff to carry out the functions required in the contract, including staff for network development, contracting, provider relations, network reporting and overall network management.

1. ESTABLISHING THE NETWORK

As of the contract start date, the Contractor shall have in effect and maintain a network of qualified providers for the delivery of Covered Services, in accordance with the terms of the contract. The Contractor shall:

a. Establish a Provider Network of qualified service providers to respond to referrals for immediate, urgent, and routine needs within the following appointment access standards:

- **i.** Emergent appointments within one hour of request, other than in rural areas designated by MLTC, where the standard is two hours;
- **ii.** Urgent appointments within forty-eight (48) hours of referral; and
- **iii.** Routine appointments within fourteen (14) calendar days.

b. Have a fully operational network of crisis response providers available twenty-four (24) hours per day, seven (7) days per week as of the contract start date.

c. In establishing the Provider Network, consider the following:

- **i.** The anticipated enrollment of Members;
- **ii.** The expected utilization of services, taking into consideration the characteristics and health care needs of specific populations enrolled with the Contractor;
- **iii.** The numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the Covered Services;
- **iv.** The numbers of network providers who are not accepting new Members;
- **v.** The geographic location of network providers and Members considering distance, travel time, the means and availability of transportation

ordinarily used by Members, and whether each service location provides physical access for Members with disabilities; and

vi. Transitioning the current NE behavioral health provider network to your BH MCO for the contract.

d. Ensure that the 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. Trauma-informed care and trauma-specific treatment (e.g., Trauma-Focused Cognitive Behavioral Therapy), including expertise in care for post-traumatic stress disorder and trauma-related disorders more broadly, for all enrollees;
v. Severe emotional disturbance (SED) among children and adolescents, including coordinated care for children served by multiple state agencies (e.g., child welfare, juvenile justice, developmental disabilities, etc.);
vi. Sex-offending behaviors;
vii. Eating disorders; and
viii. Co-occurring serious mental illness and common chronic physical illnesses.

e. Ensure that the Provider Network includes sufficient numbers of network with the needed experience and expertise to serve all behavioral health clinical populations and diagnoses currently covered by Nebraska's Medicaid program.

i. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

f. Comply with Indian Health Protections: In accordance with Section 5006(d) of the American Recovery and Reinvestment Act of 2009 (Recovery Act), Public Law 111-5, Medicaid Managed Care Organizations (MCOs) must:

i. Permit any Indian who is enrolled in a non-Indian MCO and eligible to receive services from a participating Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) provider, to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in the network as a primary care provider, to choose that I/T/U as his or her primary care provider, as long as that provider has capacity to provide the service;
ii. Demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian enrollees who are eligible to receive services from such providers; and
iii. Provide I/T/U providers, whether participating in the network or not, payment for services in the Basic Benefits package provided to Indian enrollees who are eligible to receive services from such providers either:

a) At a rate negotiated between the MCO and the I/T/U provider; or

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

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

g. The Contractor shall make good faith efforts to ensure that all network providers from the current behavioral health Medicaid ASO Contractor, that meet credentialing requirements, participate in the Contractor's Provider Network and either develop or renew service contracts prior to the contract start date;

h. Provide coverage in accordance with access standards set forth in this RFP;

i. The Contractor shall ensure that it promotes the delivery of services in a culturally competent manner to all members including those with limited English proficiency and diverse cultural and ethnic backgrounds;

j. Establish a Provider Advisory Committee representative of contracted providers throughout the state, including all levels of care, to advise the Contractor on provider network operations; and

k. The Contractor shall submit to MLTC for its review and approval a list of initial provider network agreements. Such documentation shall include a listing of fully executed subcontracts as well as submitted, but not yet approved, provider applications. This information shall be included in the implementation plan and be submitted no less than monthly between Letter of Intent to Contract and contract start date.

2. PROVIDER CREDENTIALING

The Contractor's credentialing criteria for providers shall be consistent with the criteria included in the State and Federal regulations, the NE Medicaid State Plan and the applicable waivers.

a. The Contractor shall implement written policies and procedures that comply with the MLTC requirements, NE State law and those set forth below regarding the selection, retention, and exclusion of providers from the Provider Network in compliance with 42 CFR 438.214 (a) (b)(1 & 2). Such written policies and procedures shall, at a minimum:

i. Require network providers to meet credentialing criteria approved by MLTC, unless the Contractor establishes that such criteria should be waived pursuant to the section of this document entitled "Credentialing Waiver Process" below;

ii. Maintain appropriate, documented processes for the credentialing and re-credentialing of providers who participate in the Contractor's Provider Network. At a minimum, the scope and structure of the processes shall be consistent with recognized managed care industry standards such as those provided by the National Committee for Quality Assurance (NCQA) and relevant state regulations that may pertain. The Contractor should collaborate with the Provider Advisory Committee in developing these processes. The basic components of these processes shall include the following:

a) Record of continuing professional education;

b) Medicare, Medicaid, federal tax identification number, and Social Security numbers;

c) Location service area and telephone numbers of all offices, hours of operation, and provisions for emergency care and backup;

d) Areas of special experience, skills and training;

e) Cultural and linguistic capabilities;

f) Review of Member satisfaction and any complaints made or grievances filed against the network provider within the past two years;

g) Physical accessibility for persons with disabilities;

h) Reference checks;

i) Criminal history, child and adult abuse data base, sex offender registry;

j) For facility-based network providers, a site visit and evidence of a training program for staff, collaboratively developed with providers, on the appropriate and safe use of restraint and seclusion; and

k) For network providers of 24-hour services, evidence of a training program for staff on the appropriate and safe use of restraint and seclusion.

iii. Ensure that all facility providers are credentialed prior to becoming network providers and that a site visit is conducted with recognized managed care industry standards such as those provided by the NCQA and relevant state regulations;

iv. Ensure that network providers are recredentialed every three years, at a minimum, 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;

v. Ensure that the credentialing process does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment, as well as providers that serve cultural and linguistic minority populations;

vi. The Contractor shall check the U.S. Department of Health and Human Services Office of the Inspector General's (OIG) List of Excluded Individual Entities (LEIE) found at: http://www.oig.hhs.gov/exclusions/exclusions_list.asp, as well as Medicare Exclusion Database (MED) websites before the Contractor contracts with a provider to become part of its Provider Network, at the time of a provider's credentialing and recredentialing, and at least monthly.;

vii. As applicable, the Contractor shall notify a network provider within three business days that, due to its NE Medicaid, Medicare, or another state's Medicaid program termination or suspension or a state or federal licensing action, such network provider is terminated or suspended, as appropriate, from the Contractor's Provider Network, and is no longer eligible to treat Members. The Contractor shall have a process in place to immediately effectuate such termination or suspension;

viii. When the Contractor terminates, suspends, or rejects a network provider from its network based on such provider's termination or suspension with NE Medicaid, Medicare, or another state's Medicaid

program, a state or federal licensing action, or based on any other independent action, the Contractor shall notify MLTC of the network provider termination, suspension or rejection within three business days;

ix. This section does not preclude the Contractor from suspending or terminating network providers for cause prior to such network provider's ultimate suspension and/or termination by MLTC from participation in NE Medicaid;

x. Not contract with a provider, or otherwise pay for any items or services furnished, directed or prescribed by a provider that has been excluded from participation in federal health care programs by the OIG under either section 1128 or section 1128A of the Social Security Act, or that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 CFR 1001.1801 and 1001.1901;

xi. Ensure that no network provider engages in any practice with respect to any Member that constitutes unlawful discrimination under any other state or federal law or regulation, including but not limited to, practices that violate the provisions of 45 CFR Part 80, 45 CFR Part 84, and 45 CFR Part 90;

xii. Notify MLTC when a network provider fails credentialing or re-credentialing due to breach of program integrity, and/or any of the reasons described in this section ("Credentialing Process") of the contract. Provide the information required by MLTC or state or federal laws, rules, or regulations; and

xiii. Provide annual attestation that all network providers within the Contractor's Provider Network are credentialed according to the contract.

3. NETWORK PROVIDER QUALIFICATIONS

a. The Contractor shall execute provider contracts or enter into other arrangements for the provision of Covered Services individual practitioners and organizational providers. Individual practitioners who may practice only under supervision under the scope of their license must demonstrate adequate supervisory oversight, in accord with the practice requirements of their license.

i. All providers shall meet the following credentialing criteria:

a) Meet educational degree requirements;

b) Conform to all applicable licensing, certification, or other professional standards as set forth in applicable state and federal laws and regulations;

c) Hold a current, valid, unrestricted license to practice the practitioner's profession in the State of Nebraska;

d) Enrolled as a Medicaid provider;

e) Demonstrate that any suit, claim, proceeding, or disciplinary action that occurred in the previous five years involving mental health or substance use disorder services has either been resolved without adverse findings or has been addressed so that the Contractor is assured services will be of acceptable quality;

f) Meet requirements of the credentialing application process, including but not limited to site visits and being able to demonstrate age- and population-appropriate activities,

privileges, and restrictions for all defined specialty population units/programs, unless the Contractor establishes that such criteria should be waived pursuant to this section;

g) Have in place professional liability insurance;

h) Comply with policies and regulations with respect to Member rights and privileges as applicable; and

i) Maintain records consistent with current professional standards and Medicaid regulations, as well as systems for accurately documenting the following included, but not limited to, information for each Member receiving Covered Services:

1). Demographic information;
2). Clinical history;
3). Behavioral health clinical assessments; including Trauma History;
4). Treatment plans;
5). Services provided;
6). Contacts with Members' family, guardians, or significant others;
7). Tracking of treatment outcomes; and
8). Trauma history.

j) Satisfy all federal and state requirements regarding the provider's physical plant and premises;

k) Comply with all applicable anti-discrimination requirements described in 42 CFR 438.6(d) (3) and (4);

l) Comply with all other applicable state and federal laws; and

m) Have been credentialed pursuant to the policies and procedures specified in the Contract.

b. The Contractor shall execute provider contracts or enter into other arrangements for the provision of Covered Services with licensed organizations that satisfy the following additional criteria:

i. Are financially stable, as determined by the Contractor;

ii. Have established and maintain a quality management program, which maintains the essential elements of such programs, as described in the "Quality Management" section of the contract. As an alternative, providers with fewer than 10 full time staff can develop quality management programs in partnership with other providers or can develop enhanced oversight through the Contractor's quality management program to ensure ongoing quality improvement;

iii. Are responsive to linguistic, cultural and other unique needs of any member of a cultural, racial, sexual, gender, or linguistic minority, or other special population in the region in which they provide services;

iv. Have adequate capacity within the network to communicate with Members in Spanish and other languages besides English, when necessary, as well as with those who are deaf, hard of hearing, or hearing-impaired; and

v. Ensure that those facility-based network providers, that are also network providers of inpatient services, comply with the aforementioned contractual terms requirements, as well as the following terms:

a) Comply with Nebraska statutes and CMS regulations concerning restraint and seclusion; and

b) Submit to the Contractor evidence of implementation of training programs associated with appropriate use of seclusion and restraints, as well as other consumer/patient protections as part of the credentialing and recredentialing process.

4. CREDENTIALING WAIVER PROCESS

a. The Contractor shall:

i. Develop a proposal for a credentialing waiver process to allow certain providers that do not meet all of the Contractor's credentialing criteria to be included in the Provider Network when there is an objective need for including those providers (e.g., the provider fills a cultural, linguistic, or geographic access need, or the provider is a peer/consumer provider); and

ii. Ensure that no covered service is rendered at any time during the term of the contract by any person, facility, agency or organization that does not meet all credentialing criteria under the contract, or any applicable law or regulation, unless the Contractor specifically waives in writing an applicable credentialing criterion, to the extent such waiver is within the authority of the Contractor.

5. PROVIDER OUTREACH AND APPLICATION PROCESSING

a. The Contractor shall establish standardized provider application forms and provider contracts for use with all providers, and utilize standardized processes. All applications should be processed (either approved or disapproved) within 90 days of receipt. Declined providers must receive written notification of decision on their application, with a description of their appeal rights for denials.

i. Upon receipt of completed provider application materials, the Contractor shall:

a) Review provider's requested procedure/revenue codes and recommend procedure/revenue codes to be added to the provider's fee schedule;

b) Establish and implement written policies for the selection and retention of providers, consistent with provider credentialing and recredentialing requirements that do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;

c) Establish a program of assertive outreach to rural areas where mental health services and substance use disorder services may be less available than in more urban areas;

d) Develop a plan that includes methods to ensure individuals in those areas have access to the full array of services; and

e) Submit to MLTC an annual written assessment of the results of such efforts each contract year.

6. PROVIDER CONTRACTING PRINCIPLES

a. The Contractor shall meet its responsibilities under the contract while adhering to the following key principles of behavioral health provider network management:

- **i.** Promote and implement the Principles of Care for this program, including contracting with providers that demonstrate a commitment to the Principles of Care defined in the contract, including principles of rehabilitation and recovery from mental illness and addiction, a focus on recovery-oriented, trauma-informed services, consumer and family involvement in program management and oversight, a family –driven and strength-based approach to working with children and their families cultural and linguistic competency, and training for staff on such principles;
- **ii.** Use data in decision-making. The Contractor shall develop a data dashboard-type reporting process with defined and ad hoc reporting capabilities, as required in the Data Maintenance and Reporting section of the contract. The Contractor shall obtain the input of MLTC, providers, advocates, Members, and family members on the contents of the data dashboard. The reporting specifications shall include clearly defined data elements and well established time frames for data collection and reporting;
- **iii.** Adhering to a continuous quality improvement process between the Contractor and network;
- **iv.** Promoting collaboration and alignment with state and federally funded services and programs and support of state agency missions, as well as with existing provider organizations;
- **v.** Recognizing the capacity of Members and their families to use and built on their strengths as part of their treatment and eventual recovery;
- **vi.** Promoting a Provider Network that is family-driven and consumer-driven across all levels of care;
- **vii.** Supporting and incorporating MLTC health care reform and integration initiatives as they are developed over time, including support of service delivery approaches that integrate behavioral health and primary care services, in collaboration with Medicaid physical health plans;
- **viii.** Improving the ability of the behavioral health Provider Network to meet all of the health needs of Members through strengthened collaboration with primary care providers, service providers inpatient hospital providers, and consumer/peer providers; and
- **ix.** Actively soliciting best practice models that achieve and exemplify these principles in the Contractor's programs and submitting to MLTC proposals to establish, replicate and financially support the ongoing service delivery of such programs.

7. PROVIDER CONTRACT PROVISIONS

a. The Contractor must execute and maintain, for the term of the contract, written provider contracts with a sufficient number of appropriately credentialed, licensed or otherwise qualified network providers to provide Members with all medically necessary Covered Services. The Contractor's provider contract provisions shall require contracted providers to:

i. Participate in the Contractor's care management/utilization management processes; and

ii. Participate in the Contractor's quality management activities.

b. Ensure that all provider contracts include provisions:

i. Offering hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to the hours of operation defined in the Nebraska Medicaid State Plan, if the Contractor serves only Medicaid enrollees;

ii. Requiring network providers to accept as "payment in full" the Contractor's payment for Covered Services provided to Members;

iii. Prohibiting network providers from charging Members in full or in part for any service provided under the contract or imposing any financial penalties on them, including charges for canceling or missing appointments;

iv. Including the following statement: "Providers shall not seek or accept payment from any Members for any covered service rendered, nor shall providers have any claim against or seek payment from MLTC. Instead, providers shall look solely to the Contractor for payment with respect to Covered Services rendered to Members. Furthermore, providers shall not maintain any action at law or in equity against any Members or MLTC to collect any sums that are owed by the Contractor under the contract for any reason, even in the event that the Contractor fails to pay for or becomes insolvent or otherwise breaches the terms and conditions of the contract (where "contract" refers to the agreement between the Contractor and any Subcontractor and where "provider" refers to the Subcontractor, including network providers and non-network providers with whom the Contractor is contracting);

v. Any cost-sharing imposed on Medicaid members must be in accordance with 42 CFR §447.50 through §447.58 and cannot exceed cost sharing amounts in the Nebraska Medicaid State Plan;

vi. Requiring any network provider to notify the Contractor if it has reason to be considering insolvency or is otherwise financially unsound. The Contractor shall notify MLTC within one working day of receipt of such financial notification;

vii. Prohibiting network providers from engaging in any practice with respect to any Member that constitutes unlawful discrimination on the basis of health status, need for health care, race, color, national origin, or any other basis that violates any state or federal law or regulations, including but not limited to 45 CFR Part 80, 45 CFR Part 84, and 45 CFR Part 90; and

viii. Requiring network providers to collaborate in an ongoing and effective way with primary care providers.

8. NON-NETWORK PROVIDERS

a. Members who are unable to obtain medically necessary covered services from a network provider may obtain them from non-network providers or network providers from other areas of the state, as chosen by the Member, under the following circumstances:

i. The network provider from whom the Member seeks the service is the main source of service to the Member. However, the Member shall have no right to obtain services from a provider outside the Provider Network if the Contractor gave the provider the opportunity to participate in the Provider Network under the same requirements for participation applicable to other providers, and the provider did not meet the necessary requirements to join the Provider Network;

ii. The only network provider available to the Member in the Provider Network does not provide the service the Member seeks because of moral or religious objections; and

iii. The Member's network provider or other provider determines that the Member needs a service(s); the Member would be subjected to unnecessary risk if he/she received the needed services separately; and not all of the related services are available within the Provider Network.

b. Members shall have adequate and timely access to non-network providers for Covered Services when they are unavailable through a network provider, for as long as the Contractor is unable to provide them.

c. The Contractor shall:

i. Negotiate and execute written single-case agreements or arrangements with non-network providers, when necessary, to assure access to Covered Services;

ii. Ensure that service authorizations and utilization management protocols, claims submissions and internal appeals policies for non-network providers are consistent with the terms in the Contractor's network provider contracts;

iii. Develop systematic procedures to work with non-network providers for Members who reside in a rural service area, as identified by MLTC in accordance with the provisions of 42 CFR 412.62(f)(1)(ii); and

iv. Assume responsibility for coverage and payment of services provided by non-network providers if delivered under the terms above, regardless of whether or not the provider that furnishes the services has a contract with the Contractor. The Contractor must pay for those services at rates at least equal to the current fee-for-service rate schedule.

9. ACCESS AND AVAILABILITY OF THE BEHAVIORAL HEALTH PROVIDER NETWORK

a. The Contractor shall indicate how its development and management of the Provider Network will incorporate the following principles into its provider network development and management plans, as well as how these plans are consistent with its overall quality management plan:

i. Acuity of Need:
Members with emergent needs shall be referred to services within one (1) hour generally and within two (2) hours in designated rural areas. Members with urgent needs shall be assessed within forty-eight (48) hours of a request for services. Members with routine needs shall be assessed within fourteen (14) calendar days of the date the services are requested. Delivery of emergency services should be coordinated at the regional level with each RBHA.

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

ii. Geographical Standards:

a) Inpatient and Residential Services within 60 miles or 60 minutes' travel time from the Member's residence, whichever requires less travel time; for rural areas, travel time limits may be extended up to 120 miles / 120 minutes if it is determined by MLTC that no inpatient providers are available within the 60 mile / 60 minute travel time requirement. For extremely rural areas of the state, the Contractor shall develop alternative plans for accessing comparable levels of care instead of these services, subject to approval by MLTC;

b) Emergency psychiatric services, in coordination with the crisis networks developed by the DBH RBHAs and the acute care providers previously listed;

c) All other Covered Services within 20 miles or 30 minutes' travel time from the Member's residence, based on a readily accessible mode of transportation; and

d) Accessibility for Members shall be within the identified standards for urban and rural populations. The availability of types of behavioral health programs will vary from area to area, but access problems may be especially acute in rural areas. The Contractor shall establish a program of assertive outreach to rural areas where behavioral health services may be less available than in more urban areas, and shall develop a plan that includes methods to ensure individuals in those areas have access to the full array of services. The Contractor shall monitor utilization in regions across the state and in rural and urban areas to ensure access and availability in all regions, consistent with the requirements of the contract and the needs of Members:

iii. Timeliness:

a) Access standards are the standards for the timeliness of response for the assessment of consumer need and the provision of services necessary to resolve the situation. The assessment of Member needs must be done in a manner that is consistent with applicable clinical practices, timelines and meets the needs of the Member. The timeliness of response will meet the requirements as defined in the emergent, urgent, or routine criteria for individuals already in service as well as individuals not currently in services.

b) The Contractor shall:

1). Ensure Members have access to a choice of at least two network providers who provide Covered Services to the extent that qualified, willing network providers are available. In cases where this is not feasible due to a lack of available providers, the Contractor shall document that it has undertaken assertive efforts to engage any

available providers and shall incorporate this gap into its written plan to take assertive steps to develop adequate provider availability over time;

2). Ensure access to Covered Services in accordance with state and federal laws for persons with disabilities by ensuring that physical and communication barriers do not inhibit them from obtaining services under the contract;

3). Monitor the practice of placing Members who seek outpatient Covered Services on waiting lists. If the Contractor determines that a network provider has established a waiting list and the service is available through another network provider, the Contractor shall 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; and

4). Assure MLTC that it has the capacity to serve the expected enrollment of Members in accordance with the access standards in the contract.

b. ACCESS TO COVERED SERVICES

i. The Contractor shall execute and maintain provider contracts with network providers to ensure that, at a minimum, 90 percent of Members have access to all medically necessary behavioral health Covered Services according to the following standards:

a) Inpatient and Residential Services within 60 miles or 60 minutes' travel time from the Member's residence, whichever requires less travel time; for rural areas, travel time limits may be extended up to 120 miles / 120 minutes if it is determined by MLTC that no inpatient providers are available within the 60 mile / 60 minute travel time requirement. For extremely rural areas of the state, the Contractor shall develop alternative plans for accessing comparable levels of care instead of these services, subject to approval by MLTC and in coordination with the DBH RBHA for that region; and

b) Emergency psychiatric services, in coordination with the crisis networks developed by the DBH RBHAs and the acute care providers.

All other Covered Services shall be accessible within 20 miles or 30 minutes travel time from the Member's residence, based on a readily accessible mode of transportation.

The Contractor must offer Members who require readmission to inpatient services readmission to the same network provider when there is a bed available in that facility and such admission is not clinically contra-indicated.

c. EMERGENCY SERVICES: COVERAGE AND PAYMENT

i. Emergency and Post Stabilization Care Services
The Contractor is responsible for coverage and payment of emergency behavioral health services and post stabilization care services

regardless of whether the provider that furnishes the services has a contract with the Contractor. Post Stabilization services remain covered until the Contractor contacts the Emergency Room and takes responsibility for the enrollee.

ii. Payment for Emergency for Medical Condition
The Contractor shall not deny payment for treatment obtained when an enrollee had an emergency behavioral health condition. This includes cases in which the absence of immediate medical attention would not have placed the health of the individual in serious jeopardy, impairment or dysfunction.

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

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

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

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

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

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

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

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

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

a) The Contractor does not respond to a request for pre-approval within one (1) hour;
b) The Contractor cannot be contacted; and
c) The Contractor representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached, or:

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

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

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

10. LINKAGE WITH CONSUMER AND RECOVERY/RESILIENCE INITIATIVES

a. The Contractor shall manage the behavioral health provider network to align with other programs and services that support and complement Members' participation in Covered Services and that promote Members' recovery, empowerment, and use of their strengths and the family's strengths in achieving their clinical goals and improving their health outcomes.

i. The Contractor shall actively manage network providers to complement and integrate with the following formal and informal resources and programs:

a) Rehabilitation programs that promote and provide skill-building, community support, Supported Employment and full competitive employment for Members;
b) Recovery Support services;
c) Natural community supports for Members and their families; and
d) Anonymous recovery programs (e.g., 12-step programs) for Members and their families.

ii. The Contractor shall also work with its network providers to actively collaborate with other MLTC-funded programs, including but not limited to:

a) NE Medicaid physical health Contractors;
b) DBH-funded programs;
c) DCFS-funded programs that support the safety, permanency and well-being of children in the care and custody of the State of Nebraska;
d) In the event that court-ordered services are determined by the Contractor not to be medically necessary, the Contractor's care management program will work with the court and any involved state agencies to determine if alternative Covered Services that do meet medical necessity requirements may be provided and will provide care coordination throughout the member's treatment (as long as eligibility is maintained) to transition the member to a service that is medically necessary and appropriate to meet the member's needs;
e) DDD programs that involve rehabilitative and habilitative services for persons with developmental disabilities (recognizing that habilitative services are not covered by this program); and
f) Other programs and initiatives within MLTC related to primary care and behavioral health integration/coordination and pharmacy management.

iii. The Contractor shall demonstrate through its Network management plan and individual network provider contracts the continued effort to work with network providers to access community resources and supports.

11. PROVIDER QUALITY MANAGEMENT STRATEGY

a. Beginning on the contract start date, the Contractor shall develop and implement a strategy to manage the Provider Network with an emphasis on the following:

i. Implementation of the Principles of Care for the Program;
ii. Access to care for Members;
iii. Quality of care;
iv. Application of principles of rehabilitation, recovery, and resilience to service planning and service delivery;

v. Measurement and promotion of recovery- and resiliency-oriented outcomes for Members over the course of receiving Covered Services;

vi. Integration of covered service delivery with medical services provided by Members' primary care providers or other key health care providers; and

vii. Cost-effectiveness of the delivery of Covered Services.

b. The Contractor shall ensure that its management strategy includes at least the following:

i. A systematic plan for utilizing network provider profiling and benchmarking data to identify and manage network providers who fall below established benchmarks and performance standards, and to reward and replicate practices of network providers who consistently exceed benchmarks and performance standards;

ii. A system for the Contractor and network providers to identify and establish improvement goals and periodic measurements to track network providers' progress toward improvement goals;

iii. Utilization of on-site visits to network providers at all levels of care, to support quality improvement efforts and benchmarking data; and

iv. Steps to ensure network provider compliance with the Contractor's performance specifications for each covered service.

c. The Contractor shall take appropriate management action, including the development and monitoring of corrective action plans for network providers whose performance is determined by the Contractor to be in need of improvement.

d. The Contractor shall take appropriate action related to network providers as follows:

i. Upon the Contractor's awareness of any disciplinary action or sanction taken against a network provider, either internally by the Contractor or an oversight agency or any source outside of the Contractor's organization (such as CMS), immediately inform MLTC of such action taken and work collaboratively with MLTC to maintain a process to share such information; and

ii. If notified that MLTC has taken an action or imposed a sanction against a Medicaid provider, including disenrollment of any such provider from the Medicaid program, review the provider's performance related to the contract and take any action or impose any sanction that the Contractor determines is appropriate, including disenrollment from the Contractor's Provider Network.

e. In collaboration with and as further directed by MLTC, develop and implement network provider quality improvement activities.

f. Implement, subject to MLTC approval, a network management strategy to engage with primary care providers, specialty providers, high-volume prescribers, and hospital emergency departments to improve access for Members who may be under- or over-utilizing behavioral health services.

12. NETWORK ADMINISTRATION

a. The Contractor shall maintain and continually update a Network Provider Database that contains, at a minimum, the following information on network providers:

- **i.** Network provider name;
- **ii.** Contracted services;
- **iii.** Site address(es) (street address, town, ZIP code, region of the state);
- **iv.** Site telephone numbers;
- **v.** Site hours of operation;
- **vi.** Emergency/after-hours provisions;
- **vii.** Professional qualifications and licensing;
- **viii.** Areas of specialty relating to behavioral health conditions;
- **ix.** Cultural and linguistic capabilities;
- **x.** Malpractice insurance coverage and malpractice history;
- **xi.** Credentialing status; and
- **xii.** Profiling indicators.

A list of network providers, sorted by type of service and by network providers' capability to communicate with Members in their primary languages. This list shall be available to the Contractor's clinical staff at all times, and available to network providers, DBH and other interested parties upon their request and at no charge.

13. NETWORK PROVIDER POLICY AND PROCEDURE MANUAL/HANDBOOK

a. The Contractor shall produce a provider handbook 45 days prior to the contract start date and shall make this handbook available on the web site 30 days prior to the contract start date. The provider handbook shall include but may not be limited to the following:

- **i.** Develop a provider policy and procedure manual, and distribute the manual to all network providers following MLTC review; and
- **ii.** The manual shall include, at a minimum, information on:
  - **a)** The contract, the Contractor, and program priorities;
  - **b)** Acceptance of members without discrimination or regard to the member's health status, need for health care, race, color, national origin, or any other basis that violates any state or federal law or regulations;
  - **c)** How to verify a Member's eligibility for NE Medicaid behavioral health Covered Services;
  - **d)** Network provider credentialing criteria;
  - **e)** Provider network management;
  - **f)** Procedures for service authorization, concurrent review, extensions of lengths of stay, and retrospective reviews for all Covered Services;
  - **g)** Clinical criteria for admission, continued stay, and discharge for each covered service;
  - **h)** Administrative and billing instructions, including a list of procedure codes, units and payment rates;
  - **i)** How to appeal payment and service denial decisions;

j) Reporting requirements for serious reportable events and reportable adverse incidents;
k) Contractor corporate information;
l) Confidentiality provisions;
m) Principles of Care;
n) Descriptive process for accessing services;
o) Summary of service and benefit structure;
p) Compliance with the preferred drug list for enrolled Members;
q) Procedures for submitting complaints and appeals;
r) Procedures for service authorization and registration;
s) Procedures for using WEB-based provider services;
t) Summary of utilization management requirements;
u) Summary of claims procedures; and
v) Names and contact information of provider relations staff.

iii. The Contractor shall, as necessary:

a) Modify or supplement the policy and procedure manual by distributing periodic notices to network providers;
b) Review the manual at least bi-annually and amend it, if necessary, in consultation with MLTC and the involvement of consumers, families, providers and other stakeholders in the review and upgrade of the manual; and
c) Redistribute the amended portions of the manual to network providers and Members through a clear process for communicating changes.

14. NETWORK PROVIDER PROTOCOLS

a. The Contractor shall develop, maintain and utilize MLTC-reviewed network provider protocols. The protocols must address the following:

i. How the Contractor intends to ensure, for a particular Member's needs, that a qualified and clinically appropriate network or non-network provider:

a) Is available to provide the particular Covered Service;
b) Is accessible within the access standards required by the contract, taking into account the availability of public transportation;
c) Is accessible to individuals with physical disabilities, if appropriate;
d) Has the ability, either directly or through a skilled medical interpreter, to communicate with the Member in his/her primary language; and
e) How the Contractor intends to facilitate communication between network providers and the Contractor, and between network providers and primary care providers, in a manner that engages the providers and overcomes barriers to communication.

ii. The Contractor shall require network providers to submit to the Contractor a written report of all reportable adverse incidents, according to the following guidelines:

a) Network providers of 24-hour Covered Services shall, within 24 hours of their occurrence, report to the Contractor all reportable adverse incidents involving a Member;

b) Network providers of non-24-hour Covered Services shall, within 24 hours of their occurrence, report to the Contractor all reportable adverse incidents that involve the death of a Member; and

c) The Contractor shall require network providers to coordinate Medicaid Covered Services with the Member's care manager where the Members are receiving care management services through the Contractor and/or the case manager when the Member is receiving case management through a state agency (e.g., DBH, DCFS, and DDD).

iii. The Contractor shall require network providers to comply with MLTC's regulations barring payment for services related to a serious reportable event. The Contractor shall require network providers to comply with all applicable federal and state requirements, including those concerning restraints and seclusion.

iv. The Contractor shall require its network providers to inform Members of their rights under Nebraska regulations.

v. The Contractor shall maintain a unique network provider identification number for each network provider. In addition shall:

a) Inform MLTC immediately upon enrolling any provider who is not also a NE PH Medicaid provider in its Provider Network. Such notification shall include the following data elements:

1). Network provider name, address and telephone number;

2). Legal entity's name, address and phone number of the practice (i.e., "doing business as," or d/b/a, name), if different from the above;

3). Network provider or legal entity's tax identification number; and

4). Effective date of the network provider's enrollment in the Provider Network.

vi. The Contractor shall submit to MLTC all updates to the list or its data elements whenever they occur.

15. NETWORK PROVIDER RELATIONS

a. GENERAL PROVIDER RELATIONS

The Contractor shall develop and maintain positive Contractor-provider relations; communicate with all providers in a professional and respectful manner; promote positive provider practices through communication and mutual education and provide administrative services in the most efficient manner possible in an effort to pose minimal burden on providers.

b. PROVIDER ADVISORY COMMITTEE

The Contractor shall develop, establish and maintain a Provider Advisory Committee. The Contractor shall propose a plan for forming and collaborating with a Provider Advisory Committee. The Provider Advisory Committee shall have representation from MLTC, the major provider organizations (e.g., CAFCON, NAADAC, NABHO, Nebraska Chapter of the American Association of Psychiatric Nurses, and Nebraska Chapter of the NASW, NCA, Nebraska Hospital Association, Nebraska Medical Association, Nebraska Psychiatric Society, and Nebraska Psychological Association) in Nebraska, individual providers, and consumer/peer providers. Whenever feasible, the Contractor will work collaboratively with the Provider Advisory Committee, as well as established provider organizations, to create network development and management strategies, methods, and procedures. MLTC shall review the development plan prior to establishment.

c. NETWORK COMMUNICATION PLAN

The Contractor shall promote on-going and seamless communication between providers and the Contractor. To accomplish this task the Contractor shall:

i. In addition to establishing and working collaboratively with the Provider Advisory Committee, include provider representatives in the Contractor's committee structure, to give providers a direct voice in developing and monitoring clinical policies;

ii. Offer providers consultation with respect to both clinical and administrative issues;

iii. Work with providers to reduce administrative responsibilities through the use of the Contractor's website and information technology;

iv. Provide encryption software upon request from a provider to provide for the exchange of Member data via e-mail;

v. Post all policies and procedures, handbooks and other material on the Contractor's website;

vi. Notify providers and Members of impending policy changes at least 45 days prior to implementation, to the greatest extent possible;

vii. Conduct provider satisfaction survey at least once per contract year, sharing findings with the Provider Advisory Committee and involving the Provider Advisory Committee in implementing corrective action as indicated;

viii. The Contractor shall conduct a provider satisfaction survey using a provider survey instrument approved by MLTC. The survey shall, at a minimum, address the provider's satisfaction with the Contractor's services and other administrative services provided by the State or its agents, including but not limited to authorization, courtesy and professionalism, network management services, provider appeals, provider education, referral assistance, coordination, claims processing and the perceived administrative burden experienced by providers providing behavioral health services;

ix. The survey shall be conducted within the guidelines defined in the Quality Management section of the contract;

x. Provide a monthly newsletter that includes articles covering topics of interest for providers who work both with children and adults, that appropriate medical professionals are involved in writing the assigned articles, and that the newsletters are posted to the Contractor's website; and

xi. Tracking and monitoring all complaints as part of recredentialing, and informing MLTC if intervention is required in an urgent situation.

d. PROVIDER NETWORK LIAISON

The Contractor shall identify a Provider Network Liaison, who will be responsible for working collaboratively with the Provider Advisory Committee to establish methodologies for processing and responding to provider concerns; developing provider trainings in response to identified needs or changes in protocols, processes, and forms; and enhancing Contractor-provider communication strategies.

e. PROVIDER NOTIFICATION

Throughout the term of the contract, the Contractor shall be required to 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 Contractor shall:

i. Request and obtain from providers an e-mail address, so they can be alerted to access the Contractor's website to download updates to the provider handbook and provider requirements;

ii. E-mail providers and publish on the Contractor's website any clarification or direction on matters not otherwise communicated by the MLTC; and

iii. Post notification of policy or other procedural changes on the Contractor's website. Advance notification of Members and providers of changes that will impact access to and provision of services or payment of services is required. The Contractor will make a good faith effort to provide at least 45 days' advance notice of any necessary changes.

f. PROVIDER ORIENTATION

i. During the first year of the contract, the Contractor shall conduct an initial statewide provider orientation initiative and at least two subsequent rounds of provider orientation sessions;

ii. The Contractor shall work with representatives of the provider community to develop the agenda for the initial statewide provider orientation to identify the most effective ways to encourage attendance;

iii. The Contractor shall alert providers to the various meetings through direct mailings, coordination with professional organizations, notices posted to its website; and

iv. The Contractor shall, following the initial statewide and local provider orientation sessions, determine whether the initial orientation sessions should be repeated at one or more locations to further encourage provider participation.

g. PROVIDER TRAINING AND TARGETED TECHNICAL ASSISTANCE

The Contractor shall:

i. Offer training and technical assistance to providers on clinical topics, including the priority evidence-based and emerging best practices; and

ii. Have available both clinical and administrative staff to provide targeted technical assistance onsite at the request of network providers and also non-network providers seeking to become network providers.

h. PROVIDER INQUIRIES AND COMPLAINTS

The Contractor shall:

i. Track and manage all provider inquiries and complaints related to clinical and administrative services covered under the contract;

ii. Ensure that all inquiries and complaints are addressed in compliance with the Contractor's approved Quality Management (QM) Plan and no later than 30 days from receipt;

iii. Inform MLTC immediately when urgent circumstances require an immediate response from MLTC; and

iv. Provide MLTC with a regular report outlining the Contractor's compliance with required timeframes and notifications related to inquiries and complaints. MLTC and the Contractor shall agree to the form, content and frequency of the report in advance.

i. WEB-BASED COMMUNICATION SOLUTION

i. The Contractor shall develop and implement a website specifically to serve its network providers and Members;

ii. The Contractor shall ensure that the website provides information about the Contractor's services, a link to the MLTC and MLTC primary care vendor websites and related websites, and a link to the Contractor's corporate website (if different); and

iii. The Contractor shall, in collaboration with the MLTC, determine the program content published on the website. The Contractor shall provide web-enabled transactional capabilities through the website. Such capabilities shall include, but may not be limited to:

a) Provider/Member inquiries;

b) Submission of initial authorization and registration; and

c) Web-based referral search system that will allow Contractor's and MLTC' staff, providers, Members and any other interested persons to locate network providers through an online searchable database. The searchable database shall include network providers and facilities with information regarding areas of clinical specialization, race/ethnicity, languages spoken, disciplines, and program types.

16. ANNUAL NETWORK DEVELOPMENT PLAN

a. The Contractor shall submit to MLTC an annual network plan within 60 days of the annual service start date of each year following the first year of the contract.

i. The annual plan shall contain specific action steps and measurable outcomes that are aligned with the goals and principles of MLTC network requirements. The plan shall encompass services for all Members, but contain separate sections for provider networks for Covered Services described in the contract for children/adolescents and adults. The Contractor work plan shall take into account, network-specific goals and objectives developed in collaboration with MLTC:

a) The Contractor shall include in the plan a narrative and statistical analysis consistent with the MLTC assessment methodology. At a minimum, the analysis shall be derived from:

1). Quantitative data, including performance on appointment standards/appointment availability, eligibility/enrollment data, utilization data, the network inventory, demographic (age/gender/race/ethnicity) data, and the number of single case agreements by service type;

2). Qualitative data (including outcomes data), when available; grievance information; concerns reported by eligible or enrolled Members; grievance, appeals, and request for hearings data; behavioral health Member satisfaction survey results, and prevalent diagnoses; and

3). Status of provider network issues within the prior year that were significant or required corrective action by MLTC, including findings from the current Contractor's annual administrative review:

i) A summary of network development efforts conducted during the prior year;
ii) Plans to correct any current material network gaps and barriers to network development;
iii) Priority areas for network development activities for the following year, goals, action steps, timelines, performance targets, and measurement methodologies for addressing the priorities;
iv) The participation of Members, family members/caretakers, providers, including state-operated providers, and other community stakeholders in the annual network planning process; and
v) The Contractor's network development plan shall be approved by MLTC. The Contractor shall submit progress reports as requested by MLTC**.**

M. CARE, UTILIZATION AND QUALITY MANAGEMENT

Care management is the overall system of medical and psychosocial management encompassing, but not limited to, UM, care coordination, discharge planning following restrictive levels of care, continuity of care, care transition, and QM. The major components of care management include assessment, planning, facilitation, coordination, and evaluation. The major activities of care management include advocacy, communication, problem solving, collaboration, and empowerment. Care coordination and referral activities incorporate and identify appropriate methods of assessment and referral for individual Members requiring mental health and/or substance use disorder treatment services, including linkages to primary medical care services. These activities shall include scheduling assistance, monitoring, and follow-up for Members requiring behavioral health services.

1. REQUIRED CANDIDATES FOR CARE MANAGEMENT

Care management will be provided, but not limited to, the following members with the attendant characteristics;

a. CHILDREN:

- **i.** Hospitalized, recently released, and less than 12 years old;
- **ii.** Receiving sub-acute level of care and discharged back to a community setting; or
- **iii.** With mental health or chemical dependency diagnoses and at risk of out of home placement or becoming a state ward.

b. ADOLESCENTS:

- **i.** Pregnant with substance abuse diagnoses;
- **ii.** Ages 13 to 18 with two or more admissions within 60 days to inpatient or residential treatment with a diagnosis of bipolar schizophrenia; or
- **iii.** Adult, children and adolescent high risk candidates.

2. GENERAL REQUIREMENTS FOR CARE MANAGEMENT

Care Management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost effective outcomes. The Contractor shall develop and maintain a care management function that ensures covered Mental Health and Substance Use Disorder treatment services, appropriate to the Member's level of need, are available when and where individuals need them. The Contractor shall provide services that are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The care management system shall have sufficient staffing to respond 24 hours per day, seven (7) days per week, and 365 days per year to Members, their families/caregivers, or other interested parties calling on behalf of the Member.

The Contractor shall provide to MLTC for approval a program description, flow diagrams, where appropriate or helpful, and specific policies and procedures pertaining to CM/UM practices, including, but not limited to, care management, service authorization and re-authorization procedures, and utilization review procedures, such as concurrent review, discharge review, retroactive medical necessity review, retrospective utilization review, and retrospective chart reviews. The Contractor's CM/UM policies and procedures, clinical guidelines and practice guidelines, shall be consistent with the MLTC-approved definition of medical necessity. The Contractor shall:

- **a.** Develop clinical guidelines with the input, review and approval of the Clinical Advisory Committee convened for this plan;
- **b.** Submit the CM/UM policies and procedures to MLTC for approval at least one month prior to the service start date; and
- **c.** Annually review, and update as necessary, with the input, review and approval of the Clinical Advisory Committee, the CM/UM policies and procedures and clinical guidelines, and, once approved by the Clinical Advisory Committee, submit any proposed changes to MLTC for prior review and approval. The CM/UM policies and procedures shall be conveyed through staff training and supervision and shared with providers to promote consistency of care provision and to ensure that:

  - **i.** Members receive the care that is medically necessary; and
  - **ii.** Behavioral Health Covered Services are not underutilized or over utilized or provided without documentation of medical necessity.

3. CLINICAL ADVISORY COMMITTEE

The Contractor shall develop, establish and maintain a Clinical Advisory Committee to facilitate regular consultation with experts who are familiar with standards and practices of mental health and/or substance use disorder treatment for adults, children and adolescents in Nebraska. The Clinical Advisory Committee must provide input into all policies, procedures and practices associated with care management and utilization management functions, including utilization management criteria, clinical guidelines, and practice guidelines to ensure that they reflect up-to-date standards consistent with research, requirements for evidence-based practices, and community practice standards in Nebraska.

a. The Committee shall consist of experts within the state of Nebraska who are familiar with standards and practices of mental health and/or substance use disorder treatment, including co-occurring disorders, for children, adolescents and adults in Nebraska across a variety of ages and races/ethnicities, including awareness of differences between rural and urban populations and representing a range of service providers.

b. Membership will also include at least two adult consumers who are Medicaid Members and at least two family members/guardians of children or youth who are Medicaid Members with behavioral health service needs. Members shall be chosen in consultation with consumer and family advocacy organizations.

c. In addition to review of the initial guidelines, any significant changes in guidelines shall also be reviewed by this committee prior to adoption by the Contractor.

d. The committee shall meet on an as needed basis, but at least twice a year and preferably quarterly.

e. MLTC shall review the strategy and plan for development of the Clinical Advisory Committee in advance of establishment and receive copies of the input and advice provided in the course of operation.

4. STAFFING

The Contractor shall provide adequate staffing of the CM/UM functions and shall:

a. Employ a multidisciplinary clinical staff at staffing levels that ensure an adequate ratio of staff to Members to perform the CM/UM functions of the contract, including authorizing and coordinating care.

b. Provide CM/UM staffing as follows:

i. Ensure that the Chief Medical Officer or a designee, is available 24 hours per day, seven days a week, for decision-making and consultation with the Contractor's clinical staff and network providers; and

ii. The Contractor shall ensure the following standards for clinicians who authorize services, unless otherwise approved by MLTC:

a) The Contractor shall ensure that only licensed psychologists, LIMHPs and psychiatrists acting within the scope of all applicable state laws and their professional licenses shall make final decisions regarding medical necessity determination;

b) The clinician(s) coordinating and authorizing Mental Health and Substance Use Disorder treatment services for children and adults, including co-occurring disorders, must be licensed and trained in and demonstrate knowledge of the Principles of Care and the full array of services available to Members;

c) The clinician(s) coordinating and authorizing services for Members with a coexisting medical and behavioral health diagnosis must be trained and demonstrate knowledge of co-occurring disorders and have access to appropriate clinical consultation to a physician or registered nurse as needed;

d) The Contractor shall ensure that supervisory clinical staff include subject matter experts in serious and persistent mental illness (SPMI) for adults and in severe emotional disturbances (SED) for children and adolescents; trauma-informed and trauma-specific care, and in developmental disabilities, substance use disorder treatment, and treatment of persons with co-occurring mental illness and substance use disorders, consistent with the Principles of Care defined in this RFP;

e) Appropriately trained paraprofessionals, including peers and family members, may provide care management support functions;

f) The Contractor will include provisions to ensure that conflicts of interest on the part of staff are avoided; and

g) The Contractor shall provide policies and procedures outlining the training and supervision plan for CM/UM staff. The training and supervision plan must address consistency in the application of clinical guidelines and documentation. The plan shall articulate how the following will be accomplished:

1). Promoting implementation of and adherence to the Principles of Care for the program;

2). Ensuring that clinical staff obtain the training needed to maintain their professional licensing;

3). Providing orientation and on-going training on CM/UM and QM policies and procedures;

4). Providing training on evidence-based practices;

5). Conducting live call monitoring or monitoring of recorded CM/UM telephone calls, as well as regular tests of inter-rater reliability, to assess consistency in interpreting clinical guidelines and adherence to policies and procedures; and

6). Conducting regular care management record reviews to monitor:

i) The adequacy of documentation supporting appropriateness of medical necessity;

ii) The adequacy of clinical documentation regarding quality of care, including assessment and treatment information and care management of high risk cases; and

iii) The appropriateness of care management and other Contractor management interventions, including the use of physician or other specialist consultation.

h) By contract start date, the Contractor shall provide to MLTC for approval a program description, flow diagrams, where appropriate or helpful, and specific policies and procedures pertaining to CM/UM practices, including, but not limited to, care

management, service authorization and re-authorization procedures, and utilization review procedures, such as concurrent review, discharge review, retroactive medical necessity review, retrospective utilization review, and retrospective chart reviews.

i) The Contractor shall develop and maintain a care management function that ensures covered Mental Health and Substance Use Disorder treatment services, appropriate to the Member's level of need, are available when and where individuals need them. The Contractor shall provide services that are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The care management system shall have sufficient staffing to respond 24 hours per day, 7 days per week, and 365 days per year to Members, their families/caregivers, or other interested parties calling on behalf of the Member.

1). 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 board-certified psychiatrist; and

2). Care managers shall make referrals to qualified network providers, for immediate, urgent, and routine needs within the following appointment access standards:

i) Emergent appointments within one hour of request or two hours in rural areas;
ii) Urgent appointments within 48 hours of referral; and
iii) Routine appointments within fourteen (14) calendar days.

j) The Contractor will ensure that its care managers conduct outreach to Members discharged from institutional care within 72 hours of the discharge, and will monitor and report on steps taken to carry out outreach. The Contractor will develop network capacity with the requirement that outpatient appointments following inpatient and residential stays will be available within three (3) days of discharge optimally and seven (7) days of discharge in all cases to assist with prevention of readmission.

k) The Contractor and its providers shall meet management of care standards specified in the contract for timely access to care and services, taking into account the urgency of need for services. The Contractor is responsible to ensure that provider network capacity is adequate to ensure standards can be met.

l) The Contractor's care management program shall determine if the member has a primary care physician (PCP). If the member does not have a PCP, the Contractor shall refer the individual to Nebraska Medicaid PH for appointment of a PCP and follow up to assure and document the name of the PCP in the care management record. To support this, the Contractor's CM program shall:

1). Document the individual's PCP in the care management record, or if none, follow up on the PCP referral as part of the ongoing care management process;

2). The Contractor shall develop, in collaboration with all Medicaid physical health plans, a data sharing and notification system. When Medicaid Members receive services from the provider network, the notification system will generate supporting communication (preferably electronically) to the member's PCP;

3). If medications are prescribed by the Contractor's provider, use available pharmacy data downloads to obtain a list of medications prescribed by PCP and other specialists for a complete and reconciled medication list that is updated at least every 90 days. MLTC will provide a monthly download of pharmacy claims data to the Contractor for enrolled Members to allow routine monitoring of prescribed medications. This information will be made available in electronic format to providers treating the Member on a regular basis, in accord with data sharing requirements;

4). The Contractor shall monitor psychotropic medications prescribed to children using a protocol that is approved by MLTC. The Contractor will be responsible for identifying medication utilization that is outside of the identified parameters of the protocol and will follow the approved process for addressing with the network provider and/or PCP. The Contractor is responsible for reporting on this process on a quarterly basis in a manner to be determined by MLTC;

5). Implement additional supports as needed to coordinate care with PCPs to promote overall health and wellness;

6). For Members receiving DBH-funded care from RBHAs, coordinate care with the RBHA to promote overall health and wellness;

7). For Members receiving DCFS-funded care, coordinate care with DCFS and its Contractors to promote overall health and wellness;

8). For Members receiving DDD-funded care, coordinate care with DDD and its Contractors to promote overall health and wellness;

9). Ensure that in the process of coordinating care, each Member's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164;

10). If requested, the Contractor shall offer a second opinion from a qualified health care professional within the network or arrange for a second opinion outside the network at no cost to the Member; and

11). In order to identify Members with special mental health care or substance use treatment needs, the Contractor is required to screen all Members to identify special needs Members who meet the criteria for:

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

m) The Contractor must proactively seek individuals with special needs. This includes the review by the Contractor of claims and utilization data to identify Members in need and Contractor care management efforts to provide outreach to special needs Members. This also includes the development and use of standardized, best practice screening tools to assess individuals once identified. Such development shall be carried out with the input of the Clinical Advisory Committee.

5. COORDINATION OF CARE WITH STATE AGENCIES AND OTHER SERVICE SYSTEMS

a. The Contractor shall collaborate with other state agencies that serve Members with mental health and substance use conditions, and it shall address and attempt to resolve coordination of care issues with Medicaid physical health plans, other state agencies and their Contractors, and Tribes at the lowest possible level of each organization.

b. The Contractor shall participate in local, regional and statewide planning efforts to help ensure the fullest integration of mental health treatment resources into the overall health care delivery system.

c. The Contractor must support expedited access to covered and medically necessary Medicaid services after discharge from;

i. Enhanced care management resources;
ii. Continuity of care across changes in eligibility status for Members;
iii. Care coordination with other parts of the physical health care system, including Medicaid physical health Contractor plans, community health clinics, and FQHCs;
iv. The federal Indian Health Service and with health initiatives by Tribal Governments in Nebraska; and
v. The Nebraska Medicaid Pharmacy Program.

6. COORDINATION OF PHYSICAL HEALTH AND BEHAVIORAL HEALTH CARE

a. The Contractor shall promote integration of medical and behavioral health care across the Contract by coordinating care with other systems that provide services to the same Member in compliance with Title 482 NAC:

i. When a member is not enrolled in both PH Managed Care and BH Managed Care organization responsible for BH services, the associated service is coordinated with MLTC on a fee-for-service basis;

ii. At the time when a BH provider initiates an evaluation and/or treatment for the member, the PH MCO is no longer responsible for a BH-related service. Authorization for BH services from that point forward must be obtained from the BH-MCO;

iii. When a member who is enrolled in the BH is admitted to an acute care (medical/surgical) facility as an outpatient for a 24 hour observation for purposes of a BH diagnosis, the BH-MCO is responsible for the observation stay; and

iv. The BH-MCO is no longer responsible for the service at the time that a psychiatrist initiates an evaluation and/or treatment of the member and determines that the member does not have a BH diagnosis. Authorization for acute care services from that point forward must be obtained from the PH-MCO.

b. The Contractor shall develop an organizational structure that coordinates the integration of care through:

i. Development of formal agreements and/or arrangements with each of the current MLTC physical health plan Contractors;

ii. Current initiatives to integrate behavioral health and primary care;

iii. Development of communication protocols and processes that facilitate information sharing among PCPs and network providers; and

iv. Aggregation, analysis and dissemination of data on health and integrated health and behavioral health access and outcomes.

c. The Contractor shall develop systemic processes that ensure optimal communication and collaboration between behavioral health and health care systems that serve Members.

d. The Contractor shall conduct the following activities, at a minimum, to promote coordination of behavioral health and physical health care at the broader system level:

i. In collaboration with the PH-MCO Contractors, collaboratively develop education and training mechanisms on integrated care and related issues;

ii. Jointly design, develop and distribute with PH-MCO Contractors (with input from network providers, PCPs and other primary care practitioners) linkages and policies that promote communication, coordination and collaboration across medical and behavioral health care providers; and

iii. Establish within six (6) months following the contract start date an initiative in collaboration with the PH-MCOs to develop a tracking process and data collection process for emergency department (ED) usage and inpatient admissions by Members at acute hospitals for any condition (inclusive of behavioral and other physical health needs) and evaluate the utility of this information, as appropriate for:

a) Notifying the PCPs of a Medicaid PH-MCO Member's ED usage or inpatient admission;

b) Identification of Medicaid physical health Contractor Members;

c) Designing treatment and/or discharge planning with Members; and Identification of trends in ED usage and inpatient admissions;

d) Jointly educate in collaboration with PH-MCOs, PCPs and network providers regarding the need to coordinate and manage prescribed medication use for behavioral health and medical conditions, in coordination with the Nebraska Pharmacy Benefit Manager; and

e) Utilize the Contractor's website to:

1). Provide PCPs and other non-behavioral health providers with easy access to behavioral health referral sources, treatment options and crisis intervention protocols; and

2). Provide behavioral health network providers with information on how to access customer service functions for primary care referral sources, community resources and acute and urgent care services facilities.

f) Attend and participate in all relevant DHHS meetings and workgroups as directed by DHHS, with a particular focus on workgroups targeting medical and behavioral health integration; and

g) Support related required functions through the Contractor's care management and utilization management systems.

7. CARE COORDINATION WITH TRIBES AND TRIBAL ORGANIZATIONS

The Care Coordination Plan shall include procedures for collaboration regarding services for Members with who are Tribal Members or are otherwise eligible for care through the federal Indian Health Services (IHS) or other Tribally-funded health and human services. The Contractor shall establish specific mechanisms for improving coordination with Tribes and Tribal agencies in Nebraska, including:

a. Identify and appoint a Tribal Liaison, to work with IHS and 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 Contractor's network;

c. Development of processes and procedures to coordinate eligibility and service delivery with Urban Indian Health Centers and provider facilities owned and operated by a Native American Tribe and authorized to provide services pursuant to Public Law 93-638;

d. Inclusion within the broader processes of the Contractor's QAPI Program specific methods to gather and analyze data regarding satisfaction and broader input from Members who are also Tribal Members and from providers owned and/or operated by a Native American Tribe and located in Nebraska; and

e. Develop methods for regular planning to coordinate on at least a quarterly basis with IHS, Veterans Administration, 638 providers, Urban Indian Centers, and other involved agencies to coordinate and facilitate behavioral health service delivery.

8. CARE COORDINATION TO ENSURE CONTINUITY OF CARE DURING KEY TRANSITIONS

The Contractor shall develop, implement, and monitor written policies and procedures consistent with existing state policies and procedures, regarding continuity of care. These written protocols shall be reviewed on an annual basis by the Contractor and updated as needed. In particular, the policies and procedures shall address the following situations:

a. Members whose treating qualified service provider becomes unable to continue service delivery for any reason;
b. Member transitions from the children's system to the adult system;
c. Member transitions to and from IHS or other Tribal agencies;
d. Member discharges from inpatient and residential treatment levels of care; and
e. Member discharges and transitions for children and youth leaving DCFS and other juvenile justice facilities for the continuance of prescribed medication and other behavioral health services prior to reentry into the community.

9. UTILIZATION MANAGEMENT

Utilization Management (UM) is the component of care management that evaluates the medical necessity of health care services according to established criteria and practice guidelines to ensure that the right amount of services are provided when the Member needs them. UM also focuses on individual and system outliers that require review to assess if individual Members are meeting their goals and if service utilization across the system is meeting the goals for delivery of community-based services.

a. The Contractor's UM program shall comply with federal utilization control requirements, including the certification of need and recertification of need for continued stay inpatient settings, including PRTF;
b. The Contractor shall require inpatient hospital and residential treatment providers to comply with federal requirements regarding utilization review plans, utilization review committees, plans of care, and medical care evaluation studies as prescribed in 42 CFR 441 and 456. The Contractor shall actively monitor all of the UM activities it conducts for compliance with federal and State Medicaid requirements and adherence to its QM/UM Plan;
c. The Contractor shall develop service authorization procedures with the input, review and approval of the Clinical Advisory Committee, subject to approval by MLTC, and it shall implement such procedures as of the start date of the contract. The Contractor shall:

i. Incorporate the definition of medical necessity as specified in the Medicaid State Plan for covered behavioral health services, inclusive of service definitions and levels of care, into Contractor documents, where applicable;
ii. Place appropriate limits on service delivery (applying criteria, such as clinical guidelines for utilization control), provided the services that are delivered can be reasonably expected to achieve their purpose;
iii. Not arbitrarily deny a required service solely because of the Member's diagnosis, type of illness, or condition (this also applies to the Contractor's subcontracts);
iv. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;
v. Consult with the requesting network provider, when appropriate;

vi. Provide a mechanism in which a Member may submit, whether verbally or in writing, a service authorization request for the provision of services. This process shall be included in its Member manual and incorporated in the grievance procedures as per 42 CFR §431.201; and

vii. Make authorization decisions and provide notice as follows:

a) Emergencies do not require prior authorization; and

b) For standard authorization decisions, make a decision 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 following timeframes:

1). For outpatient and rehabilitation services, as well as any non-24-hour diversionary service, the Contractor shall make a decision within five (5) business days of the request, and shall provide a written notice to both the Member and the network provider on the next business day after the decision is made. To the extent possible, the Contractor shall develop provisions to notify providers electronically via secure means of authorization decisions;

2). For expedited service authorization decisions, where the network provider indicates and the Contractor determines that following the standard timeframe outlined immediately above 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 their 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, the Contractor shall make a decision and provide notice no later than three (3) business days after receipt of the request for service. The Contract may extend the three (3) business days' time period by up to fourteen (14) calendar days if the Member requests an extension, or if the Contractor justifies a need for additional information and documents how the extension is in the Member's interest (available for review upon MLTC request). For non-emergent expedited service authorization decisions, the Contractor shall make a decision as expeditiously as the Member's health condition requires, with a routine expectation that decisions are made within 24 hours in 50% of cases, 48 hours in 90% of cases, and never any longer than within three (3) business days after receipt of the request for service, other than in cases in which an extension to fourteen (14) calendar days is made. Such an extension to fourteen (14) calendar days shall be allowed only if:

i) The Member has had necessary treatment authorized to address the immediate needs of their health condition; and either
ii) The Member or the network provider requests an extension; or
iii) The Contractor can justify (to MLTC upon request) that (a) the extension is in the Member's interest, and (b) there is a need for additional information where there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

c) The Contractor shall notify the network provider orally and notify both the Member and the network provider in writing of any denial or decision to authorize services in an amount, duration, or scope that is less than requested on the day that the decision is made;

d) The Contractor shall 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, according to federal regulations at 42 CFR 210(e);

e) The Contractor shall require providers to maintain medical record content consistent with the utilization and control requirements of 42 CFR 456. For medical records and any other health and enrollment information that identifies a particular Member, the Contractor shall establish and implement procedures consistent with confidentiality requirements in 45 CFR parts 160 and 164; and

f) The Contractor shall develop procedures to provide for expedited resolution of appeals. The Contractor shall establish and maintain an expedited review process for appeals, when the Contractor determines (for a request from the Member) or the provider indicates (in making the request on the Member's behalf or supporting the Member's request) 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. The procedure shall incorporate the following requirements:

1). Protections against punitive action. The Contractor shall ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a Member's appeal;

2). Action following denial of a request for expedited resolution. If the Contractor denies a request for expedited resolution of an appeal, it shall: (a) Transfer the appeal to the timeframe for standard resolution in accordance with the terms of this section; (b) Make reasonable efforts to give the Member oral notice

(generally within 24 hours of the denial), and follow up within two (2) calendar days with a written notice;

3). This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an action or require a notice of action. The Member may file an appeal in response to this decision;

4). Failure to make a timely decision. Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the Contractor's decision. If a determination is not made by the above timeframes, the Member's request will be deemed to have been approved as of the date upon which a final determination should have been made;

5). The Contractor is required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution. The Member or provider may file an expedited appeal either orally or in writing. No additional follow-up may be required; and

6). The Contractor shall inform the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

g) The Contractor shall develop or adopt clinical guidelines to govern the authorization of services provided under the contract. All clinical guidelines shall be in compliance with the requirements of Nebraska Administrative Codes and federal requirements:

1). Title 471 NAC 20-000 (Psychiatric Services) and Title 471, NAC 35-000 (Rehabilitation Services) for Members 21 years of age and older; and

2). Title 471, NAC 32-000 (Mental Health and Substance Use Disorder Treatment Services) for Members 20 years of age and younger.

h) The Contractor shall establish an internal UM Committee that focuses on oversight of clinical service delivery trends across individual Members, including evaluating utilization/patterns of care and key utilization indicators such as, but not limited to, re-hospitalizations within seven (7) days, high cost, high service utilization cases, high and low service use outliers, and access to care concerns. The UM Committee is chaired or co-chaired by the Medical Director and reports its findings to the Quality Assessment and Performance Improvement (QAPI) Committee. The UM Committee shall review, at a minimum:

1). Need for and approve any changes in UM policies, standards and procedures, including approval and implementation of clinical guidelines, and approving and monitoring the UM program description and work plan;

2). Grievances and appeals (including expedited appeals and State Fair Hearings) related to UM activities to address required changes;

3). Information from UM/CM operations relevant to system gaps are identified and shared with provider network staff through this committee; and

4). Results from internal audits of CM/UM (e.g., live call monitoring and documentation reviews) to effect changes in policies and procedures and plan training events.

i) The Contractor shall develop a UM Plan and shall implement service authorization procedures for specific behavioral health Covered Services, including, but not limited to the following categories of services:

1). Inpatient Service Authorization

The Contractor shall develop inpatient service authorization policies and procedures, submit them to MLTC for review and approval no later than one month prior to the contract start date, and implement them on the contract start date. Unless the Contractor proposes and MLTC approves alternative policies and procedures, the policies and procedures shall include, at a minimum, the following:

i) A plan and system in place to direct Members to the least intensive clinically appropriate service;

ii) A system for ensuring that, to the extent permitted by law, authorizations for inpatient admissions occur following a crisis assessment and determine that the admission of the Member is medically necessary;

iii) Processes to ensure placement for Members who require behavioral health inpatient services when no inpatient beds are available;

iv) A system for authorizing and assigning an initial length of stay for all admissions, and communicating information on the assigned length of stay to the Member, facility and attending physician;

v) A system of concurrent review for inpatient services to monitor the medical necessity of the need for continued stay and achievement of behavioral health inpatient treatment goals that includes provisions for multiple day approvals when the episode of care is reasonably expected to last more than one day, based on the medical necessity determination;

vi) A system for addressing discharge planning during initial authorization and concurrent review;

vii) A system to ensure post inpatient services is in place to support a safe, timely discharge plan;

viii) A system for conducting retrospective reviews of the medical records of selected inpatient authorizations, to assess the medical necessity, clinical

appropriateness, and appropriateness of the level of care and duration of the stay; and

ix) A system for ensuring that the inpatient services network provider asks for the Member's consent to notify the Member's PCP that the Member has been hospitalized and to request from the NE PH-MCO's assignment of a PCP if the Member does not currently have one.

2). Outpatient and Rehabilitation Service Authorization.
The Contractor shall develop outpatient and rehabilitation service authorization policies and procedures, submit them to MLTC for review no later than one month prior to the contract start date, and implement them on the service start date. Unless the Contractor proposes alternative policies and procedures, the policies and procedures shall include, at a minimum, a system that operates 24 hours a day, seven days a week for:

i) Outpatient services;

1. A policy and system that reviews the initial treatment service request based on clinical guidelines and medical necessity and then authorizes up to 24 sessions without variance for the type of provider performing the service;
2. A policy and system that reviews and authorizes the need for additional services based on clinical guidelines and medical necessity, beyond 12 sessions; and
3. A policy and system for conducting retrospective review of cases to ensure medical necessity;

ii) Rehabilitation services:

1. A policy and system for reviewing provider requests for medical necessity and authorization of services for up to six (6) months based on clinical guidelines and medical necessity;
2. A policy and system that reviews and authorizes the need for additional rehabilitation services beyond 6 months, based on clinical guidelines and medical necessity;
3. A policy and system for conducting retrospective review of cases to ensure medical necessity; and;
4. A policy and system for generally informing network providers of the Contractor's protocols for approving

outpatient and rehabilitation services, such as including such protocols in the provider manual.

10. RETROSPECTIVE UTILIZATION AND REVIEW OF NETWORK PROVIDERS

a. The Contractor shall develop a description of its approach to retrospective utilization review of network providers and submit it to MLTC for approval no later than six months after the contract start date;

b. Such approach shall include a system to identify utilization patterns of all network providers by significant data elements and established outlier criteria for both inpatient and outpatient services;

c. The Contractor shall not under any circumstance utilize contingency fee-based, third-party contracts for the retrospective review of medical necessity and coding;

d. The Contractor must also specify a reasonable appeal process that includes: standard communication with reasonable timelines, industry standards that are clearly communicated and developed with provider and other stakeholder review and input, and opportunities for independent peer provider review of denied claims;

e. The Contractor must conduct retrospective and peer reviews of a sample of network providers to ensure that the services furnished by network providers were provided to Members, were appropriate and medically necessary, and were authorized and billed in accordance with the Contractor's requirements.

f. The Contractor shall have the responsibility for conducting provider reviews related to Medicaid compliance issues;

g. Claims denied payment through retrospective review must be denied individually (i.e., that each claim denied must be specifically reviewed) 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; and

h. The Contractor shall develop and implement utilization review (UR) functions for examining trends, issues, and problems in utilization, particularly over and under-utilization that may need to be addressed programmatically. The Contractor shall:

- **i.** Develop and implement utilization review procedures, based on best practices in the industry, that focus resources on individual and system outliers;
- **ii.** Develop and implement processes (based in part on clinical decision support, claims and outcome data and medical record audits) for each provider that monitor and report for under-and over-utilization of services at all levels of care, including monitoring behavioral health providers' utilization of services by race, ethnicity, gender, and age; and
- **iii.** Review utilization data to ensure services are being provided in a manner consistent with medical necessity for individuals of all ages and the Principles of Care. When the Contractor detects over or under-utilization to the expected level, the Contractor shall specifically monitor and track utilization of the following services:

a) Crisis services;

b) 24 hour levels of care, including inpatient, PRTF and other residential services;

c) Out-of-home placements for children/youth;

d) Other intensive services, such as assertive community treatment and intensive outpatient programs, to ensure utilization is consistent with practice guidelines; and

e) Other indicators of under- or over-utilization based on the Contractor's utilization and clinical data. Pharmacy data for under-and over utilization and potential inappropriate utilization. As part of this monitoring, the Contractor shall use the pharmacy data to identify potential medication side effects, adverse drug interactions, Member adherence, and indications of prescription abuse. MLTC shall provide pharmacy claims data to the Contractor for Members utilizing specialized behavioral health services. In addition, the Contractor shall:

1). Take reasonable steps to ensure that network providers prescribe pharmaceuticals in accordance with the policies and instructions provided by MLTC and reflected in the State of Nebraska's Preferred Drug List, and other Nebraska publications;

2). Provide prescribers with Members' drug utilization data obtained from MLTC and the Nebraska Drug Use Review (DUR) board to inform prescribing activity. As part of this effort, the Contractor shall:

i) Work to improve collaboration across prescribers, thereby reducing conflicting or duplicate prescribing; and

ii) Assist Members in understanding their prescriptions and engage them in education about their medication and efforts to improve their compliance with prescribed medication regimens, including their ability to effectively communicate about their own preferences and needs with their prescribers to promote shared decision-making;

iii) Provide reports to PCPs, other PCP plan providers, and network providers on the patterns of prescription utilization by Members in an effort to increase collaboration across providers and reduce inappropriate prescribing patterns; and

iv) Provide to admitting physicians at behavioral health network inpatient hospitals, and if directed by MLTC, admitting physicians at other acute hospitals, sufficient pharmaceutical claims and utilization data to support medication reconciliation for Members, both at the time the Contractor authorizes admission to a behavioral health network inpatient psychiatric unit, and subsequently, upon request, in order to:

1. Encourage the use of medications that will not require prior authorization if it is

reasonably expected that the Member will continue to use the drug after discharge;

2. Improve consistency in understanding and use of prescribed medications for Members;
3. Reduce disruptions in the Member's medication regimen; and
4. Reduce incidence of harmful drug-to-drug interactions.

3). Manage the prescribing of psychoactive medications to Members age 20 and under.
To support this effort the Contractor shall:

i) Measure psychopharmacology usage and prescribing patterns for the population of Members age 20 and under;
ii) Monitor the use of and the claims related to psychopharmacology for Members age 20 and under to identify target populations (e.g., age subsets) for proposed interventions;
iii) Prepare Member-specific profiles of medication use based on the pharmacy data to inform Contractor interventions with prescribers;
iv) Develop interventions that reduce unsupported atypical antipsychotic prescribing and unsupported prescribing of multiple medications to the same Member:
v) Implement such interventions upon the approval of MLTC; and
vi) Report to MLTC on the results of the intervention;
vii) Support MLTC pharmacy initiatives by promoting and communicating the adoption of clinical policy recommendations to PCP plan providers and behavioral health network providers; and
viii) In consultation with the DUR board, propose to MLTC additional pharmacy interventions focused on Members.

11. PRACTICE GUIDELINES

The Contractor shall adopt, disseminate, and apply practice guidelines developed in collaboration with MLTC for children with SED and adults with SPMI, and other practice guidelines the Contractor chooses to adopt for all Members, consistent with CMS requirements in 42 CFR 438.236. The practice guidelines must be approved by the Clinical Advisory Committee and MLTC.

a. The Contractor shall utilize medical management criteria and practice guidelines that:

i. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
ii. Considers the needs of Members;

iii. Are adopted in consultation with contracted health care professionals; and

iv. Are reviewed and updated periodically as appropriate, but at least annually.

As part of the implementation planning for the contract, the Contractor shall collaborate with MLTC, and with the Clinical Advisory Committee on the development of appropriate practice guidelines.

The Contractor shall use practice guidelines as a basis for decisions regarding UM, Member education, provider education, coverage of services, and other areas to which practice guidelines apply;

b. The Contractor shall implement practice guidelines in a manner that includes steps to maintain and ensure fidelity to the guidelines. At a minimum, the Contractor shall monitor practice guidelines implementation annually through peer review processes and collection of fidelity measures through its Quality Assurance and Performance Improvement (QAPI) Committee;

c. Using information acquired through quality and utilization management activities, the Contractor shall recommend to MLTC each year the implementation of practice guidelines within the behavioral health delivery system, including measures of compliance, fidelity, and outcomes and a process to integrate practice guidelines into care management and utilization reviews, subject to monitoring by the QAPI Committee;

d. The Contractor shall disseminate the practice guidelines to qualified service providers, post them on its website, and, upon request, disseminate them to Members utilizing behavioral health services. The Contractor shall also provide qualified network providers with technical assistance and other resources to implement the practice guidelines;

e. The Contractor shall perform Early Periodic, Screening, Diagnostic, and Treatment (EPSDT) Services and Access to EPSDT Exams under the Medicaid NMMPH Program;

f. The Contractor shall authorize all medically necessary covered behavioral health services that may be recommended or ordered pursuant to an EPSDT periodic or inter-periodic examination; and

g. The Contractor shall facilitate access to medically necessary behavioral health services recommended pursuant to an EPSDT examination when requested by the Member or designated representative or when the Contractor otherwise determines that it is necessary and appropriate as follows.

12. QUALITY MANAGEMENT

a. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI) REQUIREMENTS

The Contractor's QAPI program shall include constant evaluation of the Contractor's operations and the specialized behavioral health systems of care under its management. The Contractor's QAPI program shall be consistent with and responsive to the State physical health Medicaid managed care program, and the Contractor must be able to incorporate relevant variables from the state's Quality of Care Reporting System. At a minimum, the Contractor will utilize a quality improvement strategy to detect both under-utilization and over utilization of services and to assess the quality and appropriateness of care

furnished to Members with special health care needs. The Contractor's annual Quality Management Work Plan must be approved by the State of Nebraska.

i. Compliance with State and Federal Requirements

The Contractor shall develop, implement, and maintain a comprehensive program for QAPI consistent with federal requirements at 42 CFR 438.204, and with the utilization management(UM) program required by CMS for MLTC's overall Medicaid program, as described in 42 CFR 456 – Utilization Control.

ii. Accreditation

The Contractor must either have NCQA accreditation, or another national certification, or it must show significant progress toward the establishment of NCQA accreditation, or another national certification. Official documentation must be submitted at the time of submission. In addition, the Contractor must have the capacity to report required HEDIS measures and performance measures.

The Contractor must include QM processes to assess, measure, and improve the QOC provided to Members in accordance with:

a) All QM requirements identified in the contract;
b) The DHHS CMS Quality Strategy;
c) All state and federal regulatory requirements;
d) Other applicable documents incorporated by reference;
e) Identify and resolve systems issues consistent with a continuous quality improvement (CQI) approach;
f) Disseminate information to MLTC, Members, providers, and key stakeholders, including families/caregivers, and promote public availability of data regarding performance;
g) Solicit feedback and recommendations from key stakeholders, subcontracts, Members, and families/caregivers, and use the feedback and recommendations to improve the quality of care and system performance; and
h) Track progress in implementation of, as well as measure and enforce adherence to, the Principles of Care defined in the Contract. Measurement and compliance with adherence to these principles shall be promoted and enforced through the following strategies, at a minimum:

1). Use of QAPI findings to improve practices at the subcontract and Contractor levels;
2). Timely reporting of findings and improvement actions taken and their effectiveness; and
3). Dissemination of findings and improvement actions taken and their effectiveness to key stakeholders, committees, Members, families/caregivers, and posting on the Contractor's website.

iii. Data Collection

The Contractor shall collect data and conduct data analysis with the goal of improving the quality of care within the behavioral health system. The Contractor's information system will support the QAPI process by

collecting, analyzing, integrating, and reporting data necessary to the State's Quality Strategy. All collected data shall be available to the MLTC. The data shall provide information on areas including, but not limited to, utilization, grievances and appeals. The system shall also collect data on Member and provider characteristics as specified by the state and on services furnished to Members through an encounter data system. The Contractor shall ensure that data received from providers is accurate and complete by:

a) Verifying the accuracy and timeliness of reported data;
b) Screening the data for completeness, logic, and consistency;
c) Collecting service information in standardized formats to the extent feasible and appropriate;
d) The Contractor shall participate in the review of QI findings and shall take action as directed by MLTC;
e) The Contractor shall have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program;
f) The Contractor shall participate in developing, implementing, and reporting on performance measures and topics for performance improvement projects (PIPs) required by other state or federal agencies, including performance improvement (PI) protocols or other measures, as directed by MLTC; and
g) The Contractor shall report performance data to DHHS in formats approved, in advance, by MLTC.

iv. Quality Improvement Staffing
The Contractor shall have a sufficient number of qualified personnel to comply with all QM requirements in a timely manner, including external quality review activities, and avoid review and monitoring activities unlikely to affect service delivery or quality of care.

v. Methodology
The Contractor shall further develop, operationalize and implement the outcome and quality performance measures listed above with the QAPI Committee, with appropriate input from, and the participation of, MLTC, Members, family members, and other stakeholders. The Contractor shall report to MLTC the results and findings of its outcome and performance measures compared to expected results and findings from performance improvement efforts and activities planned/taken to improve outcomes. The Contractor shall use an industry-recognized methodology, such as SIX SIGMA or another method(s) for analyzing data. The Contractor shall demonstrate inter-rater reliability testing of evaluation, assessment, and utilization management (UM) decisions.

vi. Satisfaction
The Contractor shall conduct an annual Member and provider satisfaction survey as directed and prior approved by MLTC, and it shall report complete results to MLTC. Satisfaction surveys shall include input from the QAPI Committee and the Contractor shall indicate to MLTC, in its attempt to obtain MLTC approval, specifically how family members, youth, and adult consumers have employed the design and

methodology of each survey. In addition, surveys shall be conducted within the following guidelines:

a) Frequency
The Contractor shall measure the satisfaction of all Members served, Members with complex needs, and providers once during each contract year.

b) Implementation
The Contractor shall commence the collection of data on Members, Members with complex needs, and provider satisfaction via survey by the end of the first year of operations and annually thereafter. The Contractor shall complete the data collection, analysis, interpretation and final reporting to MLTC by the end of the first year of the contract and annually thereafter.

c) Methodology of the Member Surveys
The methodology utilized by the Contractor shall be based on proven research methods ensuring an adequate sample size and statistically valid and reliable data collection practices with a confidence interval of at least 95% and scaling that results in a clear positive or negative finding (neutral response categories should in general be avoided). The Contractor shall utilize measures that are based on current scientific knowledge and clinical experience. The survey shall specifically address satisfaction with and perceived utility of the appeal and grievance process for Members, their families, and providers. The Member survey will also include questions about perceptions of the utility of services, including:

1). Whether Members and guardians of child Members reported that they received the services they believed they needed;
2). Perceptions regarding participation in treatment;
3). Access to prevention interventions; and
4). Whether transportation supports were adequate (particularly in rural areas).

d) Methodology of the provider Survey
The Contractor shall conduct a provider satisfaction survey using a provider survey instrument approved by MLTC. The methodology utilized by the Contractor shall be based on proven research methods ensuring an adequate sample size and statistically valid and reliable data collection practices with a confidence interval of at least 95% and scaling that results in a clear positive or negative finding (neutral response categories should in general be avoided). The Contractor shall utilize measures that are based on current scientific knowledge and clinical experience. The survey shall, at a minimum, address the provider's satisfaction with the Contractor's services and other administrative services provided by the State or its agents, including but not limited to authorization, courtesy and professionalism, network management services, provider

appeals, provider education, referral assistance, coordination, claims processing and the perceived administrative burden experienced by providers providing behavioral health services.

vii. Respondent Groups

a) Members and Members with special needs
Samples of Members 18 years of age and older and caregivers/family members of children and youth should be included in all Member surveys. Samples should be representative of Members and caregivers / family members based on the type of question asked.

b) Providers
For the provider survey, all providers should be administered the survey.

viii. Consumer – Led and Family – Led Evaluations
The Contractor shall include consumer-led and family-led evaluation methods in its quality monitoring system, involving as researchers: adult consumers, youth over the age of 17, and family members/guardians of child Members served. Methods may include participatory action research. There should be at least two focuses:

a) A consumer-driven evaluation of adult service issues;
b) A family- and youth-driven evaluation of child and young adult service issues; and
c) The consumer- and family-led evaluation component must be approved by MLTC prior to implementation. The evaluations should include appropriate incentives to promote consumer, youth and family participation in the evaluations. These evaluations should be:

1). Operated independently by consumers and family members and not administratively managed by the Contractor; and
2). Focused on evaluation to learn about the experiences of people served by the Contractor.

d) The Contractor must have a contract or a written and signed agreement with each organizational entity conducting consumer- and family-led evaluation that delineates roles and responsibilities of all parties;
e) Under the contract or written agreement, the consumer- and family-led evaluation team members will act as agents of the Contractor, and are, therefore, to have the same access to consumers and family members as the Contractor and network providers, insofar as it is necessary to perform their responsibilities;
f) Consumer- and family-led evaluation team members must be paid at least as much as other persons in the broader workforce doing similar work in the same community;

g) The consumer- and family-led evaluation team must be independent from any provider of behavioral health services or any other agency that might create a conflict of interest. If a team does not have accounting capabilities, it may contract with a provider as its fiduciary, provided the contract safeguards the independence of the evaluation team for program direction, including budget priorities, satisfaction surveys, findings, and recommendations;

h) The Contractor shall work with the consumer- and family-led evaluation teams to establish an annual plan for conducting evaluations;

i) The Contractor will ensure that the consumer- and family-led evaluation teams have adequate financial resources, training, support, and necessary equipment for the program to produce high quality quarterly reports;

j) The Contractor will identify and ensure that the consumer- and family-led evaluation teams conduct outreach efforts to under-served or un-served groups of consumers and families in order to identify system improvements that will increase the access, engagement and retention of these individuals in needed behavioral health services;

k) All employees of consumer- and family-led evaluation programs must comply with applicable state and federal laws, regulations, and rules regarding the confidentiality of mental health consumers and recipients of drug and alcohol treatment services;

l) The contract or written agreement will address confidentiality requirements;

m) Consumer- and family-led evaluation teams must provide feedback to the Contractor through written quarterly reports and regular problem resolution meetings that allow for dialogue and review of findings. The Contractor is responsible for timely reports back to the consumer- and family-led evaluation teams on specific actions and problem resolution resulting from identified issues, concerns and problems;

n) The Contractor will ensure that consumer- and family-led evaluation team members have both an initial orientation and on-going training in the following areas:

1). Basic knowledge of mental illness and addictive diseases and an understanding of the concept of recovery and resilience in relation to both adults and children and adolescents. Persons performing youth and family evaluation activities must also have an understanding of severe emotional disturbance and substance use disorders for children and adolescents;

2). Confidentiality regulations for mental health and substance use disorder services. Family and youth evaluation team members must also receive training in confidentiality issues relevant to the child and adolescent population in both mental health and substance use disorder services. Training must include an understanding of responsibilities, as applicable, under the

Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 CFR Part II; and

3). Orientation/training on the Contractor's managed care operations, policies and procedures for satisfaction team members.

o) Quarterly Reports. The Contractor shall provide MLTC with the consumer- and family-led evaluation teams' quarterly report summarizing consumer and family evaluation findings, as well as improvement actions and system changes implemented by the Contractor in response to those findings; and

p) The Contractor shall monitor and evaluate qualified service providers in order to promote improvement in the quality of care provided to Members. The Contractor shall detail a provider monitoring plan in the required Annual Quality Management Plan.

ix. Quality Reporting

a) Quality Management and Utilization Management Reporting
The Contractor shall monitor and report QM and UM data and other performance improvement activities to MLTC. The Contractor shall submit, in writing to MLTC, in a format collaborated with and approved by MLTC, the following, but not limited to, QM/UM deliverables related to the quality of care and services in the health plan:

1). The Contractor shall report results of measuring or assessing outcomes and quality, and shall incorporate these performance indicators into performance improvement projects. To the extent possible, results should be posted publicly on the Contractor's website immediately after being accepted by the QAPI Committee and reported to MLTC;

2). Any outcomes and quality indicators based on a sample of the overall Member, family, and/or provider population must include demonstration 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; and

3). Outcomes and quality indicators will include to the extent practicable, but are not limited to, the following:

i) All of the metrics involved in the performance guarantees and incentives described in the Financial Section;
ii) Call center performance;
iii) Service utilization, including trends, outliers, expenditures, and length of stay in each service by level of care, including new services developed (for example, peer support and respite). This will include standard measures, such as use/days per 1000

Members and penetration rates overall and by level of care. This will also include breakouts by age group;

iv) Seven and 30-day post-discharge (residential and acute care) ambulatory follow-up appointments; and

v) Racial and ethnic disparities (e.g., under-utilization of services by particular racial/ethnic groups) and cultural and linguistic competency. The Contractor is encouraged to utilize indicators consistent with the National Standards on Culturally and Linguistically Appropriate Services (CLAS) to include, but not limited to:

    1. Racial & Ethnic Disparities: PRTF admissions over 90 days; and
    2. Differences in service penetration rates across population groups.

vi) Access – Differences in service penetration rates across population groups;

vii) Perceptions of Care – Differences across population groups' perceptions that services are effective, understandable and respectful (this includes consumer satisfaction);

viii) Restraint and seclusion use – Track by provider the number of incidents of restraints and seclusion by program location. Involve consumer and family advocates, along with inpatient and residential providers, in the development of restraint and seclusion reporting requirements;

ix) Provider network adequacy;

x) Results of targeted quality assurance network activities for high volume providers;

xi) Monitoring psychotropic medications for children ages 12 years and under, including vulnerable populations such as children in foster care or in state custody;

xii) Performance related to grievances and appeals, including types, resolution time frames, and analysis of trends. This will include reporting of individual provider appeal rates and outcomes by level of care;

xiii) The actual number and percentage of Members involuntarily presenting for Mental Health and Substance Use Disorder treatment to 24- hour inpatient settings;

xiv) The actual number and percentage of Members presenting to hospital emergency departments (ED) within thirty (30) days of the discharge date from an acute level of care for any psychiatric or substance use disorder diagnosis – without an admission;

xv) Proportion of youth in PRTF and other residential settings with lengths of stay under 90 days;

xvi) Wait times for residential placement that measure time from initial referral to authorization to actual placement;

xvii) Admissions and readmissions to psychiatric inpatient (including PRTF) and residential facilities;
xviii) Continuity of care measures (within 7 days) from psychiatry inpatient facilities to community services;
xix) Number of children placed in residential treatment settings, relative to number of Medicaid Members, and relative to national benchmarks;
xx) Screening for Clinical Depression and Follow Up Plan;
xxi) Antidepressant Medication Management;
xxii) Adherence to Antipsychotics for Individuals with Schizophrenia;
xxiii) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment;
xxiv) Crisis services utilization, relative to number of persons (broken out by child/adolescent and adult) served and to national benchmarks; and
xxv) Emergency department utilization, using benchmarks and age breakouts.

x. External Quality Reviews
External Quality Reviews (EQR) /Independent Assessments. The Contractor and its subcontracts shall cooperate with annual, external, independent reviews performed by an EQR organization (EQRO) or independent assessor of quality outcomes, timeliness of and access to services, upon MLTC request. The Contractor shall include in its QM Work Plan, to be approved by MLTC, plans for addressing problem areas identified by the EQRO in its assessment.

b. MLTC QUALITY REVIEWS

The Contractor shall make available records and other documentation, and ensure Subcontractors' participation in and cooperation with, the annual on-site operation review of the Contractor, and any additional QM reviews. This may include participation in staff interviews and facilitation of Member/family/caregiver and subcontract interviews.

The Contractor shall use QM review findings to improve quality of care. The Contractor shall take action to address identified issues, as directed by MLTC, which may require a plan of correction, if the Contractor is determined by MLTC to be performing below quality standards.

The Contractor and its subcontractors shall cooperate with DBH and participate, as necessary, in SAMHSA core reviews of services and programs used by Members that are funded by DBH through the SAPT and CMHS Performance Partnership Grants. Core review findings shall be communicated to the Contractor's QM program and shall be used by the Contractor to enhance and improve the delivery of grant related services for Members. The development and implementation of a corrective action plan with specific, measurable, and time-limited corrective action steps is also required if weaknesses/challenges are identified during the core review. The corrective action plan shall be approved and accepted by SAMHSA and/or MLTC.

c. PERFORMANCE IMPROVEMENT

As part of its QAPI program, the Contractor shall conduct at least two (2) performance improvement projects outlined in its annual Quality Management Work Plan that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on behavioral health outcomes and Member satisfaction. The Contractor shall report the status and results of each project to the state as requested and as outlined in the most recent Nebraska MLTC Quality Strategy Plan.

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

At a minimum, the performance improvement projects shall involve the following:

i. Measurement of performance using objective quality indicators;

ii. Implementation of system interventions to achieve improvement in quality;

iii. Evaluation of the effectiveness of the interventions;

iv. Planning and initiation of activities for increasing or sustaining improvement; and

v. The Contractor shall include among its performance improvement projects at least one clinical issues study each contract year. The Contractor may submit more than one study idea, among which MLTC and the QAPI Committee will select one for approval.

a) During each year of the contract, propose to MLTC the scope of the clinical issues studies, by date TBD;

b) Submit to MLTC by date TBD or such other date as agreed to by MLTC and the Contractor, for their review and approval, a draft of the study report for each clinical issue study. The study report shall, at a minimum, include recommendations for intervention;

c) Implement the report recommendations upon approval by MLTC and the QAPI Committee; and

d) Use a methodology based on accepted research practices ensuring an adequate sample size and statistically valid and reliable data collection practices. The Contractor shall use measures that are based on current scientific knowledge and clinical experience. Qualitative or quantitative approaches may be used as appropriate.

d. QUALITY IMPROVEMENT COMMITTEE

i. The Contractor shall provide a mechanism for the input and participation of Members, Families/caretakers, MLTC and other stakeholders in the monitoring of service quality and determining strategies to improve outcomes.

ii. The Contractor shall form a QAPI Committee no later than one month following acceptance of the MLTC contract terms, form a QAPI

Committee. The Contractor's Medical Director shall serve as either the chairperson or co-chairperson of the QAPI Committee.

The Contractor shall include as members on the committee, at a minimum, the following:

a) The Contractor's Quality Management Administrator;
b) Contractor managers representing utilization management;
c) Member services;
d) Provider network management;
e) Two family members/guardians of children or youth who are Medicaid Members;
f) Two adult consumers who are Medicaid Members;
g) Six provider members knowledgeable about Mental Health and Substance Use Disorder treatment for children, adolescents and adults in Nebraska across a variety of ages and races/ethnicities, including awareness of differences between rural and urban populations and representing a range of service providers., the MLTC Quality Manager; and a liaison member from the MLTC Quality Committee; and
h) To the extent possible, family members and consumers should be nominated by family and consumer organizations in Nebraska. In addition to the six family, youth, and adult Member representatives, there will be at least two non-voting apprentice members in each category (two family, two youth, two adult members) that participate in the QAPI Committee regularly.

iii. The Contractor's QAPI Committee shall:

a) Review for approval prior to implementation the Contractor's QM Work Plan and program description that incorporates its initiatives, strategies, staff time and organization, methodologies for on-going quality assurance, quality improvement, and concurrent system for identifying issues that require immediate attention of MLTC;
b) Require the Contractor to study and evaluate issues that the MLTC may from time to time identify;
c) Establish annual performance targets as described in the Performance Targets and Withhold section;
d) Review for approval all Member and provider surveys;
e) Define the role and guidelines for the QAPI Committee, set agendas, and produce meeting summaries;
f) Include Members who have received services and family members, supporting them with training, stipends for their participation (if they are not otherwise paid for their participation as staff of an advocacy or other organization), and reimbursement for any travel, child care or other reasonable participation costs (not otherwise reimbursed by another party) to enable their participation; and
g) Annually, and as requested, provide data to the MLTC Quality Committee, which meets annually to review data and information relevant to the MLTC Quality Strategy. The Contractor shall incorporate into its QAPI program and annual QM Work Plan the

recommendations from the MLTC Quality Committee concerning performance improvement projects, study methodologies, improvement goals, and interventions to achieve improvement goals.

iv. Additional required committees shall include:

a) Clinical Advisory Committee;
b) Corporate Compliance Committee;
c) Provider Advisory Committee; and
d) Utilization Management Committee.

The additional required committees will report on at least a quarterly basis to the QAPI Committee, and the QAPI Committee will monitor their performance as part of its annual quality management work plan.

N. INFORMATION SYSTEM (IS) REQUIREMENTS

1. HEALTH INFORMATION SYSTEMS – REQUIREMENTS

The Contractor must maintain a health information system that collects, analyzes, integrates, and reports data. Reporting formats will be determined by the State after contract award. Contractor must provide documentation on its Health Information System that ensures data received from providers is accurate and complete by:

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

2. HEALTH INFORMATION SYSTEMS – FUNCTIONS

The Contractor must be able to perform the following functions electronically:

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. Accept prior authorization requests in a HIPAA compliant 278 format;
e. Allow claims inquiry and response in a HIPAA compliant 276/277 format;
f. Accept HIPAA compliant electronic claims transactions in the 837 format;
g. Generate HIPAA compliant electronic remittance in the 835 format;
h. Submit encounter data via a HIPAA 837 format; and
i. Make claims payments via electronic funds transfer.

3. HEALTH INFORMATION SYSTEMS – ENCOUNTER DATA

The Contractor must collect data on member and provider characteristics as specified by the State and on services furnished to members through an encounter data system. The Contractor must be able to submit encounter data in a format specified by the state. The Contractor must also be capable of submitting encounter data via ASC X12 formats.

The Contractor must maintain an information system that includes the capability to collect data on potential member and provider characteristics, and claims information through an encounter data system. The Contractor must submit encounter data to the

Medicaid Management Information System (MMIS) monthly per Departmental specifications.

Encounter data submission must:

a. Be submitted on a monthly basis;
b. Be submitted accurately and meet the Performance Measures for Submission and Acceptance as outlined in numbers 18. and 19. in the table under Section IV.O.11.a.v, Performance Guarantees; and
c. Include all clean claims adjudicated by the Contractor; and all services provided to the member, contracted or delegated.

Encounter data that does not meet the Submission and Acceptance rate thresholds will be rejected and reported to the Contractor. The Contractor is required to re-submit corrected encounter data in a timely manner. Contractor's which fail to meet compliance standards for submission of encounter data will result in a corrective action plan and monetary penalties, as described in Section IV.O.11.b, Performance Assessment.

4. HEALTH INFORMATION SYSTEMS – INFORMATION AVAILABILITY

The Contractor must make all collected data available to the State and, upon request, to CMS.

The Contractor's IS shall support the following key functions:

a. Twenty-four (24) hour, seven (7) days a week toll free telephone access line with user and technical support;
b. Customer services (including eligibility);
c. Care management;
d. Quality management;
e. Grievances and appeals, and incident reporting;
f. Provider network management;
g. Notification of Member rights and responsibilities;
h. Financial reporting;
i. Claims administration;
j. Utilization;
k. Implementation planning;
l. Business continuity, disaster recovery and emergency preparedness;
m. Performance measurement and accountability;
n. State and federal reporting requirements, including consistency with the MLTC and DBH data dictionaries;
o. Secure electronic data interchange as needed to accomplish the above functions;
p. State access to client-level data; and
q. The IS shall provide the required capacity for electronic data collection, analysis, transfer, error resolution and reporting of data at the client level and will provide the required data to the Medicaid Medical Information System (MMIS) for, reporting, and auditing.

i. The Contractor shall utilize current state and federal standards and procedures (e.g., HL7; HIPAA; NPI; CMS; CPT; ICD-10) for this system and will maintain a uniform service and provider (credentialing) taxonomy for billing and information management purposes. The

Contractor shall provide technical assistance and consultation to providers on establishing the means for effective, ongoing electronic collection and transfer of required data.

ii. The scope of coverage of the IS will be for all programs and services provided through the Contractor, as well as data to allow coordination with publically financed non-Medicaid services provided to the Contractor's Members as reported by other Nebraska state agencies.

iii. The data content will include, but may not be limited to, the following data sets: Client data (socio-demographic and contact information; unique client ID); assessment data (including diagnoses in current DSM format; level of functioning scores); service encounter data (e.g., date, type, duration, recipient, provider); episode data (e.g., service program; unique episode ID; date of first contact; date of admission; date of last contact; date of discharge); programmatic data (e.g., service population and eligibility; payer source; fee schedules); individual claims data; and provider data (e.g., provider agency, name, unique provider ID, discipline). The technical specifications of these data will be in keeping with current state and federal for data content. The Contractor must be able to make modifications to the data system during the term of the contract to reflect changes in the MLTC, and MLTC systems and/or federal reporting requirements. Such updates shall be available at agreed upon intervals, and notice of such updates given to service providers (preferably via electronic means) as soon as determined.

iv. The Contractor will be expected to at least bi-weekly update and monthly transfer this data set in a format and file structure (including requisite documentation) required by MLTC. The Contractor shall document the process and procedures for data management in keeping with the changing reporting requirements of the state and federal government and local programs. The Contractor will be expected to provide MLTC current documentation of the data set, process, and procedures.

v. The Contractor shall be responsible for providing training and support of all provider staff utilizing the data management system.

vi. The Contractor shall perform data quality management, in conjunction with MLTC in order to demonstrate that the data are accurate, appropriate, complete, and reported timely across all program units.

5. CARE MANAGEMENT AND CARE COORDINATION INFORMATION

The Contractor shall have the following IS capacity to facilitate care coordination:

a. PROVIDER INFORMATION

The Contractor shall have the capacity to collect, analyze, electronically and securely transfer, report, and utilize data from multiple service provider sources, and the capacity to adapt and upgrade these functions as necessary with future changes to the service and administrative operations of the program.

b. PHARMACY DATA

MLTC will provide a monthly download of pharmacy claims data to the Contractor for enrolled Members to allow routine monitoring of prescribed medications. The Contractor shall have the ability to accept and analyze electronic pharmacy data from DHHS and report on individual Member and aggregate pharmacy utilization data and provider prescribing practices, as well

as other similar reports on Member pharmacy utilization for quality management purposes.

i. The Contractor shall have the capacity to populate the Members' care management records with prescribed medications as identified through pharmacy data provided by DHHS. If medications are prescribed, the Contractor must obtain a list of medications prescribed by primary care providers (PCPs) and other specialists for a complete and reconciled medication list that is updated every 90 days.

c. Medication information will be made available in electronic format to providers treating the Member on a regular basis, in accord with data sharing requirements. For inpatient and PRTF admissions, current data on pharmacy claims will be shared with the inpatient provider within 24 hours. For other levels of care, current data on pharmacy claims will be shared with the provider within seven calendar days initially and updated regularly thereafter every thirty (30) days.

d. HEALTH PLAN AND PCP ASSIGNMENTS

The Contractor shall have the capacity to electronically accept data on Member health plan assignments from MLTC or the health plan for purposes of identifying PCPs and to incorporate PCP information into the care management record. The Contractor should receive at least monthly (and preferably weekly) data extracts from MLTC or Medicaid health plans documenting current PCPs for all Medicaid Members. The Contractor shall develop in collaboration with MLTC and Medicaid health plans a data sharing and notification system.

e. COORDINATION BETWEEN PCPS AND BH PROVIDERS

Using authorization and claims data, when Medicaid Members receive services from the provider network, the Contractors IS notification capacity will generate supporting communication electronically.

f. MEMBERS ALREADY ASSIGNED PCPS

Two sets of communication (preferably secure email or other secure electronic means) will be generated, one to the network behavioral health provider informing that provider of the name and contact information for the Member's PCP (including the health plan's procedures for emergency contact for that PCP regarding physical health needs) and one to the PCP informing that provider that behavioral health care has been authorized and the name and contact information of the network behavioral health provider.

g. MEMBERS WITHOUT AN ASSIGNED PCP

Two sets of communication (preferably secure email or other secure electronic means) will be generated by the Contractor, one to the Member's health plan requesting a PCP referral (when a Member does not have a PCP) and informing the health plan that behavioral health care has been authorized (along with the name and contact information of the network behavioral health provider) and one to the network behavioral health provider informing that provider of the initiation of a referral to a PCP. The arrangement with the physical health plans will also include provisions for them to notify the Contractor once a PCP assignment has been made, including the provider's name and contact information, and the Contractor will notify the behavioral health network provider.

6. PROVIDER NETWORK MANAGEMENT SYSTEM SUPPORT

The Contractor shall provide information technology support to manage the provider network including, but not limited to, the provider administration, including credentialing, contracting, provider database for referrals, web-based communications, provider manual, and provider complaints, as well as performance requirements defined throughout the contract.

7. CLAIMS PAYMENT

a. CLAIMS PROCESSING REQUIREMENTS

i. The Contractor shall provide an integrated claims processing and payment system for Medicaid services within the managed care program. This system will have the capability to perform eligibility, billing, accounts receivables, accounts payable, remittance advices, prior authorization, fiscal management, provider enrollment, and any other required function to manage claims for Medicaid and all State funding sources.

ii. The Contractor shall maintain a website, with both public and secure access multi-level portals (such as providers, managers and Members), for providing data/measure manuals, web-based training, standard reports, evaluation tool, and data access as needed for the effective management and evaluation of the performance of the Contractor and the service delivery system. The website may be combined with the Member services website required under the Member services requirements of the Contract.

iii. The Contractor shall conform to HIPAA-compliant standards. Transaction types are subject to change and the Contractor shall timely comply with applicable federal and HIPAA standards and regulations as they occur.

iv. The Contractor shall plan for changes such as, but not limited to, the new ANSI 5010 formats and implementation of ICD-10 diagnosis and inpatient procedure codes.

a) Upon request, the Contractor shall provide MLTC with their ICD-9 code mapping to ICD-10 coding equivalents and ICD-10 coding combinations.

v. The Contractor shall require that their providers comply at all times with standardized billing paper forms and electronic formats, and all future updates for Professional and Institutional claims. All data shall be submitted to MLTC in the standard 5010 HIPAA transaction formats, specifically the ANSI X12N 837 provider-to-payer-to-payer COB transaction formats (P - Professional, and I - Institutional).

a) The Contractor shall not revise or modify the standardized forms or formats without agreement of all parties;

b) The Contractor shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms; and

c) The Contractor shall ensure that ninety percent (90%) of clean claims for payment of services delivered to a Member are paid by the Contractor to the provider within thirty (30) calendar days

of the receipt of such claims. Process and if appropriate, pay within ninety (90) calendar days, ninety-nine percent (99%) of all provider claims for Covered Services delivered to a Member.

vi. If a claim is partially or totally denied on the basis the provider did not submit required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice shall specifically identify all necessary information and documentation that is needed for the claim to be processed. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the timeframe for claims processing.

vii. On every claim processing day, the Contractor shall utilize a randomly selected sample of all processed, adjusted, and paid or denied claims. A minimum sample of two percent of those daily claims shall be audited. Results from the audits shall be collected and reported to MLTC monthly. The minimum attributes to be tested for each claim selected shall include:

a) Claim data correctly entered into the claims processing system with an assigned transaction number;
b) Claim is associated with the correct provider;
c) Service obtained the proper authorization;
d) Authorization limits are not exceeded;
e) Member eligibility at processing date correctly applied;
f) Allowed payment amount agrees with contracted rate;
g) Duplicate payment of the same claim has not occurred;
h) Denial reason applied appropriately;
i) Co-payment application considered and applied;
j) Effect of modifier codes correctly applied;
k) Proper coding consistent with the provider's credentials;
l) Adjustments to claims are properly made with supporting documentation;
m) Payment is coordinated properly when other insurance is applicable; and
n) The results of testing, at a minimum, should be documented to include:

1). Results for each attribute tested for each claim selected;
2). Amount of overpayment or underpayment for each claim processed, adjusted or paid in error;
3). Explanation of the erroneous processing for each claim processed, adjusted or paid in error;
4). Determination if the error is the result of a keying error or the result of error in the configuration or table maintenance of the claims processing system; and
5). Claims processed, adjusted or paid in error have been corrected.

o) The Contractor shall perform front end system edits, including, but not limited to:

1). Confirming eligibility on each Member as claims are submitted on the basis of the eligibility information

provided by MLTC that applies to the period during which the charges were incurred;

2). Medical necessity – the system shall validate that medical necessity was determined;

3). Prior approval – the system shall determine whether a covered service required prior approval and if so, whether the Contractor granted such approval;

4). Duplicate claims – the system shall in an automated manner, flag a claim as being exactly the same as a previously submitted paid claim or a possible duplicate and either deny or pend the claim as needed;

5). Covered Services - ensure that the system can verify that a service is a covered service and is eligible for payment;

6). Provider validation - ensure that the system shall approve for payment only those claims received from providers eligible to render service for which the claim was submitted;

7). Quantity of service - ensure that the system shall evaluate claims for services provided to Members to ensure that any applicable benefit limits are applied; and

8). System edits for valid dates of service, and assures that dates of services are valid dates such as not in the future or outside of a Member's Medicaid eligibility span.

The location of claims processing staff shall be indicated and shall be at minimum located in the continental United States.

b. DATA CERTIFICATIONS

The Contractor must certify encounter data as provided in 42 CFR 438.606.

i. The data must be certified and shall include, but is not limited to, all documents specified by the State, enrollment information, encounter data, and other information contained in contracts, proposals;

ii. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. The MCO or PIHP must submit the certification concurrently with the certified data and documents; and

iii. For the data and documents the MCO or PIHP submits to the State, they must be certified by one of the following:

a) The MCO's or PIHP's Chief Executive Officer;

b) The MCO's or PIHP's Chief Financial Officer; or

c) An individual who has delegated authority to sign for, and who reports directly to, the MCO's or PIHP's Chief Executive Officer or Chief Financial Officer.

8. THIRD PARTY RESOURCES (TPR)

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

a. Pursuant to federal and State law, the Medicaid program is intended to be the payer of last resort. This means all other available Third Party Liability (TPL)

resources must meet their legal obligation to pay claims before the Medicaid/CHIP program pays for the care of an individual eligible for Medicaid/CHIP;

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

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

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

e. Establishing TPL takes place when the Contractor receives confirmation that another party is, by statue, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or services delivered to any member.

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

f. If a Third Party Liability insurer requires the member to pay any co-payment, coinsurance, or deductible, the Contractor is responsible for making this payment even if the services are provided outside of the Contractor network;

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

h. The Contractor shall post all third party payments to claim level detail by member;

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

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

k. 4The Contractor must provide TPL data to any provider having a claim denied by the Contractor based upon TPL;

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

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

n. 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 Contractor's reports encounter data;

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

p. Any money recovered by third parties shall be retained by the Contractor and identified monthly to MLTC;

q. If MLTC determines that the Contractor is not actively engaged in cost avoidance activities, the Contractor shall be subject to monetary penalties in an amount not less than three times the amount that could have been cost avoided; and

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

O. TRANSITION AND IMPLEMENTATION

1. TRANSITION PERIOD

The Transition Period for the contract shall begin upon contract award and shall end 90 days after the contract start date. During the Transition Period the Contractor shall implement the terms of the Contract and collaborate with MLTC to facilitate a seamless transition between Contractors, providers and programs in order to prevent interruption of services and to promote continuity of care to Members.

2. PRELIMINARY IMPLEMENTATION PLAN

The Contractor is responsible for submitting a Preliminary Implementation Plan with this proposal. The Preliminary Implementation Plan shall include all the major areas of the contract including:

a. Member services;
b. Network Development and Management;
c. Credentialing;
d. Care Management;
e. Utilization Management;
f. Service Coordination;
g. Information Management;
h. Claims Payment; and
i. Grievance and Appeals.

3. In addition, the Preliminary Implementation plan must include Human Resource Development and Staffing, Customer Service, Facilities and Data/Telephone and other pertinent operational issues as identified in this RFP and the Contractor's proposal. The Preliminary Implementation Plan shall include activities, deliverables and milestones to implement the program.

4. Upon contract award, the Contractor shall immediately begin a collaborative process with MLTC to review the contract, proposal and Preliminary Implementation Plan. The Contractor shall provide MLTC with verbal and written Implementation Plan updates and shall cooperate and communicate with MLTC to resolve transition and implementation issues to MLTC' s satisfaction.

5. The Contractor shall appoint key staff to participate in the transition coordination/collaboration process and must include at a minimum:

- **a.** Administrator/CEO/COO;
- **b.** Medical Director/CMO;
- **c.** Clinical Director/Manager;
- **d.** Operations Manager/Director;
- **e.** Network Services Director/Manager;
- **f.** Information Technology Director/Manager; and
- **g.** Quality Improvement Director/Manager.

6. THE TRANSITION/IMPLEMENTATION PROCESS IN COLLABORATION WITH MLTC SHALL:

- **a.** Define project management and reporting standards;
- **b.** Establish communication protocols between the Contractor, MLTC and existing Providers; and
- **c.** Define expectations for content and format of Contract deliverables.

7. IMPLEMENTATION PERIOD AND PLAN

- **a.** The Contractor shall develop a updated, detailed comprehensive Implementation Plan to monitor progress throughout the Transition and Implementation Periods; and
- **b.** The Contractor shall include in the Implementation Plan a detailed description of its implementation methods, staff assigned to be accountable for completing tasks and timetables, including, at a minimum, the following components:

  - **i.** Staffing Plan;
  - **ii.** Written work plan with tasks, task descriptions and timeline for completion;
  - **iii.** Data Systems Plan including system readiness testing and acceptance testing plan and a data conversion plan to include, at a minimum, intake, closure, eligibility, demographics, encounters, and other file data;
  - **iv.** Network Development Plan;
  - **v.** Clinical Transition Plan, Utilization and Care Management;
  - **vi.** Quality Improvement Plan including Grievance and Appeals;
  - **vii.** Customer Service Plan;
  - **viii.** Member Communication Plan;
  - **ix.** Security, business continuity, disaster recovery, and contingency plan;
  - **x.** Plan to meet other administrative start-up requirements;
  - **xi.** Transfer of electronic data and records;
  - **xii.** Member Handbook and Provider Manual completion;
  - **xiii.** Claims and eligibility interface development;
  - **xiv.** Compliance plan;
  - **xv.** Financial reporting plan;
  - **xvi.** Orientation and training plan; and

xvii. Post-implementation deliverables.

8. PERSONNEL

No later than two (2) months after contract award, the Contractor shall designate its Key Personnel. Prior to the Contract Start Date, the Contractor shall submit to MLTC the resumes of each Key Personnel position for MLTC approval and updated organizational charts. The Contractor shall have sufficient personnel working and operating in Nebraska during the Transition Period and Implementation Period in order to be fully compliant with the terms of the Contract.

9. TRANSITIONING OF BEHAVIORAL HEALTH RECIPIENTS AND OPERATIONS

a. When applicable, the Contractor shall transition behavioral health recipients receiving services so care is not disrupted;

b. The Contractor shall collaborate with the existing Contractor and providers to develop and implement a behavioral health recipient's service plan during the transition and deliver all services contained in the plan;

c. At a minimum, the Contractor shall provide service information, emergency telephone numbers, and instructions on how to obtain additional services to each behavioral health recipient involved in the transition of care;

d. The Contractor shall transition pending grievances, appeals, and customer service cases to assure timely resolution; and

e. The Contractor shall have a sufficient number of qualified staff to meet filing deadlines and attend all court or administrative proceedings.

10. OPERATIONAL AND FINANCIAL READINESS REVIEWS

a. Prior and subsequent to the Contract Start Date, the Contractor shall cooperate with the MLTC Operational and Financial Readiness Review process to assess the Contractor's readiness and ability to provide covered behavioral health services to behavioral health recipients and to resolve any identified operational deficiencies;

b. Upon MLTC's determination, request and approval, the Contractor shall develop and implement a corrective action plan in response to deficiencies identified during the Readiness Review;

c. The Contractor shall commence operations only if the Readiness Review factors and corrective action plan requirements are met to MLTC's satisfaction; and

d. At a minimum, the Contractor shall cooperate with MLTC to review the following areas:

i. Network sufficiency and management including reviews of subcontracts;
ii. Staffing adequacy;
iii. Customer service;
iv. CM/UM/QM;
v. Financial management;
vi. Information processing and system testing;
vii. Transition of behavioral health recipients;
viii. Routine communications with behavioral health recipients;
ix. Continuity of care for behavioral health recipients;
x. Network sufficiency; and
xi. Continuity of pending grievance, appeal, and customer service cases.

e. During the Readiness Review, the Contractor shall provide MLTC with access to staff, documentation and work space as requested by MLTC.

11. PERFORMANCE MEASUREMENT

a. PERFORMANCE GUARANTEES

i. The Contractor agrees performance guarantees and incentives shall become effective on the contract start date and remain in effect for a period of twelve (12) consecutive calendar months. In accordance with quality improvement goals, MLTC reserves the right to reevaluate, reset and add to the current performance guarantees and incentives and their corresponding threshold levels annually. The Contractor shall receive advance written notice of any changes in performance guarantee or incentive measures, thresholds, goals and related requirement in accordance with terms in the contract. Unless otherwise modified, performance guarantees and incentives shall automatically renew at the start of each new contract year;

ii. The Contractor shall submit performance reports on established metrics to DHHS on a month-by-month basis or upon DHHS' request, as well as quarter-by-quarter basis and year-to-date annualized reports. The Contractor shall submit reports in accordance with the established metrics in the contract, with all methods subject to review and approval by the State;

iii. Once submitted to and approved by the State, such metrics should also be posted publicly on the Contractor's website for the program;

iv. The Contractor shall meet and require its Subcontractors to meet the MLTC Minimum Performance Standards and Goals for services delivered to members. The table below identifies the Minimum Performance Standards and Goals for each required aspect of performance. If the Contractor's performance falls below an identified standard or goal or previous performance levels, the Contractor shall develop and implement a corrective action plan that must be approved by MLTC. The Contractor's corrective action plan shall define the problem, describe recommended interventions to improve performance, describe interim monitoring to measure the effectiveness of the interventions, and set a measurable threshold for discontinuation of the corrective action plan. The Contractor shall require a corrective action plan from any Subcontractor that fails to meet the MLTC Minimum Performance Standards; and

v. The Contractor shall cooperate with any MLTC reviews or other audits to verify compliance. If the Contractor does not comply with the corrective action plan, MLTC may impose any available remedy under the Contract.

		Performance Guarantee Threshold		Contract Incentive Threshold	
Item #	**Measures**	**Threshold**	**Percent Allocation[1]**	**Threshold**	**Percent Allocation[2]**
	Claims Administration				

		Performance Guarantee Threshold		Contract Incentive Threshold	
Item #	**Measures**	**Threshold**	**Percent Allocation[1]**	**Threshold**	**Percent Allocation[2]**
1.	**Financial payment (dollar) accuracy**: % of audited claim dollars paid accurately • Calculated as the total audited "paid" dollars minus the absolute value of over- and/or under- payments, divided by the total audited paid dollars. • Measurement using monthly system-generated reports.	97%	10%	n/a	n/a
2.	**Procedural accuracy**: 99% of audited claims processed without procedural error • Calculated as the total number of audited claims minus the number of claims processed with procedural error, divided by the total number of audited claims. • Measurement using monthly system generated reports.	99%	10%	n/a	n/a
3.	**Turn Around Time (TAT)** 99% of all provider claims paid within 90 days	99% within 90 days	n/a	100% of incentive awarded when 99% of claims paid at or before 60 days; prorated to 90 days.	10%
	Telephone responsiveness				
4.	**Call Abandonment Rate:** Member/ Provider calls less than 3 percent	< 3%	5%	n/a	n/a

Item #	Measures	Performance Guarantee Threshold		Contract Incentive Threshold	
		Threshold	Percent Allocation[1]	Threshold	Percent Allocation[2]
	• Percentage of calls that reach the 800 line and are placed in queue but are not answered because the caller hangs up before a representative answers the call. • Measured using annual system-generated reports.				
5.	**Average Speed to Answer (ASA):** Member/Provider Services Line(s) all calls answered within 30 seconds • Measured using annual system-generated reports from first ring to live answer on 24/7 single point of entry 800 line.	30 seconds	5%	n/a	n/a
	Clinical				
6.	**Ambulatory follow up within 7 days of discharge from 24-hour facility** (inclusive of acute inpatient, PRTF and residential) - Report percent of individuals discharged from a 24-hour facility with an ambulatory follow-up appointment within 7 days of discharge. - Measurement using current NCQA HEDIS specifications. - Measurement using system-generated report. - Reported annually as percent with follow-up within specified timeframe.	Above HEDIS 50th percentile for Medicaid plans as reported in the most recent version of NCQA Quality Compass	5%	Above the HEDIS 60th percentile for Medicaid plans as reported in the most recent version of NCQA Quality Compass	10%
7.	**Ambulatory follow up within 30 days of discharge from 24-hour facility** (inclusive of acute inpatient,	Above HEDIS 50th	5%	Above HEDIS 60th	10%

Item #	Measures	Performance Guarantee Threshold		Contract Incentive Threshold	
		Threshold	Percent Allocation[1]	Threshold	Percent Allocation[2]
	PRTF and residential) • Report percent of individuals discharged from a 24 hour facility with an ambulatory follow-up appointment within 30 days of discharge of discharge. • Measurement using current NCQA HEDIS specifications. • Measurement using system-generated report. • Reported annually as percent with follow-up within specified timeframe.	percentile for Medicaid plans as reported in the most recent version of NCQA Quality Compass		percentile for Medicaid plans as reported in the most recent version of NCQA Quality Compass	
8.	**Readmission Rate:** less than 12 percent of Members readmitted within 30 days to inpatient level of care (inclusive of acute facilities and PRTF) • Measurement using system-generated reports. • Percentage of Members readmitted (to the same level of care) within 30 days of the discharge date from an acute level of care for any psychiatric or substance use disorder diagnosis.	< 18%	10%	<12%; receive 100% for below 12% (pro rated between 12% and 18%);	10%
9.	**30 Day Post-Admit ED Visits:** Percent of Members presenting to hospital Emergency Departments (ED) within 30 days of the discharge date from an acute level of care for any psychiatric or substance use disorder diagnosis without an admission. • Baseline data will be collected for the first contract period of	Year One monitor only; Year Two set at pre-contract and Year One baseline	n/a	Year One monitor only; Year Two set at marginal improvement over pre-contract / Year One baseline	n/a

Item #	Measures	Performance Guarantee Threshold		Contract Incentive Threshold	
		Threshold	Percent Allocation[1]	Threshold	Percent Allocation[2]
	the risk-based contract. • Based on this, in contract Year Two, a Risk Allocation Threshold equal to the baseline year will be set for a penalty of at least 10% of the risk amount and an incentive goal of a substantial reduction in ED use will be set for an incentive of at least 12% of the incentive set aside.				
10.	**Involuntary Admissions:** The actual number and percent of Members involuntarily presenting for mental health and substance use disorder treatment to 24-hour inpatient settings. • Baseline data will be collected for the first contract period of the risk-based contract. • Based on this, in contract Year Two, a Risk Allocation Threshold equal to the baseline year will be set for a penalty of at least 10% of the risk amount and an incentive goal of a substantial reduction in ED use will be set for an incentive of at least 12% of the incentive set aside.	Year One monitor only; Year Two set at pre-contract and Year One baseline	n/a	Year One monitor only; Year Two set at marginal improvement over pre-contract / Year One baseline	n/a
11.	Follow-Up Care for children **Prescribed Attention Deficit Hyperactivity Disorder (ADHD)** Medications • Percentage of children newly prescribed ADHD medication that had at least three follow-up care visits within a10-month period, one of which was within	Year One monitor only; Year Two set at pre-contract and Year One baseline	n/a	Year One monitor only; Year Two set at marginal improvement over pre-contract / Year One	n/a

Item #	Measures	Performance Guarantee Threshold		Contract Incentive Threshold	
		Threshold	Percent Allocation[1]	Threshold	Percent Allocation[2]
	30 days from the time the first ADHSD medication was dispensed, including two rates: one for the initiation phase and one for the continuation and maintenance phase.			baseline	
12.	**Initiation and Engagement of Alcohol and Other Drug – 004 NCQA** • The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization with 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit. • Dependence Treatment: (a) Initiation, (b) Engagement.	Year One monitor only; Year Two set at pre-contract and Year One baseline	n/a	Year One monitor only; Year Two set at marginal improvement over pre-contract / Year One baseline	n/a
13.	**Discharge Plans:** 90% of all discharge plans written for members being released from a mental health inpatient hospitalization shall be written		n/a	90%	10%
	Satisfaction				
14.	**Annual Member Satisfaction Survey**: % positive response rate • Members shall rate "satisfied" or better on the annual Member satisfaction survey approved by the State; the rating method shall be balanced so that there are an equal number of satisfied and not satisfied	85%	10%	95%; 100% of incentive awarded at 95% or higher; prorated between 85% and	10%

Item #	Measures	Performance Guarantee Threshold		Contract Incentive Threshold	
		Threshold	Percent Allocation[1]	Threshold	Percent Allocation[2]
	response options and no neutral option (not applicable can be an option, as appropriate). • Survey domains to include consumer and family involvement and choice in treatment planning. • Sampling must include both adult consumers and parents/caregivers of child consumers, in proportions deemed by the State to be comparable to the distribution of Members served. • The sampling methodology must yield a 95% confidence interval with +5% error rate, including response rate as a factor.			95%	
15.	**Annual Professional Providers Satisfaction Survey:** 85% positive response rate • Providers shall rate "satisfied" or better on the annual provider satisfaction survey; the rating method shall be balanced so that there are an equal number of satisfied and not satisfied response options and no neutral option (not applicable can be an option, as appropriate). • Sampling must include (1) child and adult providers, and (2) urban and rural providers.	85%	10%	95%; 100% of incentive awarded at 95% or higher; prorated between 85% and 95%	10%

Item #	Measures	Performance Guarantee Threshold		Contract Incentive Threshold	
		Threshold	Percent Allocation[1]	Threshold	Percent Allocation[2]
	• The sampling methodology must yield a 95% confidence interval with +5% error rate, including response rate as a factor. • The survey must specifically address Contractor education to providers on administrative (e.g., claims submission) and clinical issues, promotion of administrative simplification in provider interface with the health plan, timely payment of claims, and use of due process in denied or disputed claims.				
16.	**Annual Facility Satisfaction Survey**: 85% positive response rate • Providers shall rate "satisfied" or better on the annual provider satisfaction survey; the rating method shall be balanced so that there are an equal number of satisfied and not satisfied response options and no neutral option (not applicable can be an option, as appropriate). • Sampling must include (1) inpatient and outpatient providers, and (2) urban and rural providers. • At least 30% of the facilities must respond. • The survey must specifically address Contractor education to providers on administrative (e.g., claims submission) and	85%	10%	95%; 100% of incentive awarded at 95% or higher; prorated between 85% and 95%	10%

Item #	Measures	Performance Guarantee Threshold		Contract Incentive Threshold	
		Threshold	Percent Allocation[1]	Threshold	Percent Allocation[2]
	clinical issues, promotion of administrative simplification in provider interface with the health plan, timely payment of claims, and use of due process in denied or disputed claims.				
	Account Management				
17.	**Timely completion of Implementation or Annual Plan Milestones:** • Compliance measured as the number of milestones satisfactorily completed according to MLTC by the date specified in the implementation schedule or annual project schedule as a percent of all milestones that were due under the implementation plan during the quarter. • Contractor to provide specific plans for review and approval by MLTC • Milestones not met in one quarter carry over into next quarter for evaluation. Milestones carried over. • Milestones missed due to factors beyond Contractor control will not be counted in measurement.	90%	10%	n/a	n/a
18.	**Encounter Submission Rate:** The Contractor must maintain an information system that includes the capability to collect data on	90% and written analysis	5%	95%; 100% of incentive awarded at	5%

Item #	Measures	Performance Guarantee Threshold		Contract Incentive Threshold	
		Threshold	Percent Allocation[1]	Threshold	Percent Allocation[2]
	potential enrollee and provider characteristics, and claims information through an encounter data system. The Contractor must submit encounter data to the Medicaid Management Information System (MMIS) monthly per Departmental specifications. Encounter data submission must: a) Be submitted on a monthly basis; b) Include 90% of all clean claims adjudicated by the Contractor; c) Annual written report analyzing encounters not being submitted along with improvement plan			95% or higher; prorated between 85% and 95%	
19.	**Encounter Acceptance Rate:** a) 90% of encounters submitted need to be accepted by MLTC's Medicaid Management Information System (MMIS) pursuant to Departmental specifications. b) Annual written report analyzing encounters not being submitted along with improvement plan	90% and written analysis	5%	95%; 100% of incentive awarded at 95% or higher; prorated between 85% and 95%	5%
20.	**Appeals:** 90% of appeals will be resolved as expeditiously as the enrollee's health condition requires and within 14 calendar days from the date the Contractor received the appeal			90% within 14 days	5%
21.	**Grievances:**			90% within	5%

		Performance Guarantee Threshold		Contract Incentive Threshold	
Item #	Measures	Threshold	Percent Allocation[1]	Threshold	Percent Allocation[2]
	90% of grievance will be resolved as expeditiously as the enrollee's health condition requires and within 14 calendar days from the date the Contractor received all information necessary to resolve the grievance, and 100% must be resolved within 90 calendar days of the receipt of all required documentation			14 days; 100% within 90 days	
	TOTALS		100%		100%

b. PERFORMANCE ASSESSMENT

i. The penalty and incentive payments will be calculated quarterly to track progress. Payment will be made annually based on a calculation of the entire year's performance. Payments will be determined 6 months after the end of the contract year to allow the data to complete;

ii. Proceeds from any penalties assessed, incentives, MLR and/or risk corridor not realized shall be transferred from the Reinvestment Holding Escrow Account and added to the Reinvestment Escrow Fund, described in more detail below;

iii. In the event of contract termination, the Contractor or Reinvestment Escrow Fund shall receive/pay any monies owed with respect to the guarantees, incentives, MLR and risk corridor rebates within one hundred and twenty (120) days of the termination of the contract. The Contractor will cease and MLTC will assume duties and responsibilities to both escrow fund administrators for the Reinvestment Holding Escrow Account and the Reinvestment Escrow Fund;

iv. The Contractor shall cooperate with MLTC in its verification and audit of all performance measurement results. For performance guarantee measurement purposes, the Contractor shall submit self-reported results, which are subject to a data integrity analysis. Unless otherwise approved by MLTC, the Contractor's maximum error rate in submitted data shall be five percent (5%). The Contractor shall pay the full risk penalty and earn no incentive based on the applicable metric when its submitted data submission does not meet these thresholds for accuracy; and

v. The Contractor shall cooperate with MLTC if, in its sole discretion, MLTC decides to perform an independent audit each year, covering a three (3) or more month period of the performance guarantee year. If the results of the independent audit are below the Contractor's self-reported results for the period under review, the Contractor shall agree to the independent audit results as the basis for performance guarantee measurement for the full year as the final determination or until the Contractor demonstrates to the State's satisfaction (at the State's sole

discretion) that the reliability of its self-reported results are consistent with independent audit results.

c. FAILURE TO PERFORM

i. Established Damages

In the event the Contractor fails to meet the contract performance standards outlined here, the below ascertained, designated damages may be assessed. If assessed, the designated and ascertained damages below will be used to reduce MLTC's payments to the Contractor or if the damages exceed amounts due from MLTC, the Contractor will be required to make cash payments for the amount in excess.

a) Readiness Review

MLTC will conduct a formal review of the Contractor's readiness to implement managed behavioral health services. To ensure readiness to implement the plan, the Contractor shall meet the pre-implementation deadlines discussed in Section IV.O – Transition and Implementation. Should the Contractor fail to meet the deadline for producing the required Implementation Plan and MLTC determines that the Contractor is responsible for its failure to meet the deadlines. MLTC may assess damages of $5,000 per calendar day. Upon successful completion of the readiness review, MLTC will issue the Contractor an approval letter which authorizes the Contractor to begin operations and authorizes funds for the Medicaid capitation payments for the first month of the contract period.

b) National Accreditation Status

For failure to retain accredited status as required by the terms of the contract, damages of $1,000 for each calendar day of non-compliance shall be assessed.

c) Date of Implementation

Should the Contractor fail to begin full operation of the managed behavioral health plan on September 1, 2013, and should MLTC determine that the Contractor is responsible for the delay, MLTC may assess damages of $150,000 for each month implementation is delayed. The amount of the damages may be prorated, if necessary.

d) Network Performance Requirement

Contractor shall have a contracted provider network in place, sufficient in size and composition to meet the service requirements of the covered population by September 1, 2013. The required attestation of network sufficiency shall be submitted at that time. One thousand dollars ($1,000) shall be assessed, at MLTC' discretion, per calendar day for each day that the provider network is not adequate to meet the service needs of the covered populations.

e) Timely Reports and Data Delivery Performance Requirement
This Performance Requirement applies to all reports and data, excluding encounter data, to be delivered to MLTC or designee as defined in the RFP or by MLTC. Reports and data shall be timely and produced in the format and media approved by MLTC. Encounter data shall be provided in the MLTC- required formats. One thousand dollars ($1,000) shall be assessed for each calendar day, at MLTC's discretion, that each report or data delivery is late, includes less than the required copies, or is not in the approved format.

f) Accuracy of Reports and Data Performance Requirement
The Contractor shall be responsible for the accuracy of all reports, including calculations and completeness of data, excluding encounter data, used as input. If the report is not corrected within five calendar days of the notice of failure to meet the reporting accuracy requirements, then one thousand dollars ($1,000) per day shall be, at MLTC's discretion, assessed for each report that has been identified as inaccurate from the date of notification until the date the MLTC-approved corrected report is delivered.

g) Personnel Performance Requirement
The Contractor shall meet all requirements specified in the Personnel Performance Requirement section of this RFP. One thousand dollars ($1,000) per day per position shall be assessed, at MLTC's discretion, for each day after the thirty allowed calendar days for which a Key Position remains unfilled by a qualified person approved by MLTC. Key Positions include the below positions:

1). Administrator/CEO/COO;
2). Chief Financial Officer (CFO);
3). Medical Director/CMO;
4). Corporate Compliance Officer;
5). Clinical Director/Manager;
6). Operations Director/Manager;
7). Grievance and Appeals System Director/Manager;
8). Care Management/Utilization Review Director/Manager;
9). Quality Management Director/Manager;
10). Information Technology Director/Manager;
11). Provider Network Services Director/Manager;
12). Provider Network Liaison; and
13). Tribal Network Liaison.

h) Contract Termination or Expiration: In the event that a Contractor is terminated or its contract expires, the Contractor shall provide services through the end of the contract term and pay for all covered services for all members for the period for which monthly prepayment has been received prior to the date of contract termination. The Contractor shall provide MLTC and/or its designee with all materials and information related to the Program, members and the services provided to those members,

to ensure a smooth transition to a follow-on Contractor and uninterrupted services. The Contractor shall notify all members who have received services within the past year of the upcoming transition. The notification shall be approved by MLTC and shall be developed in conjunction with a follow-on Contractor, if applicable.

i) The Contractor shall submit for approval a detailed plan for the transition of its Members to a follow-on Contractor which includes the schedule for key activities and milestones.

1). The Contractor shall:

i) Make provisions for continuing all management and administrative services and the provision of direct services to Members until the transition of all Members is completed and all other requirements of the current contract are satisfied;
ii) Designate a person with appropriate training to act as the transition coordinator. The transition coordinator shall interact closely with the Department and the staff from the follow-on Contractor to ensure a safe and orderly transition; and
iii) Provide all reports set forth in this Agreement and necessary for the transition process. This includes providing to the Department, until the Department is satisfied that the Contractor has completed all outstanding obligations, the following additional reports. These reports shall be due on the fifth (5th) day of each succeeding month for the prior month.

1. Monthly claims aging report by provider/creditor including IBNR amounts;
2. A monthly summary of cash disbursements; and
3. List of all outstanding obligations necessary to complete the contract.

2). Notify subcontractors of contract termination or expiration as directed by the Department;

3). Notify all Members that the Contractor will no longer serve as the Member's managed care organization. The Contractor shall be financially responsible for all costs associated with this notification. The notification is subject to MLTC approval;

4). Notify each Participating Provider in writing that the Contractor's contract with MLTC (NE Medicaid) has ended. The written notice shall include the contract end date and shall explain to the Participating Provider how the provider can continue participating in the Medicaid program. The Contractor shall be financially responsible for all costs associated with this notification. The notification is subject to MLTC approval;

5). Complete payment of all outstanding obligations for covered services rendered to Members. The Contractor shall cover continuation of services to Members of the period for which payment has been made, as well as for inpatient admissions up until discharge;

6). Cooperate with a follow-on managed care organization during transition period including, at minimum, sharing and transferring Member information and records. MLTC will notify the Contractor with specific instructions and required actions at the time of transfer;

7). Return any funds advanced to the Contractor for coverage of Members for periods after the contract end date to MLTC within thirty (30) calendar days of the expiration or termination of the contract;

8). Supply all information necessary for reimbursement of outstanding claims; and

9). Provide MLTC, in a format prescribed and approved by the Department:

i) A list of each Participating Provider, including Providers who are not contracted with MLTC;
ii) A list of Members who are receiving case management services;
iii) A list of all services requiring Contractor prior authorization; and
iv) A list of all Members receiving prior authorized services, the approved duration of which extends beyond the contract termination date.

P. FINANCE, REPORTING REQUIREMENTS AND RATE-SETTING

1. MEDICAL LOSS RATIO (MLR) REQUIREMENT FOR CONTRACT YEAR

All contracts and agreements relating to the medical assistance program governing at-risk managed care service delivery for behavioral health service shall provide for a minimum medical loss ratio of eighty five percent (85.0%) of the aggregate of all income and revenue earned by the Contractor and related parties under the contract. The intent of the MLR is to ensure that members receive at least 85% of the developed capitation rate.

MLR shall be defined as Net Qualified Medical Expenses divided by Earned Revenue as they relate to eligible members and services under the contract. The MLR will be defined and calculated on a “run rate” basis (not “booked”). “Run rate” is defined by reporting only incurred expenses and earned revenue that were attributable to activities in the specified contract year. The MLR will be calculated using the BH-Contractor’s submitted “Run Rate” Income Statements. MLTC reserves the right to audit, request additional information, and revise BH-Contractor’s estimates of the MLR calculation.

The MLR shall be calculated after six (6) months, but within nine (9) months of the end of the contract year, based on the formula below. If the CY MLR is less than 85.0%, the BH-Contractor shall forfeit an amount equal to the MLR Rebate formula below.

<u>Medical Loss Ratio Formulas:</u>
MLR = Net Qualified Medical Expenses ÷ Earned Revenue

MLR Rebate = Maximum of $0 and [(85% - MLR) x Earned Revenue]

MLR Rebates will be forfeited to a Reinvestment fund.

2. ADMINISTRATIVE CAP REQUIREMENTS

In compliance with Neb. Rev. Stat. §71-831, 68-908 and 71-801 (2012)., the Contractor's total administrative spending shall not exceed seven percent unless MLTC determines any additional amount above seven percent does not include additional profit and is necessary to improve the health status of the population to be served.

In addition, Total Administration shall not under any circumstances exceed ten percent. To ensure compliance with Neb. Rev. Stat. §71-831, 68-908 and 71-801 (2012), MLTC will separate the Administrative Expense Rate into a Quality Improvement (QI) Administrative Rate and a Non-QI Administrative Rate. The following 2 tests will be calculated within nine (9) months of the end of the contract year based on the formulas below.

a. ALLOWED NON-QI ADMINISTRATION TEST #1

The Non QI Administrative Rate shall not exceed seven percent. The Allowed Non-QI Administrative Rate, therefore shall be the lesser of seven percent or the actual Non-QI Administrative Rate.

b. TOTAL ALLOWED ADMINISTRATION TEST #2

The Total Administrative Rate shall not exceed ten percent (10%). Therefore, the Total Allowed Administrative Rate is the lesser of ten percent or the summation of the items below:

c. ALLOWED NON QI ADMINISTRATION RATE (DEFINED IN TEST #1)
d. ALLOWED QI ADMINISTRATION RATE
e. LESS RELATED PARTY ADMINISTRATIVE MARGIN

3. CY RISK CORRIDOR:

Annual Contractor profits shall not exceed three percent per year and annual losses shall not exceed three percent per year. These profits and losses are calculated as a percentage of the aggregate of all earned revenue by the Contractor and related parties, including parent and subsidy companies and risk bearing partners, under the contract. Excess profits will be forfeited to a Reinvestment Fund.

The Risk Corridor Calculation shall be calculated within nine (9) months of the end of the contract year based on the formula below.

Risk Corridor Calculation:
Risk Corridor Gain/Loss = Earned Premium
- MLR Rebates
- Net Qualified Medical Expenses (calculated for MLR)
- Total Allowed Administration (calculated for Administration Cap)

If the Risk Corridor calculation above produces a gain above three percent, the BH-Contractor shall rebate an amount equal the Risk Corridor Gain less three percent. This risk corridor rebate will be forfeited to the Reinvestment Fund.

If the Risk Corridor calculation produces a loss of more than three percent, the BH-Contractor shall receive an amount equal to any losses above three percent. No monies shall be paid by either party if the Risk Corridor produces an amount between a three percent gain and a three percent loss.

The Risk Corridor and MLR calculations use Earned Premium. These calculations ignore revenue taxes, non-operating income, and forfeited withholds.

4. REINVESTMENT PLAN

a. In compliance with Neb. Rev. Stat. §71-831, 68-908 and 71-801 (2012) and as noted above, a Reinvestment Fund shall be developed and managed by the Contractor for the purpose of subsidizing additional behavioral health services for children, families and adults according to a plan developed with input from stakeholders and MLTC staff, including consumers, family members, the office of consumer affairs, and the Contractor. Such plan shall address the behavioral health needs of adults and children, including filling service gaps and providing system improvements.

b. The Reinvestment Plan will be funded by the following:

- **i.** Forfeited MLR Rebates;
- **ii.** Forfeited Profits above three percent;
- **iii.** Forfeited Performance Guarantees; and
- **iv.** Forfeited Contract Incentives.

c. The Reinvestment Plan and subsequent service provision must be approved by MLTC.

d. The Contractor shall establish two escrow accounts to manage the Reinvestment Fund. The first escrow account, Reinvestment Holding, shall be created as a separate account to hold any funds paid to the Contactor before they become eligible for transfer to the Reinvestment Account. The second escrow account, Reinvestment Account, shall be created separately from other accounts required by the contract, and any other accounts that may be required by State or Federal law, to hold the reinvestment funds once they are eligible for deposit, in accordance with Neb. Rev. §71-831, 68-908 and 71-801 (2012).

A separate Escrow Administrator shall be appointed for each escrow account. Maintenance, accounting and reporting will be collectively determined upon contract award. Funds must be held in accounts that have no risk bearing investments and in accordance with escrow Fund requirements. Any interest accrued on either Fund shall be deposited to the Reinvestment Escrow Fund for use as established in Neb. Rev. Stat. §71-831, 68-908 and 71-801 (2012).

e. The Contractor will be held responsible and accountable for the necessary fiduciary duties and functions required to administer the Reinvestment Fund. Oversight of the financial accounting will be determined by the below financial management reporting.

5. FINANCIAL DATA & REPORTING REQUIREMENTS

a. In addition to any other reports discussed in RFP, MLTC will require a Quarterly and Annual Financial reporting package. The details and timing of the reports

will be developed with the input of the Contractor. Examples of expected reports include, but are not limited to:

i. Certification Statement;
ii. Balance Sheet;
iii. Income Statement;
iv. LAG (IBNR) Report – Summary;
v. Medical Loss Ratio Calculation Report;
vi. Profit/Risk Corridor Calculation Reports;
vii. Related-Party Statements;
viii. Run Rate Income Statement;
ix. Auditor's Report and Report on Internal Controls;
x. Performance/Guarantee/Incentive Calculation Reports;
xi. Annual Disclosure Reports; and
xii. Enrollment/Revenue Reconciliation

b. MLTC will also require the Contractor to electronically provide detailed claims and membership data that ties to the Run Rate Income Statement provided. A data request will be prepared by MLTC that shall include at a minimum, but are not limited to, 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. PMPM Cost;
xi. Member Months;
xii. Month of Service; and
xiii. Month of Payment

The Contractor shall provide for an annual financial audit acceptable to the MLTC for any expenditure of State-awarded funds made by the Contractor. Such audit shall include management letters and audit recommendations. The State Auditors shall have access to all records and accounts for the contract year(s) in which the award was made. The Contractor will comply with Federal and State single audit standards, as applicable. MLTC reserves the right to audit or request an audit (at the Contractor's expense) of any data or report required under the contract.

c. Inspection and audit of financial records. Risk contracts must provide that the MLT and the CMS may inspect and audit any financial records of the Contractor its Subcontractors. There shall be no restrictions on the right of the State or Federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs.

d. Insolvency. The Contractor must provide that its Medicaid enrollees are not held liable for

i. The Contractors debts, in the event of the entity's insolvency;

ii. The covered services provided to the enrollee, for which MLTC does not pay the Contractor;

iii. Covered services provided to the enrollee, for which MLTC or the Contractor does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement; and

iv. Payment for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the Contractor provided the services directly.

a) Protect Against Liability –Subcontractor and referral providers may not bill enrollees any amount greater than would be owed if the Contractor provided the services directly (i.e., no balance billing by providers;

b) Other Requirements. The Contractor must be licensed or certified by the State as a risk-bearing entity;

c) The Contractor must provide assurances that enrollees will not be liable for the Contractor's debt if the Contractor becomes insolvent; and

d) Disclosure of 5% Ownership – The Contractor must notify State of any person or corporation that has 5% or more ownership or controlling interest in the BH MCO.

v. Capitated Managed Care Rate

MLTC will contract with the Contractor using a full-risk arrangement that will pay the Contractor a prepaid monthly capitation payment to cover all services included in the Contractor contract. Capitation is designed to provide the Contractor with a prospectively determined monthly payment so it may provide services that meet program standards. Capitation payments will be made prospectively and electronically based on the enrollment file. MLTC will develop cost-effective and actuarially sound capitation rates in accordance with generally accepted actuarial principles and practices and are appropriate for the populations covered and the services provided under the Scope of Work described in this RFP. Risk adjusted rates will not be considered under the contract. MLTC will also develop capitation rates according to all applicable CMS rules and regulations.

MLTC has developed monthly capitation rates that will be offered to bidders on a "take it or leave it" basis. The monthly capitation rates offered will be in effect for the initial 10-month contract period. See Attachment B for the table of rates.

vi. Development of Prepaid Capitation Payments

Capitation payments were developed using Fee-For-Service data for the eligible populations from Fiscal 2009, 2010, and 2011 using the following adjustments:

a) Utilization trend;
b) Unit cost trend;
c) Medicaid program changes;
d) Managed care savings; and
e) Contractor administrative allowance

In the event any change occurs in federal law, federal regulations, State law, State regulations, State policies, or State Medicaid plan coverage, and MLTC determines that these changes impact materially on pricing, MLTC reserves the right to amend rates paid to Contractors. The Contractor will be required to accept these changes. All proposals shall be based upon the provisions of Federal and State laws and regulations and MLTC's approved Medicaid State Plan coverage in effect on the issuance date of this RFP, unless this RFP is amended in writing to include changes prior to the closing date for receipt of proposals.

vii. Annual Capitation Rate Determinations
For each Contract year, the State and its actuaries will jointly review the information necessary to develop actuarially sound capitation rates. This review will include an analysis of any anticipated fee schedule changes and/or other programmatic changes to the NMMCP, cost reporting information collected from the Contractor, Department of Insurance (DOI) annual statements, various trend data sources, and administrative experience. The State will require the Contractor to provide certified encounter data or other supplemental information to support rate development for future contract periods. The State will establish rates that allow for sufficient time to obtain CMS approval prior to the effective date of the renewal capitation rates.

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

6. DELIVERABLES

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

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

The following deliverables are due at the time of Technical Proposal submission:

a. GRIEVANCE SYSTEMS

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

b. PROVIDER NETWORK

- **i.** Individual GeoAccess maps for hospitals, PCP's, High Volume Specialists, FQHCs, Urgent Care Centers, and ancillary providers for whom letters of intent have been signed;
- **ii.** Written provider agreements that provide adequate access for enrollees;
- **iii.** A listing by provider type/specialty of the providers from whom a signed letter of intent to participate in the provider network has been received; and
- **iv.** The following deliverables, at a minimum, will be due under a contract resulting from this procurement.

c. MEMBER COMMUNICATION

Potential enrollee correspondence proposed to send to enrollees, including Member Handbook.

d. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

Program descriptions including policies, procedures and mechanisms for:

- **i.** Timely access monitoring;
- **ii.** Documentation of adequate capacity and services;
- **iii.** Primary care and coordination of health care services including promotion of Patient Centered Medical Home;
- **iv.** Policies and procedures for authorizing services;
- **v.** Policies and procedures for the selection and retention of providers;
- **vi.** Policies and procedures for safeguarding enrollee confidentiality;
- **vii.** Documentation of sub contractual relationships and delegation;
- **viii.** Clinical practice guidelines; and
- **ix.** A documented Quality Assessment and Performance Improvement (QAPI) Program including, at a minimum:

  - **a)** Description of Quality Assurance committee structure;
  - **b)** Designation of individuals/departments responsible for the QAPI program;
  - **c)** Description of the network participation in the QAPI program;
  - **d)** Credentialing/re-credentialing procedures;
  - **e)** Standards of Care;
  - **f)** Standards for service accessibility;
  - **g)** Medical records standards;
  - **h)** Mechanisms to detect underutilization and overutilization of services;
  - **i)** Mechanisms to assess quality and appropriateness of care;
  - **j)** QAPI program documentation methods;
  - **k)** Integration of quality assurance with other management functions;
  - **l)** Corrective Action plans; and
  - **m)** A health information system:

    - **1).** Policies and procedures for Care Management, including those for high utilizing participants of services; and
    - **2).** Provider Satisfaction Survey Tool and Methodology

e. CERTIFICATIONS AND PROGRAM INTEGRITY

i. Data certification plan; and
ii. Mandatory Compliance plan to guard against fraud and abuse

f. LEGISLATIVELY REQUIRED REPORTING

The deliverable must acknowledge and demonstrate an understanding of the required reporting called for in the following statutes, signed into law in the Legislature of Nebraska, one hundred and second legislature, second session 2012. MLTC-required reporting has not been fully defined to date in these regulations, but is expected within the upcoming months.

i. Neb. Rev. Stat. §81-3134 (2012); and
ii. Neb. Rev. Stat. §68-2005 (2012)

g. MONTHLY REPORTING TO MLTC

The deliverable must include a description of the following required reports. The final formats and contents will be collaborated with the Contractor and approved by MLTC.

i. Claims Processing Report;
ii. Provider Termination Report;
iii. Third Party Liability Report;
iv. Eligible and Number Authorized for Services;
v. State Wards in Residential Care, Group Homes and Foster Care;
vi. Out of State Placement Report;
vii. ICM Report;
viii. Duplicate Services Report;
ix. Multi-Level Readmit Report;
x. Shifted Authorized/Registered Services Report;
xi. Provider Scorecard;
xii. Average Length of Stay Comparison;
xiii. Outpatient Claims Utilization Report;
xiv. Claims Totals by Month; and
xv. Top Primary Diagnosis by Service

h. QUARTERLY REPORTING TO MLTC

The deliverable must include a description of the following required reports. The final formats and contents will be collaborated with the Contractor and approved by MLTC.

i. Provider network adequacy;
ii. Provider access analysis;
iii. Results of fraud and abuse monitoring;
iv. Geo-mapping reports;
v. Grievance and appeals process compliance;
vi. Timely access standards monitoring; and
vii. Utilization Management, including but not limited to:

a) Crisis services utilization, relative to number of persons (broken out by child/adolescent and adult) served and to national benchmarks;

b) Emergency department utilization, again using benchmarks and age breakouts;

c) Crisis services utilization, relative to number of persons (broken out by child/adolescent and adult) served and to national benchmarks; and

d) Emergency department utilization, again using benchmarks and age breakouts

viii. Results of Service verification monitoring;
ix. Out of network referrals monitoring;
x. Care management results;
xi. Quality Oversight Committee Report.;
xii. Network Expansion/Credentialed and Contracted Providers;
xiii. Contracted Residential Bed Numbers;
xiv. Number of Days on Residential Wait List;
xv. Residential Provider Acceptance Rate;
xvi. Call Center Performance;
xvii. Restraint & Seclusion QIA Report;
xviii. 30-Day Inpatient Readmission Rate;
xix. 7-Day and 30-Day Ambulatory Follow-up Following Residential Discharge;
xx. 7-Day and 30-Day Ambulatory Follow-up Rate Following Hospital Discharges;
xxi. Critical Incident Reporting;
xxii. Admissions and readmissions to psychiatric inpatient (including PTRF) and residential facilities;
xxiii. Continuity of care (within 7 days) from psychiatry inpatient facilities to community services; and
xxiv. Number of children placed in residential treatment settings, relative to number of Medicaid members, and relative to national benchmarks

i. ANNUAL REPORTING TO THE STATE

The deliverable must include a description of the following required reports. The final formats and contents will be collaborated with the Contractor and approved by MLTC.

i. Annual Quality Management Work Plan for Upcoming Year;
ii. Performance Measures data;
iii. Results of Quality Management Work Plan;
iv. Performance Improvement Project data and results;
v. Member Satisfaction Survey Results;
vi. Provider Survey Results; and
vii. Results of any corrective action/sanctions of providers

j. POLICIES AND PROCEDURES FOR THE FOLLOWING

i. Advance Directives;
ii. Member Communications;
iii. Third Party Resource (TPR);
iv. Member Rights;
v. Member Free Exercise of Rights;
vi. Compliance with Federal and State Laws and Regulations;
vii. Coverage of Emergency and Post-Hospitalization Services;

viii. Substitute Health Services;
ix. Disease Management Services;
x. Behavioral Health Screening/ Risk Assessment;
xi. Members with Special Needs;
xii. Indian Health Protections;
xiii. Access to a Second Opinion;
xiv. Provider Credentialing and Re-Credentialing;
xv. Selection and Retention of Providers;
xvi. Subcontractor Oversight;
xvii. Clinical Practice Guidelines;
xviii. Utilization Management;
xix. Member Satisfaction;
xx. Provider Satisfaction Surveys;
xxi. Fraud, Waste, and Abuse Prevention;
xxii. Service Verification; and
xxiii. Provider-Preventable Conditions Including Health Care-Acquired Conditions

k. METHODOLOGY/WORK STATEMENT

i. In addition to the specific requirements outlined in the text of this document, bidders must respond to the statements and questions contained in the chart below. Responses must be complete and succinct. These statements and questions relate directly to the major program elements described in Section IV Project Description and Scope of Work.

ii. The bidder's responses to these statements/questions are in addition to information requested in other sections of the RFP. It is expected that the bidder not limit its proposal to just responding to these questions/statements.

RFP Reference	Area	Statement/Question
IV.B	Principles of Care	Describe how your BH MCO will operate to promote the Principles of Care. How will your BH MCO measure this requirement?
IV.B	Principles of Care	Describe how your BH MCO will ensure that services provided are based on evidence-based care.
IV.B	Principles of Care	Describe how your BH MCO will ensure services provided are developmentally and culturally appropriate.
IV.B	Principles of Care	Describe how your BH MCO will operate as a part of a System of Care in Nebraska to serve persons with mental health/illness and substance use disorder needs.
IV.G	Value-Added or Substitute Services	Describe any value-added or substitute services that your BH MCO will deliver to enhance the service array and the rationale for you decision to include these particular services.
IV.J	Business Requirements	Describe the approach your BH MCO will take to ensure your BH MCO is abiding by all relevant provisions of Part 438 of Chapter 42 of the CFR, Title 471 NAC and 482 NAC.
IV.J	Business Requirements	State the status of your BH MCO's accreditation with NCQA.
IV.J	Business Requirements	Describe how your BH MCO meets the Federal definition of a BH MCO. Include a copy of the COA from the Department of Insurance.

RFP Reference	Area	Statement/Question
IV.J	Business Requirements	If applicable, describe your BH MCO's proposed risk bearing partnership/relationship including designated functions of each entity, and how delegated functions will be overseen. Bidders who submit a proposal with a partnership of risk bearing must also provide a detailed description of how both entities meet the Managed Care Organization Licensure Requirements.
IV.J	Business Requirements	Describe the risk analysis, assumptions, cost estimates and rationale supporting your BH MCO's proposed reinsurance arrangements. If any reinsurance is provided through related parties, provide a disclosure of the entities and details causing the related party relationship.
IV.J	Business Requirements	State the intention of your BH MCO to maintain a service office in Nebraska and the staff positions to be located within this service center.
IV.J	Business Requirements	Describe the process your BH MCO will use to ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.
IV.J	Business Requirements	Describe the fraud and abuse program your BH MCO will implement including: ▪ Compliance with the RFP requirements; ▪ Fraud detection methods that will be used; ▪ Steps that will be taken if fraud is detected including DHHS notification; and ▪ Plan for compliance with the Exclusion Program of the U.S. Department of HHS Office of the Inspector General or any provider restrictions imposed by the State.
IV.J	Business Requirements	Describe in detail how your BH MCO will verify that services were actually provided including: ▪ How minimum sampling criteria to ensure a representative sample will be included; and ▪ Results of monitoring will be reported to the State quarterly.
IV.J	Business Requirements	Describe your BH MCO's policies and procedures to ensure safeguards are in place which are at least equal to the Federal Safeguards of 41 USC 423, section 27.
IV.J	Business Requirements	Describe how your BH MCO will comply with the False Claims Act.
IV.J	Business Requirements	Describe the approach your BH MCO will take to provide members with written material that is easily understood including alternate formats.
IV.J	Business Requirements	Describe your approach to compliance and regulatory support, including identification of requirements, process establishment, controls identification, monitoring, correction and ongoing risk management.
IV.J	Business Requirements	Describe how your BH MCO will ensure consistent application of review criteria for authorization decisions and consult with the requesting provider when appropriate; and monitor that denial of service authorization or authorization of a service in an amount, duration, or scope that is less than requested, to be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

RFP Reference	Area	Statement/Question
IV.K	Member Rights and Responsibilities	Describe the approach your BH MCO will take to provide members notification of their rights and responsibilities at enrollment.
IV.K	Member Rights and Responsibilities	Describe the approach your BH MCO will take to provide new members grievance, appeal, and State Fair Hearing information.
IV.K	Member Rights and Responsibilities	Describe the information materials your BH MCO proposes to send to new members. Address language alternatives that will be available and how the BH MCO will ensure that reading levels will be at a sixth grade level.
IV.K	Member Rights and Responsibilities	Describe the process the BH MCO will take to inform members who has received his or her care from a provider who has been terminated from the network.
IV.K	Member Rights and Responsibilities	Describe the approach your BH MCO will take to inform members about covered health services.
IV.K	Member Rights and Responsibilities	Describe your BH MCO's methodology to assess disparities in treatment among disparate races and ethnic groups and correct those disparities.
IV.K	Member Rights and Responsibilities	Describe your BH MCO's policies, procedures, and processes to ensure that in the process of coordinating care, each member's privacy is protected.
IV.K	Member Rights and Responsibilities	Describe your BH MCO's plan to ensure members access to a second opinion.
IV.K	Member Rights and Responsibilities	Describe how your BH MCO will ensure services will be provided that are sufficient in amount, scope, and duration to reasonably be expected to achieve the purpose for which the services are furnished and are equal to those furnished under fee-for-service Medicaid.
IV.K	Member Rights and Responsibilities	Describe your BH MCO's policies, procedures, and processes for processing requests for initial and continuing authorizations of services, and ensuring consistent application of review criteria for authorization decisions.
IV.K	Member Rights and Responsibilities	Provide a listing of services your BH MCO will require to be authorized and describe how your BH MCO will communicate this information to providers and members. Also provide the process by which your BH MCO will communicate authorization information to providers.
IV.K	Member Rights and Responsibilities	Describe the content of your BH MCO's written notice of action that will be provided to members with any adverse action taken by the BH MCO.
IV.K	Member Rights and Responsibilities	Describe how your BH MCO will ensure members will receive written and timely notice of action relating to adverse actions taken by the BH MCO.
IV.K	Member Rights and Responsibilities	Describe your BH MCO's grievance and appeal process specifically addressing: ▪ Compliance with the RFP requirements ▪ Levels of review and timing ▪ Process for expedited review ▪ How complaints and appeals are tracked and trended and how you will use the data to make changes to procedures and processes ▪ Member access to State Fair Hearing
IV.K	Member Rights and Responsibilities	Describe the policies and procedures your BH MCO will put in place to ensure grievance system information is communicated to all providers and Subcontractors.

RFP Reference	Area	Statement/Question
IV.L	Provider Network Development and Management	Describe your BH MCO's approach to develop practices and assure compliance with the Nebraska Medicaid BH Principles of Care.
IV.L	Provider Network Development and Management	Describe your BH MCO's approach to promote open communication among the BH MCO, network providers, NMPHC, and members.
IV.L	Provider Network Development and Management	Describe policies and procedures your BH MCO will put in place to ensure providers are not discriminated for participation, reimbursement, or indemnification for acting within their scope of license or certification.
IV.L	Provider Network Development and Management	Describe how your BH MCO will ensure there are a sufficient number of network providers with expertise in : ▪ Co-occurring substance use, Mental Health and Developmental Disabilities; ▪ Serious and Persistent Mental Illness ▪ Trauma Informed and Trauma Specific Treatment ▪ SED coordinated services ▪ Sex offender services ▪ Co-occurring behavioral and physical health disorders
IV.L	Provider Network Development and Management	Describe your approach to transitioning the current Medicaid provider network to your BH MCO for the contract
IV.L	Provider Network Development and Management	Describe how your BH MCO will develop a Provider Advisory committee.
IV.L	Provider Network Development and Management	Describe how your BH MCO will validate provider training and expertise in specialty areas including but not limited to the following areas: Serving children with SED Serving persons with SPMI The assessment and treatment of Trauma
IV.L	Provider Network Development and Management	Describe the process for conducting site-visits with providers.
IV.L	Provider Network Development and Management	Describe your process for contracting with all provider types described in the contract.
IV.L	Provider Network Development and Management	Describe your process for compliance with Indian Health Protections.
IV.L	Provider Network Development and Management	Describe how the Network Provider data base will be maintained and updated.
IV.L	Provider Network Development and Management	Describe the timelines for credentialing and contracting and reports demonstrating your BH MCO's performance in compliance with these timelines for the contracts that you currently hold and for those you have held within the last five years.
IV.L	Provider Network Development and Management	Describe your BH MCO approach for a credentialing waiver process to allow certain providers that do not meet all of the Contractor's credentialing criteria to be included in the Provider Network.

RFP Reference	Area	Statement/Question
IV.L	Provider Network Development and Management	Describe your BH MCO's credentialing and re-credentialing process including: ▪ Ensuring that providers are enrolled in Medicaid and have a valid identification number ▪ Information on ownership and control ▪ Excluded providers database searches ▪ Disclosure related to persons convicted of crimes
IV.L	Provider Network Development and Management	Describe the processes your BH MCO will utilize to build and maintain positive relationships with the provider network.
IV.L	Provider Network Development and Management	Describe your provider QM strategy and how the BH MCO will involve the provider network in Quality Improvement processes.
IV.L	Provider Network Development and Management	Describe how the BH MCO will provide linkages with consumer and recovery/resilience initiatives.
IV.L	Provider Network Development and Management	Describe how the BH MCO will increase the number of multilingual providers in the network.
IV.L	Provider Network Development and Management	Describe how the BH MCO will monitor compliance with the requirement to provide interpreters/translators when needed.
IV.L	Provider Network Development and Management	Describe how the BH MCO will monitor and ensure network compliance with the use of seclusion and restraint.
IV.L	Provider Network Development and Management	Describe the process your BH MCO will use to utilize the eligibility and enrollment files from DHHS to manage potential membership. Include the process for resolving discrepancies between these files and your internal membership records.
IV.L	Provider Network Development and Management	Describe your BH MCO's approach to creating the Network Development Plan tailored to the NE BH population..
IV.L	Provider Network Development and Management	Describe how your BH MCO will ensure timely access monitoring of network providers, including: ▪ establish mechanisms to ensure that network providers comply with the timely access requirements; ▪ monitor regularly to determine compliance; ▪ take corrective action if there is a failure to comply.
IV.L	Provider Network Development and Management	Describe your BH MCO's approach to creating the Provider Advisory Committee.
IV.L	Provider Network Development and Management	Describe your BH MCO's approach to creating the Network Communication Plan.
IV.L	Provider Network Development and Management	Describe your BH MCO's process for developing, maintaining and utilizing network provider protocols tailored to the NE BH population.
IV.L	Provider Network Development and Management	Describe the written notice providers will be given whom your BH MCO declines to allow participation in the network
IV.L	Provider Network Development and Management	Describe the policies, procedures, and processes your BH MCO will put in place to ensure emergency services are covered regardless of whether the provider that furnishes the services has a contract with the BH MCO.
IV.L	Provider Network Development and Management	Describe the policies, procedures, and processes your BH MCO will put in place to ensure payment for treatment obtained when a member receives emergency services.

RFP Reference	Area	Statement/Question
IV.L	Provider Network Development and Management	Describe the policies, procedures, and processes your BH MCO will put in place to ensure the BH MCO does not limit what constitutes an emergency condition based on lists of diagnoses or symptoms.
IV.L	Provider Network Development and Management	Describe the policies, procedures, and processes your BH MCO will put in place to ensure the member is not held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.
IV.L	Provider Network Development and Management	Describe your BH MCO's process for insuring that non-participating providers who provide emergency services to members are paid on a timely basis. Also, describe your BH MCO's process to insure appropriate communication with the provider, follow-up communication with the member's PCP, and follow-up care for the member.
IV.L	Provider Network Development and Management	Describe your BH MCO's policies, procedures and processes for provision of services from non-network providers.
IV.L	Provider Network Development and Management	Describe your BH MCO's plan to ensure that your provider network meets the network and access requirements of the program. Describe the method your BH MCO plans to use on an ongoing basis to assess and ensure that DHHS's network standards are maintained, including standards related to: ▪ Distance ▪ Appointment access ▪ Cultural competency ▪ Afterhours access ▪ Inclusion of FQHCs and RHCs ▪ Inclusion of out-of-network and out-of-state providers for medically necessary services ▪ Inclusion of non-hospital urgent and emergent care providers
IV.L	Provider Network Development and Management	Describe how your BH MCO will use GeoAccess mapping to ensure network adequacy. Using providers, with whom you have signed letters of intent, provide individual GeoAccess maps.
IV.L	Provider Network Development and Management	Should your BH MCO be unable to secure an agreement with a key provider type in a given geographic area, what strategies will you use to ensure that potential members have access to care?
IV.L	Provider Network Development and Management	Describe your BH MCO's policies, procedures, and policies to ensure that Indian members are provided the protections listed in the Indian Health Protections Act.
IV.L	Provider Network Development and Management	Provide a listing by provider type/specialty of the providers from whom you have received a signed letter of intent to participate in your provider network.
IV.L	Provider Network Development and Management	Describe any provider incentive programs you plan to implement in order to improve access.
IV.L	Provider Network Development and Management	Describe the mechanisms your BH MCO will use to communicate with providers and the content you anticipate including in communications.
IV.L	Provider Network Development and Management	Describe the approach your BH MCO will take to assess provider satisfaction including tools you plan to use, frequency of assessment, and responsible parties.

RFP Reference	Area	Statement/Question
IV.L	Provider Network Development and Management	Describe your BH MCO's policies, procedures and processes to ensure providers are utilizing evidence-based and best practice approaches. How will this be reported, tracked and what will be the intervention with providers who are not using these practices?
IV.L	Provider Network Development and Management	Explain the process your BH MCO will put in place to maintain your provider file with detailed information on each provider sufficient to support provider payment including issuance of IRS 1099 forms, meets all federal and DHHS reporting requirements, and cross reference to state and federal identification numbers to ensure excluded providers are identified.
IV.L	Provider Network Development and Management	Submit copies of your standard provider contracts.
IV.L	Provider Network Development and Management	Describe your BH MCO's policies and procedures for the selection and retention of providers including selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
IV.L	Provider Network Development and Management	If your BH MCO proposes to use Subcontractors to provide any of the services provide a listing of those Subcontractors with their experience in providing care to Medicaid members and a description of the services they will provider if not already described.
IV.L	Provider Network Development and Management	Describe your Subcontractor oversight program. Specifically describe how your BH MCO will comply with the relevant portions of 42 CFR Part 438 and: ▪ Ensure receipt of all required data including encounter data; ▪ Ensure that utilization of health care services is at an appropriate level; ▪ Ensure delivery of administrative and health care services at an acceptable or higher level of care and meets all standards required by this RFP and your internal standards; ▪ Ensure adherence to required grievance policies and procedures; ▪ Subcontracts do not contain terms for reimbursement at rates that are less than the published Medicaid fee-for-service rate in effect on the date of service unless a request has been submitted to and approved by MLTC.
IV.L	Provider Network Development and Management	If your BH MCO proposes to use Subcontractors to provide any of the services provide a listing of those Subcontractors with their experience in providing care to Medicaid members and a description of the services they will provider if not already described.
IV.L	Provider Network Development and Management	Describe the process your BH MCO will have in place to notify providers of new practice guidelines and to monitor implementation of those guidelines.
IV.M	Care, Utilization and Quality Management	Describe how your BH MCO will ensure that policies and procedures are in place which prevent the structuring of compensation to individuals or entities that conduct utilization management activities in such a way as to provide incentives for the individual or BH MCO to deny, limit, or discontinue medically necessary services to any member.

RFP Reference	Area	Statement/Question
IV.M	Care, Utilization and Quality Management	Describe the Behavioral Health Risk Assessment that your BH MCO proposes to conduct with members.
IV.M	Care, Utilization and Quality Management	Describe your BH MCO's approach to creating the Clinical Advisory Committee.
IV.M	Care, Utilization and Quality Management	Describe the process and criteria used for case management, including how you will case manage and what services you will provide. Address the following issues in your response: ▪ How will you identify potential case management situations ▪ If you use a list of diagnoses to identify cases for management and if so provide the list ▪ Once a case is identified, how will your BH MCO determine whether to pursue the case for management ▪ How will case managers interact with members and the member's PCP, family, and other providers ▪ What procedures and processes are used to ensure that all medically necessary services are provided ▪ Any software you use to identify high risk members and track outcomes including predictive modeling software ▪ Specifically address care coordination for children who are State wards, in foster care placement and programs for members with chronic and/or special health needs.
IV.M	Care, Utilization and Quality Management	For members with special needs, describe the policies, procedures and processes your BH MCO will put in place to ensure coordination of care across the care continuum. Describe how your BH MCO will assist members with special needs in identifying and gaining access to community resources that may provide services that the Medicaid program does not cover.
IV.M	Care, Utilization and Quality Management	Describe how your BH MCO will monitor, report and implement a program to manage the use of psychotropic medication for children.
IV.M	Care, Utilization and Quality Management	Describe your BH MCO's policies, procedures and processes for adequate staffing of CM/UM and assure that staff meet the contract standards.
IV.M	Care, Utilization and Quality Management	Describe your BH MCO's processes to coordinate care with other state agencies, NMMCP, Tribes, and in program transition.
IV.M	Care, Utilization and Quality Management	Describe the policies, procedures, and processes your BH MCO will use to coordinate care management for those members also receiving NMMCP disease management for diabetes, asthma, hypertension, and obesity at a minimum.
IV.M	Care, Utilization and Quality Management	Describe the content of your BH MCO's BH medical record, including the utilization control requirements and compliance with 42 CFR 456.
IV.M	Care, Utilization and Quality Management	Describe how your BH MCO will coordinate with the contracted physical health vendors to meet legislative and the RFP requirements.
IV.M	Care, Utilization and Quality Management	Provide a description of your BH MCO's proposed QAPI program. Include the following in your description:

RFP Reference	Area	Statement/Question
		▪ The lines of accountability for the program ▪ How you will select areas of focus ▪ How you will use evidence based practices in developing your quality assurance program ▪ How you will use data to design and implement your quality assurance program ▪ The staff who will be assigned to this program and their qualifications ▪ Explain how your BH MCO will ensure separation of responsibilities between utilization management and quality assurance staff.
IV.M	Care, Utilization and Quality Management	Describe your BH MCO's process to evaluate its own QAPI program.
IV.M	Care, Utilization and Quality Management	Provide examples of innovative and unique performance improvement projects conducted by your BH MCO including how these projects were selected as a focus of your program.
IV.M	Care, Utilization and Quality Management	Describe the policies and procedures your BH MCO will put in place to control avoidable hospitalizations and hospital readmissions.
IV.M	Care, Utilization and Quality Management	Describe how your BH MCO will identify provider utilization patterns to improve care and reduce costs.
IV.M	Care, Utilization and Quality Management	Describe your approach to utilization management, including: ▪ Lines of accountability for utilization policies and procedures • Timelines for decisions and notices within the service authorization required limits outlined in 42 CFR 438.210(d)(1) ▪ Data sources and processes to determine which services require prior authorization and how often these requirements will be re-evaluated ▪ Process and resources used to develop utilization review criteria from non-participating providers or for members who require expedited prior authorization ▪ Processes to ensure consistent application of criteria by individual clinical reviewers.
IV.N	Health Information Requirements	Describe a general description of your BH MCO's Health Information System, including: ▪ A systems diagram that describes each component of the system; ▪ How each component will support the major functional areas of the NMMCP; ▪ Documentation that ensures data received from providers is accurate and complete; and ▪ How the BH MCO's system will interface with the

RFP Reference	Area	Statement/Question
		State system.
IV.N	Health Information Requirements	Describe modifications or updates to your BH MCO's Health Information system that will be necessary to meet the requirements of this program and your plan for their completion.
IV.N	Health Information Requirements	Describe your BH MCO's approach for ensuring complete encounter data is submitted accurately and timely to DHHS consistent with the required formats. Include in your response how you propose to monitor data completeness and manage the non-submission of encounter data by a provider or a Subcontractor.
IV.N	Health Information Requirements	Describe your BH MCO's data certification process which meets the requirements of the RFP.
IV.N	Health Information Requirements	Describe your claims processing operations including: ▪ The claims processing systems that will support this program ▪ Standards for speed and accuracy of processing and reports of compliance with standards for current contracts and all contracts for the past five years.
IV.O	Transition and Implementation	Describe the staff your BH MCO will appoint for the key staff positions in the transition coordination/collaboration process. Include the names of key personnel already assigned.
IV.O	Transition and Implementation	Describe your BH MCO's transition/implementation process.
IV.O	Transition and Implementation	Describe how your BH MCO will transition behavioral health recipients and operations. Include detail around the receipt of behavioral health to current members receiving services, planned collaboration with the existing Contractor and providers, provision of service information (including integration of current Contractor services), transition of pending grievances, appeals and customer service cases, assurance of adequate, qualified staff to meet filing deadlines and attend all court or administrative proceedings.
IV.P	Finance, Reporting Requirements and Rate-Setting	Describe your process for establishing the Reinvestment Plan including a statement of guiding principles that will aid in selecting input for development, services to be provided, etc., the Plan terms that will allow services to be provided to eligible members, etc.
IV.P	Finance, Reporting Requirements and Rate-Setting	Describe your process for creating the Reinvestment Escrow Holding Account and the Reinvestment Escrow Fund. Explain the process for determining the Escrow Account Administrators for each.
IV.P	Finance, Reporting Requirements and Rate-Setting	Describe your IBNP Reserving process; including (if applicable) methods used for the credible and non-credible periods, inventory backlog, look back analyses, and category of service groupings.
IV.P	Finance, Reporting Requirements and Rate-Setting	Describe your process of evaluating and setting acceptable contract levels as a percentage of State Medicaid fee schedules.
IV.P	Finance, Reporting Requirements and Rate-Setting	Describe your process of developing forecasts and budgets. Describe your process of identifying subsequent variances including analyses to determine causal factors of the variances and corrective action plans.

V. PROPOSAL INSTRUCTIONS

This section documents the mandatory requirements that must be met by bidders in preparing the Technical Proposal. Bidders should identify the subdivisions of "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 comparative evaluation.

Proposals are due by the date and time shown in the Schedule of Events. Content requirements for the Technical Proposal are presented separately in the following subdivisions:

A. TECHNICAL PROPOSAL

The Technical Proposal shall consist of four (4) sections:

1. SIGNED, in ink, "State of Nebraska Request For Proposal For Contractual Services" form;
2. Executive Summary;
3. Corporate Overview; and
4. Technical Approach.

1. REQUEST FOR PROPOSAL FORM

By signing the "Request for Proposal for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the Terms and Conditions stated in this Request for Proposal and certifies bidder maintains a drug free work place environment.

The Request for Proposal for Contractual Services form must be signed in ink and returned by the stated date and time in order to be considered for an award.

2. EXECUTIVE SUMMARY

The Executive Summary shall condense and highlight the contents of the solution being proposed by the bidder in such a way as to provide the Evaluation Committee with a broad understanding of the Contractor's Technical Proposal.

Bidders must present their understanding of the problems being addressed by implementing a new system, the objectives and intended results of the project, and the scope of work. Bidders shall summarize how their Technical Proposal meets the requirements of the Request for Proposal, and why they are best qualified to perform the work required herein.

3. CORPORATE OVERVIEW

The Corporate Overview section of the Technical Proposal must consist of the following subdivisions:

a. BIDDER IDENTIFICATION AND INFORMATION

The bidder must 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, whether the name and form of organization has changed since first organized, and Federal Employer Identification Number and/or Social Security Number.

b. FINANCIAL STATEMENTS

The bidder must provide audited financial statements applicable to the firm. If these are not available, unaudited or pro-forma statements for the past two audited years must be provided. In the latter instance, the bidder must also submit the auditor's letter to management on compliance with internal controls.

If publicly held, the bidder must 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 must 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 must 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.

c. 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 must describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded Contractor(s) will require notification to the State.

d. OFFICE LOCATION

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska must be identified.

e. RELATIONSHIPS WITH THE STATE

The bidder shall describe any dealings with the State over the previous ten (10) years. If the organization, its predecessor, or any party named in the bidder's proposal response has contracted with the State, the bidder shall identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

f. 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 sixty (60) 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.

g. CONTRACT PERFORMANCE

If the bidder or any proposed subcontractor has had a contract terminated for default during the past ten (10) 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 Bidders, and Subcontractors in this proposal, submit full details of all terminations for default experienced during the past ten (10) 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 ten (10) years, so declare.

If at any time during the past ten (10) years, the bidder, or Subcontractor in this proposal, 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.

h. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

The bidder shall provide a summary matrix listing the bidder's previous projects similar to this Request for Proposal in size, scope and complexity. The bidder must include those references in which the bidder provided BH services on a capitated, shared-risk or full-risk basis to Medicaid members.

If the bidder currently contracts with a state, county or local Medicaid agency other than Nebraska for a similar set of services, it must include a similar state agency among the references it provides.

The bidder shall also provide three references that are either consumer organizations, advocacy organizations, provider associations, or clinical professional organizations.

The State will review all references and project descriptions, but will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.

The bidder must address the following:

i. Bidder must provide narrative descriptions to highlight the similarities between their experience and this Request for Proposal by submitting a description of all BH managed care projects performed or completed within the past five (5) years. These descriptions must include:

a) The name of each project;
b) The population served and location of each project;

c) The time period of the project;

d) The scheduled and actual completion dates;

e) A brief summary of the major contract responsibilities the bidder performed, including how it managed its administrative and capitated budgets;

f) Any corrective action plans required by the project client or an external quality review organization (EQRO) relating to contract non-compliance and/or deficient contract performance;

g) Adverse contract actions and/or project-associated litigation (including terminations and/or cancellations) in which the Bidder was (or is) involved;

h) A customer name, including the name of a contact person responsible for the contract management, a current telephone number, a facsimile number and e-mail address that will represent the bidder's experience;

i) Each project description shall identify whether the work was performed as the prime Contractor or as a Subcontractor;

j) If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget;

k) If the work was performed by the bidder as a Subcontractor, the narrative description shall identify the same information as requested for the Contractors above; and

l) Contractor and Subcontractor(s) experience must be listed separately. A list identifying each Subcontractor and a narrative description of each Subcontractor's organizational history and mission must be submitted.

i. SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

i. The bidder must present a detailed description of its proposed approach to the management of the project.

ii. The bidder must identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this Request for Proposal. The names and titles of the team proposed for assignment to the State project shall 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.

iii. The bidder shall 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 Request for Proposal in addition to assessing the experience of specific individuals.

iv. Resumes must not be longer than three (3) pages. Resumes shall 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.

j. SUBCONTRACTORS

If the bidder intends to subcontract any part of its performance hereunder, the bidder must ensure compliance with the relevant portions of 42 CFR 438. The bidder must provide the same requirements as listed above in 4.h. 1.) i – vii, along with the following:

- **i.** Name, address and telephone number of the Subcontractor(s);
- **ii.** Specific tasks for each Subcontractor(s);
- **iii.** Description of the specific service(s) and/or function(s) to be subcontracted and provide specific references to the corresponding sections, and subsections of the contract;
- **iv.** Evaluation of the prospective Subcontractor's ability to perform the delegated activity;
- **v.** Describe how the subcontract(s) will be managed and monitored within the bidder's organization;
- **vi.** How each Subcontractor's delivery of the service(s) or performance of the function(s) will be coordinated with the bidder's;
- **vii.** Percentage of performance hours intended for each subcontractor;
- **viii.** Total percentage of Subcontractor(s) performance hours; and
- **ix.** A certification statement, signed by both the bidder and the proposed Subcontractor that complies with the requirements of 42 CFR 238.230(b)(2), and states that the proposed Subcontractor is, as of the Service Start Date, ready, willing, and able to perform all such services under the Contract.

k. RELATED PARTY CONTRACTORS

If the bidder is planning to utilize Related Party contracts within the proposed work, the bidder must disclose the following:

- **i.** Name, address and telephone number of the related party;
- **ii.** Specific tasks for each related party;
- **iii.** Percentage of performance hours intended for each related party;
- **iv.** Total percentage of related party performance hours;
- **v.** A written description of the related party agreement; and
- **vi.** The related party income statements.

l. TECHNICAL APPROACH

The technical approach section of the Technical Proposal must consist of the following subsections:

- **i.** Understanding of the Scope of Work: This section of the proposal should provide a summary of the overall understanding of the Contractor's responsibility to provide the services described and comply with the regulations referenced.
- **ii.** Proposed Implementation Approach: This section of the proposal shall describe the Contractor's overall technical approach to the Scope of Work described in the RFP. Bidders must respond to the statements and question contained the Methodology/Work Statement. Bidders must list each statement/question and then follow with the response. Bidders must answer "not applicable" to any item that is not relevant to their proposal.

iii. Technical Considerations: This section should identify any technical considerations that the bidder feels are pertinent to meeting the requirements of the RFP. The bidder should also include a detailed summary of bidder's ability and plan to meet the technical requirements of the RFP and how the bidder will make adjustments to accommodate any technical considerations identified.

iv. Detailed Project Work Plan: This section should include a detailed work plan that identifies the requirements of the RFP, transition, timelines, and key personnel that will be assigned to each area. The work plan should address, at a minimum, priority areas of development and implementation such as provider network, enrollee informational materials, systems-related technologies, and provider and staff training.

m. PAYMENT SCHEDULE

Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (see Neb. Rev. Stat. 81-2401 through 81-2408). Payment to the Contractor will be monthly according to the rates offered in Attachment B.

n. ENROLLMENT REPORT

The State will provide the Contractor a monthly enrollment report that will list all enrolled and disenrolled enrollees for the enrollment month. This report will be used as the basis for payment to the Contractor.

o. CAPITATION PAYMENTS

Capitation payments will be calculated as per 42 CFR 438.6(c).

p. PAYMENT RECOVERIES

The State will occasionally request recovery of payments for certain specific situations including, but not limited to: a payment was made on behalf of a deceased enrollee. When payments are made incorrectly, the State and the Contractor will work cooperatively to identify the discrepancy and reconcile payments.

Form A

Bidder Contact Sheet

Request for Proposal Number 4166Z1

Form A should be completed and submitted with each response to this Request for Proposal. 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 (Cellular):	
Fax Number:	

Each bidder shall 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 (Cellular):	
Fax Number:	