TITLE 482 NEBRASKA MEDICAID MANAGED CARE

CHAPTER 1 INTRODUCTION AND DEFINITIONS

001. SCOPE AND AUTHORITY. These regulations govern services provided under the Medical Assistance Act, Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901 et seq.

001.01 LEGAL BASIS. The Nebraska Medicaid program is authorized by the Medical Assistance Act to deliver services through managed care. The Section 1915(b) waiver permits Nebraska Medicaid to operate the managed care program.

002. DEFINITIONS. The following definitions apply:

002.01 ACTION. Action means the:

(A) Denial or limited authorization of a requested service, including the type or level of service;
(B) Reduction, suspension, or termination of a previously authorized service;
(C) Denial, in whole or in part, of payment for a service;
(D) Failure to provide services in a timely manner, as defined by Medicaid;
(E) Failure of the managed care organization to act within the timeframes; or
(F) For a rural area resident with only one managed care organization to choose from, the denial of a Medicaid enrollee's request to obtain services outside the network:
  (i) From any other provider (in terms of training, experience, and specialization) not available within the network;
  (ii) 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;
  (iii) Because the only plan or provider available does not provide the service because of moral or religious objections;
  (iv) 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
  (v) Medicaid determines that other circumstances warrant out-of-network treatment.

002.02 ADVERSE BENEFIT DETERMINATION. An action by a health plan that include:

(A) Denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
(B) Reduction, suspension, or termination of a previously authorized service;
(C) Denial, in whole or in part, of payment for a service;
(D) Failure to provide services in a timely manner;
(E) Failure of a health plan to act within grievance and appeal process timelines;
(F) Denial of a members request to exercise his or her right to obtain services outside the network (for a resident of rural area with only one health plan); and
(G) Denial of a member's request to dispute a financial liability.

002.03 AMERICANS WITH DISABILITIES. The Americans with Disabilities Act of 1990 as amended, 42 United States Code (U.S.C.) 12101 et seq.

002.04 APPEAL. A request for review of an action.

002.05 AUTO-ASSIGNMENT. The process of the enrollment broker automatically assigning a member to a health plan or a primary care provider.

002.06 CAPITATION PAYMENT. A monthly payment by Medicaid to a health plan on behalf of each member of a health plan for the provision of covered services under the contract, regardless of whether any particular member receives services during the period covered by the payment.

002.07 CARVE-OUT. The services not included in the core benefits package of managed care.

002.08 CHOICE COUNSELING. The provision of information available regarding the available health plans and unbiased decision support for selection of a health plan by the enrollment broker for Medicaid members.

002.09 CLAIM. A bill for services, a line item of service, or all services for one client within a bill.

002.10 CLEAN CLAIM. A claim, received by a health plan for adjudication, that requires no further information, adjustment, or alteration by the provider of the services, or by a third party, in order to be processed and paid by the health plan.
(A) It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

002.11 CENTERS FOR MEDICARE AND MEDICAID SERVICES. A division within the federal Department of Health and Human Services responsible for administering the Medicare, Medicaid, and Children's Health Insurance programs.

002.12 CLIENT. An individual receiving benefits under Title XIX or XXI of the Social Security Act, and under Medicaid as defined in the Nebraska Administrative Code (NAC).

002.13 COLD CALL MARKETING. Any unsolicited personal contact by a health plan with a potential member for the purpose of marketing.

002.14 CONTRACT. 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 Heritage Health.

002.15 CORE BENEFIT PACKAGE. The minimum package of services to which a member is entitled under the Nebraska Medicaid State Plan and that the health plan must provide to members enrolled in the health plan.

002.16 DENTAL HOME. An ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.

002.17 ~~002.16~~ DEPARTMENT. The Nebraska Department of Health and Human Services.

002.18 ~~002.017~~ DESIGNATED SPECIALTY CARE PHYSICIAN. A specialty care physician who has enhanced responsibilities for members with special health care needs, designated upon review and concurrence by the primary care provider (PCP) and the health plan providing the core benefits package.

(A) The designation of the specialty care physician allows for greater continuity of care between the primary care provider (PCP) and specialty care physician. This may include, but is not limited to, open referrals and shared primary care provider (PCP) responsibilities.

002.19 ~~002.18~~ DISENROLLMENT. A change in the status of a member from being enrolled with a specific health plan to being enrolled with a different health plan, or a change from being considered mandatory for participation in managed care to being ineligible for participation in managed care.

002.20 ~~002.19~~ EMERGENCY MEDICAL CONDITION. 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:

(A) 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;
(B) Serious impairment to bodily functions; or
(C) Serious dysfunction of any bodily organ or part.

002.21 ~~002.20~~ EMERGENCY SERVICES. Covered inpatient and outpatient services that are either furnished by a provider qualified to furnish these services under Title 42 of the Code of Federal Regulations or the services needed to evaluate or stabilize an emergency medical condition.

002.22 ~~002.21~~ ENCOUNTER DATA. Line-level utilization and expenditure data for services furnished to members through the health plan.

002.23 ~~002.22~~ ENROLLMENT. The process of a member selecting a health plan, whether by an active choice or through auto assignment.

002.24 ~~002.23~~ ENROLLMENT BROKER. A contracted entity responsible for enrollment activities and choice counseling.

002.25 ~~002.24~~ ENROLLMENT FILE. A proprietary data file provide by Medicaid or the enrollment broker to a health plan. The enrollment file is the basis for monthly payments to the health plan.

002.26 ~~002.25~~ ENROLLMENT MONTH. The enrollment period for a member effective the first of the month through the end of the month.

002.27 ~~002.26~~ ENTITY. A generic term used to reference any of the contracted vendors participating in Nebraska's managed care program.

002.28 ~~002.27~~ EXTERNAL QUALITY REVIEW ORGANIZATION. 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 members.

002.29 ~~002.28~~ FAMILY PLANNING SERVICES. 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.

002.30 ~~002.29~~ FEE-FOR-SERVICE. Payment of a fee for each service provided to a client who is not enrolled in managed care or for services excluded from the core benefits package.

002.31 ~~002.30~~ GRIEVANCE. An expression of dissatisfaction about any matter other than an adverse benefit determination as defined above. The term also refers to the overall system that includes grievances and appeals handled at the health plan level and access to the Medicaid administrative hearing process.

002.32 ~~002.31~~ HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET. The most widely used set of standardized performance measures used in the managed care industry, designed to allow reliable comparison of the performance of health plans. The National Committee of Quality Assurance sponsors, supports, and maintains the Healthcare Effectiveness Data and Information Set.

002.33 ~~002.32~~ HEALTH CARE PROFESSIONAL. A physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician's assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed and certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

002.34 ~~002.33~~ HEALTH PLAN. A generic term used to reference any of the contracted plans participating in Heritage Health. A healthcare entity that meets the definition of a managed care organization for the provision of the core benefits package.

002.35 ~~002.34~~ HERITAGE HEALTH. Nebraska's Medicaid managed care program.

002.36 ~~002.35~~ INTERIM PRIMARY CARE PROVIDER. A primary care provider designated by the physical health plan when the member's chosen or assigned primary care provider is

not available and the duration is only applicable until the member requests a different primary care provider.

002.37 ~~002.36~~ MANAGED CARE ORGANIZATION. An organization that has or is seeking to qualify for a comprehensive risk contract to provide services to managed care enrollees. An entity that has, or is seeking to qualify for a comprehensive risk contract that is:

(A) A federally qualified Health Maintenance Organization that meets the advance directives requirement of 42 Code of Federal Regulations (CFR) 489.100 et seq.; or
(B) Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:
    (i) Makes the services it provides to its Medicaid members 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
    (ii) Meets the solvency standards of 42 CFR 438.116.

002.38 ~~002.37~~ MEDICAID. Nebraska's Medicaid program as defined by Neb. Rev. Stat. § 68-901 et. Seq. (the Medical Assistance Act).

002.39 ~~002.38~~ MEDICAL HOME. A community-based primary care setting which provides and coordinates high quality, planned, and family-centered: health promotion, acute illness care and chronic condition management.

002.40 ~~002.39~~ MEDICAL NECESSITY. Health care services and supplies which are medically appropriate and:

(A) Necessary to meet the basic health needs of the client;
(B) Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;
(C) Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies;
(D) Consistent with the diagnosis of the condition;
(E) Required for means other than convenience of the client or his or her physician;
(F) No more intrusive or restrictive than necessary to provide a proper balance of safety, Effectiveness, and efficiency;
(G) Of demonstrated value; and
(H) The least intense level of service that 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 that do not meet the definition of medical necessity set out above are not covered.

002.41 ~~002.40~~ MEMBER. A Medicaid client who is currently enrolled with a specific health plan.

002.42 ~~002.41~~ NEBRASKA MEDICAID ELIGIBILITY SYSTEM. The automated eligibility verification system for use by Medicaid service providers.

002.43 ~~002.42~~ PATIENT-CENTERED MEDICAL HOME. An enhanced model of primary care in which a patient establishes an ongoing relationship with a primary care provider and a primary care provider-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.

002.44 ~~002.43~~ PRIMARY CARE PHYSICIAN TRANSFER. A change in a client's assignment from one establishes an ongoing relationship with a primary care provider to another primary care provider.

002.45 ~~002.44~~ PEER REVIEW ORGANIZATION. 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.

002.46 ~~002.45~~ PER MEMBER PER MONTH. The basis of capitation payment for a health plan.

~~002.46 PREPAID AMBULATORY HEALTH PLAN. An entity as defined in 42 CFR 438.2 that:~~

~~(A) Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates.~~

~~(B) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and~~

~~(C) Does not have a comprehensive risk contract.~~

002.47 PRIMARY CARE PROVIDER. A medical professional chosen by the member or assigned to provide primary care services. Provider types that can be primary care providers are licensed medical doctors or doctors of osteopathy from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, and obstetrics and gynecology. Primary care providers may also include advanced practice registered nurses and physician assistants when practicing under the supervision of a physician specializing in family practice, internal medicine, pediatrics, or obstetrics/gynecology who also qualifies as a primary care provider under the health plans.

002.48 PRIMARY CARE SERVICES. All health 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.

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

002.50 PROVIDER AGREEMENT. Any written agreement between the provider and Medicaid, for the purpose of enrolling as a Medicaid provider, or between the health plan and the provider for the purpose of participating in Heritage Health.

002.51 RESTRICTED SERVICES. A method used by Medicaid to provide safeguards when a client has been determined to be abusing or inappropriately utilizing services provided by Medicaid or a health plan.

002.52 RETURNED CLAIM. A claim that has not been adjudicated because it has a material defect or impropriety.

002.53 RISK CONTRACT. A contract under which the contractor:

(A) Assumes risk for the cost of the services covered under the contract; and

(B) Incurs loss if the cost of furnishing the services exceeds the payments under the contract.

002.54 SUBCONTRACT. Any written agreement between the health plan and another party to fulfill the requirements of title 482 of the NAC, except provider agreements as defined above.

002.55 SYSTEM CUT OFF. The last day in which data must be entered into the Medicaid eligibility system in order for changes to be effective the first of the next month.

002.56 THIRD PARTY RESOURCE. 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 client.

002.57 VALUE-ADDED SERVICES. Those services a health plan provides in addition to a service covered under a contract because the health plan has determined that the health status and quality of life for the member will be the same or better using the value-added health service as it would be using the covered service.

002.58 WAIVER OF ENROLLMENT. 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.