1-000 INTRODUCTION

1-001 SCOPE AND AUTHORITY: These regulations govern Nebraska's Medicaid Managed Care program. , known as the Nebraska Health Connection (NHC).

1-001.01 Legal Basis: The Nebraska Medical Assistance Medicaid Program, also known as Medicaid, is authorized by the State's Medical Assistance Act. Nebraska's Managed Care Program is authorized under Section 1932 of the Social Security Act, which permits a state to operate a managed care program through its State Plan. Nebraska operates a 1915(b) waiver to require special needs children and Native-Americans to participate in the Physical Health Managed Care Program.

1-001.02 Purpose: The NHCManaged Care was developed to improve the health and wellness of Nebraska's Medicaid clients by increasing their access to comprehensive health services in a way that is cost effective to the State.

1-002 DEFINITIONS: The following definitions apply: under the NHC:

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

Adverse Action means (In the case of anManaged Care Organization {MCO} health plan):

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; and
5. Failure of an MCO health plan to act within grievance process timelines.

ADA means the Americans with Disabilities Act of 1990 as amended, 42 U.S.C. 12101 et seq.

Auto-Assignment means the process by which a client in the designated coverage area for the Basic Benefits Package, who does not select a physical health plan and Primary Care Physician Provider (PCP) within a predetermined length of time during enrollment activities, is automatically assigned to a health plan and PCP. Also referred to as Assignment or Default Assignment.

Basic Benefits Package means the following physical health services that represent a minimum benefits package that must be provided by the health plan to clients enrolled in the NHCManaged Care:

1. Inpatient hospital services (see 471 NAC 10-000);
2. Outpatient hospital services (see 471 NAC 10-000, 21-000, 26-000, and 22-000);
3. Clinical and anatomical laboratory services, including administration of blood draws completed in the non-mental health physician office or non-mental health outpatient clinic for Mental Health/Substance Abuse (MH/SA) diagnoses (see 471 NAC 10-000 and 18-000);

4. Radiology services, excluding radiology services related to MH/SA (see 471 NAC 10-000 and 18-000);
5. HEALTH CHECK (Early Periodic Screening and Diagnosis and Treatment as federally mandated) services (see 471 NAC 33-000 and 482 NAC 5-003.02);
6. Physician services, including nurse practitioner services, certified nurse midwife services, and physician assistant services, anesthesia services including a Certified Registered Nurse Anesthetist, excluding anesthesia for MH/SA (see 471 NAC 18-000 and 29-000);
7. Home health agency services (see 471 NAC 9-000). (This does not include non-home health agency approved Personal Assistance Services under 471 NAC 15-000);
8. Private duty nursing services (see 471 NAC 13-000);
9. Therapy services, including physical therapy, occupational therapy, and speech pathology and audiology (see 471 NAC 14-000, 17-000, and 23-000);
10. Durable medical equipment and medical supplies, including hearing aids, orthotics, prosthetics and nutritional supplements (see 471 NAC 7-000 and 8-000);
11. Podiatry services (see 471 NAC 19-000);
12. Chiropractic services (see 471 NAC 5-000);
13. Ambulance services (see 471 NAC 4-000);
14. ~~Medical transportation services (see 471 NAC 27-000) excluding medical transportation related to MH/SA services;~~
15. Visual services (see 471 NAC 24-000);
16. Family Planning services (see 471 NAC 18-000 and 482 NAC 4-004.03);
17. Emergency and post stabilization services (see 471 NAC 10-000 and 482 NAC 4-004.04);
18. Federally Qualified Health Center (FQHC), Rural Health or Tribal Clinic services (see 471 NAC 11-000, 29-000, 34-000 and 482 NAC 5-004.06);
19. Skilled/Rehabilitative and Transitional Nursing Facility services (see 471 NAC 12-000 and 482 NAC 2-004.04);
20. Transitional Hospitalization services (see 471 NAC 10-000, 482 NAC 2-002.04D, 2-003.03 and 2-004.01A); and
21. Transitional Transplantation services (see 471 NAC 10-000 and 482 NAC 2-004).

Capitation ~~Fee~~ Payment means the fee paid by the Department to an MCO ~~Managed Care Organization (MCO)~~ on a monthly basis for each client enrolled with the physical health plan. The fee covers all services required to be provided by the MCO to the client, regardless of whether the client receives services or not.

Carve-Out means that the mental health and substance abuse package is separated or "carved-out" from the Basic Benefits Package for administrative purposes.~~ease of administration, contracting and federal waiver approval. The Nebraska Health Connection is still considered one program, encompassing both components.~~ This also means those services that are not included in the Basic Benefits package.

CFR means Code of Federal Regulations

Claim means a request for payment for services rendered or supplies provided by the provider to a client.

Clean claim means a claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstances requiring special treatment that otherwise prevents timely payment being made on the claim.

CMS means the Centers for Medicare and Medicaid Services - the division within the federal Department of Health and Human Services responsible for administering the Medicare, Medicaid, and Children's Health Insurance programs.

Choice means the client's freedom to choose a health plan and Primary Care Physician Provider (PCP) and physical health plan from all available options within the health plan network.Nebraska Health Connection in the designated coverage areas. Enrollment for the Mental Health and Substance Abuse Package is "automatic" and does not require a choice of provider or plan.

Client means any individual entitled to benefits under Title XIX or XXI of the Social Security Act, and under Medicaidthe Nebraska Medical Assistance Program as defined in the Nebraska Administrative Code. This term is used interchangeably with member and enrollee.

Contract means the legal and binding agreement between the Nebraska Department of Health and Human Services Division of Medicaid and Long-Term Care and any of the vendors participating in Managed Carethe Nebraska Health Connection.

Designated Coverage Area means areas of the State in which clients are considered mandatory for participation in the Nebraska Health Connection. For purposes of the Physical Health Managed Care, the designated coverage area includes the counties in which the client is residing. Those counties are Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Sarpy, Saunders, Seward, and Washington Counties. The Mental Health and Substance Abuse component of the NHC is provided on a statewide basis.

Covered Services means the Nebraska Health Connection Benefits Package pursuant to the Nebraska Administrative Code.

Cutoff means 5:00 p.m. Mountain Standard Time on the fourth working night before the end of the month. Data must be entered on the Department's computer system by this deadline in order for changes to be effective the first of the next month.

Department means the Department of Health and Human Services Division of Medicaid and Long-Term Care.

Designated Specialty Care Physician means a specialty care physician who has enhanced responsibilities for clients with special health care needs, designated upon review and concurrence by the Primary Care Physician (PCP) and the physical health plan providing the Basic Benefits Package. The designation of the specialty care physician allows for greater continuity of care between the PCP and specialty care physician, such as open referrals, shared PCP responsibilities, etc. The provision of a designated specialty care physician does not apply to the Mental Health and Substance Abuse component of the NHC.

Disenrollment means a change of a client's enrollment from one physical health plan to another (i.e. transfer).

Emergency Medical Condition means a medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, (including severe pain) that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services means covered inpatient and outpatient services that are furnished by a qualified Medicaid provider and are needed to evaluate or stabilize an emergency medical condition.

Encounter Data means detailed claims information line-level utilization and expenditure data for services furnished to clients and submitted by a Managed Care Organization to the Department. representing all services rendered to a client.

Enrollment means completion by the client of all requirements of the enrollment process in the designated coverage areas for purposes of the physical health managed care, including receiving managed care information, and selecting a physical health plan and Primary Care Physician Provider (PCP). In some cases, if a client does not complete enrollment, s/he is auto-matically "assigned" to a physical health plan and PCP.

Enrollment Broker Services (EBS) means a contracted entity that is responsible for enrollment activities and choice counseling.

Enrollment Month means enrollment period for a client is effective the first of the month through the end of the month.

Enrollment Report means a data file provided by the Department to the MCO health plan and the MH/SA plans that lists all clients enrolled and disenrolled/waived for the enrollment month in that plan. The enrollment report is used as the basis for the monthly capitation payment to the plan.

Entity means a generic term used to reference any of the contracted vendors participating in Managed Carethe Nebraska Health Connection.

Established Only Client means a Primary Care Physician's Provider's (PCP) intent to only provide a "medical home" to a client with whom the PCP has a previous physician-patient relationship.

External Quality Review Organization (EQRO) means an organization that meets the competence and independence requirements to perform analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that an MCOhealth plan furnishes to Medicaid clients.

Family Planning Services means services to prevent or delay pregnancy, including counseling services and patient education, examination and treatment by medical professionals, laboratory examinations and tests, medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception. This includes tubal ligations, vasectomies, and treatment for sexually transmitted diseases (STD). This does not include hysterectomies or other procedures performed for a medical reason, such as removal of an intrauterine device due to infection, or abortions

Fee-for-Service means payment of a fee by the Nebraska Medical Assistance Program for each service provided to a client who is not enrolled in Managed Carethe Nebraska Health Connection (NHC) or for services excluded from the Basic Benefits Package.

Grievance means an expression of dissatisfaction about any matter. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCOhealth plan level and access to the State fair hearing process.

Health Maintenance Organization (HMO) means a type of managed care organization that has a Certificate of Authority to do business in Nebraska as an HMO through the Nebraska Department of Insurance.

Interim PCP means a Primary Care Physician Provider (PCP) designated by the physical health plan when the client's chosen or assigned PCP is not available and the duration is only applicable until the client requests a different PCP. The duration of an interim PCP is only until a subsequent change is activated, effective with the first month possible after system cutoff.

Lock-In means a method used by the Department to limit the physical health services of a client who has been determined to be abusing or over utilizing services provided by Medicaid by the Nebraska Medical Assistance Program without infringing on the client's choice of a provider.

Managed Care File means the Department's automated file, containing client and provider information, created to support the Nebraska Health Connection.
Managed Care Plan (Health Plan) means a contracted managed care entity that provides physical health services to members enrolled in Managed Care.

Managed Care Organization (MCO) means an organization that has or is seeking to qualify for a comprehensive risk contract to provide services to Medicaid managed care enrollees. An entity that has, or is seeking to qualify for a comprehensive risk contract that is:

1. A Federally qualified HMO that meets the advance directives requirements of 42 CFR 489, Subpart I; or
2. Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:
   a. Makes itsthe 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
   b. Meets the solvency standards of 42 CFR 438.116.

~~Medicaid means the Nebraska Medical Assistance Program, administered by the Department of Health and Human Services Division of Medicaid and Long-Term Care.~~

Medical Home means a community-based primary care setting which provides and coordinates high quality, planned, family-centered: health promotion, acute illness care and chronic condition management.

Medical Necessity means health care services and supplies which are medically appropriate and -

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

The fact that the physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, or mental illness does not mean that it is covered by Medicaid. Services and supplies which do not meet the definition of medical necessity set out above are not covered.

Mental Health/Substance Abuse (MH/SA) Network means the network of MH/SA providers that constitutes the MH/SA services component of Managed Care~~the Nebraska Health Connection~~.

Mental Health and Substance Abuse (MH/SA) Package means the following MH/SA service:

1. Outpatient services, including -
   a. Evaluations and assessments by physicians, LIMHP, and licensed psychologist~~ by a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within the scope of his/her practice~~;
   b. Pre-treatment assessment;
   ~~b~~c. Individual psychotherapy;
   ~~c~~d. Individual substance abuse counseling (for clients age 20 and younger only);
   ~~d~~e. Group psychotherapy;
   ~~e~~f. Group substance abuse counseling (for clients age 20 and younger only);
   ~~f~~g. Family psychotherapy services;
   ~~g~~h. Family substance abuse counseling (for clients age 20 and younger only);

hi. Family assessment;
ij. Conferences with family or other responsible persons advising them on how to assist the client (for clients age 20 and younger only);
j. Mileage for home-based family therapy or counseling services (for clients age 20 and younger only);
k. MH/SA Community Treatment Aides (for clients age 20 and younger); and
l. Pre-treatment assessment23:59 Hours of Observation Services;

2. Intensive Outpatient Services;
3. Day treatment;
34. Professional Resource Family Care (PRFC)Treatment foster care (for clients age 20 and younger);
45. TherapeuticTreatment Ggroup Hhome (ThGH) (for clients age 20 and younger);
56. Psychiatric Residential Ttreatment Facilitycenter(PRTF) (for clients age 20 and younger);
6. Crisis intervention, which consists of -
   a. Observation room services;
   b. Residential acute (for clients age 20 and younger);
   c. Non-residential and treatment foster care (for clients age 20 and younger);
7. Partial HospitalizationAcute Hospital services;
8. Acute Psychiatric Hospital ServicesFamily preservation;

Adult Substance Abuse Services (for clients age 21 and older):
9. Outpatient Substance Abuse Services; Inpatient services;
   a. Substance Abuse Assessments;
   b. Community Support;
   c. Group Therapy;
   d. Family Therapy;
   e. Family Therapy without the Client;
   f. Individual Therapy;
10. Intensive Outpatient ServicesNon-emergency or non-urgent transportation;
11. Partial HospitalizationCoordinated MH/SA services (see 471 NAC 32-000 and 482 NAC 5-006); and;
12. Clinically Managed Low Intensity Residential Treatment;Client Assistance Program.
   a. Halfway House Dual Diagnosis Capable;
13. Clinically Managed Medium Intensity Residential Treatment which includes:
   a. Intermediate Residential (dual diagnosis capable);
   b. Therapeutic Community (dual diagnosis capable);
14. Clinically Managed High Intensity Residential Treatment –
   a. Short-term Residential (dual diagnosis capable);
   b. Dual Diagnosis Residential Treatment Services;
15. Ambulatory Detoxification with Extended Onsite Monitoring
16. Clinically Managed Residential Social Detoxification;

Medicaid Rehabilitation Option for Psychiatric Services
17. Assertive Community Treatment (ACT);
18. Alternative Assertive Community Treatment (Alt.ACT)
19. Community Support – Mental Health;
20. Day Rehabilitation Services;
21. Secure Residential Rehabilitation;
22. Residential Rehabilitation;
23. Medicaid Psychiatric Injectable Medications

NAC means the Nebraska Administrative Code.

~~NHC means the Nebraska Health Connection, the Nebraska Medicaid Managed Care Program.~~

NMES means the Nebraska Medicaid Eligibility System, which is an automated eligibility verification system for use by Medicaid providers of service.

NMMCP means the Nebrska Medicaid Managed Care Program.

Patient-Centered Medical Home means an enhanced model of primary care in which a patient establishes an ongoing relationship with a Primary Care Provider (PCP) and a PCP-directed team of health care providers. This team coordinates all aspects of a patient's physical and mental health care needs, including prevention and wellness, acute care and chronic care, across the health care system in order to improve access and health outcomes in a cost effective manner.

PCP Transfer means a change in a client's assignment from one Primary Care Provider (PCP) to another PCP.

Peer Review Organization means an organization under contract with the State to perform a review of health care practitioners of services ordered or furnished by other practitioners in the same professional fields.

Per Member Per Month (PMPM) means the basis of capitation payment for a Managed Care Organization (MCO).

Physician Extender means a nurse practitioner, physician assistant, certified nurse midwife, or second-year and third-year resident who meet the requirements for practicing in Nebraska, and who is enrolled with Medicaid. ~~in the Nebraska Medical Assistance Program~~. ~~The Physician Extender is not designated as a Primary Care Physician (PCP) but increases the number of clients to whom the PCP may provide a medical home.~~

Plan means a generic term used to reference any of the contracted health plans participating in Managed Care~~the Nebraska Health Connection~~. This is a healthcare entity that meets the definition of a Managed Care Organization for the provision of the Basic Benefits Package and referenced in the Title as the "physical health plan." For purposes of the Mental Health and Substance Abuse Package, this is referenced as the "MH/SA plan."

Primary Care ~~Physician~~ Provider (PCP) means a ~~physician~~ provider chosen by the client or assigned by the Department who provides ~~a "medical home" for the client and whose primary expertise is in~~ primary care services. Provider types that can be a PCP are from any of the following practice areas: ~~f~~Family -Ppractice, ~~p~~Pediatrics, ~~g~~General ~~p~~Practice, ~~i~~Internal ~~m~~Medicine, ~~or o~~Obstetrics/~~g~~Gynecology (OB/GYN), Advanced Practice Nurses (APRNs), and Physician Assistants (PAs) (when PA~~a~~s are practicing under the supervision of a physician specializing in Family Practice, Pediatrics, General Practice, Internal Medicine, or OB/GYN). A PCP may participate in the NHC with any of the contracting physical health plans. The PCP must be a Medicaid-enrolled provider. A specialty care physician may have enhanced responsibilities in certain circumstances, to promote greater continuity of care between the PCP and specialty care physician.

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

Provider Agreement means any written agreement between the provider and the Department, for the purpose of enrolling as a Medicaid provider, or between the physical health or MH/SA plan and the provider for the purpose of participating in Managed Carethe Nebraska Health Connection.

Returned Claim means a claim that has not been adjudicated because it has a material defect or impropriety.

Risk Contract means a contract under which the contractor:

1. Assumes risk for the cost of therre services covered under the contract; and
2. Incurs loss if the cost of furnishing the services exceeds the payments under the contract.

Slots means a designated number of clients for whom a Primary Care Physician Provider agrees to provide a medical home under Managed Carethe Nebraska Health Connection.

Subcontract means any written agreement between the pPhysical hHealth or MH/SA plan and another party to fulfill the requirements of 482 NAC except Provider Agreements as defined above.

Substitute Health Services means those services a health plan uses as a replacement for or in lieu of a services covered in the Basic Benefits package because the health plan has determined: (1) the health plan reimbursement for the Substitute Health Service is less than the MCO reimbursement for the covered service would have been had the covered service been provided; and (2) that the health status and quality of life for the client is expected to be the same or better using the Substitute Health Services as it would be using the covered service.

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

Waiver of Enrollment means a case-by-case determination by which a mandatory client is not required to participate in Managed Carethe Nebraska Health Connection.