

2-000 CLIENT PARTICIPATION AND ENROLLMENT

2-001 MANDATORY AND EXCLUDED CLIENTS

2-001.01 Mandatory for Managed Care: The following Medicaid-eligible clients are required to participate in Managed Care unless excluded.

- ~~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);~~
1. Clients participating in Children’s Medical, pregnant women and parents/caretaker relatives;
2. Clients participating in Children’s Health Insurance Programs (CHIP, previously known as Kids Connection) (see Title 477 NAC);
3. Clients participating in the Aid to Aged, Blind, and Disabled Program Grant/Medical (see Title ~~469~~ 477 NAC); and
4. 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~~ 477).

The client’s managed care status (mandatory or excluded) is determined by an automated interface between Medicaid’s eligibility system and the Managed Care system, and is based on information entered on the Medicaid eligibility system, and known at the time of the interface. Clients mandatory for managed care cannot voluntarily waive enrollment unless excluded under 482 NAC 2-001.02 or 2-001.03.

2-001.02 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 C~~lients for the period of retroactive Medicaid 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;
2. Medicaid clients who reside in Nursing Facilities (NF) at custodial levels of care or in Intermediate Care Facilities for Intellectually Disabled (ICF/ID) or in Psychiatric Residential Treatment Facilities (PRTF) (see 471 NAC 12, 471 NAC 31, 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 the~~ period of retroactive ~~Medicaid~~ eligibility;
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);~~
7. Clients who have excess income (i.e., spenddown - met or unmet) or who are designated to have a premium due;
- ~~8. Clients participating in the State Disability Program (see Title 469 NAC);~~
8. Clients eligible during a period of presumptive eligibility (see 471 NAC 28-00);
9. Organ transplant recipients from the day of transplant forward (see 471 NAC 10-000 and 482 NAC 2-004);
10. Clients who have received a disenrollment/waiver of enrollment (see 482 NAC 2-004);
11. Clients who are participating in the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Every Woman Matters Program);
12. Clients receiving Medicaid Hospice Services;
13. Individuals who are patients in Institutions of Mental Disease (IMD) who are between the ages 21-64;
14. Clients participating in the Subsidized Adoption Program, including those who receive a maintenance subsidy from another state (see ~~469 477~~ NAC);
15. Participants in an approved Program for All-inclusive Care for the Elderly (PACE) program; and
16. Unborn children of otherwise ineligible pregnant women.

2-001.04 Coverage Rules

2-001.04A 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.

2-001.04B 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 managed care plan(s) is/are responsible for the provision of the services covered by managed care for the client as long as s/he is identified as a member of that managed care plan.

2-002 ENROLLMENT

2-002.01 Purpose of Enrollment Process: Medicaid maintains responsibility for the enrollment of clients into Managed Care, through departmental and contractual arrangements. The use of an enrollment broker precludes any direct enrollment activities by the 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 managed care plans are required to have an understanding of the client population and the enrollment process, and to assist Medicaid and the enrollment broker in providing adequate information to the client. The managed care plans are also required to work cooperatively with Medicaid and EBS to resolve issues relating to client participation and enrollment, and to have the technological capability and resources available to interface with Medicaid's support systems.

2-002.02 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.

2-002.02D 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.

2-002.02E 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). 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 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 Medicaid. 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 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. 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 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.

2-002.03C Enrollment of an Unborn and 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. The State will pre-enroll unborns into managed care if the unborn has either a mother or sibling enrolled in managed care. Once the State is notified of a live birth, the newborn will be immediately enrolled in either the mother's MCO plan or an eligible sibling's MCO plan. The mother's plan supersedes the sibling's plan, in the event that both mother and sibling are enrolled in a managed care health plan.~~

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)

2-002.03D Changes in Enrollment Status: The client will be notified by 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).

2-002.03E 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 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 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 begins the first calendar day of the month of the Managed Care auto assignment or plan selection. ~~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. Medicaid's Internet Access for Enrolled Providers on the Medicaid website;
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). Medicaid electronically transmits the enrollment report to the health plan on a daily basis. 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 Medicaid for resolution. The plan must continue to provide and authorize services until the discrepancy is resolved.

The 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, Medicaid will work cooperatively with the health plan to identify responsibility for the client's services until the cause for the discrepancy is corrected.

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 Medicaid fee-for-service or 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.

2-002.05D Hospitalization: When a Medicaid client is ~~an inpatient~~ in an acute care medical or rehabilitation facility ~~on the day that prior to~~ the client's ~~participation in Physical Health enrollment in~~ managed care ~~is effective~~, 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 Medicaid's contracted peer review organization (PRO).~~ In the event that a client is admitted as an inpatient in an acute care medical or rehabilitation facility and is assigned to a managed care health plan in the same month, the MCO is responsible for that hospitalization.

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 Medicaid (see 482-000-2, Auto-Assignment Procedure Guide).

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.

Medicaid's auto-assignment algorithm will attempt to maintain family members with the same health plan as much as possible.

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 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 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 Medicaid imposes the Medicaid-established intermediate sanctions on the health plan.

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

1. The client moves out of the MCO designated coverage area;
2. The health plan does not, because of moral or religious objections, cover the service the client seeks;
3. 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

4. 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.~~

The effective date of the plan transfer will be the first day of the month following the month of the approval determination

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 Medicaid staff for a decision. 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 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.~~

The Department will take action to approve or deny the request within 60 calendar days of receipt of the request.

If the request is approved, the effective date of the plan transfer will be the first day of the month following the month of the approval determination.

If Medicaid staff fails to make a disenrollment determination within this timeframe, the disenrollment is considered approved.

Medicaid staff will process the disenrollment and enter the information in the Managed Care system. A notice is issued by 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 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 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 Medicaid which clearly establishes the reason(s) for the disenrollment request;
2. The health plan must submit the request to 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 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 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 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).

Medicaid will notify the client and 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~~ **NHG Managed Care** 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 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 Medicaid. The transplant procedure must be prior authorized by Medicaid staff. The health plan must notify Medicaid of the date of the transplant. Medicaid will initiate the waiver of enrollment of the client from Managed Care. The Medicaid eligibility system will reflect the client's waiver of enrollment from Managed Care the first month possible, given system cutoff.
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)

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. 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.)

4-002.03 Primary Care Provider (PCP) Qualifications and Responsibilities: To participate in the Managed Care, the PCP must:

1. Be a Medicaid-enrolled 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 Care requirements:
 - a. Treat Managed Care 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 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. As medically necessary, coordinate appropriate referrals and follow-up for services that 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~~ disorder (MH/SAU) Behavioral Health, 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 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 Care 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 Behavioral Health services provider as frequently as necessary based on the client's needs.
Note: Many MH/SA Behavioral Health 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 Behavioral Health Benefits 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 Care. Each health plan must monitor overall coordination between these two service areas (i.e., physical health and MH/SA Behavioral Health). The health plan must ensure the PCP is knowledgeable about the MH/SA Behavioral Health Benefits 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 treatment options, regardless of cost or whether such services are covered by Medicaid; 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.

4-002.04 PCP Voluntarily Termination: A PCP may voluntarily terminate his/her participation from Managed Care. If the PCP voluntarily terminates participation from Managed Care, s/he may remain active as a Medicaid provider on a fee-for-service basis for clients not participating in Managed Care if all Department regulations continue to be met. The termination is reported by the health plan in the Provider Network File.

4-002.04A 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.

4-002.04A1 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 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.

4-002.04A2 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 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.

4-003 PHYSICAL HEALTH MANAGED CARE PLAN REQUIREMENTS: Managed Care administers the Basic Benefits Package to Medicaid clients through two or more Managed Care Organizations (MCOs) physical health plans (health plan). The following provisions describe the health plan responsibilities:

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 Provider (PCP) slots to ensure adequate access to clients enrolled in Managed Care, 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 4-002.054A);
3. Use only providers enrolled in Medicaid to provide the services in the Basic Benefits Package;
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 482-000-823, Care Management Requirements);
9. Provide a client handbook to the clients enrolled with the health plan, and other informational materials about Managed Care 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 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 Behavioral Health services, Pharmacy, Dental Services, etc., or for services requiring additional Departmental authorization, e.g., abortions, transplants (except corneal);
 - 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;
 - c. Unrestricted access to protected services such as emergency room services, family planning services, tribal clinics, etc., according to 471 NAC;
 - 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;
 - e. Retention of plan-maintained records and other documentation during the period of contracting, and for 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 ten (10) year period ends; and
 - f. Adequate policy regarding the distribution of the client's medical records if a client changes from one PCP to another;
14. Comply with regulations providing for advance directives;

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 Care 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 fee-for-service basis under Title 471 NAC.

All services in the Basic Benefits Package must be provided or approved by the 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. Abortions (see 471 NAC); and
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-network 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. Visual services (see 471 NAC 24-000);
15. Family Planning services (see 471 NAC 18-000 and 482 NAC 5-004.03);
16. Emergency and post stabilization services (see 471 NAC 10-000 and 482 NAC 5-004.04);
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);
18. Skilled/Rehabilitative and Transitional Nursing Facility services (see 471 NAC 12-000, and 482 NAC 2-004.04);
19. Transitional Hospitalization services (see 471 NAC 10-000, 482 NAC 2-002.04D, 2-003.03 and 2-004.01A); ~~and~~
20. Transitional Transplantation services (see 471 NAC 10-000 and 482 NAC 2-004); ~~and~~
21. Free standing birth centers (see 471 NAC 42-000)

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 Excluded Services: The following Medicaid-coverable services are excluded from the Managed Care 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/~~MRDD~~ services (see 471 NAC 31-000);
4. Home and community based waiver services (see Titles 404 and 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)~~ Behavioral Health Services (see 471 NAC 20-000, and 32-000, and 35-000);
8. Dental Services (see 471 NAC 6-000);
9. ~~Non-Home Health Agency Approved Personal Care Aide Services~~ Personal Assistance 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 clients their freedom of choice for family planning services is not restricted to a provider participating in Managed Care 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~~ infections (STD)(STI) 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 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) Behavioral Health Plan~~ Coordination Issues: The following rules apply when coordination of services is required between the Physical Health Plan ~~health plan~~ responsible for the Basic Benefits Package and the MH/SA Behavioral Health Plan ~~plan~~ responsible for the MH/SA Behavioral Health Benefits Package ~~services~~, as addressed by the Department in regulations governing both components of Managed Care. In situations where the client isn't enrolled in both components of Managed Care, the associated service is coordinated with ~~the Nebraska Medicaid Assistance Program~~ Medicaid on a fee-for-service basis.

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

The Behavioral Health Plan is no longer responsible for the service, at ~~At~~ the time that an attending emergency physician or the MH/SA provider currently treating the client initiates an evaluation and/or treatment ~~for~~ of the client determines that the services are medical. ~~the health plan is no longer responsible for MH/SA related service.~~ Coverage Authorization for MH/SA services from that point forward must be obtained from the Physical Health Plan. ~~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 client is admitted to an acute care ~~(i.e., medical/surgical)~~ facility as an outpatient for 24-hour observation for purposes of a MH/SA behavioral health diagnosis, the MH/SA Behavioral Health Plan plan is responsible for authorization of the observation stay.

The Behavioral Health Plan MH/SA plan is no longer responsible for the service at the time that an attending emergency physician or the provider currently treating the client psychiatrist initiates an evaluation and/or treatment of the client and determines that the client does not have a MH/SA behavioral health diagnosis. Coverage for Authorization for acute care services from that point forward must be obtained from the Physical Health Plan health plan.

4-004.05C Chemical Detoxification Services and Substance Abuse Treatment: Coverage for chemical Chemical detoxification hospital admissions must be obtained from the Physical Health Plan, if the client is participating in the physical health component of the plan.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 Behavioral Health Services: The H&P completed for an inpatient admission for MH/SA Behavioral Health Services ~~services is are~~ the responsibility of the Physical Health Plan, ~~health plan for which the client is enrolled. The physician completing the H & P must obtain authorization from the Physical Health Plan.~~

Inpatient MH/SA Behavioral Health Services ~~services~~ provided to clients participating enrolled in the MH/SA behavioral health component of Managed Care in a freestanding or hospital-based psychiatric residential treatment facility (PRTF) center (RTG), or therapeutic group home (ThGH)~~treatment group home~~ are the responsibility of the MH/SA Behavioral Health Plan ~~plan~~. The History & Physical provided to Managed Care clients for these allowable services are the responsibility of the Physical Health Plan, ~~health plan for which the client is enrolled.~~

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

~~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.~~

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

4-004.05G Lab, X-Ray and Anesthesiology Associated with MH/SA Behavioral Health Services: Lab, X-ray and Anesthesiology services associated with the Behavioral Health Services such as ECT or CCAA authorized by the Behavioral Health Plan are the responsibility of the Physical Health Plan, if the client is participating in the physical health component of Managed Care. ~~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.~~

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 client chooses to participate with the FQHC by selecting the physician as his/her PCP.