NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

August 19, 2019
10:00 a.m. Central Time
Gold's Building – Room 534
1033 O Street, Lincoln, Nebraska

The purpose of this hearing is to receive comments on proposed changes to Title 482, of the Nebraska Administrative Code (NAC) – *Nebraska Medicaid Managed Care.* The proposed changes will implement three additional groups being enrolled into managed care; help move toward the phase out of the outdated claims payment system; will include the addition of a chapter for dental benefits manager; and update these regulations to conform to managed care waiver, program policy, and contracts. The proposed regulations also include grammar and formatting changes.

Authority for these regulations is found in Neb. Rev. Stat. § 81-3117(7).

Interested persons may attend the hearing and provide verbal or written comments or mail, fax or email written comments, no later than the day of the hearing to: DHHS Legal Services, PO Box 95026, Lincoln, NE 68509-5026, (402) 742-2382 or dhhs.regulations@nebraska.gov, respectively.

A copy of the proposed changes is available online at http://www.sos.ne.gov, or by contacting DHHS at the mailing address or email above, or by phone at (402) 471-8417. The fiscal impact statement for these proposed changes may be obtained at the office of the Secretary of State, Regulations Division, 1201 N Street, Suite 120, Lincoln, NE 68508, or by calling (402) 471-2385.

Auxiliary aids or reasonable accommodations needed to participate in a hearing can be requested by calling (402) 471-8417. Individuals with hearing impairments may call DHHS at (402) 471-9570 (voice and TDD) or the Nebraska Relay System at 711 or (800) 833-7352 TDD at least 2 weeks prior to the hearing.

FISCAL IMPACT STATEMENT

Agency: **Department of Health and Human Services**	
Title: 482	Prepared by: Catherine Gekas Steeby
Chapter: 1-7	Date prepared: 5-30-19
Subject: Nebraska Medicaid Managed Care	Telephone: 402-471-9058

Type of Fiscal Impact:

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	(☐)	(☒)	(☒)
Increased Costs	(☒)	(☐)	(☐)
Decreased Costs	(☐)	(☐)	(☐)
Increased Revenue	(☐)	(☐)	(☐)
Decreased Revenue	(☐)	(☐)	(☐)
Indeterminable	(☐)	(☐)	(☐)

Provide an Estimated Cost & Description of Impact:

State Agency: The addition of groups to mandatory enrollment into managed care will have a cost. The additional chapter governing dental benefits manager would have had an impact, however this was implemented in 2017 and is currently a part of the agency budget. The additional cost is a result of the admin load added onto the medical expenditures for the new populations. For Refugees, this is estimated to be approximately $230,000 in Total Funds per year and for the State Disabled population, this is estimated to be approximately $80,000 per year in total funds.

Political Subdivision: N/A

Regulated Public: N/A

If indeterminable, explain why: N/A

TITLE 482 NEBRASKA MEDICAID MANAGED CARE

CHAPTER 1 INTRODUCTION AND DEFINITIONS

001. SCOPE AND AUTHORITY. These regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statute (Neb. Rev. Stat.) 68-901 et seq (the Medical Assistance Act).

001.01 LEGAL BASIS. The Nebraska Medicaid program is authorized by the Medical Assistance Act to deliver services through managed care. The Section 1915(b) waiver permits Nebraska Medicaid to operate the managed care program.

002. DEFINITIONS. The following definitions apply:

002.01 ACTION. Action means the:
(A) Denial or limited authorization of a requested service, including the type or level of service;
(B) Reduction, suspension, or termination of a previously authorized service;
(C) Denial, in whole or in part, of payment for a service;
(D) Failure to provide services in a timely manner, as defined by Medicaid;
(E) Failure of the managed care organization to act within the timeframes; or
(F) For a rural area resident with only one managed care organization to choose from, the denial of a Medicaid enrollee's request to obtain services outside the network:
(i) From any other provider (in terms of training, experience, and specialization) not available within the network;
(ii) From a provider not part of the network who is the main source of a service to the recipient - provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the enrollee is given a choice of participating providers and is transitioned to a participating provider within 60 days;
(iii) Because the only plan or provider available does not provide the service because of moral or religious objections;
(iv) Because the recipient's provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network; or
(v) Medicaid determines that other circumstances warrant out-of-network treatment.

002.02 ADVERSE BENEFIT DETERMINATION. An action by a health plan that includes:

(A) Denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
(B) Reduction, suspension, or termination of a previously authorized service;
(C) Denial, in whole or in part, of payment for a service;
(D) Failure to provide services in a timely manner;
(E) Failure of a health plan to act within grievance and appeal process timelines;
(F) Denial of a members request to exercise his or her right to obtain services outside the network (for a resident of rural area with only one health plan); and
(G) Denial of a member's request to dispute a financial liability.

002.03 AMERICANS WITH DISABILITIES. The Americans with Disabilities Act of 1990 as amended, 42 United States Code (U.S.C.) 12101 et seq.

002.04 APPEAL. A request for review of an action.

002.05 AUTO-ASSIGNMENT. The process of the enrollment broker automatically assigning a member to a health plan or a primary care provider.

002.06 CAPITATION PAYMENT. A monthly payment by Medicaid to a health plan on behalf of each member of a health plan for the provision of covered services under the contract, regardless of whether any particular member receives services during the period covered by the payment.

002.07 CARVE-OUT. The services not included in the core benefits package of managed care.

002.08 CHOICE COUNSELING. The provision of information available regarding the available health plans and unbiased decision support for selection of a health plan by the enrollment broker for Medicaid members.

002.09 CLAIM. A bill for services, a line item of service, or all services for one client within a bill.

002.10 CLEAN CLAIM. A claim, received by a health plan for adjudication, that requires no further information, adjustment, or alteration by the provider of the services, or by a third party, in order to be processed and paid by the health plan.
(A) It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

002.11 CENTERS FOR MEDICARE AND MEDICAID SERVICES. A division within the federal Department of Health and Human Services responsible for administering the Medicare, Medicaid, and Children's Health Insurance programs.

002.12 CLIENT. An individual receiving benefits under Title XIX or XXI of the Social Security Act, and under Medicaid as defined in the Nebraska Administrative Code (NAC).

002.13 COLD CALL MARKETING. Any unsolicited personal contact by a health plan with a potential member for the purpose of marketing.

002.14 CONTRACT. The legal and binding agreement between the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care and any of the vendors participating in Heritage Health.

002.15 CORE BENEFIT PACKAGE. The minimum package of services to which a member is entitled under the Nebraska Medicaid State Plan and that the health plan must provide to members enrolled in the health plan.

002.16 DEPARTMENT. The Nebraska Department of Health and Human Services.

002.017 DESIGNATED SPECIALTY CARE PHYSICIAN. A specialty care physician who has enhanced responsibilities for members with special health care needs, designated upon review and concurrence by the primary care provider (PCP) and the health plan providing the core benefits package.

- (A) The designation of the specialty care physician allows for greater continuity of care between the primary care provider (PCP) and specialty care physician. This may include, but is not limited to, open referrals and shared primary care provider (PCP) responsibilities.

002.18 DISENROLLMENT. A change in the status of a member from being enrolled with a specific health plan to being enrolled with a different health plan, or a change from being considered mandatory for participation in managed care to being ineligible for participation in managed care.

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

- (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; or
- (C) Serious dysfunction of any bodily organ or part.

002.20 EMERGENCY SERVICES. Covered inpatient and outpatient services that are either furnished by a provider qualified to furnish these services under Title 42 of the Code of Federal Regulations or the services needed to evaluate or stabilize an emergency medical condition.

002.21 ENCOUNTER DATA. Line-level utilization and expenditure data for services furnished to members through the health plan.

002.22 ENROLLMENT. The process of a member selecting a health plan, whether by an active choice or through auto assignment.

002.23 ENROLLMENT BROKER. A contracted entity responsible for enrollment activities and choice counseling.

002.24 ENROLLMENT FILE. A proprietary data file provide by Medicaid or the enrollment broker to a health plan. The enrollment file is the basis for monthly payments to the health plan.

002.25 ENROLLMENT MONTH. The enrollment period for a member effective the first of the month through the end of the month.

002.26 ENTITY. A generic term used to reference any of the contracted vendors participating in Nebraska's managed care program.

002.27 EXTERNAL QUALITY REVIEW ORGANIZATION. An organization that meets the competence and independence requirements to perform analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that a health plan furnishes to Medicaid members.

002.28 FAMILY PLANNING SERVICES. 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.

002.29 FEE-FOR-SERVICE. Payment of a fee for each service provided to a client who is not enrolled in managed care or for services excluded from the core benefits package.

002.30 GRIEVANCE. An expression of dissatisfaction about any matter other than an adverse benefit determination as defined above. The term also refers to the overall system that includes grievances and appeals handled at the health plan level and access to the Medicaid administrative hearing process.

002.31 HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET. The most widely used set of standardized performance measures used in the managed care industry, designed to allow reliable comparison of the performance of health plans. The National Committee of Quality Assurance sponsors, supports, and maintains the Healthcare Effectiveness Data and Information Set.

002.32 HEALTH CARE PROFESSIONAL. A physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician's assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed and certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

002.33 HEALTH PLAN. A generic term used to reference any of the contracted plans participating in Heritage Health. A healthcare entity that meets the definition of a managed care organization for the provision of the core benefits package.

002.34 HERITAGE HEALTH. Nebraska's Medicaid managed care program.

002.35 INTERIM PRIMARY CARE PROVIDER. A primary care provider designated by the physical health plan when the member's chosen or assigned primary care provider is not available and the duration is only applicable until the member requests a different primary care provider.

002.36 MANAGED CARE ORGANIZATION. An organization that has or is seeking to qualify for a comprehensive risk contract to provide services to managed care enrollees. An entity that has, or is seeking to qualify for a comprehensive risk contract that is:

(A) A federally qualified Health Maintenance Organization that meets the advance directives requirement of 42 Code of Federal Regulations (CFR) 489.100 et seq.; or
(B) Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:
  (i) Makes the services it provides to its Medicaid members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served by the entity; and
  (ii) Meets the solvency standards of 42 CFR 438.116.

002.37 MEDICAID. Nebraska's Medicaid program as defined by Neb. Rev. Stat. § 68-901 et. Seq. (the Medical Assistance Act).

002.38 MEDICAL HOME. A community-based primary care setting which provides and coordinates high quality, planned, family-centered: health promotion, acute illness care and chronic condition management.

002.39 MEDICAL NECESSITY. Health care services and supplies which are medically appropriate and:

(A) Necessary to meet the basic needs of the client;
(B) Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;
(C) Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies;
(D) Consistent with the diagnosis of the condition;
(E) Required for means other than convenience of the client or his or her physician;
(F) No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
(G) Of demonstrated value; and
(H) The least intense level of service that can be safely provided.

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

002.40 MEMBER. A Medicaid client who is currently enrolled with a specific health plan.

002.41 NEBRASKA MEDICAID ELIGIBILITY SYSTEM. The automated eligibility verification system for use by Medicaid service providers.

002.42 PATIENT-CENTERED MEDICAL HOME. An enhanced model of primary care in which a patient establishes an ongoing relationship with a primary care provider and a primary care provider-directed team of health care providers. This team coordinates all aspects of a patient's physical and mental health care needs, including prevention and wellness, acute care and chronic care, across the health care system in order to improve access and health outcomes in a cost effective manner.

002.43 PRIMARY CARE PHYSICIAN TRANSFER. A change in a client's assignment from one establishes an ongoing relationship with a primary care provider to another primary care provider.

002.44 PEER REVIEW ORGANIZATION. An organization under contract with Medicaid to perform a review of health care practitioners of services ordered or furnished by other practitioners in the same professional fields.

002.45 PER MEMBER PER MONTH. The basis of capitation payment for a health plan.

002.46 PREPAID AMBULATORY HEALTH PLAN. An entity as defined in 42 CFR 438.2 that:

(A) Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates.
(B) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and
(C) Does not have a comprehensive risk contract.

002.47 PRIMARY CARE PROVIDER. A medical professional chosen by the member or assigned to provide primary care services. Provider types that can be primary care providers are licensed medical doctors or doctors of osteopathy from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, and obstetrics and gynecology. Primary care providers may also include advanced practice registered nurses and physician assistants when practicing under the supervision of a physician specializing in family practice, internal medicine, pediatrics, or obstetrics/gynecology who also qualifies as a primary care provider under the health plans.

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

002.49 PROVIDER. Any individual or entity that is engaged in the delivery of health care services under agreement with Medicaid and is legally authorized to do so by the State in which it delivers the services.

002.50 PROVIDER AGREEMENT. Any written agreement between the provider and Medicaid, for the purpose of enrolling as a Medicaid provider, or between the health plan and the provider for the purpose of participating in Heritage Health.

002.51 RESTRICTED SERVICES. A method used by Medicaid to provide safeguards when a client has been determined to be abusing or inappropriately utilizing services provided by Medicaid or a health plan.

002.52 RETURNED CLAIM. A claim that has not been adjudicated because it has a material defect or impropriety.

002.53 RISK CONTRACT. A contract under which the contractor:
(A) Assumes risk for the cost of the services covered under the contract; and
(B) Incurs loss if the cost of furnishing the services exceeds the payments under the contract.

002.54 SUBCONTRACT. Any written agreement between the health plan and another party to fulfill the requirements of title 482 of the NAC, except provider agreements as defined above.

002.55 SYSTEM CUT OFF. The last day in which data must be entered into the Medicaid eligibility system in order for changes to be effective the first of the next month.

002.56 THIRD PARTY RESOURCE. Any individual, entity, or program that is, or may be liable to pay all or part of the cost of medical services furnished to a client.

002.57 VALUE-ADDED SERVICES. Those services a health plan provides in addition to a service covered under a contract because the health plan has determined that the health status and quality of life for the member will be the same or better using the value-added health service as it would be using the covered service.

002.58 WAIVER OF ENROLLMENT. A change in the status of a member from being considered mandatory for participation in managed care to being not mandatory for participation in managed care.

1-000 INTRODUCTION

1-001 SCOPE AND AUTHORITY: These regulations govern Nebraska's Medicaid Managed Care program.

1-001.01 Legal Basis: The Nebraska Medicaid Program is authorized by the State's Medical Assistance Act, Neb. Rev. Stat. Section 68-901 et seq. Nebraska's Managed Care Program is authorized under Section 1932 of the Social Security Act, which permits a state to operate a managed care program through its State Plan. Nebraska operates a 1915(b) waiver to require special needs children and Native-Americans to participate in the Physical Health Managed Care Program. The 1915 (b) waiver permits Nebraska Medicaid to operate the Behavioral Health Managed Care Program.

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

1-002 DEFINITIONS: The following definitions apply:

Action means the:

1. Denial or limited authorization of a requested service, including the type or level of service;
2. Reduction, suspension, or termination of a previously authorized service;
3. Denial, in whole or in part, of payment for a service;
4. Failure to provide services in a timely manner, as defined by Medicaid;
5. Failure of the MCO to act within the timeframes; or
6. For a rural area resident with only one MCO to choose from, the denial of a Medicaid enrollee's request to obtain services outside the network:
   a. From any other provider (in terms of training, experience, and specialization) not available within the network;
   b. From a provider not part of the network who is the main source of a service to the recipient - provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the enrollee is given a choice of participating providers and is transitioned to a participating provider within 60 days;
   c. Because the only plan or provider available does not provide the service because of moral or religious objections;
   d. Because the recipient's provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network; or
   e. Medicaid determines that other circumstances warrant out-of-network treatment.

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

Adverse Action means (in the case of a Managed Care Organization {MCO} health plan):

1. Denial or limited authorization of a requested service, including the type or level of service;
2. Reduction, suspension, or termination of a previously authorized service;
3. Denial, in whole or in part, of payment for a service;
4. Failure to provide services in a timely manner; and
5. Failure of an MCO health plan to act within grievance process timelines.

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

Appeal means request for review of or Administrative Hearing on an action.

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

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

1. Inpatient hospital services (see 471 NAC 10);
2. Outpatient hospital services (see 471 NAC 10, 21, 26, and 22);
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 Behavioral Health diagnoses (see 471 NAC 10 and 18);
4. Radiology services, excluding radiology services related to MH/SA (see 471 NAC 10 and 18);
5. HEALTH CHECK (Early Periodic Screening and Diagnosis and Treatment as federally mandated) services (see 471 NAC 33 and 482 NAC 5-003.02);
6. Physician services, including nurse practitioner services, certified nurse midwife services, and physician assistant services, anesthesia services including a Certified Registered Nurse Anesthetist, excluding anesthesia for MH/SA (see 471 NAC 18 and 29);
7. Home health agency services (see 471 NAC 9). (This does not include non-home health agency approved Personal Assistance Services under 471 NAC 15);
8. Private duty nursing services (see 471 NAC 13);

9. Therapy services, including physical therapy, occupational therapy, and speech pathology and audiology (see 471 NAC 14, 17, and 23);
10. Durable medical equipment and medical supplies, including hearing aids, orthotics, prosthetics and nutritional supplements (see 471 NAC 7 and 8);
11. Podiatry services (see 471 NAC 19);
12. Chiropractic services (see 471 NAC 5);
13. Ambulance services (see 471 NAC 4);
14. Visual services (see 471 NAC 24);
15. Family Planning services (see 471 NAC 18 and 482 NAC 4-004.03);
16. Emergency and post stabilization services (see 471 NAC 10 and 482 NAC 4-004.04);
17. Federally Qualified Health Center (FQHC), Rural Health or Tribal Clinic services (see 471 NAC 11, 29, 34 and 482 NAC 5-004.06);
18. Skilled/Rehabilitative and Transitional Nursing Facility services (see 471 NAC 12 and 482 NAC 2-004.04);
19. Transitional Hospitalization services (see 471 NAC 10, 482 NAC 2-002.04D, 2-003.03 and 2-004.01A);
20. Transitional Transplantation services (see 471 NAC 10 and 482 NAC 2-004); and
21. Free Standing Birth Center services (See 471 NAC 42).

Behavioral Health Network means the network of behavioral health providers that constitutes the behavioral health services component of Managed Care.

Behavioral Health Benefits Package means the following behavioral health services:

1. Crisis Stabilization Services (see 471 NAC 20, 471 NAC 32);
2. Inpatient Services (see 471 NAC 20, 471 NAC 32);
3. Residential Services (see 471 NAC 32);
4. Outpatient Assessment and Treatment (see 471 NAC 20, 471 NAC 32);
5. Rehabilitation Services (see 471 NAC 35); and
6. Support Services.

Capitation Payment means the fee paid by Medicaid to an MCO on a monthly basis for each client enrolled with the physical health or behavioral health plan. The fee covers all services required to be provided by the MCO to the client, regardless of whether the client receives services or not.

Carve-Out means those services not included in benefit packages for managed care.

CFR means Code of Federal Regulations.

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

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

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

Choice means the client's freedom to choose a health plan and Primary Care Provider (PCP) within the health plan network. Enrollment for the Behavioral Health Package is "automatic" and does not require a choice of provider or plan.

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

Cold Call Marketing means any unsolicited personal contact by a MCO with a potential enrollee for the purpose of marketing.

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

Cutoff means the last day in which data must be entered into the Medicaid computer system in order for changes to be effective the first of the next month.

Designated Specialty Care Physician means a specialty care physician who has enhanced responsibilities for clients with special health care needs, designated upon review and concurrence by the Primary Care Physician (PCP) and the physical health plan providing the Basic Benefits Package. The designation of the specialty care physician allows for greater continuity of care between the PCP and specialty care physician, such as open referrals, shared PCP responsibilities, etc.

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

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

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

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

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

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

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

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

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

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

Entity means a generic term used to reference any of the contracted vendors participating in Managed Care.

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

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

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

Fee-for-Service means payment of a fee for each service provided to a client who is not enrolled in Managed Care or for services excluded from the Basic Benefits Packages.

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

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

Health Care Practitioner means a health care professional who is licensed, certified, or registered with Nebraska Department of Health and Human Services Division of Public Health or with the comparable agency in the state in which s/he practices his/her profession.

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

Interim PCP means a Primary Care Provider (PCP) designated by the physical health plan when the client's chosen or assigned PCP is not available and the duration is only applicable until the client requests a different PCP.

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

Managed Care Plan (Health Plan) means a contracted managed care entity that provides behavioral or physical health services to members enrolled in Managed Care.

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

1. A Federally qualified HMO that meets the advance directives requirements of 42 CFR 489.100 et seq. or
2. Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:
   a. Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served by the entity; and
   b. Meets the solvency standards of 42 CFR 438.116.

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

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

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

1. Necessary to meet the basic health needs of the client;
2. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;
3. Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies;

4. Consistent with the diagnosis of the condition;
5. Required for means other than convenience of the client or his or her physician;
6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
7. Of demonstrated value; and
8. No more intense level of service than can be safely provided.

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

Member means a Medicaid recipient who is enrolled in a MCO in a given managed care program. This term is used interchangeably with enrollee.

NAC means the Nebraska Administrative Code.

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

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

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

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

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

Physician Extender means a nurse practitioner, physician assistant, certified nurse midwife, or second-year and third-year resident who meet the requirements for practicing in Nebraska, and who is enrolled with Medicaid.

Prepaid Inpatient Health Plan (PIHP) as defined by 42 CFR 438.2, is an entity that

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

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

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

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

Provider means any individual or entity that is engaged in the delivery of health care services under agreement with the Medicaid agency and is legally authorized to do so by the State in which it delivers the services.

Provider Agreement means any written agreement between the provider and Medicaid, for the purpose of enrolling as a Medicaid provider, or between the physical health or behavioral health plan and the provider for the purpose of participating in Managed Care.

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

Risk Contract means a contract under which the contractor:

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

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

Subcontract means any written agreement between the physical health or behavioral health plan and another party to fulfill the requirements of 482 NAC except Provider Agreements as defined above.

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

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

Waiver of Enrollment means a change in the status of a member from being considered mandatory for participation in Managed Care to being not mandatory for participation in Managed Care.

TITLE 482 NEBRASKA MEDICAID MANAGED CARE

CHAPTER 2 MEMBER PARTICIPATION AND ENROLLMENT

001. SCOPE AND AUTHORITY. These regulations govern the services provided under Nebraska's Medicaid program as defined by Neb. Rev. Stat. §§ 68-901 et. Seq. the Medical Assistance Act.

002. HERITAGE HEALTH PLAN MANDATORY AND EXCLUDED MEMBERS. The following outlines those clients who are mandatory or excluded members. The member's status (mandatory or excluded) is determined by an automated interface between Medicaid's eligibility system and each Heritage Health plan's system based on information entered on the Medicaid eligibility system known at the time of the interface.

002.01 HERITAGE HEALTH PLAN MANDATORY MEMBERS. Unless excluded, the following clients are required to participate as members in Nebraska Medicaid managed care program for physical health, behavioral health, and pharmacy benefits:

(A) Families, children, and pregnant women eligible for Medicaid under Section 1931 of the federal Social Security Act, as amended ("Section 1931"), or related coverage groups.
(B) Members who are eligible for Medicaid due to blindness or disability;
(C) Members who are sixty-five (65) years of age or older and not members of the blind and disabled population or members of the Section 1931 adult population;
(D) Low-income children who are eligible to participate in Medicaid under Title XXI of the federal Social Security Act, as amended (the "Children's Health Insurance Program");
(E) Members who are receiving foster care or subsidized adoption assistance under Title IV-E of the federal Social Security Act, as amended; are in foster care; or, are otherwise in an out-of-home placement;
(F) Members who participate in a Home and Community-Based Waiver Services program. This includes groups covered by the State's Section 1915(c) waiver under the federal Social Security Act, as amended;
(G) Women who are eligible for Medicaid through the Breast and Cervical Cancer Prevention and Treatment Act of 2000;
(H) Medicaid beneficiaries during a period of retroactive eligibility, when mandatory enrollment for Heritage Health has been determined;
(I) Members eligible during a period of presumptive eligibility;
(J) Members eligible for the State Disability program under Neb. Rev. Stat. § 68-1005;

(K) Members eligible for the Refugee Resettlement program under Title IV of the Immigration and Nationality Act; and
(L) Members with continuous eligibility who have a share of cost.

002.02 HERITAGE HEALTH PLAN EXCLUDED POPULATIONS. The following clients are excluded from the Nebraska Medicaid managed care program:
(A) Aliens who are eligible for Medicaid due to an emergency condition only;
(B) Clients who have excess income or who are required to pay a premium, and are intermittently eligible;
(C) Clients who have received a disenrollment or waiver of enrollment;
(D) Clients in the Program for All-Inclusive Care for the Elderly;
(E) Clients with Medicare coverage where Medicaid only pays co-insurance and deductibles; and
(F) Inmates of public institutions.

002.03 DENTAL BENEFITS MANAGER MANDATORY MEMBERS. Any member required to participate in a Heritage Health plan must participate as a member in the Dental Benefits Manager, except for:
(A) Unborn members eligible for Children's Health Insurance Program (599 CHIP); or
(B) Members who are not physically present in the State of Nebraska.

002.04 COVERAGE FOR EXCLUDED CLIENTS. Medicaid coverage for clients excluded from participation in managed care or Dental Benefits Manager remains on a fee-for-service basis. Excluded clients cannot voluntarily enroll in managed care or the Dental Benefits Manager.

002.05 COVERAGE DURING ENROLLMENT. The Heritage Health plan and Dental Benefits Manager are responsible for providing services covered by Heritage Health plan and Dental Benefits Manager for the member as long as the member is enrolled in the Heritage Health plan and Dental Benefits Manager.

003. ENROLLMENT ACTIVITIES IN A HERITAGE HEALTH PLAN. The enrollment broker has the responsibility to enroll a member in a Heritage Health plan.

003.01 MEMBER CHOICE. A member may choose a Heritage Health plan and primary care provider or the member may be auto-assigned by the enrollment broker to a Heritage Health plan. The member must have the opportunity to choose the health plan and primary care provider of their choice, to the extent possible and appropriate.
(A) The Heritage Health plan is responsible for the assignment of the primary care provider for members who do not voluntarily enroll.

003.02 HEALTH PLAN ACCEPTANCE. The Heritage Health plan must accept members in the order in which they are enrolled through the enrollment broker.

003.03 INITIAL ENROLLMENT PLAN CHANGE. A member has ninety (90) days after the effective date of their initial Heritage Health plan enrollment to choose another Heritage Health plan. Family members may select a different primary care provider and Heritage Health plan but are encouraged to choose the same Heritage Health plan.

003.04 DEPARTMENT NOTIFICATION. Enrollment activities must be completed and communicated to the Department by the enrollment broker following the date of the notice sent to the member informing the member of the Heritage Health plan assignment.

003.05 REENROLLMENT. A member will automatically be enrolled with the previous Heritage Health plan effective the first day of the next possible month if the member is identified as mandatory for enrollment into a Heritage Health plan no later than two months of losing Medicaid eligibility.

003.05(A) REENROLLMENT EXCEPTIONS. During reenrollment the member may choose a different Heritage Health plan in the following circumstances only:

(i) If the reenrollment is during the initial ninety (90) day period;
(ii) If the reenrollment is during the open enrollment period; or
(iii) For cause, per Title 482 Nebraska Administrative Code (NAC) 2-004.02(C), by contacting the enrollment broker and completing a plan transfer request.

003.06 DEPARTMENTAL WARDS AND FOSTER CARE MEMBERS. The enrollment broker must coordinate enrollment activities for departmental wards or foster children with the Department staff responsible for the case management of the member.

003.07 ENROLLMENT OF AN UNBORN AND NEWBORN CHILD. Unborns will be pre-enrolled into a Heritage Health plan prior to birth if the unborn has either a mother or sibling enrolled. If the Department is notified after a live birth, the newborn will be immediately enrolled in either the mother's Heritage Health plan or an eligible sibling's Heritage Health plan. The mother's Heritage Health plan supersedes the sibling's plan, in the event that both mother and sibling are enrolled in a Heritage Health plan. Enrollment changes may be made as allowed for any other member participating in a Heritage Health plan per Title 482 NAC 2-004.02.

003.08 MEMBER ENROLLMENT REQUIERMENTS. The member must complete the enrollment process. For purposes of completing the enrollment process, the following rules apply:

(A) Any individual with sufficient knowledge of the member's health status may complete the informational portion of the enrollment process;
(B) The member must make the choice of the Heritage Health plan and primary care provider; and
(C) The Departmental staff or designee must act on a Department ward's behalf. The child's foster parents must be involved in the selection of the Heritage Health plan and primary care provider.

003.09 HEALTH PLAN CONTACT. The Heritage Health plans must not have any direct contact with the member or the member's legal representative, family, or friends prior to the client becoming enrolled with that Heritage Health plan, unless the contact is initiated by the enrollment broker.

003.10 EFFECTIVE DATE OF HERITAGE HEALTH PLAN AND DENTAL BENEFITS MANAGER COVERAGE. The effective date of coverage is the first calendar day of the month of the Heritage Health plan or Dental Benefits Manager enrollment. The date of enrollment

will match the Medicaid eligibility date. This date may occur up to three (3) months prior to the date of enrollment. The Heritage Health plan and Dental Benefits Manager are responsible for benefits and services in the core benefits package and dental benefits package from and including the effective date of an enrolled member's Medicaid eligibility. The Heritage Health plan and Dental Benefits Manager must reimburse a provider for appropriate covered services and that provider must reimburse a member for any payments made by the member.

003.10(A) SERVICES RECEIVED BEFORE ENROLLMENT. Medicaid-coverable services received before the Heritage Health or Dental Benefits Manager coverage becomes effective will be paid on a fee-for-service basis under the rules and regulations of the Department Title 471 NAC.

003.11 NOTIFICATION OF COVERAGE. Members will be notified of their coverage within the first month of enrollment.

003.11(A) HERITAGE HEALTH PLAN NOTIFICATION. The Heritage Health plan must provide each member a member handbook that includes general information about the member's integrated health coverage and the Heritage Health plan itself.

003.11(B) DENTAL BENEFITS MANAGER NOTIFICAITON. The Dental Benefits Manager must provide each member a member handbook that includes general information about the Dental Benefits Manager.

003.11(C) PROVIDER NOTIFICATION. Providers must verify a member's coverage through:

(i) Medicaid's internet access for enrolled providers;
(ii) The Medicaid inquiry line; or
(iii) The standard electronic health care eligibility benefit inquiry and response transaction (ASC X12N 270/271).

003.12 COVERAGE WHEN THERE IS A DISCREPENCY. The Heritage Health plan is responsible for providing the services in the core benefits package to members listed on the enrollment report generated for the month of enrollment. Any discrepancies between the member notification and the enrollment report must be reported to the Department for resolution. The Heritage Health plan must continue to provide and authorize services until the discrepancy is resolved.

003.12(A) DISCREPENCY REVIEW. In case of a discrepancy, the eligibility and enrollment databases used to build the enrollment file serves as the official source of validation. Once the cause for the discrepancy is identified, the Department will work cooperatively with the Heritage Health plan to identify responsibility for the member's services until the cause for the discrepancy is corrected.

003.13 DENTAL BENEFITS MANAGER NOTIFICATION. The Dental Benefits Manager will notify its members, through written materials and notice, of the member's enrollment and right to change dental homes.

003.14 CONTINUITY OF CARE. The Heritage Health plan and Dental Benefits Manager must continue all services authorized by Medicaid fee-for-service prior to the member becoming enrolled in the Heritage Health plan or Dental Benefits Manager. These services must be continued until the Heritage Health plan or Dental Benefits Manager determines the service no longer meets the definition of medical necessity.

003.15 HOSPITALIZATION. When a Medicaid client is admitted to an acute care medical or rehabilitation facility prior to the client's enrollment in a Heritage Health plan, Medicaid fee-for-service remains responsible for the hospitalization until the client is discharged from the facility, transferred to a lower level of care, or for sixty (60) days, whatever is earliest.

(A) In the event that a client is admitted as an inpatient in an acute care medical or rehabilitation facility and is assigned to a Heritage Health plan in the same month, the Heritage Health plan is responsible for that hospitalization.

003.16 AUTOMATIC ASSIGNMENT FOR HERITAGE HEALTH. If a choice of a Heritage Health plan is not made at the of time of application, the member will be automatically assigned to a Heritage Health plan based on criteria established by the Department.

004. DISENROLLMENT OR TRANSFERS. A disenrollment or transfer may be made at the member's request (Title 482 NAC 2-004.01) or at the primary care provider's or Heritage Health plan's request (Title 482 NAC 2-004.04). A transfer may also be made because the member requires an interim primary care provider (Title 482 NAC 2-004.03E).

(A) Transfer for the purposes of this section is a change in a member's assignment from one primary care provider to another primary care provider or one dental home to another dental home.

(B) Disenrollment for the purposes of this section is a change in a member's enrollment from one Heritage Health plan to another.

004.01 TRANSFER REQUESTS. The member must contact the Heritage Health plan or Dental Benefits Manager to request a primary care provider or dental home transfer, respectively. A member may request a transfer from one primary care provider to another primary care provider or from one dental home to another dental home at any time. The health plan must document all member transfer requests and the reason.

004.01(A) ASSISTANCE WITH SELECTING A NEW PRIMARY CARE PROVIDER. The Heritage Health plan must assist the member in selecting a new primary care provider by:

(i) Discussing the reasons for transfer with the member and attempting to resolve any conflicts when in the member's best interest;

(ii) Reviewing the member's needs to facilitate the member's choice of primary care provider;

(iii) Processing the member request; and

(iv) Notifying the Department of the primary care provider transfer via the primary care provider transfer file. The primary care provider transfer will be updated on the member's managed care file.

004.01(B) TRANSFER UNDER RESTRICTED SERVICES. Any transfer for a Heritage Health plan member under a restricted services provision must be completed per restricted services procedures (see 482-000-7).

004.02 DISENROLLMENT REQUESTS. A Heritage Health plan member may request a change from one Heritage Health plan to another. The effective date will be the first day of the month following the month of the approval determination.

004.02(A) DISENROLLMENT REASONS. The enrollment broker will allow for a disenrollment as follows:

(i) With cause, at any time;
(ii) During the ninety (90) days following the date of the member's initial enrollment with the Heritage Health plan, or the date the Department sends the member's notice of enrollment, whichever is later;
(iii) During the designated open enrollment period;
(iv) Upon automatic reenrollment if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity; or
(v) If the Department imposes the established intermediate sanctions on the Heritage Health plan.

004.02(B) CAUSE FOR DISENROLLMENT. The following are cause for disenrollment:

(i) The Heritage Health plan does not, because of moral or religious objections, cover the service the member seeks;
(ii) The member 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 member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk;
(iii) Other reasons, including but not limited to, poor quality of care, lack of access to providers experienced in dealing with the member's health care needs or lack of access to services covered under the contract; or
(iv) The Department and Heritage Health plan contract termination.

004.02(C) DETERMINATION OF DISENROLLMENT FOR CAUSE. When the disenrollment request is for cause, the enrollment broker must complete a Plan Disenrollment Member Request Form with the member and forward the request to the Department staff for a decision. The Department will approve or deny the request based on the following:

(i) Reasons cited in the request;
(ii) Information provided by the Heritage Health plan at the Department's request; and
(iii) Any of the reasons cited in Title 482 NAC 2-004.02A.

004.02(D) COERCEMENT OR ENTICEMENT. The Heritage Health plan may work with the enrollment broker to resolve any issues raised by the member at the time of request for disenrollment but may not coerce or entice the member to remain with them as a member.

004.02(E) DISENROLLMENT UNDER RESTRICTED SERVICES. Any disenrollment for a Heritage Health plan member under a restricted services provision must be completed per restricted services procedures (see 482-000-7).

004.03 PRIMARY CARE PROVIDER TRANSFER REQUESTS. The primary care provider may request that the Heritage Health plan member be transferred to another primary care provider. The primary care provider must provide the services in the core benefits package to the Heritage Health plan member until a transfer is completed.

004.03(A) TRANSFER REASONS. Transfers will be allowed based on the following situations:

(i) The primary care provider has sufficient documentation to establish that the member's condition or illness would be better treated by another primary care provider;
(ii) The primary care provider has sufficient documentation to establish that the member or provider relationship is not mutually acceptable. This may include when the member is uncooperative, disruptive, does not follow medical treatment, or does not keep appointments;
(iii) The individual provider retired, left the practice, died, or is no longer available to provide services; or
(iv) Travel distance substantially limits the member's ability to follow through the primary care provider services and referrals.

004.03(B) REASONABLE ACCOMODATIONS. The Heritage Health plan must assist the primary care providers and specialists in their efforts to provide reasonable accommodations. This may include additional funding and support to obtain the services of consultative physicians for Heritage Health plan members with special needs.

004.03(C) PROCEDURE FOR PRIMARY CARE PROVIDER TRANSFER REQUESTS. The following procedure applies when a primary care provider requests a transfer:

(i) The primary care provider must contact the Heritage Health plan for which the member is enrolled and provide documentation of the reason(s) for the transfer. The Heritage Health plan must investigate and document the reason for the request. Where possible, the Heritage Health plan must provide the primary care provider with assistance to try to maintain the medical home;
(ii) The Heritage Health plan must review the documentation and conduct any additional inquiry to clearly establish the reason(s) for transfer;
(iii) The Heritage Health plan must submit the request to the Department for approval within ten (10) business days of the request;
(iv) If a primary care provider transfer is approved, the Heritage Health plan will contact and assist the member in choosing a new primary care provider;
(v) If the member does not select a primary care provider within fifteen (15) calendar days after the decision, the Heritage Health plan will automatically assign a primary care provider; and
(vi) The Heritage Health plan must enter the approved transfer of primary care provider on the primary care provider file for the information to be reflected in the managed care system.

004.03(D) TRANSFER CRITERIA. The criteria for terminating a member from a practice must not be more restrictive than the primary care provider's general office policy regarding terminations for non-Medicaid members. The Heritage Health plan must provide documentation to the Department prior to submitting the primary care provider transfer

request that attempts were made to resolve the primary care provider member issues (see 482-000-3).

004.03(E) INTERIM PRIMARY CARE PROVIDER ASSIGNMENT. The Heritage Health plan will be responsible for assigning an interim primary care provider in the following situations:
(i) The primary care provider has terminated the member's participation with the Heritage Health plan;
(ii) The primary care provider is still participating with the Heritage Health plan but is not participating at a specific location and the member requests a new primary care provider; or
(iii) A primary care provider or Heritage Health plan initiated transfer has been approved (see Title 482 NAC 2-004.03C) but the member does not select a new primary care provider.

004.03(F) MEMBER NOTIFICATION. The Heritage Health plan must immediately notify the member, by mail or by telephone, that the member is being temporarily assigned to another primary care provider within the same health plan and that the new primary care provider must meet the member's health care needs until a transfer can be completed.

004.04 HERITAGE HEALTH DISENROLLMENT REQUESTS. The Heritage Health plan may request that the member be disenrolled from the plan and re-enrolled in another plan.

004.04(A) DOCUMENTATION. The Heritage Health plan must provide documentation showing attempts were made to resolve the reason for the disenrollment request through contact with the member, the primary care provider, or other appropriate sources.

004.04(B) COVERAGE OF SERVICES. The Heritage Health plan must provide the services in the core benefits package to the member until a disenrollment is completed. The Heritage Health plan is prohibited from requesting disenrollment because of a change in the member's health status or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the member's special needs.

004.04(C) DISENROLLMENT REASONS. Disenrollment will be allowed based on the following situations:
(i) The Heritage Health plan has sufficient documentation to establish that the member's condition or illness would be better treated by another Heritage Health plan; or
(ii) The Heritage Health plan has sufficient documentation to establish fraud, forgery, or evidence of unauthorized use or abuse of services by the member.

004.04(D) PROCEDURE FOR HERITAGE HEALTH PLAN DISENROLLMENT REQUESTS. The following procedure applies when the Heritage Health plan requests a member disenrollment:
(i) The Heritage Health plan for which the member is enrolled must provide documentation to the Department which clearly establishes the reason(s) for the disenrollment request;

(ii) The Heritage Health plan must submit the request to the Department;
(iii) The health plan must send notification of the disenrollment request to the member at the same time the request is made to the Department. The member notification must include the member's grievance and appeal rights;
(iv) The member, primary care provider and health plan are notified of the approval or denial of the disenrollment request and information will be made available electronically; and
(v) If approved, the disenrollment will become effective the first day of the following month, given system cut-off.

004.05 HOSPITALIZATION DURING TRANSFER. When a Heritage Health plan member is admitted to an inpatient for acute or rehabilitation services on the first day of the month a transfer to another Heritage Health plan is effective, the Heritage Health plan that admitted the member to the hospital is responsible for the member (hospitalization and the related services in the core benefits package) until an appropriate discharge from the hospital, transfer to a lower level of care, or for sixty days, whatever is earliest.

(A) The Heritage Health plan the member is transferring to is responsible for the member (hospitalization and the related services in the core benefits package) beginning the day of discharge, the day of transfer to a lower level of care, or on the sixty-first (61st) day of hospitalization following the Heritage Health plan transfer, whatever is earliest.
(B) The Heritage Health plans must work cooperatively with the enrollment broker and the Department to coordinate the member's transfer between the Heritage Health plans.

005. WAIVER OF ENROLLMENT. Waiver of enrollment occurs when the Department determines that a client is not mandatory for a Heritage Health plan or the Dental Benefits Manager. The Department will notify the member, health plans, or the Dental Benefits Manager of the waiver of enrollment. Waiver of enrollment is prospective and is effective the first day of the next month.

005.01 WAIVER OF ENROLLMENT DUE TO ELIGIBILITY CHANGES. Waiver of enrollment due to changes in eligibility will occur in the following situations:

(A) The member's Medicaid case is closed or suspended; or
(B) The member is no longer mandatory for a Heritage Health plan (see Title 482 NAC 2-001.02 and 2-001.03) or the Dental Benefits Manager.

005.02 HOSPITALIZATION RELATED WAIVER OF ENROLLMENT. Waiver of enrollment from Heritage Health plans will occur automatically in the following situations due to a change in mandatory status for Heritage Health plans. If the Heritage Health plan member is receiving inpatient hospital services at the time of waiver, the following rules apply:

(A) When a Heritage Health plan member is receiving inpatient acute or rehabilitation hospital services on the first day of a month that the member is no longer eligible for Medicaid benefits, the Heritage Health plan is not responsible for services effective the first day of the month the member is no longer Medicaid eligible; or
(B) When a Heritage Health plan member is receiving inpatient for acute hospital services and has enrollment waived from Heritage Health due to an eligibility status change, the Heritage Health plan is responsible for the hospitalization and services provided in the core benefits package until waiver of enrollment occurs.

005.03 ADMISSION TO NURSING FACILITY CARE. Admission to a nursing facility may affect the Heritage Health plan member's enrollment in the Heritage Health plan. Skilled nursing services are those nursing facility services provided to eligible members which are skilled or 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 Title 471 NAC and the nursing facility admission is expected to be of long term or permanent duration. The following rules apply:

(A) When a member is admitted to a nursing facility, the Heritage Health plan must determine if the level of care the member requires is skilled or rehabilitative using Medicare's definition of skilled care.

(B) When the level of care the member requires is skilled or rehabilitative, the Heritage Health plan is responsible for payment of services for the member while receiving skilled level of care services.

(C) When the member is admitted to a nursing facility for custodial care, long-term care, Medicaid fee-for-service will assume financial responsibility for the facility charges beginning on the date the custodial level of care determination is made.

   (i) Payment for all services included in the core benefits package will be the responsibility of the Heritage Health plan.

(D) When the member is admitted to a nursing facility for custodial care and the member's primary care provider does not see patients at the facility, the Heritage Health plan must work cooperatively with the member and the nursing facility to locate a primary care provider for the member.

   (i) The Heritage Health plan must make arrangements to ensure reimbursement of primary care provider services provided by the member's nursing facility physician, for referrals, and for all services included in the core benefits package.

2-000 MEMBER PARTICIPATION AND ENROLLMENT

2-001 MANDATORY MEMBERS AND EXCLUDED CLIENTS

2-001.01 Mandatory Members: The following clients are required to participate as members in Heritage Health (Nebraska's Medicaid managed care program):

1. Families, children, and pregnant women eligible for Medicaid under Section 1931 of the federal Social Security Act, as amended ("Section 1931"), or related coverage groups.
2. Members who are eligible for Medicaid due to blindness or disability.
3. Members who are sixty-five (65) years of age or older and not members of the blind/disabled population or members of the Section 1931 adult population.
4. Low-income children who are eligible to participate in Medicaid under Title XXI of the federal Social Security Act, as amended (the "Children's Health Insurance Program").
5. Members who are receiving foster care or subsidized adoption assistance under Title IV-E of the federal Social Security Act, as amended; are in foster care; or, are otherwise in an out-of-home placement.
6. Members who participate in a Home and Community-Based Waiver Services program (see Title 480 Nebraska Administrative Code (NAC)). This includes adults with intellectual disabilities or related conditions; children with intellectual disabilities and their families, aged persons, and adults and children with disabilities; members receiving targeted case management through the Division of Developmental Disabilities; Traumatic Brain Injury Waiver participants; and, any other group covered by the State's Section 1915(c) waiver under the federal Social Security Act, as amended.
7. Women who are eligible for Medicaid through the Breast and Cervical Cancer Prevention and Treatment Act of 2000 ("Every Woman Matters").
8. Medicaid beneficiaries during a period of retroactive eligibility, when mandatory enrollment for Heritage Health has been determined.
9. Members eligible during a period of presumptive eligibility.

The member's Heritage Health status (mandatory or excluded) is determined by an automated interface between Medicaid's eligibility system and each health plan's system based on information entered on the Medicaid eligibility system known at the time of the interface.

2-001.02 Heritage Health Excluded Populations: The following clients are excluded from Heritage Health:

1. Aliens who are eligible for Medicaid due to an emergency condition only.
2. Clients who have excess income or who are required to pay a premium, except those who are continuously eligible due to a share of cost obligation to a nursing facility or for Home and Community Based Waiver Services.
3. Clients who have received a disenrollment or waiver of enrollment.
4. Clients in the Program for All-Inclusive Care for the Elderly.
5. Clients with Medicare coverage where Medicaid only pays co-insurance and deductibles.

2-001.04 Coverage Rules

2-001.04A Coverage for Excluded Clients: Medicaid coverage for clients excluded from participation in Heritage Health remains on a fee-for-service basis. Excluded clients cannot voluntarily enroll.

2-001.04B Coverage During Enrollment: Due to changes in a member's Medicaid eligibility and/or mandatory for Heritage Health status, a member's enrollment in Heritage Health may periodically change. The health plan(s) is/are responsible for the provision of the services covered by Heritage Health for the member as long as the member is identified as an enrollee of that health plan.

2-002 ENROLLMENT

2-002.01 Purpose of Enrollment Process: Medicaid contracts with an enrollment broker to enroll members who are required to participate in Heritage Health and to initially assign a primary care provider to those members.

The enrollment broker assists members in understanding enrollment requirements and participation in Heritage Health. To facilitate this effort, the health plans are required to have an understanding of the member population and the enrollment process and to assist Medicaid and the enrollment broker in providing adequate information to the members. The health plans are also required to work cooperatively with Medicaid and the enrollment broker to resolve issues relating to member 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 Health Plan: The enrollment broker has the responsibility to enroll a member in a health plan. A member may choose a health plan and primary care provider or the member may be auto-assigned by the enrollment broker to a health plan. A member has ninety (90) days after the effective date of their initial health plan enrollment to choose another plan. Note: Family members may select a different primary care provider and health plan but are encouraged to choose the same health plan.

Enrollment activities must be completed and communicated to Medicaid by the enrollment broker following the date of the notice sent to the member informing the member of the health plan assignment.

The health plan must accept Medicaid members in the order in which they are enrolled through the enrollment broker's system.

The member must have the opportunity to choose the health plan and primary care provider of his or her choice, to the extent possible and appropriate.

2-002.02A Reenrollment: If the member is identified as mandatory for enrollment into Heritage Health within two months of loss of Medicaid eligibility, the member will automatically be enrolled with the previous Heritage Health plan effective the first of the next month possible given system cutoff. Medicaid or the enrollment broker will send the member notification of the re-enrollment.

The member may choose a different health plan only in the following circumstances: (a) if the reenrollment is during the initial ninety (90) day period; (b) during the open enrollment period; or (c) for cause (see Title 482 NAC 2-003.02B) by contacting the enrollment broker and completing a plan transfer request.

2-002.02B Departmental Wards/Foster Care Members: If a member is a departmental ward or foster child the enrollment broker must coordinate enrollment activities with the Child and Family Services specialist responsible for the case management of that member.

2-002.02C Enrollment of an Unborn and Newborn Child: Medicaid will pre-enroll unborns into Heritage Health if the unborn has either a mother or sibling enrolled in Heritage Health. Once Medicaid is notified of a live birth, the newborn will be immediately enrolled in either the mother's health plan or an eligible sibling's health plan. The mother's plan supersedes the sibling's plan, in the event that both mother and sibling are enrolled in Heritage Health. Enrollment changes (i.e., to a different Heritage Health plan) may be made as allowed for any other member participating in Heritage Health. (See Title 482 Nebraska Administrative Code (NAC) 2-003.02.)

2-002.02D Changes in Enrollment Status: A member will be notified by Medicaid or the enrollment broker if the member's Heritage Health status changes.

2-002.03 Enrollment Rules: The member or the member'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 member, 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 member or his/her legal representative (i.e., guardian, conservator, or Durable Power of Attorney (if the Durable Power of Attorney has this level of authority) must make the choice of the health plan and primary care provider; and

3. The Child and Family Services specialist or designee must act on a Department ward's behalf. The child's foster parents must be involved in the selection of the health plan and primary care provider.

A health plan must not have any direct contact with the member or the member's legal representative, family, or friends prior to the client becoming enrolled with that health plan, unless the contact is initiated by the enrollment broker.

2-002.04 Effective Date of Heritage Health Coverage: The effective date of Heritage Health coverage is the first calendar day of the month of the Heritage Health enrollment. The date of enrollment in a health plan should match the Medicaid eligibility date. This date may occur up to three (3) months prior to the date of enrollment. The health plan is responsible for benefits and services in the core benefits package from and including the effective date of an enrolled member's Medicaid eligibility. The health plan must reimburse a provider for appropriate covered services and that provider must reimburse a member for any payments made by the member.

Exception: Hospitalization at the time of enrollment (see Title 482 NAC 2-002.04D).

2-002.04A Services before Enrollment Heritage Health: Medicaid-coverable services received before the month of Heritage Health coverage becomes effective will be paid on a fee-for-service basis under the rules and regulations of Medicaid Title 471 Nebraska Administrative Code.

2-002.04B Notification of Heritage Health Coverage: The member or the member's legal representative will be notified of Heritage Health coverage.

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

1. Medicaid's Internet Access for Enrolled Providers;
2. The Nebraska Medicaid Eligibility System;
3. The Medicaid Inquiry Line; or
4. The standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271).

Through the enrollment broker functions, and written materials and notice, the member will be kept informed of his or her right to change health plans and/or primary care provider through the enrollment broker functions, written materials, and notice.

If the member does not voluntarily enroll, the enrollment report will not list a primary care provider. The health plan is responsible for the assignment of the primary care provider for members who do not voluntarily enroll.

The health plan is responsible for providing the services in the core benefits package to members listed on the enrollment report generated for the month of enrollment. Any discrepancies between the member notification and the enrollment

report must be reported to Medicaid for resolution. The health plan must continue to provide and authorize services until the discrepancy is resolved.

In case of a discrepancy, the eligibility and enrollment databases used to build the enrollment file serves as the official source of validation. Once the cause for the

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

2-002.04C Continuity of Care Period: Within the first month of enrollment, the health plan is responsible for providing each member general information about Heritage Health and the health plan, e.g., member handbook, etc.

The health plan must continue all services that have been authorized by Medicaid fee-for-service prior to the member becoming enrolled in Heritage Health. These services must be continued until the health plan determines that the service no longer meets the definition of medical necessity.

2-002.04D Hospitalization: When a Medicaid client is in an acute care medical or rehabilitation facility prior to the client's enrollment in managed care, 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. In the event that a client is admitted as an inpatient in an acute care medical or rehabilitation facility and is assigned to a health plan in the same month, the health plan is responsible for that hospitalization.

2-002.05 Automatic Assignment for Heritage Health: If a choice of Heritage Health plan is not made at the of time of application, the member will be automatically assigned to a health plan based on criteria established by Medicaid.

2-003 HERITAGE HEALTH DISENROLLMENT OR TRANSFERS: Disenrollment for the purposes of this section is a change in a member's enrollment from one health plan to another.

A transfer is a change in a member's assignment from one primary care provider to another primary care provider.

A disenrollment/transfer may be made at the member's request (Title 482 NAC 2-003.01) or at the primary care provider and/or health plan's request (Title 482 NAC 2-003.03). A transfer may also be made because the member requires an interim primary care provider (Title 482 NAC 2-003.03E).

2-003.01 Member Transfer Requests: The member must contact the health plan to request a primary care provider transfer. A member may request a transfer from one primary care provider to another primary care provider at any time.

The health plan must assist the member in selecting a new primary care provider by:

1. Discussing the reasons for transfer with the member and attempting to resolve any conflicts when in the member's best interest;
2. Reviewing the member's needs to facilitate the member's choice of primary care provider;
3. Processing the member request; and
4. Notifying Medicaid of the primary care provider transfer via the primary care provider transfer file. The primary care provider transfer will be updated on the member's managed care file.

If a member is requesting a primary care provider transfer, the health plan should carefully document the reason. Any transfer for a member under a "restricted services" provision must be completed per "restricted services" procedures (see 482-000-7).

2-003.02 Member Disenrollment Requests: A member may request a change from one Heritage Health plan to another by contacting the enrollment broker as follows:

1. With cause, at any time;
2. During the ninety (90) days following the date of the member's initial enrollment with the health plan, or the date Medicaid sends the member's notice of enrollment, whichever is later;
3. During the designated open enrollment period;
4. Upon automatic reenrollment if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity; or
5. If 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 health plan does not, because of moral or religious objections, cover the service the member seeks;
2. The member 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 member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; or
3. Other reasons, including but not limited to, poor quality of care, lack of access to providers experienced in dealing with the member's health care needs or lack of access to services covered under the contract.
4. Medicaid and Health Plan Contract Termination

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 member disenrollment request is for cause, the enrollment broker must complete a "Plan Disenrollment Member Request Form," with the member 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 Heritage Health plan at Medicaid's request; and
3. Any of the reasons cited in Title 482 Nebraska Administrative Code (NAC) 2-003.02A.

Medicaid will take action to approve or deny the request within sixty (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. A notice will be issued to the member or his or 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 enrollment broker to resolve any issues raised by the member at the time of request for disenrollment but may not coerce or entice the member to remain with them as a member.

2-003.02C Enrollment Broker Responsibilities: The enrollment broker must also discuss with the member when processing a disenrollment request the following:

1. The importance of maintaining a medical home;
2. How the member's medical care may be affected by the transfer and what the member'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 primary care provider and/or health plan is no guarantee of approval or authorization of the same services with the new primary care provider and/or health plan.

Any disenrollment for a member under a "restricted services" provision must be completed per "restricted services" procedures (see 482-000-7).

2-003.03 Primary Care Provider Transfer Requests: The primary care provider may request that the member be transferred to another primary care provider, based on the following situations:

1. The primary care provider has sufficient documentation to establish that the member's condition or illness would be better treated by another primary care provider;
2. The primary care provider has sufficient documentation to establish that the member/provider relationship is not mutually acceptable, e.g., the member 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 member's ability to follow through the primary care provider services/referrals.

The primary care provider must maintain responsibility for providing the services in the core benefits package to the member until a transfer is completed.

The health plan must assist its primary care providers 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 members with special needs.

2-003.03A Procedure for Primary Care Provider Transfer Requests: The following procedure applies when a primary care provider requests a transfer:

1. The primary care provider must contact the health plan for which the member 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 primary care provider 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 primary care provider transfer is approved, the health plan will contact the and assist the member in choosing a new primary care provider;
5. If the member does not select a primary care provider within fifteen (15) calendar days after the decision, the health plan will automatically assign a primary care provider; and
6. The health plan must enter the approved transfer of primary care provider on the primary care provider file for the information to be reflected in the managed care system.

The criteria for terminating a member from a practice must not be more restrictive than the primary care provider's general office policy regarding terminations for non-Medicaid members.

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

2-003.03B Interim Primary Care Provider Assignment: The health plan will be responsible for assigning an interim primary care provider in the following situations:

1. The primary care provider has terminated his or her participation with the health plan, e.g., primary care provider retires, leaves practice, dies, no longer participates in Heritage Health;
2. The primary care provider is still participating with the health plan but is not participating at a specific location and the member requests a new primary care provider (i.e., change in location only); or
3. A primary care provider or health plan initiated transfer has been approved (see Title 482 Nebraska Administrative Code (NAC) 2-003.03A) but the member does not select a new primary care provider.

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

2-003.04 Heritage Health Disenrollment Requests: The health plan may request that the member 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 member'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 member.

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

The health plan must maintain responsibility for providing the services in the core benefits package to the member until a disenrollment is completed.

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

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

1. The health plan for which the member 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;
3. The health plan must send notification of the disenrollment request to the member at the same time the request is made to Medicaid. The member notification must include the member's grievance and appeal rights;

4. The member, primary care provider and health plan are notified of the approval or denial of the disenrollment request and information will be made available electronically; and
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 member is hospitalized as an inpatient for acute or rehabilitation services on the first day of the month a transfer to another health plan is effective, the health plan which admitted the member to the hospital is responsible for the member (i.e., hospitalization and the related services in the core benefits package) until an appropriate discharge from the hospital or for sixty days, whichever is earlier. The health plan the member is transferring to is responsible for the member (i.e., hospitalization and the related services in the core benefits package) beginning the day of discharge or on the sixty-first (61st) day of hospitalization following the transfer, whichever is earlier. The health plan must work cooperatively with the enrollment broker and Medicaid to coordinate the member's transfer.

2-004 WAIVER OF ENROLLEMENT: Waiver of enrollment is the determination by Medicaid that a client is not mandatory for Heritage Health.

2-004.01 Waiver of Enrollment Due to Eligibility Changes: Waiver of enrollment will occur in the following situations:
1. The member's Medicaid case is closed or suspended; or
2. The member is no longer mandatory for Heritage Health (see Title 482 Nebraska Administrative Code (NAC) 2-001.02 and 2-001.03).

Medicaid will notify member and the health plans of the waiver of enrollment. Waiver of enrollment is prospective and is effective the first of the next month.

2-004.01A Hospitalization-Related Waivers of Enrollment: Waiver of enrollment from Heritage Health will occur automatically in the following situations due to a change in mandatory status for Heritage Health.

If the member 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 Heritage Health member is receiving inpatient acute or rehabilitation hospital services on the first day of a month that the member is no longer eligible for Medicaid benefits, the health plan is not responsible for services effective the first day of the month the member is no longer Medicaid eligible.
2. Waiver of enrollment due to eligibility category change: When a Heritage Health member is receiving inpatient for acute hospital services and has enrollment waived from Heritage Health due to an eligibility status change, e.g., the member is no longer in a mandatory group for Heritage Health participation, the health plan is responsible for the hospitalization and services provided in the core 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 member's enrollment in Heritage Health. The following rules apply:~~

1. ~~When a member is admitted to a nursing facility, the health plan must determine if the level of care the member requires is skilled/rehabilitative using Medicare's definition of skilled care.~~
   ~~When the level of care the member requires is skilled/rehabilitative, the physical health plan is responsible for payment of services for the member while receiving skilled level of care services.~~
2. ~~When the member is admitted to a nursing facility for custodial care (i.e., long term care), 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 core benefits package will be the responsibility of the health plan.~~
3. ~~When the member is admitted to a nursing facility for custodial care and the member's primary care provider does not see patients at the facility, the health plan must work cooperatively with the member and the nursing facility to locate a primary care provider for the member. The health plan must make arrangements to ensure reimbursement of primary care provider services provided by the member's nursing facility physician, for referrals, and for all services included in the core benefits package.~~

~~For purposes of Heritage Health, skilled nursing services are those nursing facility services provided to eligible members 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 Title 471 Nebraska Administrative Code (NAC) and the nursing facility admission is expected to be of long term or permanent duration.~~

TITLE 482 NEBRASKA MEDICAID MANAGED CARE

CHAPTER 3 ENROLLMENT BROKER

001. SCOPE AND AUTHORITY. These regulations govern the services provided under Nebraska's Medicaid program as defined by Neb. Rev. Stat. §§ 68-901 et. Seq. the Medical Assistance Act.

002. DEFINITIONS. The following definitions apply:

002.01 ENROLLMENT BROKER. The enrollment broker is a contracted entity that performs unbiased choice counseling and enrollment activities for health plan members.

003. ENROLLMENT MATERIALS. The enrollment broker must distribute enrollment information and marketing materials to managed care members and potential members. The enrollment broker must develop the materials in coordination with the health plans, with Medicaid's approval, and meet the following guidelines:

(A) Written materials use easily understood language and format;
(B) Written materials are available in the prevalent non-English languages, as specified by Medicaid;
(C) Written materials are available in alternative formats that take into consideration the special needs of members;
(D) Materials on all Heritage Health service components are distributed equitably and without bias to any particular health plan;
(E) All enrollment notices, information, and instructional materials are available upon request;
(F) Materials clearly state information about Heritage Health, ensure the member has adequate information to make an informed selection; and
(G) Materials are reviewed and approved by Medicaid.

004. MEMBER WEBSITE. The enrollment broker website must include general and up-to date information about Heritage Health, the enrollment broker, and health plans. The enrollment broker website will remain compliant with applicable privacy and security requirements, including but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), when providing member eligibility or identification information on its website. The enrollment broker website must include the following:

(A) Current version of the enrollment broker outreach packet, notice of anniversary letter, provider directory, health plan matrix, and all other mailings provided by the enrollment broker;
(B) Telephone contact information for the enrollment broker;

(C) Real time, searchable provider directory for each health plan; to include open and closed panels;
(D) Links to health plan websites and toll-free numbers;
(E) A link to the Medicaid eligibility website;
(F) Information on how to select a health plan and primary care provider, report family and demographic changes, and file grievances and appeals; and
(G) Secure online portal to facilitate member health plan enrollment and primary care provider selection.

005. ENROLLMENT ACTIVITIES AND CHOICE COUNSELING. The enrollment broker must complete the following enrollment and choice counseling activities for mandatory and potential mandatory members in coordination with the health plans and Medicaid:

(A) Educate members concerning Heritage Health including:
  (i) A general explanation of Heritage Health;
  (ii) Mandatory and excluded members; and
  (iii) The role of the health plans in coordinating care.
(B) Provide information specific to each health plan available in the State, including:
  (i) Covered benefits;
  (ii) Cost sharing, if any;
  (iii) Names, locations telephone numbers of, and non-English languages spoken by current contracted providers;
  (iv) Identification of providers not accepting new patients; and
  (v) For Medicaid benefits not covered under Heritage Health, the enrollment broker must provide information about how and where to obtain services, any cost sharing, and how transportation is provided;
(C) Provide an explanation of those services which do not require primary care provider or health plan approval or prior authorization;
(D) Provide an explanation of the availability of interpreter services and alternative formats for written materials;
(E) Provide an explanation of passive enrollment;
(F) Provide an explanation of disenrollment and waiver of enrollment;
(G) Provide the member with enrollment materials that are easily understood by the member, and developed in ways appropriate to meet the needs of the member; and
(H) Enter the health plan and primary care provider (PCP) selection in the Heritage Health file.

3-000 ENROLLMENT BROKER

3-001 ENROLLMENT BROKER: The Enrollment Broker (EB) is a contracted entity that performs choice counseling and enrollment activities for physical health managed care clients. The EB also assists in the coordination of support services throughout the provider network.

3-002 ENROLLMENT MATERIALS: The EB must distribute enrollment information and marketing materials to managed care clients and potential clients. The EB must ensure that materials are developed in coordination with the physical health Managed Care Organization plans (health plan), approved by the Department, and meet the following guidelines:

1. Written materials use easily understood language and format;
2. Written materials are available in the prevalent non-English languages, as specified by the Department;
3. Written materials are available in alternative formats that take into consideration the special needs of clients;
4. Materials on all NHC service components are distributed equitably and without bias to any particular health plan;
5. All enrollment notices, information, and instructional materials are available upon request;
6. Materials clearly state information about NHC, ensure the client has adequate information to make an informed selection; and
7. Materials are reviewed and approved by the Department

3-003 (Reserved)

3-004 CONFIDENTIALITY: The EB must maintain the confidentiality of client-specific information. The EB must not publish or otherwise release client information without the prior written approval of the Department.

3-005 ENROLLMENT ACTIVITIES AND CHOICE COUNSELING: The EB must complete the following enrollment and choice counseling activities for mandatory and potential mandatory clients in coordination with the health plans and the Department:

1. Educate clients concerning Medicaid managed care including:
   a. A general explanation of the managed care program;
   b. Mandatory and excluded groups of clients; and
   c. The role of the health plans in coordinating care.
2. Provide information specific to each plan available in the service area, including:
   a. Covered benefits;
   b. Cost sharing, if any;
   c. Service area;
   d. Names, locations telephone numbers of, and non-English languages spoken by current contracted providers;
   e. Identification of providers not accepting new patients; and

f. For Medicaid benefits not covered under the managed care program, the EB must provide information about how and where to obtain services, any cost sharing, and how transportation is provided;

3. Provide an explanation of those services which do not require Primary Care Physician (PCP) or health plan approval or prior authorization, e.g., family planning and emergency services;
4. Provide an explanation of the availability of interpreter services and alternative formats for written materials;
5. Provide an explanation of auto-assignment;
6. Provide an explanation of disenrollment and waiver of enrollment;
7. Provide the client with enrollment materials that are easily understood by the client, and developed in ways appropriate to meet the needs of the client;
8. Assist the client in choosing a health plan and PCP based on a process, approved by the Department, that protects the client's right to choose and that is equitable and without bias to any particular health plan, that identifies any existing relationships with health care practitioners, and that emphasizes the importance of prompt selection of a health plan and PCP. The client is free to choose a health plan and PCP from all available options, however, the EB must screen for the following and similar information:
   a. Geographical location of the client, his/her legal representative, significant family member(s), foster parent, child welfare worker, etc.
   b. Access, e.g., transportation issues;
   c. Medical need/provider specialty based on information provided by the client;
   d. Established utilization patterns based on information provided by the client;
   e. Family groupings;
   f. Current medical relationships, e.g., the client has received services from an enrolled PCP;
   g. Number of physicians in the geographical areas;
   h. Number of available slots per PCP; and
   i. Unique features about the PCP, e.g., skilled in foreign/sign language, preferences by a client's particular culture or religious beliefs, etc.
9. Enter the health plan and PCP selection in the Managed Care File.

3-006 LOCK-IN PROCEDURES: Lock-in is a method used by the Department to limit the medical services of a client who has been determined to be abusing or over-utilizing services provided by the Department without infringing on the client's choice of providers.

A lock-in client completes standard enrollment activities for the managed care program. Enrollment may change the client's previous lock-in categories of pharmacy, primary care physician, and hospital, or identify through the EB that a new lock-in status for the client is recommended. The EB completes the necessary information pertaining to a client's lock-in status at the time of enrollment.

A lock-in client may transfer (disenroll) from one PCP and health plan to another as defined in 482 NAC 2-003. (See 482-000-20, Lock-in Procedure Guide.)

TITLE 482 NEBRASKA MEDICAID MANAGED CARE

CHAPTER 4 THE HERITAGE HEALTH MANAGED CARE CORE BENEFITS PACKAGE

001. SCOPE AND AUTHORITY. These regulations govern the responsibilities of the health plan in delivering the core benefits package to the Heritage Health member. The Department, assumes primary administrative and operational responsibility for the implementation of the Heritage Health programmatic requirements. The health plan must incorporate the information contained in this Title, as well as Title 471 Nebraska Administrative Code (NAC), which defines in detail the minimum service provisions required for the physical health, behavioral health, and pharmacy services under Medicaid.

002. MANAGED CARE ORGANIZATION REQUIERMENTS. Heritage health administers the core benefits package to Medicaid members through one (1) or more health plans. The following provisions describe the health plan responsibilities.

002.01 GENERAL REQUIERMENTS. 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 health plan:

(A) Provide the services in the core benefits package according to all provisions in Title 482 NAC 4 and Title 471 NAC and ensure the services in the core benefits package are provided in the same amount, duration, and scope as defined under Title 471 NAC, but can place appropriate limits on a service based on medical necessity or utilization control;
(B) Maintain an adequate network of primary care providers to ensure adequate access for members enrolled in Heritage Health, notify the Department via the provider network file provider network file prior to the effective date of any primary care provider change whenever possible and if required, notify the member of an interim primary care provider (see 482 NAC 3-004.03(E));
(C) Use only providers enrolled in Medicaid to provide the services in the core benefits package;
(D) Provide an appropriate range of services and access to preventive and primary care services statewide, 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 members with mental, physical and communication disabilities;
(E) Accept the member choice of primary care provider and health plan;
(F) Provide care management (see 482-000-8, Care Management Requirements);
(G) Provide a member handbook to the members enrolled with the health plan, and other informational materials about Heritage Health benefits that are easy-to-read and

understand. The health plan must also provide the information in the guidebook in the most prevalent non-English speaking languages 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;

(H) Provide a comprehensive provider network directory;

(I) Medicaid prohibits the health plan from performing any direct solicitation to individual Medicaid members. The Department must approve any general marketing to Medicaid members prior to implementation. The health plan must comply with the following marketing materials:

(i) Obtain Departmental approval for all marketing materials;

(ii) Ensure marketing materials do not contain any false or potentially misleading information in a manner that does not confuse or defraud the Department;

(iii) Ensure marketing materials are available for members being served within the State;

(iv) Avoid offering other insurance products as an inducement to enroll;

(v) Comply with federal requirements for provision of information including accurate oral and written information sufficient for the member to make an informed decision about treatment options; and

(vi) Avoid any direct or indirect door-to-door, telephonic or other "cold-call" marketing.

(J) Meet all requirements of the Americans with Disabilities Act and provide appropriate accommodations for members with special needs. Ensure primary care providers and specialists are equipped in appropriate technologies, including teletype and telecommunications device for the deaf, and language services, or are skilled in various languages and areas of cultural diversity and sensitivity, and the network is appropriately staffed to ensure an adequate selection for those members who have special cultural, religious or other special requests;

(K) Coordinate activities with the Department, other Heritage Health contractors, and other providers for services outside the core benefits package, as appropriate, to meet the needs of the member, and ensure systems are in place to promote well managed patient care, including, but not limited to:

(i) Management and integration of health care through the primary care provider, and coordination of care issues with other providers outside the health plan, for services not included in the core benefits package, including behavioral health services, pharmacy, and dental services, or for services requiring additional Departmental authorization, which may include abortions and transplants (except corneal);

(ii) Provision of or arrangement for emergency medical services, twenty-four (24) hours per day, seven (7) days per week, including an education process to help assure members know where and how to obtain medically necessary care in emergency situations;

(iii) Unrestricted access to protected services such as emergency room services, family planning services, and tribal clinics in accordance with Title 471 NAC;

(iv) 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

(v) Adequate policy regarding the distribution of the member's medical records if a member changes from one primary care physician to another.

(L) Comply with regulations for advance directives;

(M) The health plan is prohibited from refusing enrollment of a member, disenrolling a member or otherwise discriminating against a member solely on the basis of age, sex, race, physical or mental handicap, national origin, or type of illness or condition;

(N) Require that all subcontractors meet the same requirements as are in effect for the health plan that are appropriate to the service or activity delegated under the subcontract;

(O) Provide member services;

(P) Maintain, at all times, an appropriate certificate of authority to operate issued by the Nebraska Department of Insurance;

(Q) Comply with all applicable state and federal regulations, such as the prohibition against assisted suicide; inappropriate use of funds/profits, lack of mental health parity, and the noncompliance with the provisions of the Hyde Amendment;

(R) Prohibit discrimination against providers based upon licensing;

(S) Prohibit hiring, employing, contracting with or otherwise conducting business with individuals or entities barred from participation in Medicaid or Medicare;

(T) Ensure adequate numbers of providers in its network to meet the needs of its members;

(U) Provide written notice to the member of any adverse action regarding the provision of services that complies with all federal and state requirements. Allow member to appeal decisions to deny, limit or terminate authorization, coverage, or payment of services. Plans must allow members to file complaints, grievances and appeals, according to Title 482 NAC 7;

(V) Comply with the Maternity and Mental Health Requirements in the Health Insurance Portability and Accountability Act of 1996 the maternity length of stay and mental health parity requirements specifically requiring coverage for a hospital stay following a normal vaginal delivery not be limited to less than forty-eight (48) hours for both the mother and newborn child, and the health coverage for a hospital stay in connection with childbirth following a cesarean section not be limited to less than ninety-six (96) hours for both the mother and newborn child;

(W) Report all fraud and abuse information to the Department;

(X) Comply with the provisions of Title 482 NAC 4-004 for provider payments;

(Y) Sign a contract with the Department and comply with all contract requirements and any other responsibilities specified by the Department in the overall operation of Heritage Health, and any other activities deemed appropriate by the Department and supported in regulations and contractual amendments;

(Z) Comply with all applicable requirements of the Health Insurance Portability and Accountability Act of 1996 and Balanced Budget Act of 1997; and

(AA) Provide access to behavioral health services necessary referrals twenty-four (24) hours per day, seven (7) days per week.

003. HEALTH CHECK EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT. The health plan must develop a program to ensure the delivery of Health Check Early and Periodic Screening, Diagnosis and Treatment services.

003.01 CONTACT WITH ELIGIBLE FAMILIES. The health plan must contact eligible families who have children age twenty (20) and younger within sixty (60) days of enrollment and encourage them to make an appointment for the required components of Health Check Early and Periodic Screening, Diagnosis and Treatment. The health plan must also counsel the family regarding the importance of health supervision and regular check-ups and assist in removing barriers to care. If necessary, the health plan must assist families with appointment scheduling and arranging transportation.

003.01(A) REQUIRED COMPONENTS. The required components are health screening, including medical, vision, hearing and dental screening (see 471 NAC 33-000).

003.02 THIRD PARTY LIABILITY REQUIREMENTS. The health plan must utilize a cost avoidance methodology whenever there is a verified third party resource. Under Federal Law, the Department is required to identify legally liable third parties and treat verified third party liability as a resource of the member. The health plan, or its subcontractors or providers, must not pursue collection from the member, but directly from the liable third party payers, except as allowed in Title 477 NAC. The health plan must assume responsibility for all third party liability requirements.

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

003.02(B) COORDINATION OF BENEFITS. The health plan shall coordinate benefits in accordance with 42 CFR 133.135 et seq and Title 471 NAC 3-004, so that costs for services otherwise payable by the health plan are cost avoided or recovered from a liable party. The two methods used are cost avoidance and post-payment recovery.

004. PROVIDER PAYMENTS. The following provisions apply regarding payments to providers by the health plans.

004.01 TIMELINESS OF PROVIDER PAYMENTS. The health plan must provide payment to a provider of services on a timely basis, consistent with Medicaid claims payments procedures and the minimum standards provided below, unless the health care provider and health plan agree to a capitated payment schedule or other arrangement.

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

004.01(B) MINIMUM TIMEFRAMES. The health plan must comply with the following minimum timeframes for the submission and processing of clean claims. Timeframes are calculated from the day the clean claim is received by the health plan until the date of the

postmark that returns the claim either to the provider or until posted on an electronic system.

(i) The health plan must pay ninety (90%) percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within fifteen (15) business days of the date of receipt. The date of receipt is the date the health plan receives the claim.

(ii) The health plan must also pay ninety-nine (99%) percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within sixty (60) days of the date of receipt. The health plan must fully adjudicate (pay or deny) all other claims within six (6) months of the date of receipt.

004.01(C) PROMPT INVESTIGATION AND SETTLEMENT OF CLAIMS. The health plan must comply with the requirements related to claim forms as set forth in Title 471 NAC. For providers of outpatient services, this must include the use of CMS-1500 form, the Health Insurance Claim form, and the standard electronic Health Care Claim: Professional Transaction form (ASC X12N 837). For hospitals providing inpatient or outpatient services, this must include the CMS-1450 form (UB-92) and the standard electronic Health Care Claim: Institutional Transaction form (ASC X12N 837).

004.01(D) SYSTEM REQUIREMENT. The health plan must maintain an editable system for recording all claims, clearly indicating the date on which a claim is received and the date(s) any action(s) on the claim occur.

004.01(E) PAYMENT STANDARD. The health plan must pay clean claims promptly as provided above after the date of receipt of or electronic notice of the claim. If, for whatever reason, the claim is submitted electronically and in written form, the date of the earlier submission of the claim will be the date of notice from which the health plan must calculate the maximum thirty day period.

004.01(F) NOTICE OF CONTESTED CLAIM. The health plan must provide written or electronic notice to the provider of a determination by the health plan that the claim is a contested claim with the returned claim. The written or electronic notice must comply with the provisions in Title 482 NAC 4-004.

004.01(G) NOTICE REQUIREMENT FOR PARTIALLY CONTESTED CLAIM. If the health plan determines that part of a claim is a contested claim and returns the claim, the health plan must provide written or electronic notice of that determination to the entity submitting the claim and must proceed to pay the portion of the claim determined by the health plan to be a clean claim timely.

004.01(H) PROHIBITED ACTION. In no instance will the health plan contest or return a claim or a portion of a claim because the claim fails to provide certain information if the missing information does not prevent the plan from adjudicating the claim.

004.01(I) NOTICE OF INSUFFICIENT INFORMATION. If the health plan determines a claim provides insufficient information for the payment of the claim, the health plan must

provide written or electronic notice of this determination to the entity submitting the claim timely including the following information:

(i) All of the reasons for the denial of the claim;
(ii) The date the service was rendered, the type of service rendered, the name of the provider who rendered the service and the name of the person to whom the service was rendered; and
(iii) The address of the office responsible for handling the claim, and means by which the office may be contacted without toll charges exceeding the charges that otherwise apply for the provider or member to place a call in their area code.

004.01(J) EFFECTIVE NOTICES AND PAYMENTS. Written notice of a claim will be effective upon the date that the claim is received. Electronic transmission of the claim will be the date the claim is posted to the electronic transfer system. Payment and notices from the health plan will be effective as of the date that:

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

004.01(K) CONTENTS OF A NOTICE OF A CONTESTED CLAIM. The health plan must specify in its notice of a returned claim at least the following information:

(i) The name, address, telephone number and facsimile number of the office handling the claim or other designated claims representative knowledgeable about the claim with which the person submitted the claim, or provider should communicate to resolve problems with the claim;
(ii) The date of the service, the type of service, the provider of the service, and the name of the person to whom the service was rendered to the extent that this information is known to the health plan;
(iii) The specific information needed by the health plan to make a determination that the claim is a clean claim; and
(iv) The date the claim was received.
(v) In addition, the health plan must include in a notice regarding a claim determination in part a contested claim, a statement specifying those portions of the claim that are considered to be clean claim, and the amounts payable with respect to the clean claim portion. Requests for information made by the health plan on a contested claim must be reasonable and relevant to the determination of whether the claim is a clean claim or claim that must be denied.

004.01(L) USE OF INTERMEDIARIES. A health plan’s use of subcontractors to perform one or more of the health plan’s claims handling functions must not mitigate, in any way, the health plan’s responsibility to comply with all of the terms of Title 482 NAC.

004.01(M) ELECTRONIC REMITTANCE ADVICE. Electronic remittance advice must be provided in accordance with the standards set forth in the Health Insurance Portability and Accountability Act of 1996.

004.01(N) CLAIM STATUS INQUIRY AND RESPONSE. Electronic claim status inquiry and response must be provided in accordance with the standards set forth in the Health Insurance Portability and Accountability Act of 1996.

004.01(O) ENCOUNTER DATA. The health plan must maintain an information system that includes the capability to collect data on member and provider characteristics, and claims information through an encounter data system. The health plan must submit encounter data to the Medicaid Management Information System monthly per Departmental specifications.

005. CORE BENEFITS PACKAGE GENERAL PROVISIONS. All services provided under managed care must meet the requirements of Title 471 NAC unless specifically waived by the Department. The health plan must apply the same guidelines for determining coverage of services for the Heritage Health member as the Department applies for other Medicaid members. The plan must base the actual provision of a service included in the core benefits package on whether the service could have been covered under Medicaid fee-for-service basis under Title 471 NAC.

005.01 PRIOR AUTHORIZATIONS. Family planning services (see 482 NAC 4-005.04), emergency services, and Native Americans seeking tribal clinic or Indian Health hospital services do not require prior authorization or provision by the primary care physician or participating network provider. All covered emergency services (see 482 NAC 4-005.05) must be available twenty-four (24) hours per day, seven (7) days per week, and are not to be limited to plan-network providers. The member may access these services from any Medicaid-enrolled provider of their choice, and the member may access these services without a referral.

005.01(A) REIMBURSEMENT. 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 4-006.07(A). Electronic referral and authorization must be provided in accordance with the standards set forth in the Health Insurance Portability and Accountability Act of 1996.

005.01(B) EXCEPTION. In addition to the health plans provision, abortions must be prior authorized by the Department.

005.02 SERVICES IN THE CORE BENEFITS PACKAGE. Services provided in the core benefits package are as follows and represent covered services under Heritage Health. The health plan is responsible for working with the Department to ensure the member has access to all services.

005.02(A) PHYSICAL HEALTH SERVICES. The physical health services include those listed below as covered by Title 471 NAC:

(i) Inpatient hospital services, including transitional hospital services and transplant services (see 471 NAC 10-000);
(ii) Outpatient hospital services (see 471 NAC 10-000)
(iii) Ambulatory surgical center (ASC) services (see 471 NAC 10-000 and 471 NAC 26-000);

(iv) Physician services, including services provided by nurse practitioners, certified nurse midwives, and physician assistants, and clinic-administered injections or medications, and anesthesia services including those provided by a certified registered nurse anesthetist (see 471 NAC 18-000);
(v) Services provided in federally-qualified health centers and rural health clinics (see 471 NAC 29-000 and 471 NAC 34-000);
(vi) Services provided in Indian Health Service facilities (see 471 NAC 11-000);
(vii) Clinical and anatomical laboratory services, including the administration of blood draws completed in the physician's office or an outpatient clinic for a behavioral health diagnosis (see 471 NAC 10-000, 471 NAC 18-000, 471 NAC 20-000, 471 NAC 26-000, 471 NAC 32-000);
(viii) Radiology services (see 471 NAC 10-000);
(ix) Health Check services (see 471 NAC 33-000);
(x) Home health services (see 471 NAC 9-000);
(xi) Private duty nursing services (471 NAC 13-000);
(xii) Therapy services (physical therapy, occupational therapy, and speech pathology and audiology) (see 471 NAC 14-000, and 471 NAC 23-000);
(xiii) Durable medical equipment and medical supplies, including hearing aids, orthotics, prosthetics, and nutritional supplements (471 NAC 7-000, 471 NAC 8-000, 471 NAC 19-000, 471 NAC 15-000);
(xiv) Podiatry services (471 NAC 19-000);
(xv) Chiropractic services (471 NAC 5-000);
(xvi) Vision services (471 NAC 24-000);
(xvii) Free standing birth center services (471 NAC 42);
(xviii) Hospice services, except when provided in a nursing facility (471 NAC 36-000 and 471 NAC 12-000);
(xix) Skilled or rehabilitative and transitional nursing facility services (471 NAC 21-000, 471 NAC 12-000, and 471 NAC 13-000);
(xx) Ambulance services (471 NAC 4-000);
(xxi) Non-emergency transportation services (471 NAC 27-000);
(xxii) Transplant services; and
(xxiii) Pharmacy services (471 NAC 16-000).

005.02(B) BEHAVIORAL HEALTH SERVICES. The behavioral health services include those listed below as covered by Title 471 NAC:
(i) Services for individuals age twenty (20) and under, see Title 471 NAC 32:
(1) Crisis stabilization services (includes treatment crisis intervention).
(2) Inpatient psychiatric hospital (acute and sub-acute).
(3) Psychiatric residential treatment facility (age 19 and under).
(4) Outpatient assessment and treatment:
(a) Partial hospitalization;
(b) Day treatment;
(c) Intensive outpatient;
(d) Medication management;
(e) Outpatient therapy (individual, family, or group);
(f) Injectable psychotropic medications;
(g) Substance use disorder treatment;
(h) Psychological evaluation and testing;

(i) Initial diagnostic interviews;
(j) Sex offender risk assessment;
(k) Community treatment aide services;
(l) Comprehensive child and adolescent assessment addendum;
(m) Hospital observation room services (up to 23 hours and 59 minutes in duration);
(n) Parent child interaction therapy;
(o) Child-parent psychotherapy;
(p) Applied behavioral analysis;
(q) Multi-systemic therapy; and
(r) Functional family therapy.

(5) Rehabilitation services:
(a) Day treatment and intensive outpatient;
(b) Community treatment aid services;
(c) Professional resource family care; and
(d) Therapeutic group home.

(ii) Services for individuals age twenty-one (21) and over, see Title 471 NAC 20:
(1) Crisis stabilization services (includes treatment crisis intervention);
(2) Inpatient psychiatric hospital services (acute and sub-acute);
(3) Outpatient assessment and treatment:
(a) Partial hospitalization;
(b) Social detoxification;
(c) Day treatment;
(d) Intensive outpatient;
(e) Medication management;
(f) Outpatient therapy (individual, family, or group);
(g) Injectable psychotropic medications;
(h) Substance use disorder treatment;
(i) Psychological evaluation and testing;
(j) Electroconvulsive therapy;
(k) Initial diagnostic interviews;
(l) Ambulatory detoxification; and
(m) In-home psychiatric nursing.

(4) Rehabilitation services:
(a) Dual-disorder residential;
(b) Intermediate residential for substance use disorder;
(c) Short-term residential;
(d) Halfway house;
(e) Therapeutic community for substance use disorder only;
(f) Community support;
(g) Psychiatric residential rehabilitation;
(h) Secure residential rehabilitation;
(i) Assertive community treatment and alternative community support; and
(j) Day rehabilitation.

005.02(C) AMOUNT, DURATION, AND SCOPE. The health plan must provide the above services in amount, duration and scope defined by the Department in Title 471 NAC. The health plan must provide care and services when medically necessary to ensure the

member receives necessary services. The health plan must also ensure the services provided to the member are as accessible (in terms of timeliness, amount, duration and scope) as those services provided to the non-enrolled Medicaid client.

005.02(D) VALUE-ADDED SERVICES. The Department allows the health plan to provide medically necessary services to the member that are in addition to those covered under Medicaid. The Department allows the health plan to provide value-added services that are more cost effective than the covered service and the health status of the member is expected to improve or at least stay the same. If the plan provides additional or value-added services, 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 the Centers for Medicare and Medicaid Services.

005.03 EXCLUDED SERVICES. The following Medicaid coverable services are excluded from the Heritage Health core benefits package and are not the responsibility of the health plan. These services are paid on a fee-for-service basis. Members must access these services through Medicaid. For all Medicaid covered services, the health plan is required to coordinate the members care to promote the continuity of care. The health plan and enrollment broker must inform the member of the availability of these services and how to access them. Excluded services:

(A) Dental services (see Title 471 NAC 6 and 482 NAC 5);
(B) Services in Intermediate Care Facilities for Persons with Developmental Disabilities (see Title 471 NAC 31);
(C) Any institutional long-term care nursing facility services at a custodial level of care (see Title 471 NAC 12 and 471 NAC 13);
(D) School-based services (see Title 471 NAC 25);
(E) All home and community-based waiver services (see Title 404 and 480 NAC);
(F) Targeted case management (see Title 480 NAC);
(G) Medicaid state plan personal assistance services (see Title 471 NAC 15).

005.04 FAMILY PLANNING SERVICES. Approval by the member's primary care provider and health plan is not required for family planning services. The health plan and enrollment broker must inform Heritage Health members of their freedom of choice for family planning services and that they are not restricted to a provider participating in Heritage Health but they must use a Medicaid enrolled provider.

005.04(A) SERVICES COVERED UNDER FAMILY PLANNING. 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. The health plan must reimburse treatment for sexually transmitted infections in the same manner as family planning services, without referral or authorizations.

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

005.05 EMERGENCY SERVICES. Approval by the member's primary care provider and health plan is not required for receipt of emergency services. The health plan and enrollment broker must inform Heritage Health members that approval of emergency services is not required and must educate members regarding the definition of an "emergency medical condition," and how to appropriately access emergency services.

005.05(A) EMERGENCY SERVICES PROVIDED TO MANAGED CARE MEMBERS. 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.

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

005.06 FEDERALLY QUALIFIED HEALTH CENTERS. The health plan must contract with any federally qualified health center located within the designated coverage area or otherwise arrange for the provision of federally qualified health center services.

(A) If a health plan reimburses a federally qualified health center on a fee-for-service basis, it cannot pay less for those services than it pays other providers.
(B) Federally qualified health center's electing to be reimbursed on a negotiated risk basis are not entitled to reasonable cost reimbursement. If the federally qualified health center requests reasonable cost reimbursement, the health plan must reimburse the federally qualified health center at the same rate it reimburses its other subcontractors of this provider type.
(C) The health plans must report to the Department the total amount paid to each federally qualified health center.
(D) Federally qualified health center payments include direct payments to a medical provider who is employed by the federally qualified health center.
(E) The same reasonable efforts that are applied to the federally qualified health center, apply to rural health clinics and tribal clinics.

006. PAYMENT FOR SERVICES. The Department pays a monthly capitation fee health plan for each enrolled member for each month of Heritage Health coverage (per member per month). The monthly capitation fee includes payment for all services in the core benefits package.

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

006.02 PAYMENT IN FULL. Payment to the health plan is payment in full for all services included in the core benefits package. The health plan shall not request additional payment from the Department or the member.

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

006.04 INCORRECT PAYMENTS. Medicaid shall not normally recoup payments from health plans. However, in situations where payments are made incorrectly, Medicaid shall work with the health plan to identify the discrepancy and shall recoup/reconcile such payments.

006.05 ENROLLMENT REPORT. On or before the first day of each month, the Department or the enrollment broker will provide to each health plan a monthly enrollment report that lists all enrolled and disenrolled members for the that month. This report will be used as the basis for the monthly capitation payments to the health plan. The health plan is responsible for payment of all services in the core benefits package provided to members listed on the enrollment report generated for the month of coverage. If an enrollment report does not list an eligible member, the Department will be responsible for all medical expenses.

006.06 COVERAGE FOR PREGNANT WOMEN, NEWBORNS, AND 599 CHIP. Coverage for pregnant women, newborns, and 599 CHIP is provided within the following parameters:

(A) Pregnant Woman and Newborn are Medicaid Eligible: Coverage is provided for the pregnant woman from the month of enrollment until disenrollment occurs; and for the newborn from the month of birth until disenrollment occurs. Payment to the health plan is made for the month(s) of enrollment for the pregnant woman and the newborn until disenrollment occurs.

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

(C) 599 CHIP: Coverage is provided for the unborn child of the pregnant woman that is otherwise ineligible for Medicaid under 599 CHIP. Coverage is limited to prenatal care and pregnancy-related services solely for the unborn child. This coverage does not include postpartum care and medical issues separate to the mother and unrelated to the pregnancy.

006.07 BILLING THE MEMBER. The health plan may not bill a member for a Medicaid coverable service, regardless of the circumstances. The provider may only bill the member pursuant to Title 471 NAC.

006.07(A) OUT-OF-NETWORK. The health plan may or may not be responsible for an out-of-network service if the service is a Medicaid-coverable service. The agreement the health plan has with the provider will determine whether the health plan is responsible to pay the provider. In some cases, the plan may not pay the provider. The health plan is not required to pay a non-Medicaid enrolled provider for a Medicaid-covered service.

006.08 REINVESTMENT AND FORFEITED FUNDS. The health plan must provide for the reinvestment of profits in excess of the contracted amount, performance contingencies imposed by the department, and any unearned (forfeited) hold back funds, pursuant to Neb. Rev. Stat. § 71-831, and any successor statutes. The health plan must establish and manage two accounts: a hold back account and a reinvestment account. Both accounts must be separate from other accounts. Neither accounts can have risk-bearing investments. Both accounts must be created and operated in full compliance with the Nebraska Uniform Trust Code (Neb. Rev. Stat. § 30-3801 to 30-38110).

006.09 QUALITY PERFORMANCE PROGRAM AND HOLD BACKS. The health plan must participate in the Departments quality performance program. The quality performance program must be in accordance with Neb. Rev. Stat. § 71-831 and any successor statutes. Pursuant to Neb. Rev. Stat. § 71-831, and any successor statutes, the health plans must hold back a pre-determined amount in a separate account. The hold back is the aggregate of all income and revenue earned by the health plans and related parties under the contract and constitutes the maximum amount available to the health plan to earn via the quality performance program. The health plans must report its performance measures that affect its eligibility to earn the hold back funds, as the Department requires.

(A) Each year of the contract constitutes a performance year, beginning on the contract start date. The Department will assess the health plan performance based on the measures annually and notify the health plan of the amount of the earned hold back and unearned (forfeited) hold back. The Department will make this determination within six (6) months after the end of each contract year.
(B) All earned hold back funds become the property of the health plan.
(C) The health plan must deposit unearned (forfeited) hold back funds into the reinvestment account. The Department will reimburse the Federal share of the forfeited funds to the Centers for Medicare and Medicaid Services. The remaining State share of the forfeited hold back funds will become the property of the Department.
(D) No interest will be due to either party on hold back funds retained by the health plan or returned to the Department.
(E) Any earned hold back will not be included in the health plan's income for the year nor considered part of the medical loss ratio calculation.

006.10 HOLD BACKS, PENALTIES, AND LIQUIDATED DAMAGES. A percentage of the aggregate of all income and revenue the health plan and related parties under the contract earn must be at risk as a penalty if the health plan fails to meet minimum performance metrics, pursuant to Neb. Rev. Stat. §71-831 and any successor statutes. The Department will provide the minimum performance metrics to the health plans prior to year two (2) of the contract. The health plans must report its performance on the minimum performance metrics, as the Department requires.

(A) The Department reserves the right to modify annually the measures and criteria for earning the hold back funds and assessing liquidated damages.
(B) In the event the Department modifies the measures or criteria, the Department will provide the health plans sixty (60) calendar days advance written notice. These measures will include operational or administrative measures that reflect the health plans' business processes and may lead to improved access to and quality of care, Centers for Medicare and Medicaid Services Medicaid Adult and Child Core Measure

sets, healthcare effectiveness data and information set measures, and Departmental-identified measures that represent opportunities for improvement as indicated by Heritage Health historical performance.

006.11 DEPARTMENTAL RESPONSIBILITIES. The Department will ensure the following:

(A) The annual financial reporting package, including the medical loss ratio rebate calculation, risk corridor calculation, and earned/unearned hold back calculation is reviewed, and written approval is provided, within forty-five (45) calendar days after receipt from the health plan.

(B) The health plan will transfer all funds deposited into the reinvestment holding account to the State by the health plan for reconciliation and reimbursement of the Federal share via reporting on Centers for Medicare and Medicaid Services Form 64.

(C) The federal share of such dollars is determined and reimbursed to the federal government.

(D) The remaining State share will return to the health plan for deposit into the reinvestment distribution account, which the health plan manages, subject to contractual requirements.

(E) The Department will hold the health plan responsible and accountable for the necessary fiduciary duties and functions required to administer the reinvestment holding and reinvestment distribution accounts. Oversight of the financial accounting will be in accordance with the financial management reporting requirements.

4-000 THE PHYSICAL HEALTH MANAGED CARE BASIC BENEFITS PACKAGE

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

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

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

4-002.01 Types of PCP Providers: To participate in the Physical Health Managed Care program, a PCP must be a Medical Doctor (MD) or Doctor of Osteopathy (DO) whose specialty is in Family Practice, General Practice, Pediatrics, Internal Medicine, Obstetrics/Gynecology, or Advanced Practice Nurses (APNs), or Physician Assistants (when practicing under the supervision of a physician specializing in Family Practice, General Medicine ,Internal Medicine, Pediatrics, or Obstetrics/Gynecology).
For approved Graduate Medical Education (GME) programs, the resident or intern may be assigned as the PCP.

4-002.01A Designated Specialty Care Physicians: Managed Care allows for the designation of appropriate specialists to function in an extended capacity with the PCP for clients with chronic conditions requiring specialty care.

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

The designated specialty care physician must have enhanced responsibilities for clients with special health care needs designated upon review and concurrence of the specialist and the health plan. The designation of the specialty care physician allows for greater continuity of care between the PCP and specialty care physician, such as open referrals, shared PCP responsibilities, etc.

~~4-002.02 Limit on Number of Enrollees: A PCP is allowed to care for no more than 1500 Medicaid clients. This allowable limit is referred to as PCP "slots." PCP limitations will be maintained in the Department's Provider Network File.~~

4-002.03 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 use disorder (MH/SU), 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 behavioral health services provider as frequently as necessary based on the client's needs.

   Note: Many 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 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 behavioral health). The health plan must ensure the PCP is knowledgeable about the 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 upon receipt of the information and activate the assignment the first of the next month possible, given system cutoff. The client can change 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 4-002.04A);
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 482-000-8, 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., 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;

15. ~~The health plan is prohibited from refusing enrollment of a client, disenrolling a client or otherwise discriminating against a client solely on the basis of age, sex, race, physical or mental handicap, national origin, or type of illness or condition;~~
16. ~~Require that all subcontractors meet the same requirements as are in effect for the health plan that are appropriate to the service or activity delegated under the subcontract;~~
17. ~~Provide Member services;~~
18. ~~Maintain, at all times, an appropriate certificate of authority to operate issued by the Nebraska Department of Insurance;~~
19. ~~Provide for a Physician Incentive Program (PIP) only if:~~
    a. ~~No specific payment is made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to a client;~~
    b. ~~The health plan provides PIP information to any Medicaid client, upon request, including a statement on its marketing materials disclosing the client's right to adequate and timely information to related physician incentives;~~
    c. ~~The health plan does not have PIPs placing a physician or physician group at substantial financial risk for the cost of services; and~~
    d. ~~Where appropriate, the physician or physician group provides adequate stop-loss protection to the individual physicians.~~
20. ~~Comply with all applicable state and federal regulations, such as the prohibition against assisted suicide; inappropriate use of funds/profits, lack of mental health parity, and the noncompliance with the provisions of the Hyde Amendment;~~
21. ~~Prohibit discrimination against providers based upon licensing;~~
22. ~~Prohibit hiring, employing, contracting with or otherwise conducting business with individuals or entities barred from participation in Medicaid or Medicare;~~
23. ~~Ensure adequate numbers of providers in its network to meet the needs of its members;~~
24. ~~Ensure that PCPs inform clients about all treatment options, regardless of cost or whether such services are covered by the health plan, and that health care professionals are not prohibited or otherwise restricted from advising clients about their health status, medical care, or treatment regardless of benefit coverage if the professional is acting within his/her scope of practice. This does~~

~~not require a health plan to cover counseling or referral if it objects on moral or religious grounds and makes available information regarding policies to clients who are enrolled with the health plan, or who may enroll with the health plan, within ninety days of a policy change regarding such counseling or referral services;~~

25. ~~Provide written notice to the client of any adverse action regarding the provision of services that complies with all federal and state requirements. Allow clients to appeal decisions to deny, limit or terminate authorization, coverage, or payment of services. Clients must be allowed to file complaints, grievances and appeals, according to 482 NAC 7-000;~~
26. ~~Comply with the Maternity and Mental Health Requirements in the Health Insurance Portability and Accountability Act (HIPPA) of 1996 the maternity length of stay and mental health parity requirements specifically requiring~~

~~coverage for a hospital stay following a normal vaginal delivery not be limited to less than forty-eight hours for both the mother and newborn child, and the health coverage for a hospital stay in connection with childbirth following a cesarean section not be limited to less than ninety-six hours for both the mother and newborn child;~~

27. ~~Provide assurances that any amount expended for home health care services be provided with the appropriate surety bond;~~
28. ~~Report all fraud and abuse information to the Department;~~
29. ~~Comply with the provisions of 482 NAC 4-003.04 for provider payments;~~
30. ~~Sign a contract with the Department and comply with all contract requirements and any other responsibilities specified by the Department in the overall operation of Managed Care, and any other activities deemed appropriate by the Department and supported in regulations and/or contractual amendments; and~~
31. ~~Comply with all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and Balanced Budget Act of 1997.~~
32. ~~Assign the PCP for clients who do not voluntarily enroll within one (1) month of the effective date of enrollment for initial and re-enrollments and within fifteen days (15) days for the Interim PCP assignment.~~

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

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

~~At a minimum, efforts must include:~~

1. ~~HEALTH CHECK (EPSDT) Screening: The health plan must provide HEALTH CHECK (EPSDT) services according to 471 NAC Chapter 33-000.~~
    a. ~~The health plan must outreach to HEALTH CHECK (EPSDT) eligible children who need to be scheduled for HEALTH CHECK (EPSDT) examinations. Targeted groups are -~~
        (1) ~~Newly Medicaid-eligible and other children who have not had a timely HEALTH CHECK (EPSDT) examination;~~
        (2) ~~Children who have been identified as not having ever been screened or not having received HEALTH CHECK (EPSDT) services within established timelines based on the periodicity schedule; and~~
        (3) ~~Children from birth to the second birthday, that may need immunizations, lead level testing, developmental testing and hearing testing.~~

b. The health plan must contact the client regarding -
(1) Screening appointments missed without cancellation to determine the barriers to care, to assist in rescheduling the appointment, and to counsel the family about keeping appointments; and
(2) Screening results from a referral for treatment and the client who does not follow up with treatment services as identified by the health plan.

c. The health plan may assist the PCP to establish a notification system for HEALTH CHECK (EPSDT) examinations. The notification system may be provided through phone calls or mailings; and

d. The health plan must use continuous quality improvement methods to achieve a performance goal of HEALTH CHECK (EPSDT) screens at the recommended participation rate.

2. Screening exams (including vision and hearing, medical and referral for dental) are to be provided according to the periodicity schedule. The minimum schedule of health screening examinations is the "Recommendations for Preventive Pediatric Health Care" published by the Bright Futures/American Academy of Pediatrics.

3. The health plan is responsible for the administration of immunizations per the standardized Periodicity and Immunization Schedules. All PCPs, as appropriate, must participate in the Vaccines for Children (VFC) program to provide childhood immunizations to Medicaid eligible children. The requirements of the VFC program administered will be reported with the appropriate procedure code and modifier to identify them as VFC vaccine immunizations. Vaccine not available through the VFC program, but recommended and published by the Advisory Committee on Immunization Practices (ACIP) or the American Academy of Pediatrics must be provided and reimbursed by the health plan to the PCP.

4. The health plan must take a proactive approach to ensure clients obtain HEALTH CHECK (EPSDT) screening services and medically necessary diagnosis and treatment services. A proactive approach includes:
a. Written notification and phone protocols for upcoming or missed appointments;
b. Protocols for conducting outreach with non-compliant members;
c. Case Management to children with special health needs, e.g., children in foster care, pregnant adolescents; and
d. Referrals to public health agencies for environmental assessments and caregiver education services for children with lead poisoning.

5. Medically necessary treatment will be provided according to 471 NAC 33-000; e.g., diagnosis and treatment, covered by Medicaid, federally defined and medically necessary, to treat, prevent or ameliorate a condition; to promote growth and development; to attain or maintain functional status; or prevent deterioration. Treatment services also include rehabilitative and habilitative services for HEALTH CHECK (EPSDT) eligible children. The health plan must provide information and referral in addressing social, educational, and other health needs as requested.

6. Using pediatric specialists for children where the need for pediatric specialty care is significantly different from the need for adult specialists, e.g., pediatric cardiologist for children with congenital heart defects.

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

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

The health plan shall coordinate benefits in accordance with 42 CFR 133.135 et seq and 471 NAC 3-004, so that costs for services otherwise payable by the health plan are cost avoided or recovered from a liable party. The two methods used are cost avoidance and post-payment recovery.

4-003.04 Provider Payments: The following provisions apply:

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

provider and health plan agree to a capitated payment schedule or other arrangement.

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

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

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

~~90 days of the date of receipt. The health plan must pay all other claims within 12 months of the date of receipt.~~

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

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

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

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

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

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

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

1. ~~All of the reasons for the denial of the claim;~~
2. ~~The date the service was rendered, the type of service rendered, the name of the provider who rendered the service and the name of the person to whom the service was rendered; and~~
3. ~~The address of the office responsible for handling the claim, and means by which the office may be contacted without toll charges~~

exceeding the charges that otherwise apply for the provider or member to place a call in his/her areas code.

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

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

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

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

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

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

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

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

4-003.04A10 Use of Intermediaries: A health plan's use of subcontractors to perform one or more of the health plan's claims handling functions must not in

any way mitigate the health plan's responsibility to comply with all of the terms of 482 NAC.

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

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

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

1. Be submitted on a monthly basis;
2. Be submitted accurately and meet the Departmental standard of 95% compliance rate;
3. Include all clean claims adjudicated by the MCO; and

4. Include all services provided to the Managed Care client, contracted or delegated.

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

4-004 BASIC BENEFITS PACKAGE GENERAL PROVISIONS: All services provided under physical health managed care must meet the requirements of 471 NAC unless specifically waived by the Department. The MCO's physical health plan (health plan) must apply the same guidelines for determining coverage of services for the Managed 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 (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 (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);
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/DD 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. Behavioral health services (see 471 NAC 20-000, 32-000, and 35-000);
8. Dental services (see 471 NAC 6-000);
9. 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 or 480 NAC). 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 infections (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 Behavioral Health Plan Coordination Issues: The following rules apply when coordination of services is required between the Physical Health Plan responsible for the Basic Benefits Package and the Behavioral Health Plan responsible for the Behavioral Health Benefits Package, 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 Medicaid on a fee-for-service basis.

4-004.05A Emergency and Post-Stabilization Services for Behavioral Health Services: Emergency room services provided to a client who is enrolled in the Behavioral Health component of Managed Care is the responsibility of the client's Behavioral Health Plan.

The Behavioral Health Plan is no longer responsible for the service at the time that an attending emergency physician or the provider currently treating the client initiates an evaluation and/or treatment of the client and determines that the services are medical. Coverage for services from that point forward must be obtained from the Physical Health Plan.

4-004.05B Admissions for 24-Hour Observation: When a Managed Care client is admitted to an acute care facility as an outpatient for 24-hour observation for purposes of a behavioral health diagnosis, the Behavioral Health Plan is responsible for authorization of the observation stay.

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

4-004.05C Chemical Detoxification Services: Coverage for 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.

4-004.05D History and Physical (H&P) Exams for Inpatient Admissions for Behavioral Health Services: The H&P completed for an inpatient admission for behavioral health services are the responsibility of the Physical Health Plan. The physician completing the H & P must obtain authorization from the Physical Health Plan.

Inpatient behavioral health services provided to clients participating in the behavioral health component of Managed Care in a freestanding or hospital-based psychiatric residential treatment facility (PRTF) or therapeutic group home (ThGH) are the responsibility of the Behavioral Health Plan. The History & Physical provided to Managed Care clients for these allowable services are the responsibility of the Physical Health Plan.

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

4-004.05F Injections Associated with Behavioral Health Services: Injections of psychotropic drugs in an outpatient setting are the responsibility of the Behavioral Health Plan.

4-004.05G Lab, X-Ray and Anesthesiology Associated with 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.

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.

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

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

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

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

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

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

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

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

~~is made for the month(s) of enrollment for the pregnant woman and the newborn until disenrollment occurs.~~

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

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

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

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

TITLE 482 MANAGED CARE

CHAPTER 5 THE DENTAL BENEFITS PACKAGE

001. SCOPE AND AUTHORITY. These regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901 et seq (the Medical Assistance Act).

001.01 INTRODUCTION. This chapter sets forth the responsibilities of the Dental Benefits Manager, a Prepaid Ambulatory Health Plan, in delivering the dental benefits package to their managed care members. While the provider is responsible for providing services to the member, the Dental Benefits Manager, as the contracting entity with the Department, assumes primary administrative and operational responsibility for the development and implementation of the managed care requirements. In developing its program for the delivery of the dental benefits package, the Dental Benefits Manager must incorporate the information contained in this Title, as well as 471 Nebraska Administrative Code (NAC) 6, which defines in detail the minimum service provisions required for dental services under Nebraska Medicaid.

002. DENTAL BENEFITS PLAN. Medicaid managed care delivers the dental benefits package to Medicaid members through a Prepaid Ambulatory Health Plan. The following provisions describe the Dental Benefits Manager's responsibilities in Managed Care.

002.01 GENERAL REQUIREMENTS. The Dental Benefits Manager is responsible for establishing a statewide system of dental services. The Dental Benefits Manager is required to comply with, but is not limited to, the following general requirements:

(A) Credential only providers enrolled in Nebraska Medicaid;
(B) Provide a full array of services along a continuum of care in accordance with 471 NAC 6;
(C) Provide access to dental services and necessary referrals twenty-four (24) hours per day, seven (7) days per week;
(D) Provide a client handbook, a comprehensive list of providers, and other informational materials about the dental benefits package to its members. The Dental Benefits Manager must not perform any direct solicitation to individual Medicaid members. The Department must approve any general marketing to Medicaid members prior to use and must comply with applicable marketing guidelines.
(E) Comply with Medicaid's continuous Quality Assessment and Performance Improvement, provide dental services meeting Medicaid's quality standards, and comply with all requests for reports and data to ensure that the Quality Assessment and Performance Improvement requirements are met (See 482 NAC 6);

(F) Coordinate activities with Medicaid, other managed care contractors, and other providers for services, as appropriate, to meet the needs of the member, and ensure systems are in place to promote well-managed patient care;
(G) Maintain, at all times, an appropriate certificate of authority to operate issued by the Nebraska Department of Insurance;
(H) Prohibit hiring, employing, contracting with or otherwise conducting business with individuals or entities barred from participation in Medicaid or Medicare;
(I) Allow members with chronic, severe conditions, or experience-sensitive conditions to go directly to a qualified provider within the Dental Benefits Manager's network;
(J) Report all fraud and abuse information to Medicaid in a timely manner; and
(K) Make available twenty-four (24) hour, seven (7) days per week access by telephone to a live voice (an employee of the plan or an answering service) so that referrals can be made for non-emergency services or so information can be given about accessing services or how to handle medical problems during non-office hours.

003. DENTAL BENEFITS PACKAGE GENERAL PROVISION. All services provided under managed care must meet the requirements of 471 NAC unless specifically waived by the Department.

003.01 GUIDELINES. The provider and Dental Benefits Manager must apply the same guidelines for determining coverage of services for the managed care member as Medicaid applies to non-managed care members.
(A) Actual provision of a service included in the dental benefits package must be based on whether the service could have been covered by Nebraska Medicaid on a fee-for-service basis under Title 471 NAC.
(B) All services in the dental benefits package must be provided or approved by the Dental Benefits Manager.

004. SERVICES IN THE DENTAL BENEFITS PACKAGE. The Dental Benefits Manager must provide the services listed in the Nebraska Medicaid Dental Fee Schedule in amount, duration and scope defined by Medicaid in 471 NAC 6.

004.01 DENTAL BENEFITS MANAGER AND ACCESS STANDARDS. The Dental Benefits Manager is responsible for ensuring the member has access to all services when medically necessary.

004.01 (A) ACCESSIBILITY. The Dental Benefits Manager must ensure services provided to the member are accessible, in terms of timeliness, amount, duration, and scope, as those services provided to the non-managed care member.

004.01(B) LIMITATIONS. The Dental Benefits Manager may place appropriate limits on services based on medical necessity or utilization control.

004.01(C) ADDITIONAL AND SUBSTITUTE SERVICES. The Dental Benefits Manager is allowed to provide additional medically necessary services than those covered by Medicaid. The Dental Benefits Manager is also allowed to provide substitute dental services when the Dental Benefits Manager determines the service is more cost effective

than the covered service and the health status of the member is expected to improve or stabilize.

(i) If the Dental Benefits Manager provides additional or substitute dental services, the Department will not adjust the rate or total payment to the Dental Benefits Manager as the contract between the two parties dictate. The rate will remain within the rate range that the Centers for Medicare and Medicaid Services approved and certified.

005. SERVICES FOR EMERGENCY MEDICAL CONDITIONS. Prior approval by the member's Dental Benefits Manager is not required for receipt of emergency dental services.

005.01 EMERGENCY SERVICES PROVIDED. The Dental Benefits Manager must cover and pay for emergency dental services regardless of whether the provider that furnishes the services participates in the Dental Benefits Manager network.

006. COORDINATION OF SERVICES. The following rules apply when coordination of services is required between the physical health plan responsible for the core benefits package and the Dental Benefits Manager responsible for the dental benefits package, as addressed by the Department in regulations governing both components of managed care. In situations where the individual is only a member of a health plan or the Dental Benefits Manager, but not both, the payment of the associated service is coordinated with the Department on a fee-for-service basis.

006.01 INPATIENT CARE AND SERVICES. The member's Heritage Health plan will be responsible for reimbursing all inpatient services. The Dental Benefits Manager will not be responsible for reimbursing any inpatient or related services.

006.02 ANESTHESIOLOGY ASSOCIATED WITH DENTAL SERVICES. Anesthesiology services associated with dental services, authorized by the Dental Benefits Manager, are the responsibility of the Heritage Health plan if the member is also a member of a health plan.

007. FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS. The Dental Benefits Manager must offer to contract with all Federally Qualified Health Centers and Rural Health Clinics in the State.

007.01 NOTIFICATION TO THE DEPARTMENT. If the Dental Benefits Manager and a Federally Qualified Health Center or Rural Health Clinic cannot agree upon a contract, the Dental Benefits Manager must notify the Department.

008. INDIAN HEALTH PROTECTIONS. The Dental Benefits Manager must reimburse Indian Health Services, Tribal 638, and Urban Indian Health providers, whether participating in the network, payment for covered services provided to Indian members who are eligible to receive services from these providers.

009. PAYMENT FOR SERVICES. The Department pays the Dental Benefits Manager a capitated payment for the services it provides. The Department pays a monthly capitation fee to the Dental Benefits Manager for each enrolled member. The monthly capitation fee includes payment for all services in the dental benefits package.

009.01 CAPITATION RATES. The capitation payment rates are actuarially determined and are based on the member's age. The Department may adjust rates when it is determined appropriate.

009.02 PAYMENT IN FULL. Payment to the Dental Benefits Manager is payment in full for all services included in the dental benefits package. The Dental Benefits Manager must not request additional payment from the Department or a member.

009.02(A) BILLING THE CLIENT. The Dental Benefits Manager must not bill a member for a coverable service, regardless of circumstances. A provider of a service may only bill the client pursuant to 471 NAC.

009.03 RECOUPMENTS AND RECONCILIATION. When the Department incorrectly makes a payment to the Dental Benefits Manager, the Department must recoup those payments from the Dental Benefits Manager. The Dental Benefits Manager must work with the Department to identify the discrepancy and must allow the Department to recoup and reconcile such payments.

5-000 THE BEHAVIORAL HEALTH BENEFITS PACKAGE

5-001 INTRODUCTION: 482 NAC 5-000 sets forth the responsibilities of the Behavioral Health Managed Care Organization (behavioral health plan) in delivering the Behavioral Health Benefits Package to the managed care client. While the provider is responsible for providing services to the client, the behavioral health plan, as the contracting entity with Medicaid, assumes primary administrative and operational responsibility for the development and implementation of the managed care requirements. In developing its program for the delivery of the Behavioral Health Benefits Package, the behavioral health plan shall incorporate the information contained in this Title, as well as 471 NAC, which defines in detail the minimum service provisions required for behavioral health services under Nebraska Medicaid.

5-002 BEHAVIORAL HEALTH MANAGED CARE PLAN: Medicaid managed care delivers the Behavioral Health Benefits Package to Medicaid clients through a Prepaid Inpatient Health Plan (PIHP). The following provisions describe the behavioral health plan's responsibilities in Managed Care.

5-002.01 General Requirements: The Behavioral Health Managed Care Plan (behavioral health plan) is responsible for establishing a statewide system of behavioral health services. The behavioral health plan is required to comply with, but is not limited to, the following general requirements:

1. Credential only providers enrolled in Nebraska Medicaid;
2. Provide a full array of services along a continuum of care in accordance with 471 NAC 20, 32, and 35 including active treatment;
3. Provide access to behavioral health services and necessary referrals 24 hours per day, 7 days per week;
4. Provide a client handbook, a comprehensive list of providers, and other informational materials about the Behavioral Health Benefits Package to the clients enrolled with the behavioral health plan. The plan is prohibited from performing any direct solicitation to individual Medicaid clients. Any general marketing to Medicaid clients must be approved by Medicaid prior to implementation and shall comply with the 482-000-9 marketing guidelines.
5. Comply with Medicaid's continuous Quality Assurance/Quality Improvement activities, provide behavioral health services meeting Medicaid's quality standards, and comply with all requests for reports and data to ensure that QA/QI performance measures are met (See 482 NAC 6);
6. Coordinate activities with Medicaid, other managed care contractors, and other providers for services, as appropriate, to meet the needs of the client, and ensure systems are in place to promote well-managed patient care;

7. Maintain, at all times, an appropriate certificate of authority to operate issued by the Nebraska Department of Insurance;
8. Prohibit discrimination against behavioral health providers based upon licensing;
9. Prohibit hiring, employing, contracting with or otherwise conducting business with individuals or entities barred from participation in Medicaid or Medicare;
10. Allow clients with chronic or severe conditions or experience-sensitive conditions, e.g., HIV-AIDS, to go directly to a qualified provider within the behavioral health plan's network;
11. Report all fraud and abuse information to Medicaid in a timely manner; and
12. Make available 24-hour, 7 days per week access by telephone to a live voice (an employee of the plan or an answering service) so that referrals can be made for non-emergency services or so information can be given about accessing services or how to handle medical problems during non-off ice hours.

5-003 BEHAVIORAL HEALTH BENEFITS PACKAGE GENERAL PROVISIONS: All services provided under managed care must meet the requirements of 471 NAC unless specifically waived by Medicaid. The provider and behavioral health plan shall apply the same guidelines for determining coverage of services for the managed care client as Medicaid applies for other Medicaid clients. Actual provision of a service included in the Behavioral Health Benefits Package must be based on whether the service could have been covered under Nebraska Medicaid on a fee-for-service basis under Title 471 NAC.

All services in the Behavioral Health Benefits Package must be provided or approved by the behavioral health plan.

5-004 SERVICES IN THE BEHAVIORAL HEALTH BENEFITS PACKAGE

1. Crisis Stabilization Services (see 471 NAC 20 and 32)
   a. Crisis Assessment;
   b. Sub-acute Hospital - Adults age 19 & over;

2. Acute Inpatient Hospital (see 471 NAC 20 and 32);

3. Residential Services (see 471 NAC 20 and 32)
   a. Psychiatric Residential Treatment Facility (PRTF) - Children under age 19
   b. Therapeutic Group Home (ThGH) - Children under age 19;
   c. Professional Resource Family Care (PRFC) - Children under age 19;
   d. Dual Disorder Residential - Adults age 19 & over;
   e. Intermediate Residential for substance abuse - Adults age 19 & over;
   f. Short-Term Residential - Adults age 19 & over;
   g. Halfway House - Adults age 19 & over;
   h. Therapeutic Community for substance abuse only - Adults age 19 & over;
   i. Community Support for substance abuse - Adults age 19 & over;

4. Outpatient Assessment and Treatment (see 471 NAC 20 and 32):
   a. Partial Hospitalization;
   b. Day Treatment-Children under age 19;
   c. Day Treatment for mental health-Adults age 19 & over;
   d. Intensive Outpatient for mental health-Children under age 19;
   e. Intensive Outpatient for substance abuse;
   f. Medication Management;
   g. Outpatient (Individual, Family, Group);
   h. Injectable Psychotropic Medications;
   i. Substance use disorder Assessment;
   j. Psychological Evaluation and Testing;
   k. Initial Diagnostic Interviews;
   l. Home-based Multi-Systemic Therapy - Children under age 19;
   m. Biopsychosocial Assessment and Addendum;
   n. Sex Offender Risk Assessment - Children under age 19;
   o. Community Treatment Aide (CTA) - Children under age 19;
   p. Client Assistant Program (CAP);
   q. Comprehensive Child and Adolescent Assessment (CCAA) - Children under age 19;
   r. Comprehensive Child and Adolescent Assessment Addendum - Children under age 19;
   s. Conferences with family or other responsible persons - Children under age 19;
   t. Hospital Observation Room Services (23:59);
   u. Social Detox - Adults age 19 & over;
   v. Electroconvulsive Therapy (ECT) - Adults age 19 & over;
   w. Crisis Outpatient Services - Adults age 19 & over;
   x. Ambulatory Detoxification - Adults age 19 & over;
   y. Psychiatric nursing (in home) - Adults age 19 & over;

5. Medicaid Rehabilitation Option (MRO) (see 471 NAC 35):
   a. Psychiatric Residential Rehabilitation;
   b. Secure Residential Rehabilitation;
   c. Assertive Community Treatment (ACT) and Alternative ACT (Alt. ACT);
   d. Community Support (MH);
   e. Day Rehabilitation; and

6. Support Services:
   a. Interpreter Services for behavioral health services;
   b. Telehealth Transmission.

The services above represent covered services under Medicaid. The behavioral health plan is responsible for working with Medicaid to ensure the client has access to all services when medically necessary. The behavioral health plan must also ensure that the services provided to the client are accessible (in terms of timeliness, amount, duration, and scope) as those services provided to the non-managed care client.

The behavioral health plan shall provide the above services in amount, duration and scope defined by Medicaid in 471 NAC. The behavioral health plan can place appropriate limits on the

above services based on medical necessity or utilization control. The behavioral health plan shall 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 behavioral health plan is allowed to provide medically necessary services to the clients that are in addition to those covered under Medicaid. The behavioral health plan is also allowed to provide substitute health services when the behavioral health plan has determined it to be more cost effective than the covered service and the health status of the client is expected to improve or stabilize. If additional or substitute health services are provided, the total payment to the behavioral health plan will not be adjusted but will remain within the certified rates agreed upon in any resulting contract and approved by Centers for Medicaid and Medicare Services.

5-005 SERVICES FOR EMERGENCY MEDICAL CONDITIONS: Prior approval by the client's behavioral health plan is not required for receipt of behavioral health emergency services.

5-005.01 Emergency Services Provided to Managed Care Clients: The behavioral health plan must cover and pay for behavioral health emergency services regardless of whether the provider that furnishes the services participates in the behavioral health plan network.

5-006 PHYSICAL HEALTH COORDINATION ISSUES: The following rules apply when coordination of services is required between the physical health plan responsible for the Basic Benefits Package and the behavioral health plan responsible for the Behavioral Health Benefits Package, as addressed by the Medicaid in regulations governing both components of managed care. In situations where the client isn't participating in both components of managed care, the associated service is coordinated with Nebraska Medicaid on a fee-for-service basis.

5-006.01 Emergency and Post Stabilization Services for Behavioral Health Services: Behavioral Health Emergency and post stabilization services provided to a managed care client are the responsibility of the client's behavioral health plan.

The behavioral health plan is no longer responsible for the service at the time that an attending emergency physician or the provider actually treating the client initiates an evaluation and/or treatment of the client and determines that the services are medical. Coverage for services from that point forward must be obtained from the physical health plan.

5-006.02 Admissions for 24-Hour Observation: When a managed care client is admitted to an acute care facility as an outpatient for 24-hour observation for purposes of a behavioral health diagnosis, the behavioral health plan is responsible for payment of the observation stay. Authorization for the admission must be obtained from the behavioral health plan.

The behavioral health plan is no longer responsible for the service at the time that an attending emergency physician or the provider actually treating the client initiates an evaluation and/or treatment of the client and determines that the client does not have a behavioral health diagnosis. Coverage for services from that point forward must be obtained from the physical health plan.

5-006.03 Chemical Detoxification Services: Coverage for chemical detoxification hospital admissions must be obtained from the physical health plan, if the client is participating in the physical health component of managed care.

5-006.04 History and Physical (H&P) Exams for Inpatient Admissions for Behavioral Health Services: The H&P completed for an inpatient admission for behavioral health services is the responsibility of the physical health plan. The physician completing the H&P must obtain authorization from the physical health plan.

Inpatient behavioral health services provided to clients participating in the behavioral health component of managed care in a freestanding or hospital-based Psychiatric Residential Treatment Facility (PRTF) or Therapeutic Group Home (ThGH) are the responsibility of the behavioral health plan. H&Ps provided to managed care clients for these allowable services are responsibility of the physical health plan.

5-006.05 Ambulance Services for Managed Care Clients Receiving Behavioral Health Treatment Services: Emergency medical transportation, regardless of diagnosis or condition, is the responsibility of the physical health plan.

5-006.06 Injections Associated with Behavioral Health Services: Injections of psychotropic drugs in an outpatient setting are the responsibility of the client's behavioral health plan.

5-006.07 Lab, X-Ray and Anesthesiology Associated with Behavioral Health Services: Lab, x-ray, and anesthesiology services associated with 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.

5-007 FEDERALLY QUALIFIED HEALTH CENTERS (FQHC): If behavioral health services are provided by the FQHC, the behavioral health plan shall contract with the FQHC or otherwise arrange for the provision of FQHC services.

5-008 PAYMENT FOR SERVICES: Payment of services provided to the behavioral health plan shall be a capitated payment. Medicaid pays a monthly capitation fee to the behavioral health plan for each enrolled client for each month of Managed Care enrollment. The monthly capitation fee includes payment for all services in the Behavioral Health Benefits Package.

The capitation payment rates are actuarially determined and are based on eligibility category and age. Medicaid shall adjust rates, and complete all necessary contract amendments, when it is determined appropriate, based on any program changes, or in instances where an error or omission in the calculation of the rates has been identified.

Payment to the MH/SA plan is payment in full for all services included in the Behavioral Health Benefits Package. No additional payment may be requested of Medicaid or the client.

5-008.01 Recoupments/Reconciliation: Medicaid shall not normally recoup payments from the behavioral health plan. However, in situations where payments are made incorrectly, Medicaid shall work with the behavioral health plan to identify the discrepancy and shall recoup/reconcile such payments.

5-009 BILLING THE CLIENT: The behavioral health plan may not bill a client for a Medicaid coverable service, regardless of the circumstances.

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

TITLE 482 NEBRASKA MEDICAID MANAGED CARE

CHAPTER 6 QUALITY

001. SCOPE AND AUTHORITY. This chapter sets forth the requirements of the Nebraska Medicaid Managed Care Quality Strategy (See 480-000-10). This chapter also establishes the Department's expectation for each of the health plans and the dental plan (collectively referred to as plans), in effectively managing and monitoring the quality of care provided to members. In addition to abiding to all provisions in this chapter, the plans must abide by the provisions found in 42 Code of Federal Regulations (CFR) 438, Subpart D.

001.01 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT REQUIERMETN. The contract between the Department and each plan requires the plan to have an ongoing quality assessment and performance improvement program that Medicaid must approve.

001.02 EVALUATION REQUIERMENTS. The Department, its contracted entities or designees, or the Centers for Medicare and Medicaid Services officials may evaluate, through inspection or other means, the quality, appropriateness, and timeliness of services performed under managed care.

002. CONTINUOUS QUALITY ASSURANCE AND QUALITY IMPROVEMENT. The departments quality strategy includes continuous assessment of how well the managed care program is meeting the quality objectives, how , based on the results of the assessment activities, the Department will attempt to improve the quality of care delivered by the health plans (based on the results of the assessment activities), and how the Department reviews the effectiveness of the quality strategy and revises it accordingly.

003. SYSTEMS FOR ASSESSMENT. The Department has implemented systems for the ongoing assessment of the quality and appropriateness of care and services furnished to all Medicaid enrollees under the health plan contracts. These systems enable the Departments monitoring of data related to the access of Medicaid clients to comprehensive, cost-effective health services, including evidence-based care options that emphasize early intervention and community-based treatment and reduced rates of costly and avoidable emergency and inpatient hospital levels of care. Through the implementation of these assessment systems, the Department can monitor trends, demonstrate success and identify challenges in achieving the objectives of the Heritage Health program.

003.01 ASSESMENT. The Department assesses the quality and appropriateness of care through multiple processes that comprise a comprehensive system of oversight:

(A) Quarterly reporting of provider accessibility analyses, timely access standards monitoring, grievances and appeals process compliance, utilization management monitoring, results of service verification monitoring, out of network referrals monitoring and case management results.
(B) Annual reporting of Medicaid selected performance measure results and trends related to quality of care, service utilization and member and provider satisfaction.
(C) Annual reporting of performance improvement projects data and results.
(D) Annual, external independent reviews of the quality outcomes, timeliness of and access to, the services covered by the plan through its external quality review organization.
(E) Annual state-staff–conducted onsite operational reviews that include validation of reports and data previously submitted by the plan and in-depth review of areas that have been identified as potentially problematic.
(F) Medicaid requires the plan to attend annual Quality Management Committee meetings, during which data and information designed to analyze the objectives of the Quality Strategy are reviewed. The Quality Management Committee recommends actions to improve quality of care, access, utilization, and client satisfaction, and to review the results of the performance improvement projects and recommend future performance improvement projects topics. The Quality Management Committee also reviews the state's overall Quality Strategy and makes recommendations for improvement.

003.02 OPERATIONAL ON-SITE REVIEW. Operational reviews are conducted for each health plan annually by the Department. Additionally, random reviews of each health plan notification of adverse actions will be completed. The Department and other agencies may use the operational review to validate a plan's accreditation.

003.02(A) COMPONENTS OF THE OPERATIONAL REVIEWS. Operational reviews include, but are not limited to, an in-depth review of each health plan's quality management work plan, review of cultural competency, general administration, and delivery system.

003.03 EXTERNAL QUALITY REVIEW. The Department is required to contract with a qualified External Quality Review Organization to perform an annual external quality review for each contracting health plan. The External Quality Review Organization is independent from the Department and from the health plans.

003.03(A) EXTERNAL QUALITY REVIEW ORGANIZATION DUTIES. The External Quality Review Organization will annually:
(i) Validate performance improvement projects required by the Department that were underway during the preceding 12 months;
(ii) Validate the health plans performance measures reported to the Department during the preceding 12 months; and
(iii) Conduct a review to determine the health plans compliance with standards.

003.03(B) EXTERNAL QUALITY REVIEW ORGANIZATION RESULTS. The Department will use the results of the reviews in assessing and monitoring the quality and appropriateness of care provided to members as part of the Departments quality strategy.

003.04 DETERMINATION OF CONTRACT COMPLIANCE. The Department will monitor the health plans contract for compliance. A plan is noncompliant if it falls below the established standards for quality of care, access, client satisfaction, utilization, and encounter submission.

003.04(A) VIOLATIONS SUBJECT TO INTERMEDIATE SANCTIONS. The following violations are grounds for intermediate sanctions that may be imposed when a health plan acts or fails to act as follows:

(i) The health plan fails substantially to provide medically necessary services that the health plan is required to provide, under law or under its contract with the State, to an enrollee covered under the contract;
(ii) The health plan imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;
(iii) The health plan acts to discriminate among enrollees on the basis of their health status or need for health care services;
(iv) The health plan misrepresents or falsifies information that it furnishes to the Centers for Medicare and Medicaid Services or to the State;
(v) The health plan misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider;
(vi) The health plan fails to comply with the requirements for physician incentive plans, if applicable;
(vii) The health plan has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information; or
(viii) The health plan has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.

003.04(B) ENFORCEMENT. The health plans that are determined to be performing below quality standards through periodic reporting, performance measures, member satisfaction surveys, encounter data submission, on-site operational review, and/or review and analysis of the quality management work plan will be required to submit a plan of correction which addresses each deficiency specifically and provides a timeline by which corrective action will be completed. Medicaid requires follow-up reporting by the health plan to assess progress in implementing the plan of correction.

003.04(B)(i) ADDITIONAL ACTIONS. If the health plan has not come into compliance upon completion of the plan of correction, the Department will take additional actions against the health plan. These additional actions include:

(1) Instituting a restriction on the types of enrollees;
(2) Changing the auto assignment algorithm to limit the number of enrollees into the plan, when applicable; or
(3) Ban new auto-assignments to the plan, when applicable.

003.04(C) INTERMEDIATE SANCTIONS. The Department will impose the following sanctions for violations subject to intermediate sanctions listed in 482 NAC 6-003.04(A):

(i) Civil monetary penalties in the following specified amounts:
    (1) A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to members, potential members, or

health care providers; failure to comply with physician incentive plan requirements; or marketing violations;

(2) A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statement to the Centers for Medicare and Medicaid Services or the Department;

(3) A maximum of $15,000 for each recipient the Department determines was not enrolled because of a discriminatory practice, subject to the $100,000 overall limit;

(4) A maximum of $25,000 or double the amount of the excess charges, whichever is greater, for charging premiums or charges in excess of the amounts permitted under the Medicaid program. The Department must deduct from the penalty the amount of overcharge and return it to the affected client member.

(ii) Appointment of temporary management as described in Section III.Y Early Termination of the health plan's contract;

(iii) Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll;

(iv) Suspension of all new enrollment, including default enrollment, after the date of the effective date of the sanction; and

(v) Suspension of payment for members enrolled after the effective date of the sanction and until the Centers for Medicare and Medicaid Services or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to occur.

004. IMPROVEMENT. Based on the results of assessment and monitoring of quality and appropriateness of care and contract compliance, the Department will target improvement efforts.

004.01. INTERVENTIONS FOR IMPROVEMENT. The Department will utilize, but is not limited to the following interventions to improve the quality and appropriateness of care:

(A) Quality Committee: The Department has established a Quality Committee;

(B) Performance Improvement Projects: The health plans are required to conduct at least two clinical and one non-clinical projects annually. For each project, the Department with the Quality Management Committee will choose the topic, develop the study methodology and determine interventions to reach improvement goals. Each plan will conduct the same project, at least one will be a joint project with another plan (See 482-000-11);

(C) Quality Performance Dashboard: In an effort to monitor a health plans performance on quality measures, a quality performance dashboard was developed. The dashboard approach provides a framework for benchmarking performance and assists health plans to prioritize quality improvement planning. The dashboard gives a multi-dimensional view of a health plans performance by comparing quality measures to national standard measures, if appropriate, to baseline measures for the program, and over two years. The dashboard results will display on the Departments website; and

(D) Health plans sanctions-See 482 NAC 6-003.04(A).

005. QUALITY MANAGEMENT COMMITTEE. The Department has established a Quality Committee for Managed Care consisting of Department staff, Medicaid staff, Public Health staff, the health plans, providers, and other stakeholders.

006. ACCREDITATION. The Heritage Health plans must have National Committee for Quality Assurance Accreditation or another national accreditation for the Medicaid Managed Care plan. The dental plan must have National Committee for Quality Assurance Accreditation or URAC accreditation. The health plans must submit a copy of the accrediting body's letter indicating the most recent accreditation status at the time of initial contracting. The plans must submit any changes or updates to the Department within thirty (30) days of receipt.

006.01 SURVEY RESULTS. Upon survey by the accrediting body, the health plan must submit a copy of the survey results to the department within thirty (30) days of receipt. The health plan must submit a copy of any work plan that addresses improvements needed or follow-up necessary because of the survey. The plan must submit any changes or updates to the survey results or work plan to the Department within 30 days of receipt.

006.02 NON-ACCREDITATION In the event that a health plan is not accredited at the time of contracting, the health plan is required to submit to the Department, for approval, a plan to be fully accredited within the five year contracting period. The health plan must submit a work plan including the timeline to accomplish plan accreditation to the Department. The health plan must provide a status update to Departmental staff at the time of the annual on-site operational review.

6-000 QUALITY

6-001 OVERALL QUALITY STRATEGY: 482 NAC 6-000 sets forth the requirements of the Nebraska Health Connection (NHC) Quality Strategy (See 480-000-10). 482 NAC 6-000 also establishes the Department's expectation for each Managed Care Organization's (MCO's) physical health plan (health plan), in effectively managing and monitoring the quality of care provided to clients. In addition to abiding to all provisions in this chapter, the MCO's physical health plans must abide by the provisions found in 42 CFR 438, Subpart D.

The Department (DHHS) requires that each MCO physical health plan to have an ongoing quality assessment and performance improvement (QAPI) program. The QAPI program must be approved by DHHS. DHHS will provide oversight and monitoring of the health plans QAPI programs. The health plans' QAPI programs must contain, at a minimum:

1. Description of Quality Assurance (QA) Committee structure: The Medical Director must have responsibility for overseeing the QA committee's activities. The committee must meet regularly, no less than quarterly. Membership must include MCO network providers;
2. Designation of individuals/departments responsible for the QAPI program implementation: MCOs must designate a high-level manager with appropriate authority and expertise (such as the Medical Director or designee) to oversee the QAPI program implementation;
3. Description of network provider participation in the QAPI program: MCOs must involve network providers in QAPI activities. The mechanism for provider participation must be described in the written QAPI program, and providers must be informed of their right to provide input on MCO policies and procedures;
4. Credentialing/recredentialing procedures: MCOs must institute a credentialing process for their providers that includes, at minimum, obtaining and verifying information such as valid licenses; professional misconduct or malpractice actions; and confirming that providers have not been sanctioned by Medicaid, Medicare, or other State agencies;
5. Standards of care: MCOs must develop or adopt practice guidelines consistent with current standards of care and meet the requirements of 42 CFR 438.236;
6. Standards for service accessibility-MCOs must develop written standards for service accessibility, which meet the standards established by DHHS (See 482-000-11);
7. Medical records standards: The QAPI program must contain a description of the medical records standards adopted by the MCO;
8. Utilization review procedures: Utilization review policies and procedures must be in accordance with the requirements set forth in 471 NAC 2-002.01;
9. Quality indicator measures and clinical studies: The QAPI program must have mechanisms which measures and reports to DHHS its performance, using standards measures required by DHHS (See 482-000-11);
10. QAPI program documentation methods: The QAPI program must contain a description of the process by which all QAPI activities will be documented, including Performance Improvement Projects (PIP), medical record audits, utilization reviews, etc;

11. Integration of quality assurance with other management functions: To be effective, quality assurance must be integrated in all aspects of MCO management and operations. The QAPI program must describe the process by which this integration will be achieved; and
12. Corrective Action Plans: The QAPI program must contain a description of the provisions for making necessary changes through corrective action plans.
13. Health Information Systems: The QAPI program must maintain a health information system that is capable of the following:
    a. Collects data on client and provider characteristics specified by DHHS;
    b. Collects data on services furnished to clients through an encounter system (see 482 NAC 6-005 Submission of Encounter Data);
    c. Ensures that data received from providers is accurate and complete;
    d. Collects, analyzes, integrates, and reports data; and
    e. Evaluates the impact and effectiveness of the QAPI program.

Each MCO physical health plan must make all QAPI records, including its findings and data available to DHHS. While DHHS considers all information provided by the health plans subject to the Nebraska Public Records Act, DHHS will only provide information regarding the NHC in the aggregate.

DHHS, its contracted entities or designees, or the Centers for Medicare and Medicaid Services (CMS) officials may evaluate, through inspection or other means, the quality, appropriateness, and timeliness of services performed under the NHC.

6-002 CONTINUOUS QUALITY ASSURANCE/QUALITY IMPROVEMENT: DHHS's Quality Strategy includes continuous assessment of how well the managed care program is meeting the Quality objectives, how, based on the results of the assessment activities, DHHS will attempt to improve the quality of care delivered by the health plans, and how DHHS reviews the effectiveness of the Quality Strategy and revises it accordingly.

6-002.01 Purpose/Goal: The overall goal of the NHC's Quality Strategy is to continuously improve the quality of care and services provided to all clients enrolled in the NHC and to identify and act upon opportunities for improvement. The NHC will promote the delivery of health care services in accordance with required access standards, standard performance measures, established benchmarks, and comparisons in order to improve quality of care provided to clients.

6-002.02 Objectives: Quantifiable, performance driven objectives for demonstrating success or challenges in meeting the overall goal have been set using data that reflects health plan quality performance, access to covered services, and client satisfaction with care.

The objectives of the NHC's Quality Strategy for the Physical Health managed care include, but may not be limited to, improved access to quality care and services, improved client satisfaction, reducing racial and ethnic health disparities, and reduction/prevention of unnecessary/inappropriate utilization. (See 482-000-13)

6-002.03 Assessment: DHHS assesses and monitors the quality and appropriateness of care delivered to clients through the collection and analyses of data from many sources. The health plans are required to maintain Health Information Systems that collects, analyzes, integrates, and reports data. The health plans must also have information systems that collect data on client and provider characteristics and on services furnished to clients through an encounter data system.

DHHS will utilize, but is not limited to the following sources for assessment and monitoring of quality and appropriateness of care:

1. Quality of Care Reporting Requirements;
2. Access Standards Reporting Requirements;
3. Client Satisfaction Surveys;
4. Utilization Reporting Requirements;
5. Encounter Data;
6. External Quality Review-Technical Report;
7. Clinical Standard Guidelines;
8. On-site Operational Reviews; and
9. Performance Improvement Projects;

(See 482-000-11).

6-002.03A Operational On-site Review: Operational reviews are conducted for each MCO annually. The reviews are designed to supplement other DHHS monitoring activities by focusing on those aspects of health plan performance that cannot be fully monitored from reported data or documentation. The operational reviews focus on validating reports and data previously submitted by the MCO through a series of review techniques that include assessment of supporting documentation and conducting more in-depth review of areas that have been identified as potential problem areas.

Additionally, DHHS staff conduct random reviews of each MCO notification of adverse actions to ensure the MCO is notifying the client in a timely manner.

Furthermore, the operational review is used to validate the MCO's accreditation status, and to identify area of noteworthy performance and accomplishment.

Components of the operational reviews include, but are not limited to, an in-depth review of each MCO's Quality Management Work Plan, review of cultural competency, general administration, and delivery system.

6-002.03B External Quality Review (EQR): DHHS is required to contract with a qualified External Quality Review Organization (EQRO) to perform an annual external

~~quality review for each contracting MCO. The EQRO is independent from DHHS and from the MCOs. The EQRO must annually:~~

1. ~~Validate performance improvement projects required by DHHS that were underway during the preceding 12 months;~~
2. ~~Validate MCO performance measures reported to DHHS during the preceding 12 months; and~~
3. ~~Conduct a review to determine MCO compliance with standards.~~

~~The results of the EQRO reviews will be used in assessing and monitoring the quality and appropriateness of care provided to clients as part of DHHS's Quality Strategy.~~

~~6-002.04 Determination of Contract Compliance: DHHS has developed a comprehensive program to assess all aspects of MCO performance. The program involves routine analysis and monitoring of quality of care, reporting data, access standards data, and utilization data submitted by the MCOs; on-site operational reviews; analysis; analysis of client satisfaction data; and analysis of encounter data. DHHS also monitors compliance with submission of encounter data.~~

~~MCO's are considered out of compliance if they fall below the established standards for quality of care, access, client satisfaction, utilization, and encounter submission.~~

~~6-002.04A Violations Subject to Intermediate Sanctions: In addition, the following violations are grounds for intermediate sanctions that may be imposed when the MCO acts or fails to act as follows:~~

1. ~~The MCO fails substantially to provide medically necessary services that the MCO is required to provide, under law or under its contract with the State, to an enrollee covered under the contract;~~
2. ~~The MCO imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;~~
3. ~~The MCO acts to discriminate among enrollees on the basis of their health status or need for health care services;~~
4. ~~The MCO misrepresents or falsifies information that it furnishes to CMS or to the State;~~
5. ~~The MCO misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider;~~
6. ~~The MCO fails to comply with the requirements for physician incentive plans, if applicable;~~
7. ~~The MCO has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information; or~~

8. ~~The MCO has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.~~

6-002.04B Enforcement: MCO's that are determined to be performing below quality standards through periodic reporting, performance measures, client satisfaction surveys, encounter data submission, on-site operational review, and/or review and analysis of the Quality Management Work Plan will be required to submit a Plan of Correction (POC) which addresses each deficiency specifically and provides a timeline by which corrective action will be completed. Follow-up reporting is required by the MCO to assess progress in implementing the Plan of Correction.

If the MCO has not come into compliance upon completion of the POC, additional actions will be taken against the MCO. These additional actions include:

1. Instituting a restriction on the types of enrollees;
2. Changing the auto assignment algorithm to limit the number of enrollees into the plan; and/or
3. Ban new auto-assignments to the plan.

6-002.04C Intermediate Sanctions: DHHS will impose the following sanctions for violations subject to intermediate sanctions listed in 482 NAC 6-002.04A:

1. Civil monetary penalties in the following specified amounts:
   a. A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to clients, potential clients, or health care providers; failure to comply with physician incentive plan requirements; or marketing violations;
   b. A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statement to CMS or DHHS;
   c. A maximum of $15, 000 for each recipient DHHS determines was not enrolled because of a discriminatory practice, subject to the $100,000 overall limit;
   d. A maximum of $25,000 or double the amount of the excess charges, whichever is greater, for charging premiums or charges in excess of the amounts permitted under the Medicaid program. DHHS must deduct from the penalty the amount of overcharge and return it to the affected client.
2. Appointment of temporary management as described in Section III.Y of the MCO contract;
3. Granting clients the right to terminate enrollment without cause and notifying the affected clients of their right to disenroll;
4. Suspension of all new enrollment, including default enrollment, after the date of the effective date of the sanction; and

5. Suspension of payment for clients enrolled after the effective date of the sanction and until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to occur.

6-002.05 Improvement: Based on the results of assessment and monitoring of quality and appropriateness of care and contract compliance, DHHS will target improvement efforts.

DHHS will utilize, but is not limited to the following interventions to improve the quality and appropriateness of care:

1. Quality Committee: DHHS has established a Quality Committee. See 482 NAC 6-003;
2. Performance Improvement Projects (PIP): MCO plans are required to conduct at least one PIP annually. For each PIP, DHHS with the Quality Management Committee will choose the topic, develop the study methodology and determine interventions to reach improvement goals. Each plan will conduct the same PIP (See 482-000-11);
3. Quality Performance Dashboard: In an effort to monitor MCO plan performance on quality measures, a quality performance dashboard was developed. The dashboard approach provides a framework for benchmarking performance and assists MCO plans to prioritize quality improvement planning. The dashboard gives a multi-dimensional view of plan performance by comparing quality measures to national standard measures, if appropriate, to baseline measures for the program, and over two years. The dashboard results are display on the DHHS website;
4. MCO Sanctions-See 482 NAC 6-002.04.

6-002.06 Review of Quality Strategy: The Quality Committee (See 482 NAC 6-003 Quality Committee) will review the effectiveness of the overall quality strategy every three years and make recommendations for improvement. The review and analysis of the overall Quality Strategy and objectives will use data from the assessment activities described in 482 NAC 6-002.3. DHHS staff will review data and provide reports to the Quality Committee in the aggregate.

Data related to on-going quality performance of the MCO's will be collected and analyzed on an ongoing basis. Trends and comparisons with standards and benchmarks that are established will be reviewed continually. The Quality Committee will also review annually the data relating to the performance of the MCO's and make recommendation for improvement or enforcement action. Examples of these data include results of performance measures, performance improvement projects, results of the EQRO technical reports, and required data reported by the MCO's related to quality, access, utilization, and satisfaction.

As changes to the Quality Strategy are made, these changes will be reported to CMS. As the Quality Strategy evolves, challenges and successes that result in changes will be documented.

6-003 QUALITY MANAGEMENT COMMITTEE: DHHS has established a Quality Committee for physical health consisting of Department staff, Medicaid staff, Public Health staff, MCO plans, providers, and other stakeholders. The Quality Committee meets annually to review data and information designed to analyze the objectives of the Quality Strategy, and recommend actions to improve the quality of care, access, utilization, and client satisfaction.

The Quality Committee also reviews the results of the MCO's Performance Improvement Projects and determines future PIP topics, study methodologies, and recommends improvement goals,

and interventions to reach improvement goals. The Quality Committee also determines if the MCO has achieved sustained improvement.

Finally, the Quality Committee reviews the effectiveness of the overall strategy every three years and makes recommendations for improvement.

6-004 ACCREDITATION: The MCOs must have NCQA Accreditation or another national accreditation for the Medicaid Managed Care plan. MCOs must submit a copy of the accrediting body's letter indicating the most recent accreditation status at the time of initial contracting. Any changes or updates must be sent to DHHS within 30 days of receipt.

Upon survey by the accrediting body, the MCO must submit a copy of the survey results to DHHS within 30 days of receipt. The MCO must submit a copy of any work plan that addresses improvements needed or follow-up necessary as a result of the survey. Any changes or updates to the survey results or work plan must be submitted to DHHS within 30 days of receipt.

In the event that the MCO's specific Medicaid Managed Care plan is not accredited at the time of contracting, the MCO is required to submit to DHHS the plan to be fully accredited within the three-year contracting period. The MCO must submit a work plan including the timeline to accomplish plan accreditation to DHHS. The MCO must provide a status update to DHHS staff at the time of the annual on-site operational review.

6-005 SUBMISSION OF ENCOUNTER DATA: DHHS requires the MCOs to submit encounter data to the Medicaid Management Information System (MMIS) per DHHS specifications. The MCOs must also participate in all encounter data review and technical-readiness assessments.

Encounter data submission must:

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

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

Reports of encounter data are used by DHHS to provide a source of comparative information for MCO's and are used for purposes such as monitoring service utilization, evaluating access and continuity of service issues, and cost effective analysis.

TITLE 482 NEBRASKA MEDICAID MANAGED CARE

CHAPTER 7 RIGHTS AND RESPONSIBILITIES

001. SCOPE AND AUTHORITY. This chapter sets forth responsibilities of the health plans, Dental Benefits Manager, and providers of services to ensure the member is fully informed, in writing and verbally, of their rights and responsibilities as well as avenues for pursuing complaints and grievances. Similarly, providers participating in the health plan networks are entitled to the same processes as any Medicaid-enrolled provider according to Title 471 Nebraska Administrative Code (NAC).

002. RIGHTS AND RESPONSIBILITIES. The following rights and responsibilities apply to a member participating in Heritage Health. The health plans haves the requirement to inform the member, in writing and verbally, regarding their rights and responsibilities. No person may be subjected to discrimination in any Departmental program or activity based on their race, color, sex, age, national origin, religious creed, political beliefs, or disability.

002.01 MEMBER RIGHTS. The member has the right to:

(A) Be treated with respect, dignity, and without discrimination or retaliation;
(B) Be given information about their illness, or medical condition; understand the treatment options, risks and benefits; and make an informed decision about whether they will receive treatment;
(C) Participate in decisions about their healthcare including the right to refuse treatment;
(D) Talk with their doctor and health plan and know their medical information will be kept confidential;
(E) Choose their health plan and primary care physician provider;
(F) Have access to their health plan and primary care provider;
(G) Receive medical care in a timely manner;
(H) Request a copy of their medical record and request changes to their medical record;
(I) Make a complaint about the provider or health plan, and receive a timely response;
(J) Receive information on the medical services provided by their health plan;
(K) Change their primary care provider at any time;
(L) Change their health plan within 90 days of initial enrollment or every 12 months without cause thereafter;
(M) Have Heritage Health and health plan materials explained or interpreted;
(N) Have interpreters at no cost, if necessary, during medical appointments and in all discussions with their primary care provider or health plan;
(O) Request an appeal if services are denied, terminated, or reduced;
(P) Make advance directives, if desired, and receive assistance if needed; and
(Q) Receive proper medical care twenty-four (24) hours a day, seven (7) days a week.

002.02 MEMBER RESPONSIBILITES. The member has the responsibility to:
- (A) Understand, to the best of his or her ability, how Heritage Health is used to receive health care;
- (B) Choose a primary care provider within the health plan's network;
- (C) Take their Medicaid ID card and health plan ID card to all medical appointments and to the pharmacy for prescriptions;
- (D) Keep their scheduled appointments;
- (E) Call their doctor's provider's office at least 24 hours in advance if their appointment must be rescheduled;
- (F) Tell their doctor about any medical problems;
- (G) Ask questions about things they do not understand;
- (H) Follow the provider's orders and advice;
- (I) Assist with the transfer of their medical records;
- (J) Receive services from their primary care provider unless referred elsewhere by their primary care provider; and
- (K) Cooperate with all Heritage Health inquiries and surveys.

002.03 PROVIDER RIGHTS AND RESPONSIBILIITES. Providers participating in Heritage Health or Dental Benefits Manager have the same rights and responsibilities as any Medicaid enrolled provider pursuant to Title 471 NAC.

003. GRIEVENCE PROCESS. The health plan or dental benefits manager must inform the member, in writing, of the grievance process for issuing a complaint involving access to care, quality of care, or communication issues with the plan or primary care provider. The member, or legal representative, must file the grievance with the health plan or dental benefits manager, according to the same plans' internal grievance procedure, pursuant to 1931(b)(4) of the Social Security Act.
- (A) A member may file a grievance either orally or in writing;
- (B) A provider may file a grievance when acting as the client's authorized representative;
- (C) The health plan must resolve each grievance and provide notice, as expeditiously as the member's health condition requires, not to exceed 90 days from the day the plan receives the grievance;
- (D) The plan must provide notice of the grievance resolution in writing in a language and format which is easily understood by the member. The plan must make reasonable effort to notify the member orally of the grievance resolution; and
- (E) All contacts with the health plan regarding grievances must be documented and submitted to the Department.

004. APPEALS PROCESS. The Heritage Health plan or Dental Benefits Manager must notify the member in writing of the appeals process for challenging any adverse benefit determinations. The member, or the provider on behalf of the member, may request an appeal with the Heritage Health plan or Dental Benefits Manager, request a State fair hearing, or both.

004.01. AVENUES FOR REQUESTING AN APPEAL. The member, or the provider with the member's written consent on behalf of the member, has the following avenues for requesting an appeal:
- (A) File a Heritage Health plan or Dental Benefits Manager Level Appeal: The member may contact verbally or in writing the Heritage Health plan or Dental Benefits Manager

to request a hearing and following that Heritage Health plan's or Dental Benefits Manager's internal appeal process. The request for appeal must be within sixty (60) days from the date on the notice of adverse benefit determination. An appeal filed orally must be followed by a written, signed appeal; or

(B) Request a State Fair Hearing: A member may request a State fair hearing only after the member has exhausted the Heritage Health plans or Dental Benefits Manager's internal appeal process. The member must submit in writing to the DHHS Legal and Regulatory Services within one hundred twenty (120) days from the date of the Heritage Health plan's or Dental Benefits Manager's notice of resolution. Hearings are scheduled and conducted according to the procedures outlined in 465 NAC.

004.02 NOTICE OF ADVERSE BENEFIT DETERMINATION. The Heritage Health plan or Dental Benefits Manager must notify the requesting provider, and give the member written notice of any adverse benefit determination. The notice must be in writing and be a language and format that is easily understandable to the member. The notice to the provider need not be in writing.

004.02(A) TIMEFRAMES FOR NOTICE OF ADVERSE BENEFIT DETERMINATION. The following are timeframes for notice of adverse benefit determination:

(i) Denial of Payment: The Heritage Health plan or Dental Benefits Manager must give notice on the date of adverse benefit determination when the adverse benefit determination is a denial of payment.

(ii) Standard Service Authorization Denial: Notice must be given as expeditiously as the member's health condition requires not to exceed fourteen (14) calendar days following the receipt of the request for service. The timeframe may be extended up to fourteen (14) additional calendar days if the member or provider requests the extension or if the Heritage Health plan or Dental Benefits Manager shows that there is need for additional information and demonstrates that the delay is in the member's interest. If the timeframe is extended, the member must be provided written notice of the reason for the decision to extend the timeframe and right to file a grievance if he or she disagrees with that decision. The determination must be issued and carried out as expeditiously as the member health condition requires and no later than the date the extension expires.

(iii) Termination, Suspension, or Reduction of Services: Notice must be given at least ten (10) days before the date of adverse benefit determination when the adverse benefit determination is a termination, suspension, or reduction of a previously authorized Medicaid-covered service. The period of advance notice is shortened to five (5) days if probable fraud has been verified. Notice by the date of the adverse benefit determination must be given by the date of the adverse benefit determination for the following circumstances:

(1) Death of the member;

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

(3) The member's admission to an institution where the member is ineligible for further services;

(4) The member's address is unknown and mail directed to him or her has no forwarding address;
(5) The member has been accepted for Medicaid services by another jurisdiction;
(6) The member's physician or dentist prescribes the change in the level of medical care; or
(7) The safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs.

(iv) Expedited Service Authorization Denial: For cases in which a provider indicates or the Heritage Health plan or Dental Benefits Manager determines that following the standard timeframe could seriously jeopardize the member's life, or health, or ability to attain, maintain, or regain maximum function, an expedited authorization decision must be made and notice provided as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service. This timeframe may be extended up to fourteen (14) additional calendar days if the member requests the extension or if the Heritage Health plan or Dental Benefits Manager shows that there is need for additional information and demonstrates that the delay is in the member's interest. If the timeframe is extended, the member must be provided written notice of the reason for the decision to extend the timeframe and right to file a grievance if they disagree with that decision. The determination must be issued and carried out as expeditiously as the member's health condition requires and no later than the date the extension expires.

(v) Untimely Service Authorization Decision: Notice must be provided on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse benefit determinations.

004.03 RESOLUTION AND NOTIFICATION. The Heritage Health plan or Dental Benefits Manager must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, not to exceed thirty (30) days from the day the appeal is received. This timeframe may be extended up to fourteen (14) calendar days if the member requests an extension or the Heritage Health plan or Dental Benefits Manager shows that there is need for additional information and how the delay is in the member's interest. For any extension not requested by the member, notice of the reason for delay must be provided to the member.

004.03(A) WRITTEN NOTICE OF RESOLUTION. Written notice of resolution of the appeal must be provided to the member. The written resolution must include:

(i) Results and date of the appeal resolution; and
(ii) For decisions not wholly in the member's favor:
(1) The right to request a state fair hearing for decisions not wholly in the member's favor;
(2) How to request a State fair hearing;
(3) The right to receive benefits pending a hearing;
(4) How to request the continuation of benefits; and

(5) If the appeal decision is upheld, that the member may be liable for the cost of continued benefits received while the appeal was pending.

004.04 CONTINUATION OF BENEFITS. The member may have his or her benefits continue while an appeal is pending.

004.04(A) REQUIERMENTS FOR CONTINUATION OF BENEFITS. The Heritage Health plan or Dental Benefits Manager must continue member benefits if all of the following apply:

(i) The appeal is filed timely, meaning on or before the later of the following:
  (1) Ten (10) calendar days of the Heritage Health plan or Dental Benefits Manager mailing of the notice of adverse benefit determination; or
  (2) The intended effective date of the proposed adverse benefit determination;
(ii) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
(iii) The services were ordered by an authorized provider;
(iv) The authorization period has not expired; and
(v) The member requests a continuation of benefits.

004.04(B) REQUIERMENTS FOR ENDING CONTINUED BENEFITS. If the member's benefits are continued or reinstated while the appeal is pending, the benefits must be continued until one of the following occurs:

(i) The member withdraws the appeal;
(ii) The member does not request a fair hearing and continuation of benefits within ten (10) calendar days from when the Heritage Health plan or Dental Benefits Manager mails the notice of adverse resolution to the member's appeal;
(iii) A state fair hearing decision adverse to the member is made; or
(iv) The authorization expires or authorization service limits are met.

004.04(C) RECOVERY OF COSTS DURING CONTINUATION OF BENEFITS. The Heritage Health plan or Dental Benefits Manager may recover the cost of the continuation of benefits furnished to the member while the appeal was pending if the final resolution of the appeal upholds the Heritage Health plan's or Dental Benefits Manager's adverse benefit determination.

004.04(D) PAYMENT OF COSTS DURING CONTINUATION OF BENEFITS. The Heritage Health plan or Dental Benefits Manager must pay for disputed services if the Heritage Health plan or Dental Benefits Manager or State fair hearing decision reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending.

004.05 EXPEDITED APPEALS PROCESS. The Heritage Health plan or Dental Benefits Manager must conduct an expedited review process when the Heritage Health plan or Dental Benefits Manager determines, for a request from the member, or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Expedited appeals must follow all standard appeal regulations. The Heritage Health plan or Dental Benefits Manager must not

take punitive action against a provider who either requests an expedited appeal or supports a member's appeal.

004.05(A) REQUESTING AN EXPEDITED APPEAL. The member or provider may file an expedited appeal either orally or in writing. No additional member follow-up is required.

004.05(B) TIMEFRAMES FOR EXPEDITED APPEALS. The Heritage Health plan or Dental Benefits Manager must resolve each expedited appeal and provide notice as expeditiously as the member's health condition requires and in no event longer than seventy-two (72) hours after the Heritage Health plan or Dental Benefits Manager received the appeal. This timeframe may be extended by up to fourteen (14) calendar days if the member requests the extension or if the Heritage Health plan or Dental Benefits Manager shows that there is need for additional information and demonstrates that the delay is in the member's interest. For any extension not requested by the member, written notice of the reason for delay must be provided to the member.

004.05(C) TIMEFRAMS FOR PROVIDING EVIDENCE AND ALLEGATIONS. The Heritage Health plan or Dental Benefits Manager must inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing.

004.05(D) DENIAL OF AN EXPEDITED APPEAL. If the Heritage Health plan or Dental Benefits Manager denies a request for an expedited resolution of an appeal, the Heritage Health plan or Dental Benefits Manager must:

(i) Transfer the appeal to the standard timeframe of no longer than thirty (30) days from the day the Heritage Health plan or Dental Benefits Manager receives the appeal; and
(ii) Make reasonable effort to give the member prompt oral notice of the denial and a written notice within two (2) calendar days.

004.05(E) NOTIFICATION OF APPEAL RESOLUTION. The Heritage Health plan or Dental Benefits Manager must provide written notice of the appeal resolution. In addition to written notice, reasonable effort must be made to provide oral notice of resolution.

005. CULTURAL SENSITIVITY AND DIVERSITY. The Department is a culturally diverse environment that exercises zero tolerance of any acts of discrimination, racism, or prejudice. Understanding, valuing, and promoting cultural sensitivity and diversity is part of the ongoing philosophy of the Department and any of its programs. Heritage Health and the Dental Benefits Manager is required to promote this philosophy with the member, providers, and within the workplace.

005.01 USE OF MEMBER INFORMATION. The Heritage Health plan and Dental Benefits Manager will receive information on the member's race, ethnicity, and primary language from the eligibility file transmitted to the plans by the Department or the enrollment broker. The Heritage Health plans and Dental Benefits Manager is expected to use this information to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

7-000 RIGHTS AND RESPONSIBILITIES

7-001 RIGHTS AND RESPONSIBILITIES FOR CLIENTS ENROLLED IN THE NEBRASKA HEALTH CONNECTION (NHC): 482 NAC 7-000 sets forth the responsibilities of the NHC, the Managed Care Organization (MCO) physical health plan (health plan) and MH/SA plans, and providers of services to ensure the client is fully informed, in writing and verbally, of his/her rights and responsibilities as well as avenues for pursuing complaints and grievances. Similarly, providers participating in the MCO networks are entitled to the same processes as any Medicaid-enrolled provider according to 471 NAC.

The following rights and responsibilities apply to a client participating in the NHC. The health and MH/SA plans haves the requirement to inform the client, in writing and verbally, regarding his/her rights and responsibilities.

The client has the right to:

1. Be treated with respect, dignity, and without discrimination or retaliation;
2. Be given information about his/her illness, or medical condition; understand the treatment options, risks and benefits; and make an informed decision about whether s/he will receive a treatment;
3. Participate in decisions about his/her healthcare including the right to refuse treatment;
4. Talk with his/her doctor and health plan and know his/her medical information will be kept confidential;
5. Choose his/her physical health plan and Primary Care Physician (PCP) (Basic Benefits Package only) or MH/SA provider under the MH/SA plan's network;
6. Have access to his/her health plan and doctor (PCP);
7. Receive medical care in a timely manner;
8. Request a copy of his/her medical record and request changes to his/her medical record;
9. Make a complaint about the provider or physical health and/or MH/SA plans, and receive a timely response;
10. Receive information on the medical services provided by his/her health plan or MH/SA Package;
11. Change his/her PCP or MH/SA provider at anytime;
12. Change his/her health plan within 90 days of initial enrollment or every 12 months without cause thereafter;
13. Have NHC and health plan materials explained or interpreted;
14. Have interpreters at no cost, if necessary, during medical appointments and in all discussions with his/her PCP or health plan;
15. Request a fair hearing if services are denied, terminated, or reduced;
16. Make advance directives, if desired, and receive assistance if needed; and
17. Receive proper medical care 24 hours a day, 7 days a week.

The client has the responsibility to:

1. Understand, to the best of his/her ability, how the NHC is used to receive health care;
2. Choose a PCP and health plan within 15 days of enrollment, or MH/SA provider within the MH/SA plan's network;
3. Take his/her Medicaid ID card and health plan ID card to all medical appointments and to the pharmacy for prescriptions;
4. Keep his/her scheduled appointments;
5. Call his/her doctor's office at least 24 hours in advance if his/her appointment must be rescheduled;
6. Tell his/her doctor about his/her medical problems;
7. Ask questions about things s/he does not understand;
8. Follow the provider's orders and advice;
9. Assist with the transfer of his/her medical records;
10. Receive services from his/her PCP unless referred elsewhere by his/her PCP;
11. Inform DHHS staff if his/her address has changed, she is or becomes pregnant, or any other change that could affect his/her Medicaid eligibility or NHC coverage; and
12. Cooperate with all NHC inquiries and surveys.

No person may be subjected to discrimination in any DHHS program or activity based on his/her race, color, sex, age, national origin, religious creed, political beliefs, or handicap.

7-001.01 Provider Rights and Responsibilities: Providers participating in the NHC have the same rights and responsibilities as any Medicaid-enrolled provider pursuant to 471 NAC.

7-002 GRIEVANCE PROCESS: The physical health or MH/SA plan must inform the client, in writing, of the grievance process for issuing a complaint involving access to care, quality of care, or communication issues with the plan or PCP. The client, or his/her legal representative, must file the grievance with the physical health or MH/SA plan, according to the same plans' internal grievance procedure, pursuant to 1931(b)(4) of the Social Security Act.

A client may file a grievance either orally or in writing. A provider may file a grievance when acting as the client's authorized representative.

The physical health or MH/SA plan must resolve each grievance and provide notice, as expeditiously as the client's health condition requires, not to exceed 90 days from the day the plan receives the grievance. The plan must provide the client notice of the grievance resolution in writing in a language and format which is easily understood by the client. The plan must make reasonable effort to notify the client orally of the grievance resolution.

All contacts with the physical health or MH/SA plan regarding grievances must be documented and submitted to DHHS.

7-003 APPEALS PROCESS: The physical health and MH/SA plans must notify the client in writing of the appeals process for challenging the denial or limitation of an authorization, reduction, suspension, or termination of a previously authorized service, the denial, in whole or part of payment for a service, or failure to provide services in a timely manner. The client, his/her legal representative, or the provider on behalf of the client, with the client's written consent, has the following avenues for requesting an appeal:

1. File a Plan level appeal: The client may contact verbally or in writing the physical health or MH/SA plan to request a hearing and following that plans internal process pursuant to section 1931(b)(4) of the Social Security Act. The request for appeal must be within 90 days from the date on the notice of action. An appeal filed orally must be followed up with a written, signed appeal; or
2. Request a State Fair Hearing: The client may request a State fair hearing submitted in writing to the DHHS Legal and Regulatory Services within 90 days from the date on the notice of action. Hearings are scheduled and conducted according to the procedures outlined in 465 NAC 2-001.02.

The client, his/her legal representative, or the provider on behalf of the client may request an appeal with the plan, request a State fair hearing, or both.

7-003.01 Notice of Action: The physical health or MH/SA plan must notify the requesting provider, and give the client written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must be in writing and be a language and format that is easily understandable to the client. The notice to the provider need not be in writing.

7-003.01A Timeframes for Notice of Action:

1. Denial of payment: The physical health MCO must give notice on the date of action when the action is a denial of payment.
2. Standard Service Authorization Denial: Notice must be given as expeditiously as the client's health condition requires not to exceed fourteen (14) calendar days following the receipt of the request for service. The timeframe may be extended up to fourteen (14) additional calendar days if the client or the provider requests an extension of the physical health or MH/SA plan justifies a need for additional information and how the extension is in the client's interest. If the timeframe is extended, the client must be provided written notice of the reason for the decision to extend the timeframe and right to file an appeal if s/he disagrees with that decision. The determination must be issued and carried out as expeditiously as the client's health condition requires and no later than the date the extension expires.

3. Termination, Suspension, or Reduction of Services: Notice must be given at least ten days before the date of action when the action is a termination, suspension, or reduction of a previously authorized Medicaid-covered service. The period of advance notice is shortened to five days if probably fraud has been verified. Notice by the date of the action must be given by the date of the action for the following circumstances:
   a. Death of the client;
   b. A signed written client statement requesting service termination or giving information requiring termination or reduction of services (where the client understands that this action must be the result of supplying that information);
   c. The client's admission to an institution where s/he is ineligible for further services;
   d. The client's address is unknown and mail directed to him/her has no forwarding address;
   e. The client has been accepted for Medicaid services by another local jurisdiction; or
   f. The client's physician prescribes the change in the level of medical care.
4. Expedited Service Authorization Denial: For cases in which a provider indicates or the physical health or MH/SA plan determines that following the standard timeframe could seriously jeopardize the client's life, or health, or ability to attain, maintain, or regain maximum function, an expedited authorization decision must be made and notice provided as expeditiously as the client's health condition requires and no later than three working days after receipt of the request for service. The timeframe may be extended up to 14 additional calendar days if the client or the provider requests an extension of the physical health or MH/SA plan justifies a need for additional information and how the extension is in the client's interest. If the timeframe is extended, the client must be provided written notice of the reason for the decision to extend the timeframe and right to file an appeal if s/he disagrees with that decision. The determination must be issued and carried out as expeditiously as the client's health condition requires and no later than the date the extension expires.
5. Untimely Service Authorization Decision: Notice must be provided on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions.

7-003.02 Resolution and Notification: The physical health or MH/SA plan must resolve each appeal, and provide notice, as expeditiously as the client's health condition requires, not to exceed 45 days from the day the appeal is received. This timeframe may be extended up to 14 calendar days if the client requests an extension or the plan shows that there is need for additional information and how the delay is in the client's interest. For any extension not requested by the client, notice of the reason for delay must be provided to the client.

~~Written notice of disposition of the appeal must be provided to the client. The written resolution must include:~~

1. ~~Results and date of the appeal resolution;~~
2. ~~The right to request a State fair hearing for decisions not wholly in the client's favor;~~
3. ~~How to request a State fair hearing;~~
4. ~~The right to receive benefits pending a hearing;~~
5. ~~How to request the continuation of benefits; and~~
6. ~~If the appeal decision is upheld, that the client may be liable for the cost of continued benefits.~~

~~7-003.03 Continuation of Benefits: The physical health or MH/SA plan must continue client benefits if:~~

1. ~~The appeal is filed timely, meaning within ten (10) days of the plan mailing of the Notice of Action or on or before the intended effective date of the proposed action/~~
2. ~~The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;~~
3. ~~The serviced were ordered by an authorized provider;~~
4. ~~The authorization period has not expired; or~~
5. ~~The client requests an extension of benefits.~~

~~If the client's benefits are continued or reinstated while the appeal is pending, the benefits must be continued until one of the following occurs:~~

1. ~~The client withdraws the appeal;~~
2. ~~The client does not request a fair hearing within ten (10) days from when the plan mails the notice of action;~~
3. ~~A State fair hearing decision adverse to the client is made; or~~
4. ~~The authorization expires or authorization service limits are met.~~

~~The physical health MCO may recover the cost of the continuation of benefits furnished to the client while the appeal was pending if the final resolution of the appeal upholds the MCO action.~~

~~The physical health MCO must pay for disputed services if the MCO or State fair hearing decision reverses a decision to deny authorization of services and the client received the disputed services while the appeal was pending.~~

~~7-003.04 Expedited Appeals Process: The physical health or MH/SA plan must conduct an expedited review process when the plan determines, for a request from the client, or the provider indicates that taking the time for a standard resolution could seriously jeopardize the client's life or health or ability to attain, maintain, or regain maximum function. Expedited appeals must follow all standard appeal regulations.~~

The client or provider may file an expedited appeal either orally or in writing. No additional client follow-up is required.

The physical health or MH/SA plan must inform the client of the limited time available for the client to present evidence and allegations of fact or law, in person and in writing.

The physical health or MH/SA plan must resolve each expedited appeal and provide notice, as expeditiously as the client's health condition requires, not to exceed three working days after the plan receives the appeal. This timeframe may be extended by up to 14 calendar days if the client requests the extension of the plan shows that there is need for additional information and how the delay is in the client's interest. For any extension not requested by the client, written notice of the reason for delay must be provided to the client.

The physical health or MH/SA plan must provide written notice of the appeal resolution. In addition to written notice, reasonable effort must be made to provide oral notice of resolution.

The physical health or MH/SA plan must not take punitive action against a provider who either requests an expedited appeal or supports a client's appeal.

If the physical health or MH/SA plan denies a request for an expedited resolution of an appeal, the plan must:

1. Transfer the appeal to the standard timeframe of no longer than 45 days from the day the plan receives the appeal; and
2. Make reasonable effort to give the client prompt oral notice of the denial and a written notice within two calendar days.

7-004 CULTURAL SENSITIVITY AND DIVERSITY: DHHS is a culturally diverse environment that exercises zero tolerance of any acts of discrimination, racism, or prejudice. Understanding, valuing and promoting cultural sensitivity and diversity is part of the ongoing philosophy of the DHHS and any of its programs. The NHC is required to promote this philosophy with the client, providers, and within in the workplace.

The physical health plans receive information on the client's race, ethnicity, and primary language from the eligibility file transmitted to the MCO by the State. Each MCO is expected to use this information to promote the delivery of services in a culturally competent manner to all clients, including those with limited English proficiency and diverse cultural and ethnic backgrounds.