NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

February 11, 2021
10:00 a.m. Central Time
Nebraska State Office Building – Lower Level A
301 Centennial Mall South, Lincoln, Nebraska
Phone call information: 888-820-1398; Participant code: 3213662#

The purpose of this hearing is to receive comments on proposed changes to Title 477, Chapter 29 of the Nebraska Administrative Code (NAC) – *Heritage Health Adult Program.* The proposed changes will implement Medicaid's Section 1115 Demonstration Waiver. Additional proposed changes include: updating definitions; updating provisions specific to demonstration enrollment; updating the eligibility and benefit tier sections; and adding sections for benefit tier reviews, wellness and personal responsibility activities, and the good cause review process.

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

Due to the current public health crisis, the agency will enforce any Directed Health Measure Order on the size of gatherings that is in effect at the time of the hearing. In order to encourage participation in this public hearing, a phone conference line will be set up for any member of the public to call in and provide oral comments.

Interested persons may provide verbal comments by participating via phone conference line by calling 888-820-1398; Participant code: 3213662#.

Interested persons may provide written comments by mail, fax, or email, 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) 471-8223. 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: 477	Prepared by: Erin Noble
Chapter: 29	Date prepared: 11/19/2020
Subject: Heritage Health Adult Program	Telephone: 531.530.7154

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: Due to the prior implementation of the Heritage Health Adult group, the fiscal impact of the expansion implementation was captured with the previous updates. The regulatory changes needed in order to implement Nebraska's approved 1115 Demonstration Waiver do not result in any additional fiscal impact.

Political Subdivision:

Regulated Public:

If indeterminable, explain why:

TITLE 477 MEDICAID ELIGIBILITY

CHAPTER 29 HERITAGE HEALTH ADULT PROGRAM

The regulations contained in this chapter will become effective on ~~October~~ April 1, ~~2020~~ 2021.

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

002. DEFINITIONS. The following definitions apply:

002.01 ANNUAL HEALTH VISIT. At a minimum, a visit occurring no less frequently than once every 12 months with a primary care provider or specialist practicing within the scope of their respective practice acts, for a detailed or a comprehensive evaluation and management.

002.02 BENEFIT TIER PERIOD. A six-month period of enrollment in either the Basic or Prime benefit tier. The first benefit tier period begins with the month of approval for Medicaid in the Heritage Health Adult program.

002.03 BENEFIT TIER REVIEW DATE. The date upon which the Department reviews benefit tier eligibility criteria in order to determine benefit tier eligibility for the next benefit tier period. This occurs on the first day of the fifth month of the benefit tier period.

002.04 DEMONSTRATION DETERMINATION DATE. The date upon which the Department determines an individual's eligibility within the Heritage Health Adult Demonstration program.

002.05 DEMONSTRATION ENROLLMENT DATE. The first day of the month in which an individual becomes eligible and enrolled in the Heritage Health Adult Demonstration program.

002.06 HERITAGE HEALTH ADULT DEMONSTRATION PROGRAM. A demonstration program created in accordance with section 1115 of the Social Security Act through which an individual eligible in the Heritage Health Adult Program can qualify for the Prime benefit tier through participation in wellness and personal responsibility activities.

002.07 HERITAGE HEALTH ADULT PROGRAM. The Medicaid program which includes individuals eligible for Medicaid as outlined in this chapter.

002.08 PERSONAL RESPONSIBILITY ACTIVITIES. A group of activities individuals are required to maintain in order to earn and remain in the Prime benefit tier. These activities include attending appointments and maintaining employer-sponsored coverage.

002.09 PRIME EXCLUSIONARY PERIOD. A period of time, lasting two benefit tier periods, during which an individual is excluded from the Prime benefit tier due to not meeting the personal responsibility activities.

002.10 WELLNESS ACTIVITIES. A group of activities a Heritage Health Adult enrollee must complete to earn and remain in the Prime benefit tier. These activities include attending an annual health visit and completion of a health risk screening.

~~002.~~003. ~~HERITAGE HEALTH ADULT PROGRAM~~ ELIGIBILITY REQUIREMENTS. In order to be eligible for Medicaid under the Heritage Health Adult program, an individual must meet the following eligibility criteria. 477 Nebraska Administrative Code (NAC) 14 through 18 apply to eligibility determinations in the Heritage Health Adult program.

~~002.01~~003.01 METHODOLOGY AND INCOME LIMIT. Eligibility for the Heritage Health Adult program is determined using the modified adjusted gross income (MAGI) methodology. In order to be eligible in the Heritage Health Adult program, an individual must have household income equal to or less than 133% of the Federal Poverty Level (FPL). ~~477 Nebraska Administrative Code (NAC) 14 through 18 apply to eligibility determinations in the Heritage Health Adult program.~~

~~002.02~~003.02 NON-FINANCIAL CRITERIA. In order to be eligible in the Heritage Health Adult program, an individual must:

(A) Be age 19 or older and under age 65;
(B) Not be pregnant;
(C) Not be entitled to or enrolled in Medicare part A or B; and
(D) Not be eligible for or enrolled in coverage in any of the following groups: parents and caretaker relatives, pregnant women, children under age 19, former foster care, individuals receiving IV-E assistance, transitional medical assistance (TMA) with or without a premium, and Medicaid for the aged, blind, and disabled.

~~002.03~~003.03 COVERAGE FOR DEPENDENT CHILDREN. Parents and caretaker relatives of dependent children are ineligible for coverage under the Heritage Health Adult program unless all dependent children living in the household are enrolled in Medicaid, the Children's Health Insurance Program (CHIP), or are otherwise enrolled in minimum essential coverage as defined at 26 United States Code (U.S.C.) 5000(A).

~~002.04~~003.04 INDIVIDUALS WHO BECOME PREGNANT WHILE ENROLLED IN THE HERITAGE HEALTH ADULT PROGRAM. If an individual becomes pregnant during enrollment in the Heritage Health Adult program, the individual will remain in the Heritage Health Adult program until eligibility is redetermined during the annual eligibility renewal unless the individual becomes otherwise ineligible in this category, see 477 NAC 3. Once the pregnancy is reported to the Department, the individual will be placed in the Prime benefit tier on the first calendar day of the following month.

003.05 ENROLLMENT IN THE DEMONSTRATION PROGRAM. Individuals enrolled in the Heritage Health Adult program who are not medically frail, pregnant, or under age 21 are enrolled in the Heritage Health Adult Demonstration program. These individuals will be

required to complete the wellness and personal responsibility activities described in this chapter in order to earn and remain eligible for the Prime benefit tier.

~~003.~~004. BENEFIT TIERS. Individuals ~~eligible~~ enrolled in the Heritage Health Adult program will be eligible for coverage in one of two benefit tiers, the Nebraska Basic Alternative Benefit Plan, also known as the Basic benefit tier, and the Nebraska Prime Alternative Benefit Plan, also known as the Prime benefit tier. For plan benefits, see 471 NAC 39.

~~003.01~~004.01 BASIC BENEFIT TIER. Individuals newly enrolled in the Heritage Health Adult program ~~who are not targeted for enrollment in the Prime benefit tier will be enrolled in the Basic benefit tier~~ will be enrolled in the Basic benefit tier. Individuals who have not completed the defined wellness and personal responsibility activities, or are in a Prime Exclusionary Period will remain in the Basic benefit tier. This includes individuals whose Medicaid has been closed for more than 90 days.

~~003.02~~004.02 PRIME BENEFIT TIER. Individuals who are enrolled in the demonstration program, have completed the defined wellness and personal responsibility activities, and who are not in a Prime Exclusionary Period at the time of their benefit tier review will be approved for coverage in the Prime benefit tier. Individuals in the following groups will be targeted for enrollment in the Prime benefit tier and will not be enrolled in the demonstration program. Individuals targeted for enrollment in the Prime benefit tier will not be subject to wellness activities, personal responsibility activities, or Prime Exclusionary Periods. When an individual no longer meets the criteria of a targeted group, he or she will be enrolled in the demonstration program and placed in the Basic benefit tier for the first month available, allowing for adequate and timely notice.

(A) Individuals determined to be medically frail;
(B) Pregnant individuals; and
(C) Individuals age 19 and 20.

~~003.03~~004.03 MEDICALLY FRAIL.

~~003.03(A)~~004.03(A) MEDICALLY FRAIL DETERMINATION. For an individual to be determined medically frail, he or she must have a documented medical condition attested to by a healthcare provider who is able to diagnose within the scope of his or her respective practice act and is licensed and in good standing within the state in which they practice, identified through analysis and evaluation of historical claims data performed by the Medicaid managed care organization, or identified through information supplied by the Department, that falls into one or more of the following categories:

(i) A disabling mental disorder;
(ii) A chronic substance abuse disorder;
(iii) A physical, intellectual, or developmental disability with functional impairment that significantly impairs the individual from performing one or more activities of daily living each time the activity occurs, see 471 NAC 12 for the definition of activities of daily living for adults;
(iv) A disability determination based on Social Security criteria;
(v) A serious and complex medical condition; or
(vi) Chronically homeless as defined by the United States Department of Housing and Urban Development.

~~003.03(B)~~004.03(B) ACTIVITIES OF DAILY LIVING. For each activity of daily living an individual must require help to complete the task safely and the helper is required to be physically present throughout the task for each occurrence.

~~003.03(C)~~004.03(C) REFERRALS FOR DETERMINATION. Individuals may be referred to the Department in the following ways:

(i) The individual may self-identify as medically frail;

(ii) Referral by the Medicaid managed care organization after interaction with a case and care manager or through analysis of historical claims data; and

(iii) ~~Identification by the Department~~ Upon internal review by the Department.

~~003.03(D)~~004.03(D) MEDICALLY FRAIL PERIOD. The Department will approve medically frail determinations for a period of either 12 or 36 months. The medically frail period will be based on the individual's health care condition and the Department's established clinical guideline criteria. At the end of the approved medically frail period, a review must be completed to determine whether the individual remains medically frail.

~~003.03(E)~~004.03(E) EFFECTIVE DATE OF MEDICALLY FRAIL DETERMINATION. Medically frail determinations approved by the Department on or before the last business day of the month will become effective on the first calendar day of the following month.

004.04 BENEFIT TIER REVIEW. Eligibility within the benefit tier system will be reviewed every six-months. Individuals who have been targeted for enrollment in the Prime benefit tier do not participate in the Heritage Health Adult Demonstration Program and will not be subject to a benefit tier review.

004.04(A) RE-ENTERING THE CURRENT BENFIT TIER PERIOD. Individuals who exit the Heritage Health Adult Demonstration Program and then re-enter the demonstration program after one or two months will resume the benefit tier and tier period in which they were previously enrolled. If a benefit tier review is due when the individual re-enters the demonstration, the review will be completed and the individual placed in the appropriate benefit tier. If the individual re-enters the demonstration program after three or more months, the individual will be considered newly enrolled in the demonstration program and a new benefit tier period will begin.

005. WELLNESS ACTIVITIES. In order to become and remain eligible for the Prime benefit tier, individuals must complete wellness activities, including attending an annual health visit and completing an annual health screening.

005.01 ANNUAL HEALTH VISIT. Individuals must attend a qualifying annual health visit within the 12 months prior to the benefit tier review date.

005.02 ANNUAL HEALTH SCREENING. Individuals must complete an annual health screening within 90 days of either their demonstration determination date or their demonstration enrollment date, whichever is later, and annually thereafter.

006. PERSONAL RESPONSIBILITY ACTIVITIES. In order to be eligible for the Prime benefit tier, individuals must maintain personal responsibility activities. Individuals who do not maintain the following activities will be subject to a Prime Exclusionary Period:

(A) Attending appointments: Individuals must attend scheduled appointments or give reasonable notice of cancellation as defined by the provider. Beginning with the individual's second benefit tier review, if an individual misses three or more appointments in the preceding benefit tier period, he or she will be subject to a Prime Exclusionary Period; and

(B) Maintaining employer-sponsored coverage: Individuals who voluntarily discontinue coverage while participating in the demonstration program will be subject to a Prime Exclusionary Period.

007. GOOD CAUSE. When an individual is assigned to the Basic benefit tier due to a lack of participation in wellness or personal responsibility activities, he or she may provide good cause for not completing an activity in order to receive a redetermination for benefit tier eligibility.

007.01 REQUEST FOR A GOOD CAUSE REVIEW. An individual may request a good cause review via any mode of communication currently used for application submission listed at 42 Code of Federal Regulations (CFR) 435.907(a). A request to review good cause must be received within 30 days of the date of the Notice of Action.

007.02 BENEFIT TIER ELIGIBILITY DURING A GOOD CAUSE REVIEW. An individual who has requested a good cause review within 30 days of the date of the Notice of Action will remain enrolled in the benefit tier in which they were enrolled at the time of the benefit tier review.

007.03 GOOD CAUSE REASONS. The Department will review good cause claims and supporting documentation for the following reasons:

(A) Good cause reasons for not completing an annual health visit:
- (i) Physical or mental health emergency;
- (ii) Acute or chronic medical conditions;
- (iii) Weather-related travel difficulty;
- (iv) Unforeseen transportation difficulty;
- (v) Family emergency or crisis;
- (vi) Unforeseen work schedule change; and
- (vii) Other reasons as approved by the Department.

(B) Good cause reasons for not completing the health risk screening:
- (i) Physical or mental health emergency;
- (ii) Acute or chronic medical conditions;
- (iii) Lack of access to mail or telephone; and
- (iv) Other reasons as approved by the Department.

(C) Good cause reasons for missed appointments:
- (i) Physical or mental health emergency;
- (ii) Acute or chronic medical conditions;
- (iii) Weather-related travel difficulty;
- (iv) Unforeseen transportation difficulty;
- (v) Family emergency or crisis;
- (vi) Unforeseen work schedule change; and
- (vii) Other reasons as approved by the Department.

(D) Good cause reasons for not maintaining employer-sponsored coverage:
- (i) The coverage is not cost effective for the household;

(ii) Change in employment;
(iii) The plan does not provide adequate coverage of health conditions;
(iv) Extended leave from employment in an unpaid status, resulting in non-payment of the employer-paid portion of the plan;
(v) Change in status of the policy holder or a qualifying life event; and
(vi) Other reasons as approved by the Department.

007.04 GOOD CAUSE DECISION. If good cause has been met, the individual will be placed into the Prime benefit tier for the current enrollment period and any applicable Prime Exclusion Period removed. If good cause has not been met, the individual will be placed in the Basic benefit tier and any applicable Prime Exclusion period will be applied.

007.05 REPAYMENT OF BENEFITS PROVIDED DURING A GOOD CAUSE REVIEW. When a good cause review results in a denial, an individual who has received Prime benefits during a good cause review may be subject to recovery of payment for any services received for which he or she was not eligible, consistent with 42 CFR 431.230(b).