TITLE 482 NEBRASKA MEDICAID MANAGED CARE

CHAPTER 4 THE HERITAGE HEALTH MANAGED CARE CORE BENEFITS PACKAGE

001. SCOPE AND AUTHORITY. These regulations govern the responsibilities of the health plan in delivering the core benefits package to the Heritage Health member. The Department, assumes primary administrative and operational responsibility for the implementation of the Heritage Health programmatic requirements. The health plan must incorporate the information contained in this Title, as well as Title 471 Nebraska Administrative Code (NAC), which defines in detail the minimum service provisions required for the physical health, behavioral health, and pharmacy services under Medicaid.

002. MANAGED CARE ORGANIZATION REQUIREMENTS. Heritage health administers the core benefits package to Medicaid members through one ~~(1)~~ or more health plans. The following provisions describe the health plan responsibilities.

002.01 GENERAL REQUIREMENTS. The health plan is required to comply with, but is not limited to, the following general requirements and as specified in the contract between the Department and the health plan:

(A) Provide the services in the core benefits package according to all provisions in Title 482 NAC 4 and Title 471 NAC and ensure the services in the core benefits package are provided in the same amount, duration, and scope as defined under Title 471 NAC, but can place appropriate limits on a service based on medical necessity or utilization control;

(B) Maintain an adequate network of primary care providers and dental homes to ensure adequate access for members enrolled in Heritage Health, notify the Department via the provider network file prior to the effective date of any primary care provider or dental home change whenever possible and if required, notify the member of an interim primary care provider or dental home, per ~~(see~~ 482 NAC 3~~-004.03(E))~~;

(C) Use only providers enrolled in Medicaid to provide the services in the core benefits package;

(D) Provide an appropriate range of services and access to preventive and primary care services statewide, and maintain a sufficient number, mix, and geographic distribution of providers that are skilled in areas such a cultural diversity and sensitivity, languages, and accessibility to members with mental, physical and communication disabilities;

(E) Accept the member choice of primary care provider, dental home, and health plan;

(F) Provide care management ~~(see 482-000-8, Care Management Requirements)~~;

(G) Provide a member handbook to the members enrolled with the health plan, and other informational materials about Heritage Health benefits that are easy-to-read and

understand. The health plan must also provide the information in the guidebook in the most prevalent non-English speaking languages and alternative formats in a manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency;

(H) Provide a comprehensive provider network directory;

(I) Medicaid prohibits the health plan from performing any direct solicitation to individual Medicaid members. The Department must approve any general marketing to Medicaid members prior to implementation. The health plan must comply with the following marketing materials:

(i) Obtain ~~D~~ddepartmental approval for all marketing materials;

(ii) Ensure marketing materials do not contain any false or potentially misleading information in a manner that does not confuse or defraud the Department;

(iii) Ensure marketing materials are available for members being served within the State;

(iv) Avoid offering other insurance products as an inducement to enroll;

(v) Comply with federal requirements for provision of information including accurate oral and written information sufficient for the member to make an informed decision about treatment options; and

(vi) Avoid any direct or indirect door-to-door, telephonic or other ~~"~~cold-call~~"~~ marketing.

(J) Meet all requirements of the Americans with Disabilities Act and provide appropriate accommodations for members with special needs. Ensure primary care providers and specialists are equipped in appropriate technologies, including teletype and telecommunications device for the deaf, and language services, or are skilled in various languages and areas of cultural diversity and sensitivity, and the network is appropriately staffed to ensure an adequate selection for those members who have special cultural, religious or other special requests;

(K) Coordinate activities with the Department, other Heritage Health contractors, and other providers for services outside the core benefits package, as appropriate, to meet the needs of the member, and ensure systems are in place to promote well managed patient care, including, but not limited to:

(i) Management and integration of health care through the primary care provider, and coordination of care issues with other providers outside the health plan, for services not included in the core benefits package, including behavioral health services~~,~~ and pharmacy services, ~~and dental services,~~ or for services requiring additional Departmental authorization, which may include abortions and transplants (except corneal);

(ii) Provision of or arrangement for emergency medical services, twenty-four ~~(24)~~ hours per day, seven ~~(7)~~ days per week, including an education process to help assure members know where and how to obtain medically necessary care in emergency situations;

(iii) Unrestricted access to protected services such as emergency room services, family planning services, and tribal clinics in accordance with Title 471 NAC;

(iv) Retention of plan-maintained records and other documentation during the period of contracting, and for ten ~~(10)~~ years after the final payment is made and all pending matters are closed, plus additional time if an audit, litigation, or other legal action involving the records is started before or during the original ten ~~(10)~~ year period ends; and

(v) Adequate policy regarding the distribution of the member's medical records if a member changes from one primary care physician to another.

(L) Comply with regulations for advance directives;

(M) The health plan is prohibited from refusing enrollment of a member, disenrolling a member or otherwise discriminating against a member solely on the basis of age, sex, race, physical or mental handicap, national origin, or type of illness or condition;

(N) Require that all subcontractors meet the same requirements as are in effect for the health plan that are appropriate to the service or activity delegated under the subcontract;

(O) Provide member services;

(P) Maintain, at all times, an appropriate certificate of authority to operate issued by the Nebraska Department of Insurance;

(Q) Comply with all applicable state and federal regulations, such as the prohibition against assisted suicide; inappropriate use of funds/profits, lack of mental health parity, and the noncompliance with the provisions of the Hyde Amendment;

(R) Prohibit discrimination against providers based upon licensing;

(S) Prohibit hiring, employing, contracting with or otherwise conducting business with individuals or entities barred from participation in Medicaid or Medicare;

(T) Ensure adequate numbers of providers in its network to meet the needs of its members;

(U) Provide written notice to the member of any adverse action regarding the provision of services that complies with all federal and state requirements. Allow member to appeal decisions to deny, limit or terminate authorization, coverage, or payment of services. Health plans ~~Plans~~ must allow members to file complaints, grievances and appeals, according to Title 482 NAC 7;

(V) Comply with the Maternity and Mental Health Requirements in the Health Insurance Portability and Accountability Act of 1996 the maternity length of stay and mental health parity requirements specifically requiring coverage for a hospital stay following a normal vaginal delivery not be limited to less than forty-eight ~~(48)~~ hours for both the mother and newborn child, and the health coverage for a hospital stay in connection with childbirth following a cesarean section not be limited to less than ninety-six ~~(96)~~ hours for both the mother and newborn child;

(W) Report all fraud and abuse information to the Department;

(X) Comply with the provisions of Title 482 NAC 4~~-004~~ for provider payments;

(Y) Sign a contract with the Department and comply with all contract requirements and any other responsibilities specified by the Department in the overall operation of Heritage Health, and any other activities deemed appropriate by the Department and supported in regulations and contractual amendments;

(Z) Comply with all applicable requirements of the Health Insurance Portability and Accountability Act of 1996 and Balanced Budget Act of 1997; and

(AA) Provide access to behavioral health services necessary referrals twenty-four ~~(24)~~ hours per day, seven ~~(7)~~ days per week.

003. HEALTH CHECK EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT. The health plan must develop a program to ensure the delivery of Health Check Early and Periodic Screening, Diagnosis and Treatment services.

003.01 CONTACT WITH ELIGIBLE FAMILIES. The health plan must contact eligible families who have children age twenty ~~(20)~~ and younger within sixty ~~(60)~~ days of enrollment and encourage them to make an appointment for the required components of Health Check Early and Periodic Screening, Diagnosis and Treatment. The health plan must also counsel the

family regarding the importance of health supervision and regular check-ups and assist in removing barriers to care. If necessary, the health plan must assist families with appointment scheduling and arranging transportation.

003.01(A) REQUIRED COMPONENTS. The required components are health screening, including medical, vision, hearing and dental screening, per ~~(see~~ 471 NAC 33-000~~)~~.

003.02 THIRD PARTY LIABILITY REQUIREMENTS. The health plan must utilize a cost avoidance methodology whenever there is a verified third party resource. Under Federal Law, the Department is required to identify legally liable third parties and treat verified third party liability as a resource of the member. The health plan, or its subcontractors or providers, must not pursue collection from the member, but directly from the liable third party payers, except as allowed in Title 477 NAC. The health plan must assume responsibility for all third party liability requirements.

003.02 (A) ASSIGNMENT OF RIGHTS. The health plan shall exercise full assignment rights as applicable and shall be responsible for making every reasonable effort to determine third parties to pay for services rendered to members and cost avoid and/or recover any such liability for the third party.

003.02(B) COORDINATION OF BENEFITS. The health plan shall coordinate benefits in accordance with 42 CFR 133.135 et seq and Title 471 NAC 3~~-004~~, so that costs for services otherwise payable by the health plan are cost avoided or recovered from a liable party. The two methods used are cost avoidance and post-payment recovery.

004. PROVIDER PAYMENTS. The following provisions apply regarding payments to providers by the health plans.

004.01 TIMELINESS OF PROVIDER PAYMENTS. The health plan must provide payment to a provider of services on a timely basis, consistent with Medicaid claims payment procedures and the minimum standards provided below, unless the health care provider and health plan agree to a capitated payment schedule or other arrangement.

004.01(A) ELECTRONIC CLAIMS SYSTEM. The health plan must maintain a health information system that includes the capability to electronically accept claims for adjudication and make payments in accordance with the standards set forth in the Health Insurance Portability and Accountability Act of 1996. Such electronic system must have the ability to transmit data to a central data repository that complies with the requirements for confidentiality of information under the Medicare program.

004.01(B) MINIMUM TIMEFRAMES. The health plan must comply with the following minimum timeframes for the submission and processing of clean claims. Timeframes are calculated from the day the clean claim is received by the health plan until the date of the postmark that returns the claim either to the provider or until posted on an electronic system;

(i) The health plan must pay ninety ~~(90%)~~ percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within fifteen ~~(15)~~ business days of the date of receipt. The date of receipt is the date the health plan receives the claim; and

(ii) The health plan must also pay ninety-nine ~~(99%)~~ percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared

health facilities, within sixty ~~(60)~~ days of the date of receipt. The health plan must fully adjudicate, either ~~(~~pay or deny,~~)~~ all other claims within six ~~(6)~~ months of the date of receipt.

004.01(C) PROMPT INVESTIGATION AND SETTLEMENT OF CLAIMS. The health plan must comply with the requirements related to claim forms as set forth in Title 471 NAC. For providers of outpatient services, this must include the use of CMS-1500 form, the Health Insurance Claim form, and the standard electronic Health Care Claim: Professional Transaction form, ~~(~~ASC X12N 837~~)~~. For hospitals providing inpatient or outpatient services, this must include the CMS-1450 form, ~~(~~UB-92~~)~~, and the standard electronic Health Care Claim: Institutional Transaction form, ~~(~~ASC X12N 837~~)~~.

004.01(D) SYSTEM REQUIREMENT. The health plan must maintain an editable system for recording all claims, clearly indicating the date on which a claim is received and the date(s) any action(s) on the claim occur.

004.01(E) PAYMENT STANDARD. The health plan must pay clean claims promptly as provided above after the date of receipt of or electronic notice of the claim. If, for whatever reason, the claim is submitted electronically and in written form, the date of the earlier submission of the claim will be the date of notice from which the health plan must calculate the maximum thirty day period.

004.01(F) NOTICE OF CONTESTED CLAIM. The health plan must provide written or electronic notice to the provider of a determination by the health plan that the claim is a contested claim with the returned claim. The written or electronic notice must comply with the provisions in Title 482 NAC 4~~-004~~.

004.01(G) NOTICE REQUIREMENT FOR PARTIALLY CONTESTED CLAIM. If the health plan determines that part of a claim is a contested claim and returns the claim, the health plan must provide written or electronic notice of that determination to the entity submitting the claim and must proceed to pay the portion of the claim determined by the health plan to be a clean claim timely.

004.01(H) PROHIBITED ACTION. In no instance will the health plan contest or return a claim or a portion of a claim because the claim fails to provide certain information if the missing information does not prevent the plan from adjudicating the claim.

004.01(I) NOTICE OF INSUFFICIENT INFORMATION. If the health plan determines a claim provides insufficient information for the payment of the claim, the health plan must provide written or electronic notice of this determination to the entity submitting the claim timely including the following information:

(i) All of the reasons for the denial of the claim;
(ii) The date the service was rendered, the type of service rendered, the name of the provider who rendered the service and the name of the person to whom the service was rendered; and
(iii) The address of the office responsible for handling the claim, and means by which the office may be contacted without toll charges exceeding the charges that otherwise apply for the provider or member to place a call in their area code.

004.01(J) EFFECTIVE NOTICES AND PAYMENTS. Written notice of a claim will be effective upon the date that the claim is received. Electronic transmission of the claim will

be the date the claim is posted to the electronic transfer system. Payment and notices from the health plan will be effective as of the date that:

(i) A draft or other valid instrument equivalent to payment is placed in the United States mail in a properly addressed, postage-paid envelope;
(ii) The date of posting of the item to an electronic transfer system; or
(iii) The date of delivery of the draft or other valid instrument equivalent to payment if (i) or (ii) do not otherwise apply.

004.01(K) CONTENTS OF A NOTICE OF A CONTESTED CLAIM. The health plan must specify in its notice of a returned claim at least the following information:

(i) The name, address, telephone number and facsimile number of the office handling the claim or other designated claims representative knowledgeable about the claim with which the person submitted the claim, or provider should communicate to resolve problems with the claim;
(ii) The date of the service, the type of service, the provider of the service, and the name of the person to whom the service was rendered to the extent that this information is known to the health plan;
(iii) The specific information needed by the health plan to make a determination that the claim is a clean claim;
(iv) The date the claim was received; and
(v) In addition, the health plan must include in a notice regarding a claim determination in part a contested claim, a statement specifying those portions of the claim that are considered to be clean claim, and the amounts payable with respect to the clean claim portion. Requests for information made by the health plan on a contested claim must be reasonable and relevant to the determination of whether the claim is a clean claim or claim that must be denied.

004.01(L) USE OF INTERMEDIARIES. A health plan's use of subcontractors to perform one or more of the health plan's claims handling functions must not mitigate, in any way, the health plan's responsibility to comply with all of the terms of Title 482 NAC.

004.01(M) ELECTRONIC REMITTANCE ADVICE. Electronic remittance advice must be provided in accordance with the standards set forth in the Health Insurance Portability and Accountability Act of 1996.

004.01(N) CLAIM STATUS INQUIRY AND RESPONSE. Electronic claim status inquiry and response must be provided in accordance with the standards set forth in the Health Insurance Portability and Accountability Act of 1996.

004.01(O) ENCOUNTER DATA. The health plan must maintain an information system that includes the capability to collect data on member and provider characteristics, and claims information through an encounter data system. The health plan must submit encounter data to the Medicaid Management Information System monthly per Departmental specifications.

005. CORE BENEFITS PACKAGE GENERAL PROVISIONS. All services provided under managed care must meet the requirements of Title 471 NAC unless specifically waived by the Department. The health plan must apply the same guidelines for determining coverage of services for the Heritage Health member as the Department applies for other Medicaid members. The plan must base the actual provision of a service included in the core benefits package on whether the service could have been covered under Medicaid fee-for-service basis under Title 471 NAC.

005.01 PRIOR AUTHORIZATIONS. Family planning services, per ~~(see~~ 482 NAC 4-~~005.04)~~, emergency services, and Native Americans seeking tribal clinic or Indian Health hospital services do not require prior authorization or provision by the primary care physician or participating network provider. All covered emergency services, per ~~(see~~ 482 NAC 4-~~005.05)~~, must be available twenty-four ~~(24)~~ hours per day, seven ~~(7)~~ days per week, and are not to be limited to plan-network providers. The member may access these services from any Medicaid-enrolled provider of their choice, and the member may access these services without a referral.

005.01(A) REIMBURSEMENT. The Department requires the health plan to reimburse providers, network and out-of-network, for appropriate medical screening performed during an emergency room visit. The payment of claims to out-of-network providers are subject to the requirements in 482 NAC 4-~~006.07(A)~~. Electronic referral and authorization must be provided in accordance with the standards set forth in the Health Insurance Portability and Accountability Act of 1996.

005.01(B) EXCEPTION. In addition to the health ~~plans~~ plan's provision, abortions must be prior authorized by the Department.

005.02 SERVICES IN THE CORE BENEFITS PACKAGE. Services provided in the core benefits package are as follows and represent covered services under Heritage Health. The health plan is responsible for working with the Department to ensure the member has access to all services.

005.02(A) PHYSICAL HEALTH SERVICES. The physical health services include those listed below as covered by Title 471 NAC:

(i) Inpatient hospital services, including transitional hospital services and transplant services ~~(see 471 NAC 10-000)~~;
(ii) Outpatient hospital services ~~(see 471 NAC 10-000)~~;
(iii) Ambulatory surgical center (ASC) services ~~(see 471 NAC 10-000 and 471 NAC 26-000)~~;
(iv) Physician services, including services provided by nurse practitioners, certified nurse midwives, and physician assistants, and clinic-administered injections or medications, and anesthesia services including those provided by a certified registered nurse anesthetist ~~(see 471 NAC 18-000)~~;
(v) Services provided in federally-qualified health centers and rural health clinics ~~(see 471 NAC 29-000 and 471 NAC 34-000)~~;
(vi) Services provided in Indian Health Service facilities ~~(see 471 NAC 11-000)~~;
(vii) Clinical and anatomical laboratory services, including the administration of blood draws completed in the physician's office or an outpatient clinic for a behavioral health diagnosis ~~(see 471 NAC 10-000, 471 NAC 18-000, 471 NAC 20-000, 471 NAC 26-000, 471 NAC 32-000)~~;
(viii) Radiology services ~~(see 471 NAC 10-000)~~;
(ix) Health Check services ~~(see 471 NAC 33-000)~~;
(x) Home health services ~~(see 471 NAC 9-000)~~;
(xi) Private duty nursing services ~~(471 NAC 13-000)~~;
(xii) Therapy services (physical therapy, occupational therapy, and speech pathology and audiology) ~~(see 471 NAC 14-000, and 471 NAC 23-000)~~;

(xiii) Durable medical equipment and medical supplies, including hearing aids, orthotics, prosthetics, and nutritional supplements ~~(471 NAC 7-000, 471 NAC 8-000, 471 NAC 19-000, 471 NAC 15-000)~~;
(xiv) Podiatry services ~~(471 NAC 19-000)~~;
(xv) Chiropractic services ~~(471 NAC 5-000)~~;
(xvi) Vision services ~~(471 NAC 24-000)~~;
(xvii) Free standing birth center services ~~(471 NAC 42)~~;
(xviii) Hospice services, except when provided in a nursing facility ~~(471 NAC 36-000 and 471 NAC 12-000)~~;
(xix) Skilled or rehabilitative and transitional nursing facility services ~~(471 NAC 21-000, 471 NAC 12-000, and 471 NAC 13-000)~~;
(xx) Ambulance services ~~(471 NAC 4-000)~~;
(xxi) Non-emergency transportation services ~~(471 NAC 27-000)~~;
(xxii) Transplant services; ~~and~~
(xxiii) Pharmacy services ~~(471 NAC 16-000)~~; and~~.~~
(xxix) Dental services.

005.02(B) BEHAVIORAL HEALTH SERVICES. The behavioral health services include those listed below as covered by Title 471 NAC:
(i) Services for individuals age twenty ~~(20)~~ and under, see Title 471 NAC 32:
(1) Crisis stabilization services (includes treatment crisis intervention);
~~(2) Inpatient psychiatric hospital (acute and sub-acute); and~~
(3) Psychiatric residential treatment facility (age 19 and under).
(4) Outpatient assessment and treatment:
~~(a) Partial hospitalization;~~
(a)~~(b)~~ Day treatment;
~~(c) Intensive outpatient;~~
(b)~~(d)~~ Medication management;
(c)~~(e)~~ Outpatient psychotherapy (individual, family, or group);
(d)~~(f)~~ Injectable psychotropic medications;
(e)~~(g)~~ Substance use disorder ~~treatment~~ outpatient psychotherapy;
(f)~~(h)~~ Psychological evaluation and testing;
(g)~~(i)~~ Initial diagnostic interview~~s~~;
(h)~~(j)~~ Sex offender risk assessment;
~~(k) Community treatment aide services;~~
~~(l) Comprehensive child and adolescent assessment addendum;~~
(i)~~(m)~~ Hospital observation room services (up to 23 hours and 59 minutes in duration);
(j)~~(n)~~ Parent child interaction therapy;
(k)~~(o)~~ Child-parent psychotherapy;
(l)~~(p)~~ Applied behavioral analysis;
(m)~~(q)~~ Multi-systemic therapy; and
(n)~~(r)~~ Functional family therapy.
(5) Rehabilitation services:
(a) Day treatment and intensive outpatient;
(b) Community treatment aid services;
~~(c) Professional resource family care; and~~
(c)~~(d)~~ Therapeutic group home.
(ii) Services for individuals age twenty-one ~~(21)~~ and over, see Title 471 NAC 20 and 35:

(1) Crisis stabilization services (includes ~~treatment~~ crisis treatment and stabilization ~~intervention~~);
(2) Inpatient psychiatric hospital services (acute and sub-acute);
(3) Outpatient assessment and treatment:
  (a) ~~Partial hospitalization;~~
  (b) ~~Social detoxification;~~
  (c) (a) Day treatment;
  (d) (b) Intensive outpatient;
  (e) (c) Medication management;
  (f) (d) Outpatient psychotherapy (individual, family, or group);
  (g) (e) Injectable psychotropic medications;
  (h) ~~Substance use disorder treatment;~~
  (i) (f) Psychological evaluation and testing;
  (j) (g) Electroconvulsive therapy, and;
  (k) (h) Initial diagnostic interviews;
  (l) ~~In-home psychiatric nursing.~~
  (m) ~~Ambulatory detoxification; and~~
  (n) ~~In-home psychiatric nursing.~~

(4) Rehabilitation services:
  (a) ~~Dual-disorder residential;~~
  (b) ~~Intermediate residential for substance use disorder;~~
  (c) ~~Short-term residential;~~
  (d) ~~Halfway house;~~
  (e) ~~Therapeutic community for substance use disorder only;~~
  (f) (a) Community support;
  (g) (b) Psychiatric residential rehabilitation;
  (h) (c) Secure residential rehabilitation;
  (i) (d) Assertive community treatment ~~and alternative community support~~; ~~and~~
  (j) (e) Day rehabilitation;~~.~~
  (f) Medically Monitored Inpatient Withdrawal Management (MMIW); and
  (g) Opioid Treatment Program (OTP).

005.02(C) AMOUNT, DURATION, AND SCOPE. The health plan must provide the above services in amount, duration and scope defined by the Department in Title 471 NAC. The health plan must provide care and services when medically necessary to ensure the member receives necessary services. The health plan must also ensure the services provided to the member are as accessible, ~~(~~in terms of timeliness, amount, duration and scope,~~)~~ as those services provided to the non-enrolled Medicaid client.

005.02(D) VALUE-ADDED SERVICES. The Department allows the health plan to provide medically necessary services to the member that are in addition to those covered under Medicaid. The Department allows the health plan to provide value-added services that are more cost effective than the covered service and the health status of the member is expected to improve or at least stay the same. If the plan provides additional or value-added services, the total payment to the health plan will not be adjusted but will remain within the certified rates agreed upon in any resulting contract and approved by the Centers for Medicare and Medicaid Services.

005.03 EXCLUDED SERVICES. The following Medicaid coverable services are excluded from the Heritage Health core benefits package and are not the responsibility of the health plan. Members must access these services through Medicaid. For all Medicaid covered services, the health plan is required to coordinate the members care to promote the continuity of care. The health plan and enrollment broker must inform the member of the availability of these services and how to access them. Excluded services include:

~~(A) Dental services (see Title 471 NAC 6 and 482 NAC 5);~~

(A)~~(B)~~ Services in intermediate care facilities for persons with developmental disabilities ~~Intermediate Care Facilities for Persons with Developmental Disabilities~~, per ~~(see~~ Title 471 NAC 31~~)~~;

(B)~~(C)~~ Any institutional long-term care nursing facility services at a custodial level of care, per ~~(see~~ Title 471 NAC 12 and 471 NAC 13~~)~~;

(C)~~(D)~~ School-based services, per ~~(see~~ Title 471 NAC 25~~)~~;

(D)~~(E)~~ All home and community-based waiver services, per ~~(see~~ Title 404 and 480 NAC~~)~~;

(E)~~(F)~~ Targeted case management, per ~~(see~~ Title 480 NAC~~)~~; and

(F)~~(G)~~ Medicaid state plan personal assistance services, per ~~(see~~ Title 471 NAC 15~~)~~.

005.04 FAMILY PLANNING SERVICES. Approval by the member's primary care provider and health plan is not required for family planning services. The health plan and enrollment broker must inform Heritage Health members of their freedom of choice for family planning services and that they are not restricted to a provider participating in Heritage Health but they must use a Medicaid enrolled provider.

005.04(A) SERVICES COVERED UNDER FAMILY PLANNING. Family planning services are 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 and vasectomy. The health plan must reimburse treatment for sexually transmitted infections in the same manner as family planning services, without referral or authorizations.

005.04(A)(i) EXCLUSIONS. Family planning services do not include hysterectomies, other procedures performed for a medical reason (such as removal of an intrauterine device due to infection) or abortions.

005.04(A)(ii) PAYMENT. Family planning services are to be paid by the health plan even if the provider is not part of the health plan's network.

005.05 EMERGENCY SERVICES. Approval by the member's primary care provider and health plan is not required for receipt of emergency services. The health plan and enrollment broker must inform Heritage Health members that approval of emergency services is not required and must educate members regarding the definition of an ~~"~~emergency medical condition~~,"~~ and how to appropriately access emergency services.

005.05(A) EMERGENCY SERVICES PROVIDED TO MANAGED CARE MEMBERS. The health plan must cover and pay for emergency services regardless of whether the provider that furnishes the services has contracted with the health plan.

005.05(B) EMERGENCY MEDICAL CONDITIONS. An emergency medical condition is a medical condition, which manifests itself by acute 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~~i) 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~~ii) Serious impairment to bodily functions; or

(~~3~~iii) Serious dysfunction of any bodily organ or part.

005.06 FEDERALLY QUALIFIED HEALTH CENTERS. The health plan must contract with any federally qualified health center located within the designated coverage area or otherwise arrange for the provision of federally qualified health center services:

(A) If a health plan reimburses a federally qualified health center on a fee-for-service basis, it cannot pay less for those services than it pays other providers;

(B) Federally qualified health center's electing to be reimbursed on a negotiated risk basis are not entitled to reasonable cost reimbursement. If the federally qualified health center requests reasonable cost reimbursement, the health plan must reimburse the federally qualified health center at the same rate it reimburses its other subcontractors of this provider type;

(C) The health plans must report to the Department the total amount paid to each federally qualified health center;

(D) Federally qualified health center payments include direct payments to a medical provider who is employed by the federally qualified health center; and

(E) The same reasonable efforts that are applied to the federally qualified health center, apply to rural health clinics and tribal clinics.

006. PAYMENT FOR SERVICES. The Department pays a monthly capitation fee health plan for each enrolled member for each month of Heritage Health coverage ~~(per member per month)~~. The monthly capitation fee includes payment for all services in the core benefits package.

006.01 TIMELY PAYMENT FOR SERVICES. The health plan must provide payment to providers for services rendered on a timely basis consistent with Medicaid claims payment procedures, unless the health care provider and organization agree to an alternative payment schedule.

006.02 PAYMENT IN FULL. Payment to the health plan is payment in full for all services included in the core benefits package. The health plan shall not request additional payment from the Department or the member.

006.03 CAPITATION RATES. The capitation rates are actuarially determined and are based on geographic location, eligibility category, gender, age and type of services. The Department will adjust rates, and complete all necessary contract amendments, when it is determined appropriate, based on any changes in Medicaid fee-for-service rates, or in instances where an error or omission in the calculation of the rates has been identified.

006.04 INCORRECT PAYMENTS. Medicaid shall not normally recoup payments from health plans. However, in situations where payments are made incorrectly, Medicaid shall work with the health plan to identify the discrepancy and shall recoup/reconcile such payments.

006.05 ENROLLMENT REPORT. On or before the first day of each month, the Department or the enrollment broker will provide to each health plan a monthly enrollment report that lists all enrolled and disenrolled members for that month. This report will be used as the basis for the monthly capitation payments to the health plan. The health plan is responsible for

payment of all services in the core benefits package provided to members listed on the enrollment report generated for the month of coverage. If an enrollment report does not list an eligible member, the Department will be responsible for all medical expenses.

006.06 COVERAGE FOR PREGNANT WOMEN, NEWBORNS, AND 599 CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP). Coverage for pregnant women, newborns, and 599 Children's Health Insurance Program (CHIP) is provided within the following parameters:

(A) Pregnant Woman and Newborn are Medicaid Eligible: Coverage is provided for the pregnant woman from the month of enrollment until disenrollment occurs; and for the newborn from the month of birth until disenrollment occurs. Payment to the health plan is made for the month(s) of enrollment for the pregnant woman and the newborn until disenrollment occurs;

(B) Only the Newborn is Medicaid Eligible: Coverage is provided for the pregnant woman from the month of enrollment until disenrollment occurs. Coverage for the birth and post-partum care for the mother is provided for the month of birth through the month in which disenrollment occurs ~~the sixtieth 60th day following the month of birth occurs~~. Coverage for ~~only~~ the newborn is provided from the month of birth until disenrollment occurs ~~continues past the sixty (60) day postpartum period as long as the newborn remains eligible and enrolled~~. Payment to the health plan is made for the month(s) of enrollment for the pregnant woman and the newborn until disenrollment occurs; and

(C) 599 Children's Health Insurance Program (CHIP): Coverage is provided for the unborn child of the pregnant woman that is otherwise ineligible for Medicaid under 599 Children's Health Insurance Program (CHIP). Coverage is limited to prenatal care and pregnancy-related services solely for the unborn child. This coverage does not include postpartum care and medical issues separate to the mother and unrelated to the pregnancy.

006.07 BILLING THE MEMBER. The health plan may not bill a member for a Medicaid coverable service, regardless of the circumstances. The provider may only bill the member pursuant to Title 471 NAC.

006.07(A) OUT-OF-NETWORK. The health plan may or may not be responsible for an out-of-network service if the service is a Medicaid-coverable service. The agreement the health plan has with the provider will determine whether the health plan is responsible to pay the provider. In some cases, the plan may not pay the provider. The health plan ~~is not required to~~ cannot pay a non-Medicaid enrolled provider with Medicaid dollars for a Medicaid-covered service. Emergency services provided by an out-of-network provider must be paid by the health plan according to Title 482 NAC 4.

006.08 REINVESTMENT AND FORFEITED FUNDS. The health plan must provide for the reinvestment of profits in excess of the contracted amount, performance contingencies imposed by the department, and any unearned ~~(forfeited)~~ hold back funds, pursuant to Neb. Rev. Stat. § 71-831, and any successor statutes. The health plan must establish and manage two accounts: a hold back account and a reinvestment account. Both accounts must be separate from other accounts. Neither accounts can have risk-bearing investments. Both accounts must be created and operated in full compliance with the Nebraska Uniform Trust Code, per ~~(~~Neb. Rev. Stat. § 30-3801 to 30-38,110~~)~~.

006.09 QUALITY PERFORMANCE PROGRAM AND HOLD BACKS. The health plan must participate in the Department's quality performance program. The quality performance

program must be in accordance with Neb. Rev. Stat. § 71-831 and any successor statutes. Pursuant to Neb. Rev. Stat. § 71-831, and any successor statutes, the health plans must hold back a pre-determined amount in a separate account. The hold back is the aggregate of all income and revenue earned by the health plans and related parties under the contract and constitutes the maximum amount available to the health plan to earn via the quality performance program. The health plans must report its performance measures that affect its eligibility to earn the hold back funds, as the Department requires:

(A) Each year of the contract constitutes a performance year, beginning on the contract start date. The Department will assess the health plan performance based on the measures annually and notify the health plan of the amount of the earned hold back and unearned ~~(forfeited)~~ hold back. The Department will make this determination within six ~~(6)~~ months after the end of each contract year;

(B) All earned hold back funds become the property of the health plan;

(C) The health plan must deposit unearned ~~(forfeited)~~ hold back funds into the reinvestment account. The Department will reimburse the Federal share of the forfeited funds to the Centers for Medicare and Medicaid Services. The remaining State share of the forfeited hold back funds will become the property of the Department;

(D) No interest will be due to either party on hold back funds retained by the health plan or returned to the Department; and

(E) Any earned hold back will not be included in the health plan's income for the year nor considered part of the medical loss ratio calculation.

006.10 HOLD BACKS, PENALTIES, AND LIQUIDATED DAMAGES. A percentage of the aggregate of all income and revenue the health plan and related parties under the contract earn must be at risk as a penalty if the health plan fails to meet minimum performance metrics, pursuant to Neb. Rev. Stat. §71-831 and any successor statutes. The Department will provide the minimum performance metrics to the health plans prior to year two ~~(2)~~ of the contract. The health plans must report its performance on the minimum performance metrics, as the Department requires:

(A) The Department reserves the right to modify annually the measures and criteria for earning the hold back funds and assessing liquidated damages; and

(B) In the event the Department modifies the measures or criteria, the Department will provide the health plans sixty ~~(60)~~ calendar days advance written notice. These measures will include operational or administrative measures that reflect the health plans' business processes and may lead to improved access to and quality of care, Centers for Medicare and Medicaid Services Medicaid Adult and Child Core Measure sets, healthcare effectiveness data and information set measures, and Departmental-identified measures that represent opportunities for improvement as indicated by Heritage Health historical performance.

006.11 DEPARTMENTAL RESPONSIBILITIES. The Department will ensure the following:

(A) The annual financial reporting package, including the medical loss ratio rebate calculation, risk corridor calculation, and earned/unearned hold back calculation is reviewed, and written approval is provided, within forty-five ~~(45)~~ calendar days after receipt from the health plan;

(B) The health plan will transfer all funds deposited into the reinvestment holding account to the State by the health plan for reconciliation and reimbursement of the Federal share via reporting on Centers for Medicare and Medicaid Services Form 64;

(C) The federal share of such dollars is determined and reimbursed to the federal government;

(D) The remaining State share will return to the health plan for deposit into the reinvestment distribution account, which the health plan manages, subject to contractual requirements; and

(E) The Department will hold the health plan responsible and accountable for the necessary fiduciary duties and functions required to administer the reinvestment holding and reinvestment distribution accounts. Oversight of the financial accounting will be in accordance with the financial management reporting requirements.