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NEBRASKA DEPARTMENT OF  
HEALTH AND HUMAN SERVICES

482 NAC 2

TITLE 482 NEBRASKA MEDICAID MANAGED CARE

CHAPTER 2 MEMBER PARTICIPATION AND ENROLLMENT

001. SCOPE AND AUTHORITY. 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) 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) 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**.

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 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 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 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.