NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

April 9, 2020
10:00 a.m. Central Time
Nebraska State Office Building – Lower Level A
301 Centennial Mall South, Lincoln, Nebraska

The purpose of this hearing is to receive comments on proposed changes to Title 482, Chapters 1, 2, 4, and 5 of the Nebraska Administrative Code (NAC) – *Nebraska Medicaid Managed Care.* The proposed changes will allow the managed care entities to enroll the new Heritage Health Adult population, as required by Neb. Rev. Stat. § 68-992. These changes will work together with updates to other titles to facilitate the enrollment of the adult population into Medicaid, and to implement the 1115 waiver Nebraska is currently seeking from CMS for the implementation of expansion, including basic and prime benefits. Additional changes include correcting typographical errors and updating formatting.

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: Jeremy Brunssen
Chapter: 1, 2, 4, and 5	Date prepared: 12.19.2019
Subject: Nebraska Medicaid Managed Care	Telephone: 402-471-5046

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: Medicaid estimates a small fiscal impact based on the mandatory enrollment of the new expansion group into managed care regulated by chapter 2. Specifically payments to the Enrollment Broker for the additional members eligible. Nebraska Medicaid contracts with the enrollment broker for member plan assignment and pays a per member per month fee for these services. The estimated Fiscal impact is as noted:

SFY	Total Funds	Federal Funds	State Funds
2020	$0	$0	$0
2021	$215,304	$107,652	$107,652

The funds have already been appropriated in LB294.

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).~~ These regulations govern services provided under the Medical Assistance Act, Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901 et seq.

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 health 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.

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.~~ These regulations govern services provided under the Medical Assistance Act, Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901 et seq.

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~~Individuals 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.

(M) Members who are eligible in the Heritage Health Adult group as described in 477 Nebraska Administrative Code (NAC) 29 under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

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~~ Non-Citizens eligible under the Emergency Medical Services Assistance (EMSA) for non-citizens program;

(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~~.~~; or

(C) Members who are in the Heritage Health Adult group and enrolled in the Nebraska Basic Alternative Benefit Plan as described in 477 NAC 29.

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 for services they are eligible for. 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 REQUIREMENTS. 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 NOTIFICATION. 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 DISCREPANCY. 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) DISCREPANCY 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.

003.15(A) HOSPITALIZATION IN MONTH OF ASSIGNMENT. 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).

004(A) TRANSFERS. 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.

004(B) DISENROLLMENT. 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 ACCOMMODATIONS. 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.

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 REQUIREMENTS. 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 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 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 addressed, 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), with the exception of those services which are limited for members who are in the Heritage Health Adult group and enrolled in the Nebraska Basic Alternative Benefit Plan found in 471 NAC 39;
(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), with the exception of those services which are limited for members who are in the Heritage Health Adult group and enrolled in the Nebraska Basic Alternative Benefit Plan as found in 471 NAC 39.

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.

005.02(D)(i) RESTRICTED VALUE ADDS. The health plan may not provide certain value-added services. Those services which may not be provided as a value-add are:

(1) Eyeglasses and Optometrist Services not available under the Nebraska Basic Alternative Benefit Plan.
(2) Over-the-counter pharmacy services not available under the Nebraska Basic Alternative Benefit Plan.
(3) Dental services and dentures not available under the Nebraska Basic Alternative Benefit Plan.

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~~ 471 NAC 40);
(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 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 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 30-38,110).

006.09 QUALITY PERFORMANCE PROGRAM AND HOLD BACKS. The health plan must participate in the Department's 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.

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).~~ These regulations govern services provided under the Medical Assistance Act, Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901 et seq.

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 eligible 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.
(C) Members who are in the Heritage Health Adult group and enrolled in the Nebraska Basic Alternative Benefit Plan are not eligible to receive dental benefits as found in 471 NAC 39.

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 eligible 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.