1-000 INTRODUCTION

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

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

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

1-002 DEFINITIONS: The following definitions apply:

Action means the:

1. Denial or limited authorization of a requested service, including the type or level of service;
2. Reduction, suspension, or termination of a previously authorized service;
3. Denial, in whole or in part, of payment for a service;
4. Failure to provide services in a timely manner, as defined by Medicaid;
5. Failure of the MCO to act within the timeframes; or
6. For a rural area resident with only one MCO to choose from, the denial of a Medicaid enrollee's request to obtain services outside the network:

    a. From any other provider (in terms of training, experience, and specialization) not available within the network;
    b. From a provider not part of the network who is the main source of a service to the recipient - provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the enrollee is given a choice of participating providers and is transitioned to a participating provider within 60 days;
    c. Because the only plan or provider available does not provide the service because of moral or religious objections;
    d. Because the recipient's provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network; or
    e. Medicaid determines that other circumstances warrant out-of-network treatment.

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

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

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

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

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

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

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

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

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

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

Behavioral Health Benefits Package means the following behavioral health services:

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

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

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

CFR means Code of Federal Regulations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NAC means the Nebraska Administrative Code.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Risk Contract means a contract under which the contractor:

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

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

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

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

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

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