Department of Health and Human Services
FAQs
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NEBRASKA
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COMMON PROVIDER QUESTIONS

What is Heritage Health?

Heritage Health is a person-centered approach to administering Medicaid benefits that provides Medicaid and CHIP enrollees a choice of a single plan that provides all of their physical health, behavioral health, and pharmacy benefits and services in an integrated health care program.

What is new in Heritage Health?

Prior to Heritage Health most Medicaid and CHIP enrollees in Nebraska received their physical health benefits through one of two regional health plans, their behavioral health services through a separate statewide health plan, and their pharmacy benefits through a State-managed pharmacy program. Nebraska Medicaid developed Heritage Health to create a health care delivery system in which all of a Medicaid member's behavioral health, physical health, and pharmacy services are provided by a single statewide health plan.

Why did Nebraska Medicaid make the changes that are part of Heritage Health?

Integration of services supports better communication among primary care providers and behavioral health providers, more opportunities for preventive care, and more consistent, all-inclusive coverage for individuals. Heritage Health will improve health outcomes and the financial sustainability of Medicaid.

When did Heritage Health begin?

Heritage Health plans began operations on January 1, 2017.

Heritage Health is referred to as managed care. What is managed care?

Managed care is a system in which the State contracts with a managed care organization (commonly referred to as a health plan or MCO) to provide health care benefits and services to Medicaid and CHIP enrollees. Managed care is designed to improve access to care, enhance health outcomes, and reduce costs by eliminating inappropriate and unnecessary care through the use of preventive services and improved care coordination.

Will all Nebraska Medicaid and Nebraska CHIP beneficiaries be enrolled in a Heritage Health plan?

Nearly all Medicaid and CHIP enrollees receive their physical health, behavioral health and pharmacy benefits through a Heritage Health plan. Beneficiaries who are not enrolled in a Heritage Health plan include participants in the Program for All-Inclusive Care for the Elderly (PACE), beneficiaries with Medicare coverage for whom Medicaid only pays co-insurance and deductibles, aliens who are eligible for emergency conditions only, and those who are required to pay a premium and are not continuously eligible due to a share of cost obligation.

What did not change under Heritage Health?

Not all services changed under Heritage Health. Dental services, school-based services, and long-term care services (LTC) continue to be managed and reimbursed through the fee-for-service program. LTC includes

home and community-based waiver services, State Plan personal assistance service, and long-term residential services provided through facilities like nursing homes or intermediate care facilities for people with developmental disabilities (ICF-DDs).

Non-emergency transportation is also currently covered outside of the Heritage Health program via fee-for-service, but this service will be carved into Heritage Health effective July 1, 2019.

What does the transportation carve-in mean for health care providers?

Following the carve-in, each of the three Heritage Health MCOs will have their own transportation vendor, which are identified in ***Provider Bulletin 18-21.*** Providers who are treating a member who utilizing their plan's transportation vendor will need to contract with that transportation vendor in order to bill them. Providers should not expect a significant increase in volume of patients utilizing transportation services, as the eligibility requirements for this service will not change.

How many plans can Medicaid and CHIP enrollees choose from?

Nebraska Medicaid contracted with three health plans: Nebraska Total Care (Centene), UnitedHealthcare Community Plan of Nebraska, and Healthy Blue Nebraska for the Heritage Health program. All three contracted plans are statewide, so members can enroll with one of the health plans no matter where they live in the State.

I am not currently a Medicaid provider. Can I participate in Heritage Health?

To participate in Heritage Health, a provider must be enrolled with Medicaid. More information on Medicaid provider enrollment is available online at http://dhhs.ne.gov/Pages/Medicaid-Provider-Screening-and-Enrollment-Requirements.aspx

Why was the name Heritage Health selected?

Nebraska has a proud heritage of taking care of ourselves, our families, and our neighbors. The new managed care program is called Heritage Health to reflect those values and to help foster a heritage of health for Nebraskans.

What information is available about Heritage Health and how can I stay updated?

Information about Heritage Health, including updated common questions, scheduled public events, presentation materials and additional resources are available on the Heritage Health Resources website at www.dhhs.ne.gov/HeritageHealth. If you have any questions, please email dhhs.heritagehealth@nebraska.gov.

Will the health plans accept all Medicaid providers in their networks?

Heritage Health plans are encouraged to build as large a network of providers as possible. Networks created by Heritage Health plans must be adequate to meet State guidelines for timely access to care for plan members. Heritage Health plans are required to include providers that are currently serving Medicaid beneficiaries and will need to be part of the network to continue to care for these beneficiaries. All providers in a plan's network need to meet that plan's credentialing standards.

Will billing processes be different?

All Heritage Health plans are required to implement a comprehensive provider education effort aimed at instructing providers on the plan's billing processes and all other provider requirements. Furthermore, Heritage Health plans are required to participate in the *Administrative Simplification Committee* that the State is overseeing to identify areas where plans can stream-line and simplify requirements for providers such as billing, service authorization, and credentialing.

How will providers be paid?

Each managed care organization must have an adequate provider network and may negotiate reimbursement rates with providers in its network. If a member obtains emergency services from an out-of-network provider, the managed care organization must pay the provider 100% of the Medicaid rate. If a member obtains services other than emergency services from an out-of-network provider, the managed care organization is not obligated to pay a rate more than 90% of the Medicaid rate in effect on the date of service to providers with whom/which it has made a minimum of three documented attempts to contract. Heritage Health plans are also required to establish plans for value-based purchasing which will provide added financial opportunities for providers.

What should providers expect from Heritage Health plans for claims payment timeliness?

Nebraska Medicaid has strengthened requirements for the timely payment of claims. Heritage Health plans must process 90% of all clean claims within 15 business days and 99% of all clean claims within 60 calendar days. For pharmacy providers, 99% of all clean claims must be processed within 7 calendar days and 99% of all clean claims must be processed within 14 calendar days.

How will service authorizations be affected?

All Heritage Health plans are required to offer comprehensive provider education aimed at instructing providers on the plan's service authorization processes and all other provider requirements. Heritage Health plans' service authorization processes must adhere to all federal and State regulations, and requirements within the Heritage Health contract. Furthermore, Heritage Health plans are required to participate in the *Administrative Simplification Committee* that the State will oversee to identify areas where plans can stream-line and simplify requirements for providers such as billing, service authorization, and credentialing.

Do I need to contract with all three of the health plans?

As a provider, you can decide to contract with one, two, or three of the Heritage Health plans. You do not have to have an agreement with all three; however, contracting with all three health plans will ensure that your entity can provide services to any Medicaid Heritage Health members.

Are dual-eligible clients covered under Heritage Health?

Yes, the physical, behavioral and pharmacy services of those clients are covered under Heritage Health. For these Heritage Health members, physical health, behavioral health and pharmacy service, Medicare will remain the primary payer and Medicaid will be the payer of last resort. The billing flow will be similar to what is common when a person has two (or more) insurance policies: The bill is submitted to the primary insurer and the Explanation of Benefits (EOB) will be sent to the person and will indicate if there is an unpaid/balance due remaining on the bill. The remaining balance, via the EOB, is then submitted to the secondary or final payer to determine what portion that insurer will pay.

Are vision services covered under Heritage Health?

Yes, vision services are covered under Heritage Health.

FOR PHARMACY PROVIDERS

Will existing prior authorizations transfer to the Heritage Health plans?

Current prior authorizations will be transferred to the Heritage Health Plans and will be permitted for a minimum of 90 days after January 1, 2017.

Are Heritage Health plans required to cover over-the-counter drugs? If so, what will the reimbursement calculation be?

Health plans are required to cover OTC drugs in accordance with the State Medicaid covered services requirements. Providers will be reimbursed based on their contracted agreement with the health plan.

Will prospective drug utilization review (ProDUR) and prior authorization criteria change under Heritage Health?

Heritage Health plans must follow the State's criteria surrounding Psychotropics in Youth. Medications on the State's Preferred Drug List (PDL) must be adjudicated as payable without prior authorization, unless they are subject to clinical or utilization edits, as defined by Nebraska Medicaid. Heritage Health plans must also submit prior authorization and step therapy policies and procedures to Nebraska Medicaid for review and approval.

FOR BEHAVIORAL HEALTH PROVIDERS

How will the state monitor the integration of behavioral health with other services in Heritage Health?

Heritage Health plans are required to participate in Nebraska Medicaid's *Behavioral Health Integration Advisory Committee* (BHIAC) which will meet regularly throughout the implementation of Heritage Health. In addition to the health plans, committee participants include behavioral health provider associations, individual providers, behavioral health experts, and Nebraska Medicaid representatives. The goal of the BHIAC is to ensure the successful integration of behavioral health services by facilitating strong communication and proactive problem solving between providers and Heritage Health plans.

Are there changes to the amount, duration and scope of services under Heritage Health?

Managed care has to cover the services in the Benefits package (Medical or Behavioral Health) in the same amount, duration, and scope as Fee-For Service Medicaid. The Heritage Health plans can place appropriate limits on a service based on medical necessity or utilization control. What constitutes medical necessity cannot be more restrictive than what is used in the State Medicaid program and does not have to mirror the determinations made by Magellan.

Is the authorization process universal for each of the Heritage Health plans?

The authorization process does vary by plan and the continuity of care period was partly developed to give providers time to adjust to new procedures. During this time, MLTC and the health plans established common initial authorization time frames for several services. Permitting the plans to receive authorization requests by fax, phone, paper and online allows for providers to send and receive in the method that works best for them. Tracking utilization of services for clients is a common expectation for all types of providers using all types of payor sources. The authorization process should not be unduly lengthy or onerous and MLTC will assist the Heritage Health plans in identifying efficiencies.

How is MLTC monitoring claims and billing issues?

MLTC receives weekly updates from the plans tracking every provider complaint received, and has issued guidance on billing for clients with Medicare or commercial insurance. The MLTC contract management staff

maintains an issue log of all issues received. The issue log is monitored daily and the MLTC contract management staff are in contact with the health plans on a daily basis. The Director meets with the health plans biweekly to review behavioral health claims and billing. The plans currently submit monthly reports on the claims received and paid, to allow for identifying further trouble spots. Claims and billing will continue to be a focus between MLTC senior leadership and the health plans.

Who should behavioral health providers contact for assistance with Heritage Health?

Provider representatives are available for each of the Heritage Health plans and each provider has a specific representative assigned to assist them with any questions, concerns or issues. If you've had difficulty reaching the assigned representative please call the health plans' customer service and ask for the Behavioral Health Director. If you're unable to get connected with these individuals or have additional concerns please email MLTC: dhhs.heritagehealth@nebraska.gov.

FOR NURSING HOMES/ASSISTED LIVING FACILITIES

Can residents disenroll from Heritage Health and remain in only fee for service?

No, the physical, behavioral and pharmacy services will all be administered through Heritage Health while the long-term care services will remain the fee for service system.

How active will the health plans be in managing care for residents that are dual eligible?

With dual eligible members, Medicare is the primary payer. The plans will offer case management services if a referral is made for the member, but they will not have much involvement in managing the utilization as the secondary payer.

Cross over claims for dual eligible members, is the managed care plan obligated to pay the Medicaid co-insurance amount to a provider who is not in their network?

The Heritage Health plans will be required to pay cross-over claims regardless of network participation of the provider. All of the health plans have signed agreements with Medicare to receive cross-over claims directly from Medicare.

When a Medicaid-covered nursing facility resident switches to hospice services, will those services be covered by the Heritage Health plan?

No. The hospice payment for both the service and the "room-and-board" for nursing facility residents is carved out of managed care and reimbursed fee-for-service.