7-000 RIGHTS AND RESPONSIBILITIES

7-001 RIGHTS AND RESPONSIBILITIES FOR CLIENTS ENROLLED IN THE NEBRASKA HEALTH CONNECTION (NHC):

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

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

The client has the right to:

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

The client has the responsibility to:

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

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

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

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

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

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

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

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

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

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

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

7-003.01A Timeframes for Notice of Action:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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