4-000 THE PHYSICAL HEALTH MANAGED CARE BASIC BENEFITS PACKAGE

4-001 INTRODUCTION: 482 NAC 4-000 sets forth the responsibilities of the Primary Care Physician Provider(PCP) and Managed Care Organization (MCO) health plan in delivering the Physical Health Basic Benefits Package to the Managed CareNHC client. While the PCP is responsible for providing the client a patient centered medical home and ensuring appropriate health care services, the medical/surgical health plan, as the contracting entity with the Department, assumes primary administrative and operational responsibility for the implementation of the NHC Managed Care programmatic requirements. The Managed Care Organization's physical health plan (health plan) must incorporate the information contained in this Title, as well as 471 NAC, which defines in detail the minimum service provisions required for the NHC Physical Health services under Medicaid.

The NHC delivers Physical Health Managed Care Program administers the Basic Benefits Package to Medicaid clients through one or more Managed Care Organizations (MCOs) and/or a Primary Care Case Management (PCCM) Network.

4-002 PRIMARY CARE PHYSICIAN PROVIDER (PCP): The following provisions describe the Primary Care Physician's Provider's (PCP's) responsibilities in the NHCPhysical Health Managed Care program.

4-002.01 Functionality of the PCP: The client chooses or is assigned to a Primary Care Physician (PCP). The PCP is the physician who provides a medical home for the client and is responsible for providing or referring for all medically necessary services. PCPs may participate in one or all of the MCO networks. The PCP must be a Medicaid-enrolled provider (see 471 NAC 2-000). A specialty care physician may function in an extended capacity with the PCP in certain circumstances with health plan approval (see 482 NAC 4-002.02A).

4-002.012 Types of PCP Providers: To participate in the NHCPhysical Health Managed Care program, a PCP must be a primary care physician Medical Doctor (MD) or Doctor of Osteopathy (DO) whose primary expertisespecialty is in fFamily pPractice;, gGeneral pPractice;, pPediatrics;, iInternal mMedicine;, or oObstetrics/gGynecology, or Advanced Practice Nurses (APNs), or Physician Assistants (when practicing under the supervision of a physician specializing in Family Practice, General Medicine ,Internal Medicine, Pediatrics, or Obstetrics/Gynecology). as identified as the primary specialty in the Department's Provider File System. These five specialties will be available for the client to choose as his/her PCP in both of the MCO providers networks.

For approved Graduate Medical Education (GME) programs, the resident or intern may be assigned as the PCP.

4-002.012A Designated Specialty Care Physicians: Managed CareThe NHC allows for the designation of appropriate specialists to function in an extended capacity with the PCP for clients with chronic conditions requiring specialty care.

The following procedure applies when a client, PCP, or other person on behalf of the client requests such an arrangement:

1. The requester must contact the health plan and provide documentation, in the form of a letter, stating the reason(s) for the request;
2. The health plan must review the documentation and conduct any additional inquiry to clearly establish the reason(s) for request;
3. The health plan approves or denies the request within five working days responds to the client and PCP, along with written justification in the case of a denial, and alternatives for the client to consider, e.g., expanded consultative services;
4. The health plan must inform the Department of the decision; and
5. The health plan must monitor the effectiveness of the PCP and specialist in providing continuity of care for the client.

If the request is initiated by or made to the Department, the request will be forwarded to the health plan within five working days.

The PCP for the client does not change, only the shared responsibility and ease of referral patterns between the PCP and the designated specialist under the health plan's oversight. The health plan must also consider providing consultative services to the PCP and/or specialist for certain experience-sensitive conditions, e.g., HIV/AIDS.

The designated specialty care physician must have enhanced responsibilities for clients with special health care needs designated upon review and concurrence of the specialist and the health plan. 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.

4-002.023 Limit on Number of Enrollees: A PCP is allowed to care for no more than 1500 Medicaid clients. When a PCP employs one or more physician extenders (i.e., nurse practitioners, physician assistants, certified nurse midwives, second-year and third-year residents), the PCP may care for up to an additional 500 clients, for a total of 2000 Medicaid clients. This allowable limit is referred to as PCP "slots." PCP limitations will be maintained in the Department's Provider Network File.

4-002.034 Primary Care Provider (PCP) Qualifications and Responsibilities: To participate in the Managed CareNHC, the PCP must:

1. Be a Medicaid-enrolled physician provider and agree to comply with all pertinent Medicaid regulations;
2. Sign a contract with the MCOs physical health plan as a PCP which explains the PCP's responsibilities and compliance with the following Managed CareNHC requirements:
   a. Treat Managed CareNHC clients in the same manner as other patients;
   b. Provide the services in the Basic Benefits Package per 471 NAC to all clients who choose or are assigned to the PCP's practice according to the Enrollment Report and comply with all requirements for referral management and prior-authorization;
   c. Provide a patient-centered medical home to coordinate comprehensive, accessible, and continuous evidence-based primary and preventive care for the client's health care needs across the health care system.the NHC client with a medical home including, whenAs medically necessary, coordinate appropriate referrals and follow-upto for services that typically extend beyond those services provided directly by the PCP, including but not limited to specialty services, emergency room services, hospital services, nursing services, mental health/substance abuse (MH/SA), ancillary services, public health services, and other community based agency services;
   d. As appropriate, work cooperatively with specialists, consultative services and other facilitated care situations for special needs clients such as accommodations for the deaf and hearing impaired, experience-sensitive conditions such as HIV/AIDS, self-referrals for women's health services, family planning services, etc.;
   e. Provide continuous access to PCP services and necessary referrals of urgent or emergent nature available 24-hour, 7 days per week, access by telephone to a live voice (an employee of the PCP or an answering service) or an answering machine that must immediately page an on-call medical professional so referrals can be made for non-emergency services or so information can be given about accessing services or procedures for handling medical problems during non-office hours;
   f. Not refuse an assignment or transfer a client or otherwise discriminate against a client solely on the basis of age, sex, race, physical or mental handicap, national origin, type of illness or condition, except when that illness or condition can be better treated by another provider type;
   g. Ensure that ADA requirements and other appropriate technologies are utilized in the daily operations of the physician's provider's office, e.g., TTY/TDD and language services, to accommodate the client's special needs.
   h. Request transfer of the client to another PCP only for the reasons identified in 482 NAC 2-003.03 and continue to be responsible for the client as a patient until another PCP is chosen or assigned;
   i. Comply with 482 NAC 4-002.05 if disenrolling from participation in Managed Carethe NHC and notify the health plan in a timely manner so that an Interim PCP (see 482 NAC 2-003.03E) can be assigned;
   j. Maintain a medical record for each client and comply with the requirement to coordinate the transfer of medical record information if the client selects another PCP;

k. Maintain a communication network providing necessary information to any MH/SA services provider as frequently as necessary based on the client's needs.

Note: Many MH/SA services require concurrent and related medical services, and vice versa. These services, include, but are not limited to anesthesiology, laboratory services, EKGs, EEGs, and scans. The responsibility for coordinating services between the Basic Benefits Package and the MH/SA Package (see 482 NAC 4-004.05), and in sharing and coordinating case management activities, is shared by providers in both areas.

A focused effort to coordinate the provision, authorization, payment and continuity of care is a priority for providers participating in Managed Carethe NHC. Each medical/surgical health plan must monitor overall coordination between these two service areas (i.e., medical/surgicalphysical health and MH/SA). The medical/surgicalhealth plan must ensure the PCP is knowledgeable about the MH/SA Package and other similar services and ensure that appropriate referrals are made to meet the needs of the client;

l. Communicate with agencies including, but not limited to, local public health agencies for the purpose of participating in immunization registries and programs, e.g., Vaccines for Children, communications regarding management of infectious or reportable diseases, cases involving children with lead poisoning, special education programs, early intervention programs, etc.;

m. Comply with all disease notification laws in the State;

n. Provide information to the Department as required;

o. Inform clients about all treatment options, regardless of cost or whether such services are covered by Medicaidthe Nebraska Medical Assistance Program; and

3. Provide accurate information to the health plan in a timely manner so that PCP information can be exchanged with the Department via the Provider Network File.

4-002.045 PCP Voluntarily Termination: A PCP may voluntarily terminate his/her participation from Managed Carethe NHC. If the PCP voluntarily terminates participation from Managed Care NHC, s/he may remain active as a Medicaid provider on a fee-for-service basis for clients not participating in Managed Carethe NHC if all Department regulations continue to be met. The termination is reported by the health plan in the Provider Network File.

4-002.045A Interim PCP Assignment: The health plan will be responsible for assigning an interim PCP in the following situations:

1. The PCP has terminated his/her participation with the health plan, e.g., PCP retires, leaves practice, dies, no longer participates in managed care; or
2. The PCP is still participating with the health plan but is not participating at a specific location (i.e., change in location only); or

3. A PCP/plan initiated transfer has been approved (see 482 NAC 2-003.03A) but the client does not select a new PCP.

The health plan is responsible for ensuring a smooth transition for the client through the assignment of an interim PCP.

The health plan must immediately notify the client, by mail or telephone that the client is being temporarily assigned to another PCP within the same health plan and the new PCP will be responsible for meeting the client's health care needs until a transfer can be completed.

4-002.045A1 Client Notification: The notification sent to client by the health plan must include the following information:

1. Client name, address and Medicaid number;
2. Reason for the change;
3. Name, address and telephone number of the new PCP;
4. Notification that the client has fifteen working days to contact the health plan if s/he wishes to change the temporary PCP assignment. If the client does not contact the health plan to effect a change, the temporary interim PCP will "automatically" become permanent; and
5. Information on how to contact the health plan.

If a PCP changes location, the health plan, after considering the needs of the client, may use its judgment in determining whether the client should be moved with the PCP or remain with a different PCP at the same location. The health plan must notify the client of the change in location. If the client is not satisfied with the PCP's new location, s/he can request a new PCP.

Exception: If the PCP has actually moved out of state, and the PCP is no longer within coverage distance to the Nebraska Medicaid client, the PCP should be treated as a terminated PCP.

4-002.045A2 Department and Physical Health Plan Coordination: The actual transfer of the client from the client's current PCP to the health plan designated Interim PCP will be accomplished by the health plan and the Department via an exchange of information that will systematically be loaded into the Managed Care File system by the Department. The Department will process the transfer immediately upon receipt of the information and activate the assignment the first of the next month possible, given system cutoff. The client can change the "interim" transfer at any time by following standard transfer procedures.

~~The Department, based on a termination date on the Provider Network File, will automatically change the name of the PCP on the Nebraska Medical Eligibility System (NMES), and on the standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271) to indicate "Call your plan" (see 471 NAC). This will allow the health plan to work with the client in applying the interim PCP regulations, if applicable.~~

~~The effective date of transfer to the Interim PCP will be the first of the next month possible, even if this is prior to the fifteen working day notification period.~~

~~In situations where a provider changes his/her Medicaid provider number, the health plan is not required to notify the client. The Department must automatically make the change from the old number to the new number, as soon as the number change is identified (i.e., on a nightly basis). NOTE: An automated transfer will occur when a provider changes his/her Medicaid provider number, within the Medicaid provider system. This type of transfer is transparent to the client, if the provider has not made any other changes.~~

4-003 PHYSICAL HEALTH MANAGED CARE PLAN REQUIREMENTS: Managed Care~~The NHC delivers~~ administers the Basic Benefits Package to Medicaid clients through two or more Managed Care Organizations (MCOs) physical health plans (health plan)~~ and/or one Primary Care Case Management (PCCM) Network~~. The following provisions describe the health plan responsibilities~~ in the NHC~~:

4-003.01 General Requirements: The health plan is required to comply with, but is not limited to, the following general requirements and as specified in the contract between the Department and the MCO:

1. Provide the services in the Basic Benefits Package according to all provisions in 482 NAC 4-000 and 471 NAC and ensure the services in the Basic Benefits Package are provided to clients in the same manner (i.e., in terms of timeliness, amount, duration, quality and scope) as those services provided to the non-managed care Medicaid client;
2. Maintain sufficient numbers of Primary Care ~~Physician~~ Provider (PCP) slots to ensure adequate access to clients enrolled in Managed Care~~the NHC~~, notify the Department via the Provider Network Enrollment File prior to the effective date of any PCP change whenever possible and if required, notify the client of an interim PCP (see 482 NAC 4-002.05A);
3. Use only providers enrolled in Medicaid to provide the services in the Basic Benefits Package~~ under the NHC~~;

4. Provide an appropriate range of services and access to preventive and primary care services in the designated coverage areas, and maintain a sufficient number, mix, and geographic distribution of providers that are skilled in areas such a cultural diversity and sensitivity, languages, and accessibility to clients with mental, physical and communication disabilities;
5. Provide services directly or arrange for services through subcontractors;
6. Ensure the PCPs participating in the health plan's network comply with all PCP requirements identified in 482 NAC 4-002.04;
7. Accept the client's choice of PCP and health plan;
8. Provide case management (see 482-000-8~~23~~, Case Management Requirements);
9. Provide a client handbook to the clients enrolled with the health plan, and other informational materials about Managed Care~~NHC~~ benefits that are easy-to-read and understand. The health plan must also provide the information in the guidebook in Spanish and alternative formats in a manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency;
10. Provide a comprehensive list of PCP's, Specialists, Hospitals, Urgent Care Centers, and ancillary service providers participating in the health plan's network.
11. The health plan is prohibited from performing any direct solicitation to individual Medicaid clients. Any general marketing to Medicaid clients must be approved by the Department prior to implementation.
    The health plan must comply with the following marketing guidelines:
    a. Obtain Departmental approval for all marketing materials;
    b. Ensure marketing materials do not contain any false or potentially misleading information (in a manner that does not confuse or defraud the Department);
    c. Ensure marketing materials are available for the client population being served in the designated coverage areas;
    d. Avoid offering other insurance products as an inducement to enroll;
    e. Comply with federal requirements for provision of information including accurate oral and written information sufficient for the client to make an informed decision about treatment options; and
    f. Avoid any direct or indirect door-to-door, telephonic or other "cold-call" marketing;
12. Meet all requirements of the Americans with Disabilities Act (ADA) and provide appropriate accommodations for clients with special needs. Ensure PCPs and specialists are equipped in appropriate technologies, e.g., TTY/TDD and language services, or are skilled in various languages and areas of cultural diversity/sensitivity, and/or the network is appropriately staffed to ensure an adequate selection for those clients who have special cultural, religious or other special requests;
13. Coordinate activities with the Department, other Managed Care~~NHC~~ contractors, and other providers for services outside the Basic Benefits Package, as appropriate, to meet the needs of the client, and ensure systems are in place to promote well managed patient care, including, but not limited to:

a. Management and integration of health care through the PCP, and coordination of care issues with other providers outside the health plan, for services not included in the Basic Benefits Package, e.g., MH/SA services, Pharmacy, Dental Services, etc., or for services requiring additional Departmental authorization, e.g., abortions, ~~HEALTH CHECK (EPSDT) treatment services not covered by the Nebraska Medical Assistance Program,~~ transplants (except corneal);

~~b. Required referral/prior authorization requirements for medically necessary specialty and ancillary services;~~

~~c~~b. Provision of or arrangement for emergency medical services, 24 hours per day, seven days per week, including an education process to help assure clients know where and how to obtain medically necessary care in emergency situations;

~~d~~c. Unrestricted access to protected services such as emergency room services, family planning services, tribal clinics, etc., according to 471 NAC;

~~e~~d. Clearly identified expectations for the PCPs, subcontractors and any other service providers participating in the client's managed care and documentation of that care for quality assurance/quality improvement purposes;

~~f~~e. Retention of plan-maintained records and other documentation during the period of contracting, and for ~~six~~ ten (10) years after the final payment is made and all pending matters are closed, plus additional time if an audit, litigation, or other legal action involving the records is started before or during the original ~~six~~ ten (10) year period ends; and

~~g~~f. Adequate policy regarding the distribution of the client's medical records if a client changes from one PCP to another~~, or from one health plan to another according to Department specifications~~;

14. Comply with regulations providing for advance directives;
15. The health plan is prohibited from refusing enrollment of a client, disenrolling a client or otherwise discriminating against a client solely on the basis of age, sex, race, physical or mental handicap, national origin, or type of illness or condition;
16. Require that all subcontractors meet the same requirements as are in effect for the health plan that are appropriate to the service or activity delegated under the subcontract;
17. Provide Member services;
18. Maintain, at all times, an appropriate certificate of authority to operate issued by the Nebraska Department of Insurance;
19. Provide for a Physician Incentive Program (PIP) only if:
    a. No specific payment is made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to a client;
    b. The health plan provides PIP information to any Medicaid client, upon request, including a statement on its marketing materials disclosing the client's right to adequate and timely information to related physician incentives;
    c. The health plan does not have PIPs placing a physician or physician group at substantial financial risk for the cost of services; and
    d. Where appropriate, the physician or physician group provides adequate stop-loss protection to the individual physicians.

20. Comply with all applicable state and federal regulations, such as the prohibition against assisted suicide; inappropriate use of funds/profits, lack of mental health parity, and the noncompliance with the provisions of the Hyde Amendment;
21. Prohibit discrimination against providers based upon licensing;
22. Prohibit hiring, employing, contracting with or otherwise conducting business with individuals or entities barred from participation in Medicaid or Medicare;
23. Ensure adequate numbers of medical specialistsproviders in its network to meet the needs of its members. Clients with chronic or severe medical conditions, e.g., HIV/AIDS, will be allowed to go directly to a qualified specialist within the health plan's network;
24. Ensure that PCPs inform clients about all treatment options, regardless of cost or whether such services are covered by the health plan, and that health care professionals are not prohibited or otherwise restricted from advising clients about their health status, medical care, or treatment regardless of benefit coverage if the professional is acting within his/her scope of practice. This does not require a health plan to cover counseling or referral if it objects on moral or religious grounds and makes available information regarding policies to clients who are enrolled with the health plan, or who may enroll with the health plan, within ninety days of a policy change regarding such counseling or referral services;
25. Provide written notice to the client of any adverse action (i.e., denial or reduction or termination of services, or denial or termination of an authorization) regarding the provision of services that complies with all federal and state requirements. Allow clients to challenge appeal decisions to deny, limit or terminate authorization, coverage, or payment of services. Clients must be allowed to file complaints, grievances and appeals, according to 482 NAC 67-000;
26. Comply with the Maternity and Mental Health Requirements in the Health Insurance Portability and Accountability Act (HIPPA) of 1996 the maternity length of stay and mental health parity requirements specifically requiring coverage for a hospital stay following a normal vaginal delivery not be limited to less than forty-eight hours for both the mother and newborn child, and the health coverage for a hospital stay in connection with childbirth following a cesarean section not be limited to less than ninety-six hours for both the mother and newborn child;
27. Provide assurances that any amount expended for home health care services be provided with the appropriate surety bond;
28. Report all fraud and abuse information to the Department;
29. Comply with the provisions of 482 NAC 4-003.04 for provider payments;
30. Sign a contract with the Department and comply with all contract requirements and any other responsibilities specified by the Department in the overall operation of Managed Carethe NHC, and any other activities deemed appropriate by the Department and supported in regulations and/or contractual amendments; and
31. Comply with all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and Balanced Budget Act of 1997.
32. Assign the PCP for clients who do not voluntarily enroll within one (1) month of the effective date of enrollment for initial and re-enrollments and within fifteen days (15) days for the Interim PCP assignment.

4-003.02 HEALTH CHECK (EPSDT): The health plan must develop a program to ensure the delivery of HEALTH CHECK (i.e., Early and Periodic Screening, Diagnosis and Treatment or EPSDT services).

The health plan must contact HEALTH CHECK (EPSDT) eligible families (families who have children age twenty (20) and younger) within sixty days of enrollment and encourage them to make an appointment for the required components of HEALTH CHECK. The required components are health screening, including medical, vision, hearing and dental screening (see 471 NAC 33-000). The health plan must also counsel the family regarding the importance of health supervision and regular check-ups and assist in removing barriers to care. If necessary, the health plan must assist families with appointment scheduling and arranging transportation.

At a minimum, efforts must include:

1. HEALTH CHECK (EPSDT) Screening: The health plan must provide HEALTH CHECK (EPSDT) services according to 471 NAC Chapter 33-000.
   a. The health plan must outreach to HEALTH CHECK (EPSDT) eligible children who need to be scheduled for HEALTH CHECK (EPSDT) examinations. Targeted groups are -
      (1) Newly Medicaid-eligible and other children who have not had a timely HEALTH CHECK (EPSDT) examination;
      (2) Children who have been identified as not having ever been screened or not having received HEALTH CHECK (EPSDT) services within established timelines based on the periodicity schedule; and
      (3) Children from birth to the second birthday, that may need immunizations, lead level testing, developmental testing and hearing testing.
   b. The health plan must contact the client regarding -
      (1) Screening appointments missed without cancellation to determine the barriers to care, to assist in rescheduling the appointment, and to counsel the family about keeping appointments; and
      (2) Screening results from a referral for treatment and the client who does not follow up with treatment services as identified by the medical/surgicalhealth plan.
   c. The health plan may assist the PCP to establish a recall notification system for HEALTH CHECK (EPSDT) examinations. The recall notification systems may be provided notification through phone calls or post cardmailings. The health plan's case management may substitute their recall system in place of the PCP's; and
   d. The health plan must use continuous quality improvement methods to achieve a performance goal of HEALTH CHECK (EPSDT) screens at the recommended participation rate, according to the contract with the Department.

2. If a client requests a HEALTH CHECK (EPSDT) screen for the initial screen, the health plan must provide the screening examination(s) within 14 calendar days. Subsequent sScreening exams (including vision and hearing, medical and referral for dental) are to be provided according to the periodicity schedule, or an inter-periodic examination if appropriate. The minimum schedule of health screening examinations is the "Recommendations for Preventive Pediatric Health Care" published by the Bright Futures/American Academy of Pediatrics.
3. The health plan is responsible for the administration of immunizations per the standardized Periodicity and Immunization Schedules. All PCPs, as appropriate, must participate in the Vaccines for Children (VFC) program to provide childhood immunizations to Medicaid eligible children. The requirements of the VFC program administered will be reported with the appropriate procedure code and modifier to identify them as VFC vaccine immunizations. Vaccine not available through the VFC program, but recommended and published by the Advisory Committee on Immunization Practices (ACIP) or the American Academy of Pediatrics must be provided and reimbursed by the health plan to the PCP.
4. The health plan must take a proactive approach to ensure clients obtain HEALTH CHECK (EPSDT) screening services and medically necessary diagnosis and treatment services. A proactive approach includes:
   a. Written notification and phone protocols for upcoming or missed appointments;
   b. Protocols for conducting outreach with non-compliant members;
   c. Case Management to children with special health needs, e.g., children in foster care, pregnant adolescents; and
   d. Referrals to public health agencies for environmental assessments and caregiver education services for children with lead poisoning.
5. Medically necessary treatment will be provided according to 471 NAC 33-000; e.g., diagnosis and treatment, covered by Medicaidthe Nebraska Medical Assistance Program, federally defined and medically necessary, to treat, prevent or ameliorate a condition; to promote growth and development; to attain or maintain functional status; or prevent deterioration. Treatment services also include rehabilitative and habilitative services for HEALTH CHECK (EPSDT) eligible children. The health plan must provide information and referral in addressing social, educational, and other health needs as requested. Refer requests for treatment not covered by the Nebraska Medical Assistance Program to the Department.
6. Using pediatric specialists for children where the need for pediatric specialty care is significantly different from the need for adult specialists, e.g., pediatric cardiologist for children with congenital heart defects.

4-003.03 Third Party Liability (TPL) Requirements: The MCO physical health plan (health plan) must utilize a cost avoidance methodology whenever there is a verified third party resource (TPR). Under Federal Law, the Department is required to identify legally liable third parties and treat verified TPL as a resource of the client. The plan, or its subcontractors or providers, must not pursue collection from the client, but directly from the liable third party payers, except as allowed in 468 NAC, 469 NAC and 477 NAC. The health plan must assume responsibility for all TPL requirements.

~~A client enrolled in managed care will not have active commercial (e.g. HMO, PPO, etc) insurance and/or Medicare. A Medicaid client may become retroactively eligible for Medicare or a non-custodial parent may acquire commercial insurance for a child after enrollment into managed care. When these situations occur, the client will be waived from enrollment from managed care the first of the month after the new third party resource is entered into the eligibility system, given system cutoff. Until disenrollment is effective, the plan is required to pursue the TPL (see 482-000-10).~~

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

The health plan 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 health plan are cost avoided or recovered from a liable party. The two methods used are cost avoidance and post-payment recovery.

4-003.04 Provider Payments: The following provisions apply:

4-003.04A Timeliness of Provider Payments: The health plan must provide payment to a provider of services on a timely basis, consistent with Medicaid claims payments procedures and the minimum standards provided below, unless the health care provider and health plan agree to a capitated payment schedule or other arrangement.

The health plan must maintain a health information system that includes the capability to electronically accept claims for adjudication and make payments in accordance with the standards set forth in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such electronic system must have the ability to transmit data to a central data repository which complies with the requirements for confidentiality of information under the Medicare program.

The health plan must comply with the following minimum timeframes for the submission and processing of clean claims. Timeframes are calculated from the day the clean claim is received by the health plan until the date of the postmark that either returns the claim to the provider or until posted on an electronic system.

The health plan must pay 90% of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt. The date of receipt is the date the physical health plan receives the claim. The health plan must also pay 99% of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 90 days of the date of receipt. The health plan must pay all other claims within 12 months of the date of receipt.

4-003.04A1 Prompt Investigation and Settlement of Claims: The health plan must comply with the requirements related to claim forms as set forth in 471 NAC. This must include the use of Form CMS-1500, Health Insurance Claim Form and the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) for providers of outpatient services and Form CMS-1450 (UB-92) and the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837) for hospitals providing inpatient or outpatient services.

4-003.04A2 System Requirement: The health plan must maintain an editable system for recording all claims, clearly indicating the date on which a claim is received and the date(s) any action(s) on the claim occur~~, which must also include an identified of the office handling the claim on behalf of the health plan~~.

4-003.04A3 Payment Standard: The health plan must pay clean claims promptly as provided above after the date of receipt of or electronic notice of the claim. If, for whatever reason, the claim is submitted electronically and in written form, the date of the earlier submission of the claim will be the date of notice from which the health plan must calculate the maximum thirty day period.

4-003.04A4 Notice of Contested Claim: The health plan must provide written or electronic notice to the provider of a determination by the health plan that the claim is a contested claim with the returned claim. The written or electronic notice must comply with the provisions in 482 NAC 4-003.04.

4-003.04A5 Notice Requirement for Partially Contested Claim: If the health plan determines that part of a claim is a contested claim and returns the claim, the health plan must provide written or electronic notice of that determination to the entity submitting the claim and must proceed to pay the portion of the claim determined by the health plan to be a clean claim timely.

4-003.04A6 Prohibited Action: In no instance will the health plan contest or return a claim or a portion of a claim because the claim fails to provide certain information if the information determined to be lacking has no factual impact upon the health plan's ability to adjudicate the claim.

4-003.04A7 Notice of Insufficient Information: If the health plan determines that a claim provides insufficient information for the payment of the claim, the health plan must provide written or electronic notice of this determination to the entity submitting the claim timely including the following information:

1. All of the reasons for the denial of the claim;
2. The date the service was rendered, the type of service rendered, the name of the provider who rendered the service and the name of the person to whom the service was rendered; and
3. The address of the office responsible for handling the claim, and means by which the office may be contacted without toll charges exceeding the charges that otherwise apply for the provider or member to place a call in his/her areas code.

4-003.04A8 Effective Notices and Payments: Written notice of a claim will be effective upon the date that the claim is received. Electronic transmission of the claim will be-the date the claim is posted to the electronic transfer system.

Payment and Notices from the health plan will be effective as of the date that:

1. A draft or other valid instrument equivalent to payment is placed in the United States mail in a properly address, postage-paid envelope;
2. The date of posting of the item to an electronic transfer system; or
3. The date of delivery of the draft or other valid instrument equivalent to payment if 1 or 2 do not otherwise apply.

Payment and notices distributed by a health plan's subcontractor must be effective when made in compliance with this section, as appropriate.

4-003.04A9 Contents of a Notice of a Contested Claim: The health plan must specify in its notice of a returned claim at least the following information:

1. The name, address, telephone number and facsimile number of the office handling the claim or other designated claims representative knowledgeable about the claim with which the person submitted the claim, or provider should communicate to resolve problems with the claim;
2. The date of the service, the type of service, the provider of the service, and the name of the person to whom the service was rendered to the extent that this information is known to the health plan;
3. The specific information needed by the health plan to make a determination that the claim is a clean claim; and
4. The date the claim was received.

In addition, the health plan must include in a notice regarding a claim determination in part a contested claim, a statement specifying those portions of the claim that are considered to be clean claim, and the amounts payable with respect to the clean claim portion.

Requests for information made by the health plan on a contested claim must be reasonable and relevant to the determination of whether the claim is a clean claim or claim that must be denied.

4-003.04A10 Use of Intermediaries: A health plan's use of subcontractors to perform one or more of the health plan's claims handling functions must not in any way mitigate the health plan's responsibility to comply with all of the terms of 482 NAC.

4-003.04A11 Electronic Remittance Advice: Electronic remittance advice must be provided in accordance with the standards set forth in the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

4-003.04A12 Claim Status Inquiry and Response: Electronic claim status inquiry and response must be provided in accordance with the standards set forth in the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

4-003.04B Encounter Data: The health plan must maintain an information system that includes the capability to collect data on client and provider characteristics, and claims information through an~~d~~ encounter data system. The health plan must submit encounter data to the Medicaid Management Information System (MMIS) monthly per Departmental specifications. Encounter data submission must:

1. Be submitted on a monthly basis;
2. Be submitted accurately and meet the Departmental standard of 95% ~~submission~~ compliance rate;
3. Include all clean claims adjudicated by the MCO; and
4. Include all services provided to the Managed Care~~NHC~~ client, contracted or delegated.

Encounter data that does not meet the 95% submission rate will be rejected and returned to the health plan. The health plan is required to re-submit corrected encounter data in a timely manner. Health plan~~'~~s which fail to meet compliance standards for submission of encounter data for three consecutive months will have ~~the auto assignment algorithm changed to limit enrollment in the health plan until the health plan~~administrative actions taken until the health plan comes into compliance as specified in the contract between the Department and the MCO.

4-004 BASIC BENEFITS PACKAGE GENERAL PROVISIONS: All services provided under physical health managed care must meet the requirements of 471 NAC unless specifically waived by the Department. The MCO's physical health plan (health plan) must apply the same guidelines for determining coverage of services for the Managed CareNHC client as the Department applies for other Medicaid clients. Actual provision of a service included in the Basic Benefits Package must be based on whether the service could have been covered under Medicaid the Nebraska Medical Assistance Program on a fee-for-service basis under Title 471 NAC.

Copayments are not allowed for clients enrolled in NHC, with the exception of prescription drugs or other Medicaid-covered services not included in the Basis Benefits Package. Copayments are not allowed for Mental Health/Substance Abuse (MH/SA) services for clients enrolled in the MH/SA component of NHC, except for services not included in the MH/SA Package.

All services in the Basic Benefits Package must be provided or approved by the health plan and Primary Care Physician (PCP). All providers of services in the Basic Benefits Package must be Medicaid-enrolled providers.

In addition to the health plan provision/approval, the following services must be prior authorized by the Department:

1. HEALTH CHECK (EPSDT) treatment services not covered by the State Plan (see 471 NAC);
2. 1. Abortions (see 471 NAC); and
3. 2. Transplants (see 482 NAC 2-004).

Family planning services (see 482 NAC 4-004.03), emergency services, and Native Americans seeking tribal clinic or Indian Health hospital services do not require prior authorization or provision by the PCP or participating network provider. All covered emergency services (see 482 NAC 4-004.04) must be available 24 hours per day, seven days per week, and are not to be limited to plan-affiliatednetwork providers. The client may access these services from any Medicaid-enrolled provider s/he chooses, and the client may access these services without a referral.

The Department requires the health plan to reimburse providers, network and out-of-network, for appropriate medical screening performed during an emergency room visit. The payment of claims to out-of-network providers are subject to the requirements in 482 NAC 4-003.04.

Electronic referral/authorization must be provided in accordance with the standards set forth in the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

4-004.01 Services in the Basic Benefits Package: Services included in the Basic Benefits Package:

1. Inpatient hospital services (see 471 NAC 10-000);
2. Outpatient hospital services (see 471 NAC 10-000);
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 MH/SA diagnoses.(see 471 NAC 10-000 and 18-000);
4. Radiology services (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, clinic administered medications/injections, and 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 14-000). (This does not include non-home health agency approved Personal Care Aide 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) except for medical transportation related MH/SA services;~~
15. ~~15~~14. Visual services (see 471 NAC 24-000);
16. ~~16~~15. Family Planning services (see 471 NAC 18-000 and 482 NAC 5-004.03);
17. ~~17~~16. Emergency and post stabilization services (see 471 NAC 10-000 and 482 NAC 5-004.04);
18. ~~18~~17. Federally Quality Health Center (FQHC), Rural Health or Tribal Clinic services (see 471 NAC 11-000, 29-000, 34-000 and 482 NAC 4-004.06);
19. ~~19~~18. Skilled/Rehabilitative and Transitional Nursing Facility services (see 471 NAC 12-000, and 482 NAC 2-004.04);
20. ~~20~~19. Transitional Hospitalization services (see 471 NAC 10-000, 482 NAC 2-002.04D, 2-003.03 and 2-004.01A); and
21. ~~21~~20. Transitional Transplantation services (see 471 NAC 10-000 and 482 NAC 2-004).

The services above represents covered services under Medicaid. The physical health plan is responsible for working with the Department to ensure the client has access to all services.

The health plan must provide the above services in amount, duration and scope defined by the Department in 471 NAC. The health plan must provide care and services when medically necessary to ensure the client receives necessary services. The health plan must also ensure that the services provided to the client are as accessible (in terms of timeliness, amount, duration and scope) as those services provided to the non-enrolled Medicaid client.

The health plan is allowed to provide medically necessary services to the client that are in addition to those covered under Medicaid. The health plan is also allowed to provide substitute health services when the health plan has determined to be more cost effective than the covered service and the health status of the client is expected to improve or at least stay the same. If additional or substitute health services are provided, the total payment to the health plan will not be adjusted but will remain within the certified rates agreed upon in any resulting contract and approved by CMS.

4-004.02 ~~NHC~~ Excluded Services: The following Medicaid-coverable services are excluded from the Managed Care~~NHC~~ Basic Benefits Package, and are not the responsibility of the health plan:

1. Pharmacy Services (471 NAC 16-000);
2. Nursing Facility Services - custodial level of care (i.e., long term care) (see 471 NAC 12-000 and 482 NAC 2-004.04);
3. ICF/MR services (see 471 NAC 31-000);
4. Home and community based waiver services (see Title 480 NAC);
5. School-based services covered under Medicaid in Public Schools (see 471 NAC 25-000);
6. Optional targeted case management services (see Title 480 NAC);
7. Mental Health/Substance Abuse (MH/SA) Services (see 471 NAC 20-000 and 32-000);
8. Dental Services (see 471 NAC 6-000); ~~and~~
9. Non-Home Health Agency Approved Personal Care Aide Services (471 NAC 15-000); and
10. Medical transportation services (see 471 NAC 27-000).~~.~~

These services are paid on a fee-for-service basis. Clients must access these services through Medicaid (i.e., 471 NAC or 480). For all Medicaid-covered services, the health plan is required to coordinate the client's care to promote continuity of care for the client.

The health plan and EBS must inform the client of the availability of these services and how to access them.

4-004.03 Family Planning Services: Approval by the client's PCP and health plan is not required for family planning services. The health plan and EBS must inform Managed Care ~~NHC~~ clients~~-~~ their freedom of choice for family planning services is not restricted to a provider participating in Managed Care~~the NHC~~ but that they must use a Medicaid enrolled provider.

Family planning services are 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 and vasectomy. Treatment for sexually transmitted diseases (STD) is to be reimbursed by the health plan in the same manner as family planning services, without referral or authorizations.

Family planning services do not include hysterectomies, other procedures performed for a medical reason, (such as removal of an intrauterine device due to infection) or abortions.

Family planning services are to be paid by the health plan even if the provider is not part of the health plan's network.

4-004.04 Emergency Services: Approval by the client's PCP and health plan is not required for receipt of emergency services. The health plan and EBS must inform NHC clients that approval of emergency services is not required and must educate clients regarding the definition of an "emergency medical condition," and how to appropriately access emergency services.

4-004.04A Emergency Services Provided to Managed Care~~NHC~~ Clients: The health plan must cover and pay for emergency services regardless of whether the provider that furnishes the services has contracted with the health plan.

An emergency medical condition is a medical condition, that manifests itself by acute 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 a) 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, b) serious impairment to bodily functions, c) serious dysfunction of any bodily organ or part.

4-004.05 Mental Health/Substance Abuse (MH/SA) Coordination Issues: The following rules apply when coordination of services is required between the health plan responsible for the Basic Benefits Package and the MH/SA plan responsible for the MH/SA services, as addressed by the Department in regulations governing both components of Managed Care~~the NHC~~. In situations where the client isn't enrolled in both components of Managed Care~~the NHC~~, the associated service is coordinated with the Nebraska Medicaid Assistance Program on a fee-for-service basis.

4-004.05A Emergency Room Services for MH/SA Services: Emergency room services provided to a client who is enrolled in the MH/SA component of Managed Care~~the NHC~~ is the responsibility of the client's health plan regardless of the client's final or principle diagnosis.

At the time a MH/SA provider initiates an evaluation and/or treatment for the client, the health plan is no longer responsible for MH/SA related service. Authorization for MH/SA services from that point forward must be obtained from the MH/SA plan.

4-004.05B Admissions for 24-Hour Observation: When a client who is enrolled in the MH/SA component of Managed Care~~the NHC~~ is admitted to an acute care (i.e., medical/surgical) facility as an outpatient for 24-hour observation for purposes of a MH/SA diagnosis, the MH/SA plan is responsible for authorization of the observation stay.

The MH/SA plan is no longer responsible for the service at the time that a psychiatrist initiates an evaluation and/or treatment of the client and determines that the client does not have a MH/SA diagnosis. Authorization for acute care services from that point forward must be obtained from the health plan.

4-004.05C Chemical Detoxification Services and Substance Abuse Treatment: Chemical detoxification is a covered hospital service for clients of any age. Coverage for hospital admissions must be provided by the health plan.

Substance abuse treatment services are covered for Medicaid-eligible clients age 20 and younger only. Allowable substance abuse services for a client must be authorized by the MH/SA plan for clients enrolled in the MH/SA plan.

4-004.05D History and Physical (H&P) Exams for Inpatient Admissions for MH/SA Services: The H&P completed for an inpatient admission for MH/SA services is the responsibility of the health plan for which the client is enrolled.

Inpatient MH/SA services provided to clients enrolled in the MH/SA component of Managed Care~~the NHC~~ in a freestanding or hospital-based residential treatment center (RTC), treatment group home are the responsibility of the MH/SA plan. The History & Physical provided for these allowable services are the responsibility of the health plan for which the client is enrolled.

4-004.05E Ambulance Services for Managed Care~~NHC~~ Clients Receiving MH/SA Treatment Services: Emergency medical transportation, regardless of diagnosis or condition is the responsibility of the health plan.

All other MH/SA related medically necessary ambulance services are the responsibility of the MH/SA plan, if the client is enrolled in the MH/SA component of Managed Care~~the NHC~~.

Non-ambulance and non-emergency medical transportation for MH/SA services is the responsibility of the MH/SA plan, if the client is enrolled in the MH/SA component of Managed Care~~the NHC~~.

4-004.05F Injections Associated with MH/SA Services: Injections of psychotropic drugs in an outpatient setting are the responsibility of the MH/SA plan, if the client is enrolled in the MH/SA component of Managed Care~~the NHC~~.

4-004.05G Lab, X-Ray and Anesthesiology Associated with MH/SA Services: Services associated with the treatment of MH/SA services and authorized by a MH/SA provider participating in the MH/SA plan's network, such as lab fees, x-ray charges and the administration of anesthesiology, is the responsibility of the MH/SA plan, if the client is participating in the MH/SA component of Managed Care~~the NHC~~.

4-004.06 Federally Qualified Health Centers (FQHC): The health plan must contract with any FQHC located within the designated coverage area or otherwise arrange for the provision of FQHC services. If an FQHC is reimbursed by the health plan on a fee-for-service basis, it cannot pay less for those services than it pays other providers. FQHC's electing to be reimbursed on a negotiated risk basis are not entitled to reasonable cost reimbursement. If the FQHC requests reasonable cost reimbursement, the health plan must reimburse the FQHC at the same rate it reimburses its other subcontractors of this provider type. The health plans must report to the Department the total amount paid to each FQHC. FQHC payments include direct payments to a medical provider who is employed by the FQHC.

In Managed Care~~the NHC~~, the client chooses to participate with the FQHC by selecting the physician as his/her PCP.

The same reasonable efforts that are applied to the FQHC, apply to the Rural Health Clinics and Tribal Clinics.

4-005 PAYMENT FOR SERVICES: The Department pays a monthly capitation fee to the Managed Care Organization's (MCO's) physical health plan (health plan) for each enrolled client for each month of Managed Care~~NHC~~ coverage (per member per month). The monthly capitation fee includes payment for all services in the Basic Benefits Package.

The health plan must provide payment to providers for services rendered on a timely basis consistent with Medicaid claims payment procedures, unless the health care provider and organization agree to an alternative payment schedule.

Payment to the health plan is payment in full for all services included in the Basic Benefits Package. No additional payment may be requested of the Department or the client.

The capitation rates are actuarially determined and are based on geographic location, eligibility category, gender, age and type of services. The Department will adjust rates, and complete all necessary contract amendments, when it is determined appropriate, based on any changes in Medicaid fee-for-service (FFS) rates, or in instances where the an error or omission in the calculation of the rates has been identified.

4-005.01 Enrollment Report: On or before the first day of each month, the Department will provide to each health plan a monthly enrollment report that lists all enrolled and disenrolled clients for the that month. This report will be used as the basis for the monthly capitation payments to the health plan. The health plan is responsible for payment of all services in the Basic Benefits Package provided to clients listed on the enrollment report generated for the month of coverage. If an eligible client is not listed on the enrollment report, the Department will be responsible for all medical expenses (see 482 NAC 2-002.05.)

4-005.02 Coverage for Pregnant Women/Newborns: Coverage for a pregnant woman and/or the newborn is provided within the following parameters:

1. Pregnant Woman and Newborn are Medicaid Eligible: Coverage is provided for the pregnant woman from the month of enrollment until disenrollment occurs; and for the newborn from the month of birth until disenrollment occurs. Payment to the health plan is made for the month(s) of enrollment for the pregnant woman and the newborn until disenrollment occurs.
2. Only the Newborn is Medicaid Eligible: Coverage is provided for the pregnant woman from the month of enrollment until disenrollment occurs. Coverage for the birth and post partum care for the mother is provided for the month of birth through the month in which the 60th day following the month of birth occurs. Coverage for only the newborn continues past the 60-day postpartum period as long as the newborn remains eligible and enrolled. Payment to the health plan is made for the month(s) of enrollment for the pregnant woman and the newborn until disenrollment occurs.

4-005.03 Billing the Client: The health plan may not bill a client for a Medicaid coverable service, regardless of the circumstances.

The provider of service may only bill the client pursuant to 471 NAC.

The health plan may or may not be responsible for an out-of-network service if the service is a Medicaid-coverable service. Whether the health plan is responsible to pay the provider is determined by the agreement the health plan has with that provider. In some cases, the provider may not get paid.

The health plan is not required to pay a non-Medicaid enrolled provider for a Medicaid-covered service.