2-000 CLIENT PARTICIPATION AND ENROLLMENT – ~~PHYSICAL HEALTH MANAGED CARE~~

2-001 MANDATORY AND EXCLUDED CLIENTS

2-001.01 Mandatory for ~~Physical Health~~ Managed Care: The following Medicaid-eligible clients are required to participate in ~~Physical Health~~ Managed Care unless excluded ~~in 482 NAC 2-001.03~~.

1. Clients participating in the Aid to Dependent Children Program - Grant/Medical (see Title 468 NAC). For purposes of Managed Care, this includes clients participating in the Medical Assistance Programs for Children (i.e., Ribicoff), Medical Assistance for Children (MAC), School Age Medical (SAM) and Kids Connection (see Title 477 NAC);
2. Clients participating in the Aid to Aged, Blind, and Disabled Program - Grant/Medical (see Title 469 NAC); and
3. Clients participating in the Child Welfare Payments and Medical Services Program (i.e., IV-E, Non-IV-E, Former Wards, Subsidized Guardianship cases) (see Title 479).

The client's managed care status (mandatory or excluded) is determined by an automated interface between ~~the Department's~~ Medicaid's eligibility system and the Managed Care system, and is based on information entered on the Medicaid eligibility system ~~by the Department of Health and Human Services' staff~~, and known at the time of ~~the time of~~ the interface. Clients mandatory for managed care cannot voluntarily waive enrollment unless excluded under 482 NAC 2-001.0~~3~~2 or 2-001.03.

2-001.02 ~~(Reserved)~~ Excluded Clients for Behavioral Health: The following clients are excluded from Behavioral Health Managed Care (based on the information known to the DHHS eligibility system):

1. Medicaid clients for the period of retroactive eligibility;
2. Aliens who are eligible for Medicaid for an emergency condition only (see Titles 468, 469, 477, 479 NAC);
3. Medicaid clients who have excess income or who are designated to have a Premium Due;
4. Medicaid clients eligible during the period of presumptive eligibility;
5. Participants in an approved Program for All-inclusive Care for the Elderly (PACE) program;
6. Clients with Medicare coverage where Medicaid only pays co-insurance and deductibles; and
7. Unborn children of otherwise ineligible pregnant women.

2-001.03 Excluded Clients for Physical Health: The following clients are excluded from Physical Health Managed Care (based on the information known to the DHHS eligibility system):

1. Medicaid clients who have Medicare~~. This exemption does not apply to the MH/SA services components of Managed Care~~;
2. Medicaid clients who reside in Nursing Facilities (NF) at custodial levels of care or in Intermediate Care Facilities for Mental Retardation (ICF/MR) or in Psychiatric Residential Treatment Facilities (PRTF) (see 471 NAC 12~~-000~~, 471 NAC 31~~-000~~, 471 NAC 32, and 482 NAC 2-004.04);

3. Medicaid clients who participate in a Home and Community Based Waiver (HCBS). This includes adults with mental retardation or related conditions, aged persons or adults or children with disabilities (AD waiver), children with mental retardation and their families, clients receiving Developmental Disability Targeted Case Management Services, adults with traumatic brain injury (TBI waiver), and any other group for whom the State has received approval of the 1915 (c) waiver of the Social Security Act;
4. Medicaid clients for any period of retroactive eligibility~~. Managed Care enrollment is for prospective only~~;
5. Clients residing out-of-state or those who are considered to be out-of-state (i.e., children who are placed with relatives out-of-state, and who are designated as such by DHHS personnel);
6. Aliens who are eligible for Medicaid for an emergency condition only (see Titles 468, 469, 477, 479 NAC);
7. Clients participating in the Refugee Resettlement Program - Grant/Medical (see Title 470 NAC);
8. Clients who have excess income (i.e., spenddown - met or unmet) or who are designated to have a premium due ;
9. Clients participating in the State Disability Program (see Title 469 NAC);
10. Clients eligible during a period of presumptive eligibility (see 471 NAC 28-00);
11. Organ transplant recipients from the day of transplant forward (see 471 NAC 10-000 and 482 NAC 2-004);
12. Clients who have received a disenrollment/waiver of enrollment (see 482 NAC 2-004);
13. Clients who are participating in the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Every Woman Matters Program);
14. Clients receiving Medicaid Hospice Services;
15. Individuals who are patients in Institutions of Mental Disease (IMD) who are between the ages 21-64; ~~and~~
16. Clients participating in the Subsidized Adoption Program, including those who receive a maintenance subsidy from another state (see 469 NAC)~~.~~;
17. Participants in an approved Program for All-inclusive Care for the Elderly (PACE) program; and
18. Unborn children of otherwise ineligible pregnant women.

2-001.04 Coverage Rules

2-001.03A Coverage before enrollment: Medicaid coverage for clients excluded from Managed Care participation remains on a fee-for-service basis. Clients who are excluded cannot voluntarily enroll.

2-001.03B Coverage during enrollment: Due to changes in a client's Medicaid eligibility and/or mandatory for managed care status, a client's enrollment in managed care may periodically change. The ~~physical health~~ managed care plan(s) is responsible for the provision of the ~~Basic Benefits Package~~ services covered by managed care for the client as long as s/he is identified as a member of that ~~health~~ managed care plan.

2-002 ENROLLMENT

2-002.01 Purpose of Enrollment Process: ~~The Department~~ Medicaid maintains responsibility for the enrollment of clients into ~~a Physical Health~~ Managed Care ~~Plan (health plan~~), through departmental and contractual arrangements. The use of an enrollment broker precludes any direct enrollment activities by the ~~health~~ managed care plan. The role of the enrollment broker services (EBS) is the enrollment of the mandatory managed care clients into a physical health plan and assignment of a Primary Care Provider (PCP).

The enrollment broker services are intended to assist the client in understanding enrollment requirements and participation in Managed Care. To facilitate this effort, the ~~health~~ managed care plans ~~is~~ are required to have an understanding of the client population and the enrollment process, and to assist ~~the Department~~ Medicaid and the enrollment broker in providing adequate information to the client. The ~~health~~ managed care plans ~~is~~ are also required to work cooperatively with ~~the Department~~ Medicaid and EBS to resolve issues relating to client participation and enrollment, and to have the technological capability and resources available to interface with ~~the Department's~~ Medicaid's support systems.

2-002.02 ~~(Reserved)~~ Enrollment Activities in the Behavioral Health Managed Care Organization: Clients are enrolled in Behavioral Health Managed Care (behavioral health plan) by virtue of their eligibility for Medicaid in the categories listed in 482 NAC 2-001.01. There is no separate enrollment process for these services. The Behavioral Health plan shall agree to accept Medicaid clients in the order in which they are enrolled

2-002.02A Changes in Eligibility: Changes in the client's eligibility may affect his/her managed care status, e.g., mandatory or excluded. The client receives a notice with a change in managed care coverage.

2-002.02B Effective Date of Behavioral Health Coverage: The effective date of coverage is the first day of the month of mandatory status determination and enrollment into the behavioral health plan.

The behavioral health plan is responsible for the client effective with the date of managed care coverage under Nebraska Medicaid regardless of the client's level of care at the time of enrollment. The first payment to the plan begins the first month of Behavioral Health enrollment.

2-002.02C Behavioral Health Services Before Enrollment in Nebraska Medicaid: If eligibility for Nebraska Medicaid is determined, Medicaid-coverable Behavioral Health services received before the month of Nebraska Medicaid coverage in the benefits package will be paid on a fee-for-service basis under the rules and regulations of Nebraska Medicaid in 471 NAC.

2-002.03D Client Notification of Managed Care Coverage: The client or the client's legal representative will be notified of managed care coverage and will be issued a notice of enrollment.

2-002.03E MCO Notification of Managed Care Coverage: The behavioral health plan will be notified of enrolled clients via an enrollment report (in the form of a data file). ~~The Department~~ Medicaid electronically transmits the enrollment report to the behavioral health plan on or before the first day of each enrollment month. The enrollment report provides the behavioral health plan with ongoing information about its clients and will be used as the basis for the monthly capitation.

The behavioral health plan is responsible for providing the Behavioral Health Benefits Package to clients listed on the enrollment report generated for the month of enrollment. Any discrepancies between the client notification and the enrollment report will be reported to ~~the Department~~ Medicaid for resolution. The behavioral health plan shall continue to provide and authorize services until the discrepancy is resolved.

2-002.03 Enrollment Activities in the Physical Health MCO: The client must, after receiving Managed Care information, choose a Physical Health Managed Care plan (health plan) and Primary Care Provider (PCP) (i.e. voluntary choice). Note: Family members may select different PCP and health plans but will be encouraged to choose the same health plan.

Voluntary choice and all enrollment activities must be completed and entered on the Managed Care system by the EBS within fifteen calendar days following the date of the notice sent to the client informing of the need to enroll. After fifteen calendar days, if a choice has not been made (i.e. voluntary choice), automatic assignment (see 482 NAC 2-002.06) will be completed by ~~the Department~~ Medicaid ~~and will become active the first of the next month possible, given system cutoff~~. Enrollment activities may be completed via, telephone call, or by mail.

The health plan must agree to accept Medicaid clients in the order in which they are enrolled through the EBS and ~~the Department's~~ Medicaid's auto-assignment process.

The client must have the opportunity to choose the health plan and PCP of his/her choice, to the extent possible and appropriate.

Enrollment in Physical Health Managed Care is prospective, and is activated the first of the next month, given system cutoff.

2-002.03A Reenrollment: If the client is identified as mandatory for enrollment in the Managed Care within two months of loss of Medicaid eligibility, the client will automatically be enrolled with the previous health plan effective the first of the next month possible given system cutoff. ~~The Department~~ Medicaid will send the client notification of the re-enrollment.

The client is free to choose a different health plan only in these circumstances: (a) if the reenrollment is during the initial ninety (90) day period; (b) during the open enrollment period; or (c) for cause (see 482 NAC 2-003.02) by contacting the EBS and completing enrollment activities.

2-002.03B ~~(Reserved)~~

~~2-002.03B2~~ Departmental Wards/Foster Care Clients: The EBS must coordinate enrollment activities with the Child and Family Services Specialist (CFS Specialist) responsible for the case management of the ward/foster child. ~~The CFS Specialist must work with the client and the client's family or legal representative, as appropriate, to explore the most appropriate choice of health plan and PCP.~~

~~The CFS Specialist must notify the EBS of the choice of health plan and PCP.~~

2-002.03C Enrollment of a Newborn Child: During the enrollment process for the newborn, an eligible woman is required to choose the same health plan, but not necessarily the same PCP, for herself and her eligible newborn child. Enrollment changes (i.e., to a different health plan) may be made as allowed for any other client participating in the Managed Care. (see 482 NAC 2-003.02)

2-002.03E Changes in Enrollment Status: The client will be notified by ~~the Department~~ Medicaid if the client's Managed Care status changes, e.g., mandatory to excluded. Depending on the status change, the client may be required to contact the EBS and complete an enrollment, unless reenrollment rules apply (see 482 NAC 2-002.03A).

2-002.03F Follow-Up Contact by the EBS: The EBS must conduct follow-up until enrollment occurs or the client is automatically assigned to a health plan and PCP. The EBS must make reasonable efforts to contact those clients who have been automatically assigned but who have not had the benefit of an explanation of Managed Care.

Follow-up contact may include, but is not limited to, the following:

1. Telephone calls; and
2. Informational mailings.

2-002.04 Enrollment Rules: The client or the client's legal representative must complete the enrollment process. For purposes of completing the enrollment process, the following rules apply:

1. A friend or relative of the client, who does not have legal authority, may complete the informational portion of the enrollment process if the individual is determined to have sufficient knowledge of the client's health status;
2. The client or his/her legal representative (i.e., guardian, conservator, or Durable Power of Attorney (DPOA) if the DPOA has this level of authority) must make the choice of the health plan and PCP; and
3. The CFS Specialist ~~must act~~ on a Department ward's behalf. The child's foster parents must be involved in the selection of the health plan and PCP. ~~The CFS Specialist must consider whether it is appropriate for the biological parents to be involved in the enrollment activity~~.

The ~~MCO~~ health plan must not have any direct contact with the client or the client's legal representative, family or friends prior to the client becoming enrolled with the ~~MCOs~~ health plan, unless the contact is initiated by the EBS in an effort to facilitate the choice of health plan and PCP and as it relates to continuity of care issues.

2-002.05 Effective Date of Physical Health Managed Care Coverage: The effective date of Physical Health Managed Care coverage is the first day of the month following the month during which enrollment is completed in the system, given system cutoff. Exception: Hospitalization at the time of enrollment (see 482 NAC 2-002.05D).

2-002.05A Services Before Enrollment in Physical Health Managed Care: Medicaid-coverable services received before the month of physical health managed care coverage becomes effective will be paid on a fee-for-service basis under the rules and regulations of Medicaid Title 471 NAC.

2-002.05B Notification of Managed Care Coverage: The client or the client's legal representative will be notified of Managed Care coverage.

The client's status must be verified by the medical provider through:

1. ~~The Department's~~ Medicaid's Internet Access for Enrolled Providers http://dhhs.ne.gov/medicaid/Pages/med_internetaccess.aspx
2. The Nebraska Medicaid Eligibility System (NMES) at 800-642-6092 (in Lincoln 471-9580);
3. The Medicaid Inquiry Line at 877-255-3092 (in Lincoln 471-9128); or
4. The standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271).

Through the EBS functions, and written materials and notice, the client will be kept informed of his/her right to change health plans and/or PCP.

The health plan will be notified of clients enrolled with their plan via an enrollment report (in the form of a data file). ~~The Department~~ Medicaid electronically transmits the enrollment report to the health plan before the first day of each enrollment month. The enrollment report provides the plan with ongoing information about its clients and will be used as the basis for the monthly capitation payments.
If the client does not voluntarily enroll, the enrollment report will not list a Primary Care Provider. The health plan is responsible for the assignment of the PCP for clients who do not voluntarily enroll.

The health plan is responsible for providing the services in the Basic Benefits Package to clients listed on the enrollment report generated for the month of enrollment. Any discrepancies between the client notification and the enrollment report must be reported to ~~the Department~~ Medicaid for resolution. The plan must continue to provide and authorize services until the discrepancy is resolved. ~~The Department will be responsible for all covered services in the event that a client is not reflected on the enrollment report.~~

The ~~Department's~~ Eligibility and Enrollment databases used to build the Enrollment File is the official source of validation in the case of a discrepancy. Once the cause for the discrepancy is identified, ~~the Department~~ Medicaid will work cooperatively with the health plan to identify responsibility for the client's services until the cause for the discrepancy is corrected. ~~In reconciling the discrepancy, an adjustment will be made in the following manner:~~

~~1. If the Department assumes claims payment for the client, the health plan must reimburse the Department for any capitation payment made for that month of service;~~
~~2. If the health plan assumes claims payment for the client, the plan will receive a capitation payment; and/or~~
~~3. If the error results in an incorrect amount of capitation payment, the difference will be appropriately reimbursed, either to the health plan or to the Department.~~

2-002.05C Transition Period: Within the first month of enrollment, the health plan is responsible for providing each member general information about the plan, e.g., member handbook, etc.

The health plan must work cooperatively with a client who is experiencing difficulty in transitioning to a managed care environment during the first sixty days of enrollment.

The health plan must continue all services that have been authorized by ~~the Department~~ Medicaid fee-for-service or the ~~Department's~~ Medicaid's Peer Review Organization (PRO) prior to the client becoming enrolled in Managed Care. These services must be continued until the health plan determines that the service no longer meets the definition of medical necessity.

~~The transitional period may require, but is not limited to, the health plan providing additional case management and member services, contracting with out-of-network providers to ensure continuity of care, and taking into consideration the unique needs of the client in understanding and following the managed care rules, e.g., referral and prior authorizations for services.~~

2-002.05D Hospitalization: When a Medicaid client is an inpatient in an acute care medical or rehabilitation facility on the day that the client's participation in Physical Health managed care is effective, ~~the Department~~ Medicaid fee-for-service remains responsible for the hospitalization until the client is discharged from the facility or transferred to a lower level of care. Authorization for inpatient hospitalizations for rehabilitation services must be obtained from ~~the Department's~~ Medicaid's contracted peer review organization (PRO).

~~The health plan is responsible for a Managed Care client, who is an inpatient for acute medical or rehabilitation services on the first of the month that the Medicaid eligible client is no longer enrolled in a health plan (i.e., termed enrollment or waiver of enrollment) until the client is discharged from the facility or transferred to a different level of care.~~

2-002.06 Automatic Assignment for the Physical Health Managed Care: All enrollment activities must be concluded within fifteen calendar days. If a choice of health plan and PCP, is not made, the client will be automatically assigned to a health plan based on criteria established by ~~the Department~~ Medicaid (see 482-000-~~3~~2, Auto-Assignment Procedure Guide).

~~The Department~~ Medicaid provides a report to the EBS prior to the effective date of the auto-assignment enrollment. The EBS must complete any necessary transfers if an incorrect assignment is identified.

Auto-assignment of a client is indicated on the health plan's Enrollment Report.

~~The Department's~~ Medicaid's auto-assignment algorithm ~~gives priority to provider-client proximity and~~ will attempt to maintain family members with the same health plan as much as possible.

~~The Department~~ Medicaid attempts, but does not guarantee, an equal distribution of clients to available health plans during auto-assignment.

2-003 PHYSICAL HEALTH MANAGED CARE DISENROLLMENT/TRANSFERS: Disenrollment for the purposes of this section is a change in a client's enrollment from one Physical Health Managed Care plan (health plan) to another.

A transfer is a change in a client's assignment from one PCP to another PCP. A disenrollment/transfer may be made at the client's request (482 NAC 2-003.01) or at the PCP and/or health plan's request (482 NAC 2-003.03). A transfer may also be made because the client requires an Interim PCP (482 NAC 2-003.03E).

2-003.01 Client Transfer Requests: The client must contact the health plan to request a PCP transfer. A client may request a transfer from one PCP to another PCP at any time.

. The health plan must assist the client in selecting a new PCP by:

1. Discussing the reasons for transfer with the client and attempting to resolve any conflicts when in the client's best interest;
2. Reviewing the client's needs to facilitate the client's choice of PCP;
3. Processing the client request; and
4. Notifying ~~the Department~~ Medicaid of the PCP transfer via the PCP Transfer file. The PCP transfer will be updated on the client's Managed Care File.

If a client is requesting a PCP transfer, the health plan should carefully document the reason. Any transfer for a client under a "lock-in" provision must be completed per lock-in procedures (see 482-000-7).

2-003.02 Client Disenrollment Requests: A client may request a change from one health plan to another by contacting the EBS as follows:

1. With cause, at any time;
2. During the 90 days following the date of the client's initial enrollment with the MCO, or the date ~~the Department~~ Medicaid sends the client's notice of enrollment, whichever is later;
3. Without cause once every 12 months thereafter;
4. Upon automatic reenrollment if the temporary loss of Medicaid eligibility has caused the client to miss the annual disenrollment opportunity; or
5. When ~~the Department~~ Medicaid imposes the ~~Department~~ Medicaid-established intermediate sanctions on the health plan.

2-003.02A Cause for Disenrollment: The following are cause for disenrollment:

a. The client moves out of the MCO designated coverage area;
b. The health plan does not, because of moral or religious objections, cover the service the client seeks;
c. The client needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the client's PCP or another provider determines that receiving the services separately would subject the client to unnecessary risk; or

d. Other reasons, including but not limited to, poor quality of care, lack of access to providers experienced in dealing with the client's health care needs or lack of access to services covered under the contract.

The disenrollment will be effective the first of the month following the request but no later than the second month following the request, given system cutoff.

2-003.02B Determination of Disenrollment for Cause: When the client disenrollment request is for cause, the EBS must complete Form MS-25, "Plan Disenrollment Client Request Form," (see 482-000-3) with the client and forward the request to ~~Departmental~~ Medicaid staff for a decision. ~~Departmental~~ Medicaid staff will take action to approve or deny the request based on the following:

1. Reasons cited in the request;
2. Information provided by the health plan at the ~~Department's~~ Medicaid's request; and
3. Any of the reasons cited in 482 NAC 2-003.02A.

The effective date of an approved disenrollment will be no later than the first day of the second month following the month in which the request was filed. If ~~Departmental~~ Medicaid staff fail to make a disenrollment determination within this timeframe, the disenrollment is considered approved.

~~Departmental~~ Medicaid staff will process the disenrollment and enter the information in the Managed Care system. A notice is issued by ~~the Department~~ Medicaid to the client or his/her legal representative when the disenrollment is completed. The health plan will be notified via the Enrollment Report.

The health plan may work with the EBS to resolve any issues raised by the client at the time of request for disenrollment but may not coerce or entice the client to remain with them as a member.

2-003.02C EBS Responsibilities: The EBS must also discuss with the client when processing a disenrollment request the following:

1. The importance of maintaining a medical home;
2. How the client's medical care may be affected by the transfer and what the client's responsibility is in obtaining new referrals or authorizations;
3. That outstanding services may require additional referrals/authorizations in order to maintain the continuation of medical care; and
4. That services approved or authorized by one PCP and/or health plan is no guarantee of approval/authorization of the same services with the new PCP and/or health plan.

Any disenrollment for a client under a "lock-in" provision must be completed per lock-in procedures (see 482-000-7).

2-003.03 Primary Care Provider(PCP) Transfer Requests: The PCP may request that the client be transferred to another PCP, based on the following situations:

1. The PCP has sufficient documentation to establish that the client's condition or illness would be better treated by another PCP;
2. The PCP has sufficient documentation to establish that the client/provider relationship is not mutually acceptable, e.g., the client is uncooperative, disruptive, does not follow medical treatment, does not keep appointments, etc.;
3. The individual provider retired, left the practice, died, etc.; or
4. Travel distance substantially limits the client's ability to follow through the PCP services/referrals.

The PCP must maintain responsibility for providing the services in the Basic Benefits Package to the client until a transfer is completed.

The health plan must assist its PCPs and specialists in their efforts to provide reasonable accommodations, e.g., provide additional funding and support to obtain the services of consultative physicians, etc., for clients with special needs, e.g., HIV/AIDS.

2-003.03A Procedure for PCP Transfer Requests: The following procedure applies when a PCP requests a transfer:

1. The PCP must contact the health plan for which the client is enrolled and provide documentation of the reason(s) for the transfer. The health plan is responsible for investigating and documenting the reason for the request. Where possible, the health plan must provide the PCP with assistance to try to maintain the medical home;
2. The health plan must review the documentation and conduct any additional inquiry to clearly establish the reason(s) for transfer;
3. The health plan must submit the request to ~~the Department~~ Medicaid for approval within ten (10) working days of the request;
4. If a PCP transfer is approved, the health plan will contact the client and assist the client in choosing a new PCP;
5. If the client does not select a PCP within fifteen (15) calendar days after the decision, the health plan will automatically assign a PCP.
6. The health plan must enter the approved transfer of PCP on the PCP file for the information to be reflected in the Managed Care system;

The criteria for terminating a Medicaid client from a practice must not be more restrictive than the PCP's general office policy regarding terminations for non-Medicaid clients.

The health plan must provide documentation to ~~the Department~~ Medicaid prior to submitting the PCP transfer request that attempts were made to resolve the PCP-client issues (see 482-000-3 Health Plan Disenrollment/Primary Care Provider (PCP) Transfer Procedure Guide).

2-003.03B 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;
2. The PCP is still participating with the health plan but is not participating at a specific location and the client requests a new PCP (i.e., change in location only); or
3. A PCP/health plan initiated transfer has been approved (see 482 NAC 2-003.03A) but the client does not select a new PCP.

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

2-003.03B1 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 calendar 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 PCP will automatically become permanent; and
5. Information on how to contact the health plan.

2-003.03B2 (Reserved)

2-003.04 Physical Health Plan Disenrollment Requests: The Physical Health Managed Care plan (health plan) may request that the client be disenrolled from the plan and re-enrolled in another plan, based on the following situations:

1. The health plan has sufficient documentation to establish that the client's condition or illness would be better treated by another health plan; or
2. The health plan has sufficient documentation to establish fraud, forgery, or evidence of unauthorized use/abuse of services by the client.

The health plan must provide documentation showing attempts were made to resolve the reason for the disenrollment request through contact with the client or his/her legal representative, the PCP, or other appropriate sources.

The health plan must maintain responsibility for providing the services in the Basic Benefits Package to the client until a disenrollment is completed.

The health plan is prohibited from requesting disenrollment because of a change in the client's health status or because of the client's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his/her special needs.

2-003.04A Procedure for Physical Health Managed Care Plan Disenrollment Requests: The following procedure applies when the health plan requests a client disenrollment:

1. The health plan for which the client is enrolled must provide documentation to ~~the Department~~ Medicaid which clearly establishes the reason(s) for the disenrollment request;
2. The health plan must submit the request to ~~the Department~~ Medicaid via Form NHC-5 (see 482-000-3);
3. The health plan must send notification of the disenrollment request to the client at the same time the request is made to ~~the Department~~ Medicaid. The client notification must include the client's grievance and appeal rights;
4. The client, PCP and health plan are notified of the approval or denial of the disenrollment request and information will be made available electronically.
5. If approved, the disenrollment will become effective the first day of the following month, given system cut-off.

2-003.05 Hospitalization During Transfer: When a Managed Care client is hospitalized as an inpatient for acute or rehabilitation services on the first day of the month a transfer to another physical health plan is effective, the physical health plan which admitted the client to the hospital is responsible for the client (i.e., hospitalization and the related services in the Basic Benefits Package) until an appropriate discharge from the hospital or for sixty days, whichever is earlier. The physical health plan the client is transferring to is responsible for the client (i.e., hospitalization and the related services in the Basic Benefits Package) beginning the day of discharge or on the 61st day of hospitalization following the transfer, whichever is earlier. The physical health plan must work cooperatively with the EBS and ~~the Department~~ Medicaid to coordinate the client's transfer.

2-004 WAIVER OF ENROLLMENT: Waiver of enrollment is the determination that a client is not mandatory for physical health and/or behavioral health managed care.

2-004.01 Waiver of Enrollment Due to Eligibility Changes: Waiver of enrollment will occur ~~automatically~~ in the following situations:

1. The client's Medicaid case is closed or suspended; or
2. The client is no longer mandatory for Managed Care (see 482 NAC 2-001.02 and 2-001.03).

~~The Department~~ Medicaid will notify the client and ~~health~~ managed care plans of the waiver of enrollment. Waiver of enrollment is prospective and is effective the first of the next month possible, given system cutoff.

2-004.01A Hospitalization-Related Waivers of Enrollment: Waiver of enrollment from Managed Care will occur automatically in the following situations due to a change in mandatory status for Managed Care. If the client is receiving inpatient hospital services at the time of waiver, the following rules apply:

1. Waiver of enrollment due to loss of Medicaid eligibility: When a Managed Care client is receiving inpatient acute or rehabilitation hospital services on the first day of a month that the client is no longer eligible for Medicaid benefits, the health plan is not responsible for services effective the first day of the month the client is no longer Medicaid eligible.
2. Waiver of enrollment due to Medicare eligibility: When an NHC client is receiving inpatient acute or rehabilitation hospital services on the first day of the month that the client's Medicare coverage has been entered on the ~~Department's~~ Medicaid eligibility system and is effective, the health plan is no longer responsible for the hospitalization effective with the client's waiver of enrollment from Managed Care.
   The health plan is responsible for coordinating benefits with Medicare and is responsible for all applicable coinsurance/copayments until the client's disenrollment from Managed Care is effective.
3. Waiver of enrollment due to transplant: All services provided to the Managed Care client from the day of the transplant or the day that preparatory treatment (chemotherapy or radiation therapy) for bone marrow/stem cell transplants begins, the health plan is no longer responsible for the hospitalization and the provider will be reimbursed on a fee-for-service basis by ~~the Department~~ Medicaid. The transplant procedure must be prior authorized by ~~Department~~ Medicaid staff. The health plan must notify ~~the Department~~ Medicaid of the date of the transplant.
   ~~The Department~~ Medicaid will initiate the waiver of enrollment of the client from Managed Care. The ~~Department's~~ Medicaid eligibility system will reflect the client's waiver of enrollment from Managed Care the first month possible, given system cutoff. ~~Transplant recipients are permanently excluded from Managed Care participation.~~
4. Waiver of enrollment due to Level of Care Change: When a Managed Care client is receiving inpatient acute or rehabilitation hospital services and the client's enrollment from Managed Care is waived due to a level of care change, e.g., the level of care the client requires changes from acute care services to custodial care, the health plan is responsible for the hospitalization and all services provided in the Basic Benefits Package until waiver of enrollment occurs.
5. Waiver of enrollment due to eligibility category change: When Managed Care client is receiving inpatient for acute medical/surgical or rehabilitation hospital services and has enrollment waived from Managed Care due to an eligibility status change, e.g., the client is no longer in a mandatory group for Managed Care participation, the health plan is responsible for the hospitalization and services provided in the Basic Benefits Package until waiver of enrollment occurs.

2-004.02 -Reserved ~~Waiver of Enrollment Due to Special Circumstance: The Department will manually waive the client from Managed Care in the following situations by entering the waiver of enrollment in the Managed Care File:~~

~~1. The client is a transplant recipient;~~
~~2. The client is residing out of the designated coverage areas of the managed care program; or~~
~~3. The client begins receiving hospice service.4.~~

~~Waiver of enrollment is prospective and is effective the first of the next month possible following the decision, given system cutoff.~~

~~The client shall receive notification of the waiver of enrollment.~~

~~All waivers of enrollment will be provided to the health plan on the enrollment report.~~

2-004.03 Admission to Nursing Facility Care: Admission to a nursing facility may affect the client's enrollment in Physical Health Managed Care. The following rules apply:

1. When a Managed Care client is admitted to a nursing facility, the physical health plan must determine the level of care the client requires - skilled/rehabilitative or custodial/maintenance - using Medicare's definition of skilled care.
   When the level of care the client requires is skilled/rehabilitative, the physical health plan is responsible for payment of services for the client while receiving skilled level of care services.
2. When the client is admitted to a nursing facility for custodial care (i.e., long term care), the client will be waived from enrollment. ~~The Department~~ Medicaid fee-for service will assume financial responsibility for the facility charges beginning on the date the custodial level of care determination is made. Payment for all services included in the Basic Benefits Package will be the responsibility of the health plan until the waiver of enrollment from Managed Care is effective.
3. Waiver of enrollment from Managed Care will be effective the first of the next month possible, given system cutoff.
4. When the client is admitted to a nursing facility for custodial care and the client's PCP does not see patients at the facility, the health plan must work cooperatively with the client and the nursing facility to locate a PCP for the client. The health plan must make arrangements to ensure reimbursement of PCP services provided by the client's nursing facility physician, for referrals, and for all services included in the Basic Benefits Package until the client's waiver of enrollment from Physical Health Managed Care is effective.

For purposes of Physical Health Managed Care, skilled nursing services are those nursing facility services provided to eligible clients which are skilled/rehabilitative in nature as defined by Medicare and the nursing facility admission is expected to be short term. Custodial services are those nursing facility services as defined in 471 NAC and the nursing facility admission is expected to be of long term or permanent duration.

(See 482-000-6, Nursing Facility Procedure Guide.)