DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 235
Kansas City, Missouri 64106

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Division of Medicaid and Children's Health Operations

June 22, 2010

Kerry Winterer
Chief Executive Officer
Nebraska Dept of Health & Human Services
301 Centennial Mall South, 3rd Floor
PO Box 95026
Lincoln, Nebraska 68509-5026

Dear Mr. Winterer:

On May 10, 2010, the Centers for Medicare & Medicaid Services (CMS) received Nebraska's state plan amendment (SPA) transmittal #10-11. This SPA replaces the State's primary care case management (PCCM) program with a program utilizing two managed care organizations (MCO).

Based on the information provided, we are pleased to inform you that SPA 10-11 is approved as of June 21, 2010 with an effective date of August 1, 2010. Enclosed is a copy of the CMS 179 form as well as the approved pages for incorporation into the Nebraska State Plan. If you have any questions concerning this letter, please contact Michelle Opheim or Gail Brown Stevenson at (816) 426-5925.

Sincerely,

James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

Enclosure

cc: Vivianne Chaumont
Jenifer Roberts Johnson
Margaret Booth
Heather Leschinsky

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: NE 10-11

2. STATE: Nebraska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: August 1, 2010

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 $(1,588,676)
b. FFY 2011 $(8,765,442)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-F, pp 1-19

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-F, pp 1-19

10. SUBJECT OF AMENDMENT:
Discontinuation of the PCCM program with the implementation of 2 MCO's.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Governor has waived review

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Vivianne M. Chaumont

14. TITLE: Director, Division of Medicaid and Long-Term Care

15. DATE SUBMITTED: May 10, 2010

16. RETURN TO:
Patricia (Pat) Taft
Division of Medicaid & Long-Term Care
Nebraska Department of Health & Human Services
301 Centennial Mall South
Lincoln, NE 68509

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: May 10, 2010

18. DATE APPROVED: June 21, 2010

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: August 1, 2010

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: James G. Scott

22. TITLE: Associate Regional Administrator for Medicaid and Children's Health Operations

23. REMARKS:

State/Territory: Nebraska

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Nebraska

Nebraska Health Connection (NHC)
MCO and enhanced PCCM programs

Citation: Section 1932 of the Social Security Act

A. General Description of the Program

1. This program is called Nebraska Health Connection (NHC). All Medicaid beneficiaries as described in Section C are required to enroll in an Managed Care Organization (MCO). Those described In Section D are not subject to mandatory enrollment. The enhanced PCCM program is an enhanced primary care case management program in which Nebraska PCCM Primary Care Physicians (PCPs) have an administrative entity assisting with case management for eligibles who are identified as having multiple medical conditions and who incur high medical costs. The administrative entity has developed care management and disease management strategies targeted at their respective populations. Enrollment in the enhanced PCCM program is available statewide and is voluntary. The administrative entity receives an administrative management fee for the enhanced services.

2. The objectives of these programs are to improve access to quality care and services, improve client satisfaction, reduce racial and ethnic health disparities, reduce costs, and prevent/reduce inappropriate/unnecessary utilization to care for Medicaid recipients.

3. This program is intended to enroll Medicaid recipients in an MCO which will provide or authorize all primary care services and all necessary specialty services, where the assigned medical practitioner will provide or authorize all primary care services and all necessary specialty services. The MCO assigned practitioner will act as the Primary Care Physician (PCP). The PCP and enhanced PCCM are responsible for monitoring the care and utilization of non-emergency services. Neither emergency nor family planning services are restricted under this program.

4. The Enhanced PCCM will assist the participant in gaining access to the health care system and will monitor the participant's condition, health care needs, and service delivery on an ongoing basis. The PCP and enhanced PCCM will be responsible for locating, coordinating, and monitoring all primary care and other covered medical and rehabilitation services on behalf of recipients enrolled in the program.

5. The enhanced PCCM entity will receive a per enrollee per month payment for enhanced case management services.

6. Recipients enrolled under this program will be restricted to receive covered services from the PCP or upon referral or authorization of the PCP. The PCP will manage the recipient's health care delivery. The NHC program is intended to enhance existing provider-patient relationships and to establish a relationship where there has been none. It will enhance continuity of care and efficient and effective service delivery. This is accomplished by providing the recipient with a choice between at least two MCOs. Recipients will have a minimum of 15 days to make the selection but may change the initial selection within 90 days. Recipients can then change health plans without cause every 12 months thereafter. The enrollment broker facilitates this through enrollment counseling and information distribution so recipients may make an informed decision. (See Section E for more details.)

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7. A non-MCO contractor will act as an enrollment broker in assisting eligible recipients in choosing among competing health plans in order to provide recipients with more information about the range of health care options open to them.

8. The state will share cost savings with recipients resulting from the use of more cost-effective medical care with recipients by eliminating co-payments for those who enroll into an MCO.

9. The state requires recipients in enhanced PCCM to obtain services through a referral from their PCP to a Medicaid-participating provider who provides such services. Providers must meet reimbursement, quality, and utilization standards that are consistent with access, quality, and efficient and economic provisions of covered care and services. Recipients enrolled in MCO plans may be referred to any MCO-credentialed provider. The plan may also choose to allow non-emergency care to be provided by other practitioners on a case-by-case basis if it benefits the enrollee.

10. The enhanced PCCM may operate in all counties of the state except in those geographical areas without an adequate number of primary care case managers participating in an enhanced PCCM. The MCO program will operate in Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Sarpy, Saunders, Seward, and Washington counties where MCOs have contracted with the state. Mandatory assignment will only occur if the recipient has a choice between at least two MCOs.

11. Public process for proposed changes in the Nebraska MCO and the enhanced PCCM programs. The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act. Public notice will be published in the Nebraska Register which is available to the public on a weekly basis. In addition ongoing public input is solicited through the Nebraska Medicaid Advisory Committee.

B. Assurances and Compliance

1. Consistent with this description, the state assures that all the requirements of Sections 1932, 1903(m), and 1905(t) of the Social Security Act will be met.

2. Consistent with this description, the state assures that all the requirements of 42 CFR 438 will be met.

3. Consistent with this description, the state assures that all the requirements of 42 CFR 438.10(i) will be met.

4. The NHC program is available in selected counties in Nebraska which includes Cass, Dodge, Douglas, Gage, Otoe, Sarpy, Saunders, Seward, Washington, and Lancaster counties. Mandatory enrollment provisions will not be implemented unless a choice of at least two MCOs is available. The enhanced PCCM is available in all counties.

5. Nebraska has safeguards in effect to guard against conflict of interest on the part of employees of the state and its agents.

6. Nebraska will monitor and oversee the operation of the mandatory managed care program, ensuring compliance with all federal program requirements, federal and state laws and regulations, and the requirements of the contracts agreed upon by Medicaid and its contractors.

7. Nebraska will evaluate compliance by review and analysis of reports prepared and sent to the Nebraska Medicaid agency by the contractors. Deficiencies in one or more areas will result in the contractor being required to prepare a corrective action plan, which will be monitored by the Nebraska Medicaid agency.

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8. Reports from the grievance and appeals process will be analyzed and used for evaluation purposes.

9. Nebraska staff will provide technical assistance as necessary to ensure that contractors have adequate information and resources to comply with all requirements of law and their contracts.

10. Nebraska staff will evaluate each contractor for financial viability/solvency, access and quality assurance.

C. Target Groups of Recipients

The NHC program is limited to the following target groups of recipients:

1. Families, children, and pregnant women eligible for Medicaid under Section 1931 of the Social Security Act or related coverage groups.

2. Recipients eligible for Medicaid through the Medicaid expansion under the State Child Health Insurance Program (SCHIP).

3. AABD Adults

D. Mandatory Enrollment Exclusions

1. The following groups will not be enrolled in managed care:

   a. Clients with Medicare coverage pursuant to 471 NAC 3-000;

   b. Clients residing in nursing facilities and receiving custodial care pursuant to 471 NAC 12-000;

   c. Clients residing in intermediate care facilities for the mentally retarded (ICF/MR) pursuant to 471 NAC 31-000;

   d. Clients who are residing out of state (i.e. Children placed with relatives out of state, and who are designated as such by HHSS personnel);

   e. Certain children with disabilities who are receiving in-home services, also known as the Katie Beckett program pursuant to 469 NAC 2-010.01 F;

   f. Aliens who are eligible for Medicaid for an emergency condition only pursuant to Titles 468, 469,477, and 479 NAC;

   g. Clients participating in the refugee resettlement program/medical pursuant to Title 470 NAC;

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h. Clients receiving services through the following home and community based waivers pursuant to Title 480 NAC for:
   1. Adults with mental retardation or other related conditions;
   2. Aged persons, adults or children, with disabilities;
   3. Children with mental retardation and their families;
   4. Clients receiving Developmental Disability Targeted Case Management Services; and
   5. Any other group for whom which the Nebraska HHS System has received approval of a 1915(c) waiver of the Social Security Act.

i. Clients who have excess income (i.e. spenddown - met or unmet) pursuant to 471 NAC 3000.

j. Clients participating in the Subsidized Adoption Program, including those receiving subsidy from another state pursuant to Title 469 NAC.

k. Clients participating in the State Disability Program pursuant to Title 469 NAC.

l. Clients eligible during the period of presumptive eligibility pursuant to 471 NAC 28-000.

m. Transplant recipients pursuant to 471 NAC 10-000.

n. Clients who have received a specific disenrollment/waiver of enrollment from the Nebraska Medicaid Managed Care program.

o. American Indians and Alaskan Natives (Nebraska uses the 1915(b) Waiver Authority to mandate enrollment into managed care).

p. Clients having other "qualified" insurance.

q. Clients enrolled in another Medicaid Managed Care Program (except the PHP program).

r. Clients who have an eligibility program that is only retro-active.

s. Clients receiving Medicaid hospice services.

t. Clients what are participating in the Breast and Cervical Cancer Prevention and Treatment Act of 2000.

E. Enrollment and Disenrollment

State/Territory: Nebraska

1. All recipients will be given the opportunity to choose from at least two NHC providers. This will be a choice of MCO's if two or more are available in a county. If a recipient has a prior provider relationship that they wish to maintain, the enrollment broker will assist the recipient in choosing a managed care entity that will maintain this relationship.

   Nebraska contracts with an independent contractor to conduct the enrollment process and related activities. The enrollment broker performs services and supplies information as follows to facilitate the enrollment process:

   a. Answer NHC-related questions from recipients and providers.

   b. Prepare enrollment materials for NHC program, for Department approval, and store NHC materials (MCO and NHC in general).

   c. Process new enrollments and plan transfers (disenrollments) for those NHC eligibles identified by the Department.

   d. Process the recipient's choice of NHC option.

   e. Log grievances from NHC enrollees.

   h. Perform various quality assurance activities for the NHC program.

   i. Supply an enrollment packet upon request to the recipients that includes MCO materials and information supplied by the state and plans (enrollment packet initially and annually provided by the State).

   j Provides enrollment counseling which includes:

      (1) Inquiring about patient/provider experience and preference.

      (2) Providing information on which MCOs are available to maintain a prior patient-provider relationship.

      (3) Facilitating direct contact with individual PCPs and MCOs, as necessary.

      (4) Providing any information and education concerning the enrollment process, individuals', benefits offered, the enrollment packet, client right's and responsibilities and any of the other information provided for in this section.

State/Territory: Nebraska

k. The state will identify high risk enrollees. High risk enrollees are identified as having multiple medical conditions and who incur medical costs in excess of $50,000 annually. The identified enrollees will be listed on a roster and provided to the enhanced PCCM contractor. The enhanced PCCM contractor will invite the enrollees to participate in the enhanced PCCM program. Enhanced PCCM information will be provided by the enhanced PCCM contractor after approval by the state and selected by the enrollee. High risk individuals that are mandatory for managed care who meet the multiple medical high/ high cost criteria will not be invited to participate in the enhanced PCCM. Individuals living in non-managed care counties who meet the multiple medical/high cost criteria will be invited to participate in the enhanced PCCM.

1. If the recipient fails to choose an MCO within a minimum of 15 calendar days after receiving enrollment materials, the Department assigns the recipient to a MCO and PCP in a MCO.
2. Default enrollment will be based upon maintaining prior provider-patient relationships, proximity and prior familial/provider relationships.
3. Information in an easily understood format will be provided to beneficiaries on providers, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, benefits not covered under the managed care arrangement, and comparative information among managed care entities regarding benefits and cost sharing, service areas, and quality and performance (to the extent available).
4. Any selection or assignment of a PCP and enhanced PCCM may be changed at any time.
5. Enrollees will be provided notification 60 days before the end of a lock-in period of their opportunity to make a new choice of MCO.
6. Enrollees will be given an opportunity to change PCPs and will be sent a notice to that effect.
7. MCOs and enhanced PCCMs will not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of services.
8. The MCOs and enhanced PCCM will not terminate enrollment because of an adverse change in the recipient's health.
9. An enrollee who is terminated from an MCO, or enhanced PCCM solely because the enrollee has lost Medicaid eligibility for a period of two months or less will automatically be re-enrolled into the same MCO or enhanced PCCM upon regaining eligibility to the extent possible.
10. The recipient will be informed at the time of enrollment of the right to disenroll.
11. An enrollee will be allowed to choose his or her health professional in the MCO to the extent possible and appropriate and will be allowed to change his or her health professional as often as requested.

State/Territory: Nebraska

12. Enrollees will have access to specialists to the extent possible and appropriate and female enrollees will have direct access to women's health services.

F. Process for Enrollment in an MCO and enhanced PCCM

The following process is in effect for recipient enrollment in the NHC Program:

1. The Department shall provide beneficiaries with information in an easily understood format on providers, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, benefits not covered under the managed care arrangement, and comparative information among managed care entities regarding benefits and cost sharing, service areas, and quality and performance (to the extent available).

2. All materials will be in an easily understood format (6th grade reading level or less). Materials will be translated Spanish and other languages upon request, including Braille.

3. Recipients will be able to select an MCO from a list of available managed care entities in their service area. If the recipient wishes to remain with a PCP or plan with whom a patient/physician relationship is already established, the recipient is allowed to do so to extent possible. Each recipient shall notify the Department by mail, telephone or in person, of his or her choice of plans. If voluntary selection is not made within the 15 day period describe above, the NHC shall assign a PCP and a MCO in accordance with the procedures outlined in E above. Enrollment in enhanced PCCM is voluntary.

4. As indicated in Section E, if the recipient does not choose a PCP, the Department will assign the recipient to a PCP and notify the recipient of the assignment.

5. The MCOs will be informed electronically of the recipient's enrollment in that plan. The enhanced PCCM administrator will inform the state electronically of the recipient's enrollment in that plan.

6. The recipient will be notified of enrollment.

State/Territory: Nebraska

7. Additionally, each MCO will provide recipients the following information as soon as practicable after activation of enrollment:

   a. Benefits offered, the amount, duration, and scope of benefits and services available.

   b. Procedures for obtaining services.

   c. Names and locations of current network providers, including providers that are not accepting new patients.

   d. Any restrictions on freedom of choice.

   e. The extent to which there are any restrictions concerning out-of-network providers.

   f. Policies for specialty care and services not furnished by the primary care providers.

   g. Grievance and appeal process.

   h. Member rights and responsibilities.

G. Maximum Payments

The contract with the actuary requires that calculated rates shall be actuarially sound and consistent with generally accepted actuarial principles and practices as required by 42 CFR 438.6(c). State payments to contractors will comply with actuarial soundness in 42 CFR 438.6(c).

H. Covered Services

1. Services not covered by the NHC program will be provided under the Medicaid fee-for-service program. Medicaid recipients will be informed of the services not covered under the NHC Program, the process for obtaining such services. The State assures that the services provided within the managed care network and out-of plan and excluded services will be coordinated. The required coordination is specified in the state contract with the MCOs and enhanced PCCM and is specific to the service type and service provider.

State/Territory: Nebraska

2. MCOs are directed to develop subcontracts or memoranda of understanding with federally qualified health centers (FQHCs) and rural health clinics (RHCs) as well as family planning clinics.

3. Preauthorization of emergency services and emergency post stabilization services and family planning services by the recipient's MCO is prohibited. Recipients will be informed that emergency and family planning services are not restricted under the NHC Program. "Emergency services" are defined in the MCO contract.

4. The MCO capitated contracts will contain the services marked below in Column (4). All Medicaid-covered services not marked in those columns will be provided by the Nebraska Plan (under the requirements of that program) or Medicaid fee for service (without referral). Mental health and substance abuse treatment services are provided under the Nebraska Plan for Behavioral Health under the current 1915(b) Act waiver in effect for those services.

Service (1)	State Plan Approved (2)	MCO/PHP Capitated Reimbursement (4)	Fee-for-Services Reimbursement Impacted by MCO/PHP (5)	Fee-for-Service Reimbursement for MCO/PHP (6)	PCCM Referral/ Prior Auth. Required (7)	Wraparound Service Impacted by PCCM (8)	PCCM Referral/Prior Authorization Not Required or Non-Waiver Services (9)
Day Treatment Services	X						
Dental	X			X			
Detoxification	X	X					
Durable Medical Equipment	X	X					
Education Agency Services	X			X			
Emergency Services	X	X					
EPSDT	X	X					
Family Planning Services	X	X					
Federally Qualified Health Center Services	X	X					
Home Health	X	X					
Inpatient Hospl - Psych	X			X			

State/Territory: Nebraska

Service (1)	State Plan Approved (2)	MCO/PHP Capitated Reimbursement (4)	Fee-for-Services Reimbursement Impacted by MCO/PHP (5)	Fee-for-Service Reimbursement for MCO/PHP (6)	PCCM Referral/ Prior Auth. Required (7)	Wraparound Service Impacted by PCCM (8)	PCCM Referral/Prior Authorization Not Required or Non-Waiver Services (9)
Inpatient Hospital – Other	X	X					
Immunizations	X	X					
Lab and X-ray for Medical Surgical Services	X	X					
Nurse Midwife	X	X					
Nurse Practitioner	X	X					
Nursing Facility				X			
Obstetrical Services	X	X					
Occupational Therapy	X	X					
Other Fee-for-Service Services	X	X					
Other Psych Practitioner	X			X			
Outpatient Hospital – All Other	X	X					
Outpatient Hospital – Lab & X-ray for Medical Surgical Services	X	X					
Pharmacy	X			X			
Physical Therapy	X	X					
Physician	X	X					
Prof. & Clinic and Other Lab and X-ray	X	X					
Psychologist	X			X			

State/Territory: Nebraska

Service (1)	State Plan Approved (2)	MCO/PHP Capitated Reimbursement (4)	Fee-for-Services Reimbursement Impacted by MCO/PHP (5)	Fee-for-Service Reimbursement for MCO/PHP (6)	PCCM Referral/ Prior Auth. Required (7)	Wraparound Service Impacted by PCCM (8)	PCCM Referral/Prior Authorization Not Required or Non-Waiver Services (9)
Rehabilitation Treatment Services	X						
Respiratory Care							
Rural Health Clinic	X	X					
Speech Therapy	X	X					
Substance Abuse Treatment	X			x			
Testing for Sexually Transmitted Diseases	X	X					
Transportation - emergency	X	X					
Transportation – non-emergency	X	X					
Vision Exams and Glasses	X	X					

Mandate

1. In the NHC program, Nebraska will enter into contracts with State licensed MCOs. Nebraska will enter into comprehensive risk contracts with the MCOs. These organizations will arrange for comprehensive services, including inpatient or outpatient hospital, laboratory, x-ray, physician, home health, early periodic screening, diagnosis and treatment, family planning services and all other Medicaid optional services, except for those described in Section H.1.

   All contracts will comply with Sections 1932 and 1903(m) of the Act. All contracts Nebraska has selected the MCOs that operate under the NHC program in the following manner: Nebraska has used a competitive procurement process and ensures that qualifying MCO contracts comply with federal procurement requirements and 45 CFR Section 92.36. The Department requires all participating MCOs to be licensed by the Nebraska Department of Commerce, Insurance Division. This licensure also identifies the MCO service area, by county in the state. The Department sets the capitation rates and any contracting MCO must accept those rates for the respective Medicaid covered services.

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2. The following is a list of the types of providers that qualify to be primary care providers under the NHC program: physicians (pediatricians, family practitioners, internists, general practitioners, obstetrician/gynecologists).

   Certified nurse practitioners are not included as a PCP type; however these services will be made available: The Department covers these services in the same manner as fee-for-service. The only difference is that a referral from the PCP provider is required for reimbursement of the services. Any Nebraska Medicaid provider of this type is able to see and treat a NHC recipient with the required referral.

   Nurse midwives are not included as a PCP type, however these services will be made available: The Department covers these services in the same manner as under fee for service. The only difference is that a referral from the PCP is required for reimbursement of the services. Any Nebraska Medicaid provider of this type is able to see and treat a NHC recipient with the required referral.

3. The enhanced PCCM entity will receive a per enrollee per month administrative payment for enhanced care coordination services.

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4. Qualifications and requirements for PCPs are noted in the provider agreements. MCOs and enhanced PCCMs shall meet all of the following requirements as applicable:

   a. An MCO shall be a Medicaid-qualified provider and agree to comply with all pertinent Medicaid regulations and state plan standards regarding access to care and quality of services.

   b. The MCO shall sign a certification agreement that explains the responsibilities MCOs must comply with.

   c. The MCO shall have a state-approved grievance and appeal process.

   d. The MCO shall provide comprehensive primary health care services to all eligible Medicaid recipients who choose, or are assigned to, the MCO's Program.

   e. The MCO and enhanced PCCM entity shall refer enrollees for specialty care, hospital care, or other services when medically necessary.

   f. The MCO shall make available 24-hour, 7-day-a-week access by telephone to a live voice (an employee of the MCO or a representative) or an answering machine which will immediately direct an enrollee as to how to contact an on-call medical professional, so that referrals can be made for non-emergency services and information can be given.

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g. The MCO and enhanced PCCM shall not refuse an assignment, disenroll a participant, or otherwise discriminate against a participant solely on the basis of age, sex, physical or mental disability, national origin, or type of illness or condition, except when that illness or condition can be better treated by another provider type.

h. The MCO may request reassignment of the participant to another MCO only if the patient/provider relationship meets the provisions set forth in Title 482 NAC. All reassignments must be state-approved.

   The Department reviews all reasons for transfer on a quarterly basis.

i. All MCO and enhanced PCCM subcontractors shall be required to meet the same requirements as those that are in effect for the contractor.

j. The MCO shall be licensed by the Division of Insurance in the Nebraska Department of Commerce in order to ensure financial stability (solvency) and compliance with regulations.

k. Access to medically necessary emergency services shall not be restricted. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (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, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

l. Nebraska ensures enrollee access to emergency services by requiring the MCO/ enhanced PCCM to provide adequate information to all enrollees regarding emergency service access.

m. Nebraska ensures enrollee access to emergency services by including in the contract requirements for MCOs to cover the following.

   (1) The screening or evaluation and all medically necessary emergency services, when an enrollee is referred by the PCP or other plan representative to the emergency room, regardless of whether the prudent layperson definition was met,

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(2) The screening or evaluation, when an absence of clinical emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition,

(3) Both the screening or evaluation and stabilization services, when a clinical emergency is determined,

(4) Continued emergency services until the enrollee can be safely discharged or transferred,

(5) Post-stabilization services that are pre-authorized by the MCO or were not pre-authorized, but the MCO failed to respond to request for pre-authorization within one hour, or could not be contacted. Post-stabilization services remain covered until the MCO contacts the emergency room and takes responsibility for the enrollee.

n. Not have an affiliation with person debarred, suspended, or otherwise excluded from federal procurement activities per Section 1932(d)(1) of the Act.

J. Additional Requirements

1. Any marketing materials available for distribution under the Social Security Act, state statutes and regulations shall be provided to the Department for its review and approval.

2. The MCO shall certify that no recipient will be held liable for any MCO debt as the result of insolvency or for services Nebraska Medicaid will not pay for.

3. The MCO shall include safeguards against fraud and abuse, as provided in state statutes.

4. The MCO shall allow the state to take sanctions as prescribed by federal or state statutes. Also, the MCO shall provide assurance that due process will be provided.

K. FQHC and RHC Services

The program is mandatory and the enrollee is guaranteed a choice of either a PCP employed or contracted with an FQHC as a PCP or at least one MCO which has at least one FQHC as a participating provider.

The MCO contracts specifically mentions the encouragement to contract with FQHCs in the service area. FQHC reimbursement will follow all applicable federal requirements. The MCOs must pay FQHCs and RHCs rates comparable to non-FQHC and RHC providers. Nebraska State Medicaid Plan provides for the prospective payments to FQHC's and RHC's.

State/Territory: Nebraska

L. Quality of Health Care and Services, Including Access

1. Nebraska requires all MCOs and providers, by contract, to meet state-specified standards for internal Quality Assessment and Performance Improvement programs (QAPIs).

2. On a periodic or continuous basis, Nebraska monitors the adherence to these standards by all MCOs, through the following mechanisms:

   a. Review of the written QAPI for each MCO to monitor adherence to the Nebraska QAPI standards. Such review shall take place at least annually.

   b. Periodic review of numerical data or narrative reports describing clinical and related information on health services and outcomes of health care for the Medicaid enrolled population. This data will be submitted to the Department as required by the contract with the MCOs.

   c. Monitoring of the implementation of the QAPI to ensure compliance with Nebraska QAPI standards. This monitoring is conducted on-site at the MCO administrative offices. At least one such monitoring visit shall occur per year.

   d. Monitoring through the use of Department personnel and contracted staff.

3. The Department will arrange for an independent, external review of the quality of services delivered under each MCO's contract with the state. The review will be conducted for each MCO contractor on an annual basis. The entity which provides the annual external quality reviews shall not be a part of the state government, an MCO, or an association of any MCOs.

4. Recipient access to care will be monitored as part of each MCO's internal QAPI and through the annual external quality review for MCOs. The periodic reporting, state monitoring activities and the external quality review shall all derive the following information:

   a. Grievance and appeal data.

   b. Recipient satisfaction surveys.

   c. Periodic recipient surveys which the MCOs will conduct containing questions about recipient access to services.

   d. Measurement of access standards to obtain health care services.

   e. Measurements of referral rates to specialists.

f. Assessment of recipient knowledge about how to obtain health care services.

g. Utilization and encounter data submitted by MCOs.

M. Access to Care.

Nebraska assures that recipients will have a choice between at least two MCOs. When fewer than two choices are available in the geographic area, the managed care program is voluntary. Participation in enhanced PCCM is voluntary in all geographic areas. In addition to this process, the NHC program is not likely to substantially impair access because of the following:

1. Recipients may choose any of the participating MCOs in the service areas. In addition, as per 42 CFR 434.29, within an MCO each Medicaid enrollee has a choice of health professional to the extent possible and feasible.

2. The same range and amount of services that are available under the Medicaid fee-for-service program are available for enrollees covered under the NHC Program.

3. Access standards for distances and travel miles to obtain services for recipients under the NHC program have been established. Specifically, the NHC program must have a PCP within 30 miles or 30 minutes.

   The Department utilizes the 30-mile/30-minute guideline for all PCP providers. This is applied to the MCOs at the time they request service to a new county, as well as quarterly thereafter. This report is submitted to the Department for review.

   The Department utilizes an 60-mile guideline for Specialist providers. This is applied to the MCO's at the time of contract implementation as well as quarterly thereafter.

   The enhanced PCCM option allows the PCP to give a referral to any Nebraska Medicaid provider, thus the panel of specialists would be the entire Nebraska Medicaid provider network. This allows any enhanced PCCM enrollee to see any specialist that accepts Nebraska Medicaid. Therefore, this network is no less than the network available to a person not in the NHC program.

   The Department realizes that there are some counties in the state that do not have a hospital. While the normal guideline is to have at least one hospital in the county being served, consideration is given to those counties without a hospital.

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Additionally, if a county has multiple hospitals, the Department expects to see a fair representation on the provider network.

4. The number of providers to participate under the NHC program is expected to increase.

5. Primary care and health education are provided to enrollees by a chosen or assigned MCO. This fosters continuity of care and improved provider/patient relationships.

6. Pre-authorization is precluded for emergency care and family planning services under the NHC Program.

7. Recipients have the right to change plans at any time if good cause is shown.

8. MCOs and PCPs are required to provide or arrange for coverage 24 hours a day, 7 days a week.

9. Recipients have available a formal appeals process under 42 CFR Part 438, Subpart F. The same appeals hearing system in effect under the Medicaid fee-for-service program is in effect under the NHC program pursuant to Title 467 NAC.

10. Nebraska assures that state-determined access standards are maintained by quarterly analysis of provider panels.

11. Under the terms and conditions of their existing contracts, MCOs must:

    a. Assure that covered services are accessible to all enrollees, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, and with physical or mental disabilities.

    b. Provide to enrollees and prospective enrollees: an informational letter written in the applicable language explaining the MCO policies, a toll-free number to obtain further information about the MCO in the applicable language, all enrollment materials written in the applicable language, and translation services when necessary to ensure delivery of covered services.

    c. Inform a non-English-speaking enrollee about any provider who speaks the same non-English language, if the MCO is aware of any such provider.

12. Nebraska has a limit in Title 482 NAC on the number of recipients that can be managed by a physician in the NHC program in effect under the NHC program. The limit guarantees access to appointments within acceptable time parameters for urgent and illness-related conditions as well as non-symptomatic preventive care. The limit of Medicaid recipients also allows for the PCP to serve a sufficient number of private-pay and commercially insured patients to create a mixture of patients reflective of the insurance status of the community.

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The Department allows an additional enrollment for PCPs with a physician assistant participating in the program. Contracted MCOs are expected to hold this requirement as part of the evaluation of provider panels for individual counties in which they are approved for participation.