1-000 General Information - Nebraska Health Connection

1-001 Background Information: In 1993, State legislation was passed which directed the Department to develop a managed care program. Managed care in Nebraska was implemented in July, 1995.

The Nebraska Health Connection (NHC) consists of the following program components:

1. NHC Benefits Package, including -
   a. The Basic Benefits Package (see 482 NAC 4-000, i.e., medical/surgical services), and
   b. The Mental Health and Substance Abuse (MH/SA) Package (see 482 NAC 5-000);
2. Enrollment Broker Services (see 482 NAC 2-000 and 3-000 for regulations applicable to the Basic Benefits Package); and
3. Data Management Services. (Data Management provides the technological infrastructure for data retrieval and reporting and is not programmatically discussed in this Title.)

The Basic Benefits Package was implemented on July 1, 1995, in the designated coverage area (see 482 NAC 2-001). The Mental Health/Substance Abuse (MH/SA) Package was implemented on a statewide basis on July 17, 1995.

The NHC utilizes one Primary Care Case Management (PCCM) Network and one Health Maintenance Organization (HMO) for delivery of the Basic Benefits Package. A Prepaid Health Plan (PHP) is utilized for the delivery of the MH/SA Package, as a carve-out from the Basic Benefits Package.

Enrollment into the NHC is mandatory for specified clients (see 482 NAC 2-001). During enrollment in the designated coverage area, the client chooses a Primary Care Physician (PCP) and medical/surgical plan for the Basic Benefits Package, ensuring each client a "medical home." In these areas, the client's enrollment is facilitated by the Enrollment Broker Services (EBS). Enrollment for the MH/SA package is "automatic," i.e., the client is not required to make a choice of PCP and medical/surgical plan, but is required to access MH/SA services through the contracted MH/SA plan.

1-002 Purpose: The Department developed the NHC 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 the State. The program shall offer clients expanded choices, increased access to primary care, greater coordination and continuity of care, cost effective quality health services, and better health outcomes through effective care management.

1-003 Legal Basis: The Managed Care Plan Act, codified as sections 68-1048 through 68-1066, Neb.Rev.Stat. and 68-1030 and 68-1031, Neb.Rev.Stat. R.R.S., 1943, directed the Department to develop a managed care program.

The NHC, as part of the Nebraska Medical Assistance Program (NMAP), operates under the federal authority of the Medicaid program, Title XIX of the Social Security Act. Certain requirements of the Social Security Act have been waived by the federal government upon the Department's request under section 1915(b) of the Act. These elements include: statewideness (under 1902(a)(1) of the Act); comparability of services (under 1902(a)(10)(B) of the Act); and freedom of choice (under 1902(a)(23) of the Act). In addition, the Department is relying on Section 1915(b)(2) of the Act to allow a central broker to assist clients in choosing among health plans and Section 1915(b)(4) to require clients to obtain services only from specified providers under the NHC.

The above reference to the pertinent federal law may not be an exhaustive list. Any provision of the NHC which is in conflict with federal Medicaid statutes, regulations, or other Centers for Medicare and Medicaid Services (CMS) policy guidance will be amended to conform to the provisions of these laws, regulations and federal policy. Such changes will be effective on the effective date of the statutes or regulations necessitating them, and will be binding on the medical/surgical or MH/SA plan even though such changes, and subsequent amendments to the medical/surgical plan's contract, may not have been reduced to writing and formally agreed upon and executed by the Department.

1-004 Definitions: The following definitions apply under the NHC:

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

Auto-Assignment: The process by which a client in the designated coverage area for the Basic Benefits Package, who does not select a Primary Care Physician (PCP) and medical/surgical plan within a predetermined length of time during enrollment activities, is automatically assigned to a PCP and medical/surgical plan. Also referred to as Assignment or Default Assignment.

Basic Benefits Package: The following medical/surgical services represent a minimum benefits package that must be provided by the medical/surgical plan to clients enrolled in the NHC:

1. Inpatient hospital services (see 471 NAC 10-000);
2. Outpatient hospital services (see 471 NAC 10-000);
3. Clinical and anatomical laboratory services, excluding laboratory services related to Mental Health/Substance Abuse (MH/SA) (see 471 NAC 10-000 and 18-000);
4. Radiology services, excluding radiology services related to MH/SA (see 471 NAC 10-000 and 18-000);
5. HEALTH CHECK (Early Periodic Screening and Diagnosis and Treatment as federally mandated) services (see 471 NAC 33-000 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 18-000 and 29-000);
7. Home health agency services (see 471 NAC 9-000). (This does not include non-home health agency approved Personal Care Aide Services under 471 NAC 15-000);
8. Private duty nursing services (see 471 NAC 13-000);
9. Therapy services, including physical therapy, occupational therapy, and speech pathology and audiology (see 471 NAC 14-000, 17-000, and 23-000);
10. Durable medical equipment and medical supplies, including hearing aids, orthotics, prosthetics and nutritional supplements (see 471 NAC 7-000 and 8-000);
11. Podiatry services (see 471 NAC 19-000);
12. Chiropractic services (see 471 NAC 5-000);
13. Ambulance services (see 471 NAC 4-000);
14. Medical transportation services (see 471 NAC 27-000) (Note: Clients participating in the PCCM Network receives non-urgent medical transportation through the Department);
15. Visual services (see 471 NAC 24-000);
16. Family Planning services (see 471 NAC 18-000 and 482 NAC 5-004.03);
17. Emergency services (see 471 NAC 10-000 and 482 NAC 5-004.04);
18. Transitional MH/SA services (see 471 NAC 20-000 and 32-000 and 482 NAC 5-006);
19. Federally Qualified Health Center (FQHC), Rural Health or Tribal Clinic services (see 471 NAC 11-000, 29-000, 34-000 and 482 NAC 5-004.06);
20. Certified Nurse Midwife services (see 471 NAC 18-000 and 482 NAC 5-004.07);
21. Skilled/Rehabilitative and Transitional Nursing Facility services (see 471 NAC 12-000 and 482 NAC 2-004.04);
22. Transitional Hospitalization services (see 471 NAC 10-000, 482 NAC 2-002.04D, 2-003.03 and 2-004.01A); and
23. Transitional Transplantation services (see 471 NAC 10-000 and 482 NAC 2-004).

Medicaid regulations governing coverage of these services are contained in 471 NAC.

Capitation Fee: The fee paid by the Department to a Health Maintenance Organization (HMO) or a Prepaid Health Plan (PHP) on a monthly basis for each client enrolled with the medical/surgical plan. The fee covers all services required to be provided by the HMO or PHP to the client, regardless of whether the client receives services or not.

Carve-Out: A term used to indicate that the mental health and substance abuse package is separated or "carved-out" from the Basic Benefits Package for ease of administration, contracting and federal waiver approval. The Nebraska Health Connection is still considered one program, encompassing both components.

Case Management Fee: The fee paid by the Department to the Primary Care Physician within the Primary Care Case Management Network on a monthly basis for primary care case management services provided to each enrolled client.

Choice: The client's freedom to choose a Primary Care Physician and medical/surgical plan from all available options within the Nebraska Health Connection in the designated coverage areas. Enrollment for the Mental Health and Substance Abuse Package is "automatic" and does not require a choice of provider or plan.

Client: Any individual entitled to benefits under Title XIX of the Social Security Act, and under the Nebraska Medical Assistance Program as defined in the Nebraska Administrative Code.

CMS: Centers for Medicare and Medicaid Services. The division within the federal Department of Health and Human Services responsible for administering the Medicaid program.

Contract: The legal and binding agreement between the Nebraska Department of Health and Human Services Finance and Support and any of the vendors participating in the Nebraska Health Connection.

Covered Services: The Nebraska Health Connection Benefits Package pursuant to the Nebraska Administrative Code and all other directives issued by the Department.

Cutoff: 5:00 p.m. Mountain Standard Time on the fourth working night before the end of the month. Data must be entered on the Department's computer system by this deadline in order for changes to be effective the first of the month.

Department: The Department of Health and Human Services Finance and Support.

Designated Coverage Area: Areas of the State in which clients are considered mandatory for participation in the Nebraska Health Connection. For purposes of the Basic Benefits Package, the designated coverage area includes those areas in which the mandatory client's eligibility assistance case is managed by the Health and Human Services (HHS) Office, primarily in the Douglas and Sarpy Counties in the Eastern HHS District Office (also referred to as District 8), or in the Southeastern District Office, primarily in Lancaster County (also referred to as District 7) (see 482-000-1, Map Identifying Designated Coverage Areas). The Mental Health and Substance Abuse component of the NHC is provided on a statewide basis.

Designated Specialty Care Physician: 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 medical/surgical 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. The provision of a designated specialty care physician does not apply to the Mental Health and Substance Abuse component of the NHC.

Disenrollment: Removal of a client from the Nebraska Health Connection.

Emergency Medical Condition: A medical or behavioral health condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing 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 person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
2. Serious impairment to such person's bodily functions;
3. Serious impairment of any bodily organ or part of such person; or
4. Serious disfigurement of such person.

Emergency Services: Covered inpatient and outpatient services that are furnished by a qualified Medicaid provider and are needed to evaluate or stabilize an emergency medical condition.

Encounter Data: Detailed claims information submitted by a Health Maintenance Organization or Prepaid Health Plan representing all services rendered to a client.

Enrollment: Completion by the client of all requirements of the enrollment process in the designated coverage areas for purposes of the Basic Benefits Package, including receiving managed care information, completing the health assessment, and selecting a Primary Care Physician (PCP) and medical/surgical plan. In some cases, if a client does not complete enrollment, s/he is automatically "assigned" to a PCP and medical/surgical plan.

Enrollment Broker Services (EBS): A contracted entity that is responsible for the following Nebraska Health Connection functions in the designated coverage areas for purposes of the Basic Benefits Package: initial client marketing, education and outreach, enrollment activities, health assessment, health services coordination, public health nursing, Helpline, client advocacy, and satisfaction surveys.

Enrollment Month: Enrollment for a client is effective the first of the month through the end of the month.

Enrollment Report: A data file provided by the Department to the medical/surgical plan and the MH/SA plan that lists all clients enrolled in the plan and disenrolled for the enrollment month. The enrollment report is used as the basis for the monthly payment to the plan, and to the Primary Care Physician for providing care management for the Primary Care Case Management Network.

Entity: A generic term used to reference any of the contracted vendors participating in the Nebraska Health Connection.

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

Family Planning Services: For purposes of the Basic Benefits Package, 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 vasectomies. Treatment for sexually transmitted diseases (STD) is to be reimbursed by the medical/surgical plan in the same manner as family planning services, without referral or authorizations by the Primary Care Physician and medical/surgical plan. 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: Payment of a fee by the Nebraska Medical Assistance Program for each service provided to a client who is not enrolled in the Nebraska Health Connection (NHC). Fee-for-service payment also applies to a client who is enrolled in the Primary Care Case Management Network of the NHC or who meets certain programmatic exceptions.

Health Maintenance Organization (HMO): For purposes of the Basic Benefits Package, an HMO with a Certificate of Authority to do business in Nebraska that has contracted with the Department under the NHC. The HMO is a risk-based or capitated model of managed care.

Interim PCP: For purposes of the Basic Benefits Package, a Primary Care Physician (PCP) designated by the medical/surgical plan when the client's chosen or assigned PCP is not available, and is only applicable until the client requests a different PCP. The duration of an interim PCP is only until a subsequent change is activated, effective with the first month possible after system cutoff.

Lock-In: For purposes of the Basic Benefits Package, a method used by the Department to limit the medical/surgical services of a client who has been determined to be abusing or overutilizing services provided by the Nebraska Medical Assistance Program without infringing on the client's choice of a provider.

Managed Care File: The Department's automated file, containing client and provider information, created to support the Nebraska Health Connection.

Medical Necessity: 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.

Mental Health/Substance Abuse (MH/SA) Network: The network of MH/SA providers that constitutes the MH/SA services component of the Nebraska Health Connection.

Mental Health and Substance Abuse (MH/SA) Package: The following MH/SA services represent a minimum benefits package that must be provided by the Prepaid Health Plan to clients in the NHC:

1. Outpatient services, including -
   a. Evaluations by a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within the scope of his/her practice;
   b. Individual psychotherapy;
   c. Individual substance abuse counseling (for clients age 20 and younger only);
   d. Group psychotherapy;
   e. Group substance abuse counseling (for clients age 20 and younger only);
   f. Family psychotherapy services;
   g. Family substance abuse counseling (for clients age 20 and younger only);
   h. Family assessment;
   i. Conferences with family or other responsible persons advising them on how to assist the client (for clients age 20 and younger only);
   j. Mileage for home-based family therapy or counseling services (for clients age 20 and younger only);
   k. Community Treatment Aides (for clients age 20 and younger); and
   l. Pre-treatment assessment;

2. Day treatment;
3. Treatment foster care (for clients age 20 and younger);
4. Treatment group home (for clients age 20 and younger);
5. Residential treatment center (for clients age 20 and younger);
6. Crisis intervention, which consists of -
   a. Observation room services;
   b. Residential acute (for clients age 20 and younger);
   c. Non-residential and treatment foster care (for clients age 20 and younger);
7. Acute Hospital services;
8. Family preservation;
9. Inpatient services;
10. Non-emergency or non-urgent transportation;
11. Coordinated MH/SA services (see 471 NAC 20-000 and 32-000 and 482 NAC 5-006); and
12. Client Assistance Program.

Medicaid regulations governing coverage of these services are contained in 471 NAC 20-000 and 32-000.

NAC: Nebraska Administrative Code.

NHC: Nebraska Health Connection, the Nebraska Medicaid Managed Care Program.

NMAP: The Nebraska Medical Assistance Program, administered by the Department of Health and Human Services Finance and Support. Also referred to as Medicaid.

NMES: The Nebraska Medicaid Eligibility System, which is an automated eligibility verification system for use by Medicaid providers of service.

PCCM Network Administrator: The contracting entity responsible for development, oversight, and operation of the PCCM Network and all related PCCM Network administrative services.

PCCM (Primary Care Case Management) Network Payment: The Department provides two separate payments for the PCCM Network on a per member per month basis. An administrative fee is paid to the PCCM Network Administrator for completing the contracted administrative duties, and a primary care case management fee to the Primary Care Physician for contracted primary care case management duties.

Per Member Per Month (PMPM): The basis of payment for a Health Maintenance Organization or Prepaid Health Plan, the Primary Care Case Management Network (PCCM) administrative fee, and the Primary Care Physician primary care case management fee in the PCCM Network.

Physician Extender: For purposes of the Basic Benefits Package, a nurse practitioner, physician assistant, certified nurse midwife, or second-year and third-year resident who meet the requirements for practicing in Nebraska, who is enrolled in the Nebraska Medical Assistance Program. The Physician Extender is not designated as a Primary Care Physician (PCP) but increases the number of clients to whom the PCP may provide a medical home.

Plan: A generic term used to reference any of the contracted health plans participating in the Nebraska Health Connection. This is a healthcare entity that meets the definition of a Health Maintenance Organization or the Primary Care Case Management (PCCM) Network for the provision of the Basic Benefits Package and referenced in the Title as the "medical/surgical plan." For purposes of the Mental Health and Substance Abuse Package, this is referenced as the "MH/SA plan."

Prepaid Health Plan: An entity that provides Mental Health and Substance Abuse services to enrolled clients, under contract with the Department and on the basis of prepaid capitation fees, but is not subject to requirements in Section 1903(m)(2)(A) of the Social Security Act.

Primary Care Case Management (PCCM) Network: A network of contracted Primary Care Physicians who provide the Basic Benefits Package to Nebraska Health Connection clients. Services provided through the PCCM Network are reimbursed on a fee-for-service basis by the Department. The PCCM Network is a non-risked-based managed care model. The Department contracts with a PCCM Network Administrator who is responsible for the development, oversight and operation of the PCCM Network and all related PCCM Network administrative duties.

Primary Care Physician (PCP): A physician chosen by the client or assigned by the Department who provides a "medical home" for the client and whose primary expertise is in family practice, pediatrics, general practice, internal medicine, or obstetrics/gynecology. A PCP may participate in the NHC with any of the contracting medical/surgical plans. The PCP must be a Medicaid-enrolled provider. A specialty care physician may have enhanced responsibilities in certain circumstances, to promote greater continuity of care between the PCP and specialty care physician.

PRO: Peer Review Organization under contract with the Department to perform specified level(s) of care determinations.

Provider Agreement: Any written agreement between the provider and the Department, for the purpose of enrolling as a Medicaid provider, or between the medical/surgical or MH/SA plan and the provider for the purpose of participating in the Nebraska Health Connection.

Slots: A designated number of clients for whom a Primary Care Physician agrees to provide a medical home under the Nebraska Health Connection.

Subcontract: Any written agreement between the medical/surgical or MH/SA plan and another party to fulfill the requirements of 482 NAC except Provider Agreements as defined above.

TPL (Third Party Liability): 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.

Transfer: A change in a client's enrollment/assignment from one Primary Care Physician (PCP) to another PCP, or from one medical/surgical plan to another.

Waiver of Enrollment: A case-by-case determination by which a mandatory client is not required to participate in the Nebraska Health Connection.

Terms that are not defined above shall have their primary meaning identified in the Nebraska Administrative Code (NAC) and other directives issued by the Department.