Department of Health & Human Services
DHHS
NEBRASKA

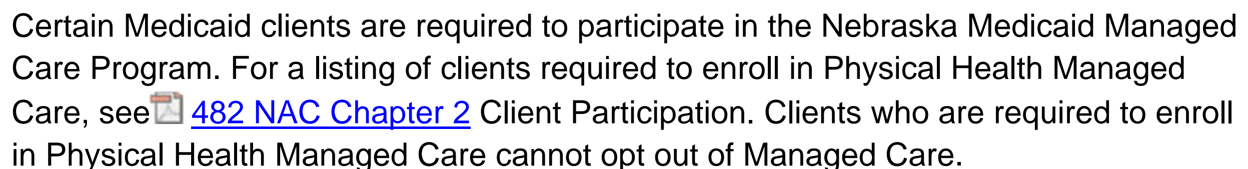
Provider

Medicaid Managed Care Frequently Asked Questions for Providers

1. What is Physical Health Managed Care?

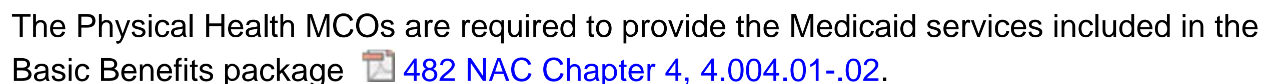
Managed Care Organizations (MCOs) are authorized to operate a health care delivery plan that authorizes, arranges, provides, and pays for the delivery of health care services to enrolled clients. The care of clients enrolled in the health plan is managed by the MCO through its network of Primary Care Providers (PCPs), specialists, hospitals, and other providers of care who contract directly with the MCO. Managed Care offers an opportunity to assure access to a PCP, emphasizes preventive care, and encourages the appropriate utilization of services in the most cost-effective settings.

2. Are all Medicaid Clients required to enroll in Physical Health Managed Care?



Certain Medicaid clients are required to participate in the Nebraska Medicaid Managed Care Program. For a listing of clients required to enroll in Physical Health Managed Care, see 482 NAC Chapter 2 Client Participation. Clients who are required to enroll in Physical Health Managed Care cannot opt out of Managed Care.

3. What is included in the Physical Health Managed Care package?



The Physical Health MCOs are required to provide the Medicaid services included in the Basic Benefits package 482 NAC Chapter 4, 4.004.01-.02.

4. Will Medicaid clients have a chance to choose their health plan?

Clients who are required to enroll in Physical Health Managed Care will receive the Client Guidebook. Once the Client Guidebook has been received, enrollment into an MCO health plan can be made by calling the Medicaid Enrollment Center at 1-888-255-2605 or 402-477-4600 (in the Lincoln area), between 8:00 a.m. and 6:00 p.m., Central Time, Monday through Friday.

Service Area 1

Service Area 1 includes the following counties: Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Sarpy, Saunders, Seward, and Washington.

If you live in this service area, you can choose Aetna Better Health of Nebraska or UnitedHealthcare Community Plan for your Physical Health Managed Care Plan.

Service Area 1 Guidebooks:

- Client Guidebook Service Area 1
- Client Guidebook Service Area 1 Spanish

Service Area 2

Service Area 2 includes the following counties: Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Burt, Butler, Cedar, Chase, Cherry, Cheyenne, Clay, Colfax, Cuming, Custer, Dakota ,Dawes, Dawson, Deuel, Dixon, Dundy, Fillmore, Franklin, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Nemaha, Nuckolls, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Richardson, Rock, Saline, Scottsbluff, Sheridan, Sherman, Sioux, Stanton, Thayer, Thomas, Thurston, Valley, Wayne, Webster, Wheeler, and York.

If you live in this service area, you can choose Aetna Better Health of Nebraska or Arbor Health Plan for your Physical Health Managed Care Plan.

Service Area 2 Guidebooks

- Client Guidebook Service Area 2
- Client Guidebook Service Area 2 Spanish

5. When will the client's Managed Care enrollment become effective?

Once the client's enrollment becomes effective in one of the Managed Care health plans, the client will receive a health plan card in addition to the blue and white Nebraska Medicaid card. This health plan card will display the ID number providers must use when billing the health plan for services.

6. How do providers verify Medicaid and Managed Care eligibility?

- http://dhhs.ne.gov/medicaid/Pages/med_eligibility.aspx
- Call the Nebraska Medicaid Eligibility System at 1-800-642-6092 or 402-471-9580

7. If a provider is not in the Managed Care health plan network can they treat the client and get reimbursed?

No, only Family Planning, Emergency, and Indian Health services will be paid to out-of network providers. Providers must be participating in the network to be reimbursed by the Managed Care health plan. Claims will be paid by the Managed Care health plan where the client is enrolled. It is the provider's responsibility to verify client Medicaid eligibility and Managed Care health plan eligibility.

8. If a claim is denied by the Managed Care health plan, can providers bill Fee for Service Medicaid?

No, Providers who have claims denied for a service in the Basic Benefits package by the Managed Care health plan cannot bill Fee for Service Medicaid. The provider is responsible for obtaining authorization (if required by the Managed Care health plan) and billing the Managed Care health plan the client is enrolled in.

9. How do providers enroll in a health plan network?

To enroll in one of the Managed Care Plans, the provider must be an approved Medicaid provider. Providers need to contact the health plans directly to complete the network enrollment process. Providers are not required to enroll in any health plan network but may not be reimbursed by the Managed Care health plan or Fee for Service Medicaid for care provided to clients enrolled in Managed Care.

Arbor Health Plan

(888) 738-0004 or http://www.arborhealthplan.com/provider/index.aspx

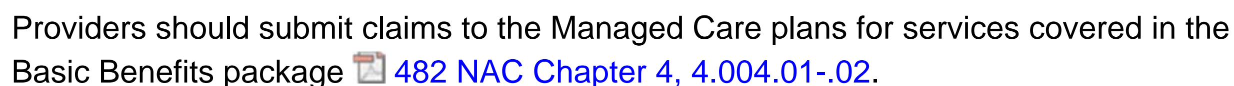
Aetna Better Health of Nebraska

(888) 784-2693 or http://www.aetnabetterhealth.com/nebraska/providers/

UnitedHealthcare Community Plan

(800) 284-0626 or UnitedHealthcare Community Plan

10. Where and how do claims get submitted for the Managed Care health plans?

Providers should submit claims to the Managed Care plans for services covered in the Basic Benefits package  482 NAC Chapter 4, 4.004.01-.02.

11. I am a Pharmacy provider but I am still receiving letters asking me to participate in the Managed Care health plan networks, why?

Durable Medical Equipment (DME) and medical supplies including diabetic supplies, orthotics, prosthetics, and nutritional supplements are services provided in the Basic

Benefits package and, therefore, must be covered by the Managed Care health plan when medically necessary. Pharmacies who do not participate in the Managed Care health plan network that the client is enrolled in will have their claims denied.

12. I am a Skilled Nursing Facility provider but I am still receiving letters asking me to participate in the Managed Care health plan networks, why?

If a Managed Care client is admitted to a nursing facility for a short term rehab stay (as defined by Medicare), this service is included in the Basic Benefits Package, therefore, the nursing facility will need to be a network provider of that Managed Health Care plan to be paid for their services.

13. How is long term care handled?

If a Managed Care client is admitted to a nursing facility for long term care, the client is waived out of Managed Care. However, the enrollment in Managed Care is monthly, so the waiver of enrollment will not occur until the month following admission to the facility. In the interim, the Managed Care health plan is responsible for the Basic Benefits package provided to the client until the end of the month. The nursing facility would need to be participating in the network of the Managed Care health plan to be paid for services in the interim period.