NEBRASKA
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FREQUENTLY ASKED PROVIDER QUESTIONS

What is Heritage Health?
Heritage Health is a person-centered approach to administering Medicaid benefits that provides Medicaid and Children's Health Insurance Program (CHIP) enrollees a choice of a single plan that provides all of their physical health, behavioral health, dental and pharmacy benefits and services in an integrated health care program.

Why did Nebraska Medicaid make the changes that are part of Heritage Health?
Integration of services supports better communication among primary care, behavioral health, and dental 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 the Medicaid Expansion begin?
Medicaid Expansion eligibility began October 1,2020. This allowed anyone over the age of 19 access to health care through Nebraska Medicaid if found eligible.

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 medical, vision, dental, 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. 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).

How many plans can Medicaid and CHIP enrollees choose from?

Nebraska Medicaid contracted with three health plans: Nebraska Total Care, UnitedHealthcare Community Plan of Nebraska, and Molina Healthcare of 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 https://dhhs.ne.gov/Pages/Medicaid-Provider-Screening-and-Enrollment-Forms.aspx.

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 https://dhhs.ne.gov/Pages/Heritage-Health-Contacts.aspx. 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 required to build an adequate network of providers. Networks created by Heritage Health plans must be adequate to meet State guidelines for timely access to care for plan members. All providers in a plan's network need to meet that plan's credentialing standards.

Will billing processes be different?

While billing process can have some variations between the Heritage Health plans, all 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.

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 in effect on the date of service. Heritage Health plans are also required to establish plans for value-based purchasing which will provide added financial opportunities for providers. If you have further questions, please contact your provider relations representative at the designated health plan.

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, 90% 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.

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

The Heritage Health plans cover all Medicaid covered services 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.

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

The authorization process can vary by health plan. 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.

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 all Medicaid Heritage Health members.

What is centralized credentialing?

Effective January 1, 2025, providers in the medical, behavioral health, and dental fields are required to participate in centralized credentialing. Heritage Health has started to work with Verisys, a centralized verification organization, to help streamline the verification process for all of Nebraska's managed care providers.

Are dual-eligible clients covered under Heritage Health?

Yes, dual-eligible clients are covered under Heritage Health. For these Heritage Health members, physical health, behavioral health, dental and pharmacy service, Medicare will remain the primary payer and Medicaid will be the payer of last resort.

Are vision services covered under Heritage Health?
Yes, vision services are covered under Heritage Health.

Is dental coverage part of Heritage Health?
Yes, dental services are now provided as a part of the Heritage Health managed care program as of January 1, 2024.

Where can I find the Provider Bulletins?
Provider Bulletins can be found at the website: https://dhhs.ne.gov/Pages/Medicaid-Provider-Bulletins.aspx

Where can I find the Medicaid Provider Rates and Fee Schedule?
Medicaid provider rates and fee schedule can be found at this website:
https://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx

Who should 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' provider services call center. If you're unable to get connected with these individuals or have additional concerns, please email MLTC: dhhs.heritagehealth@nebraska.gov.

What do I do if I suspect a member of committing fraud?
Medicaid fraud is a serious offense. If you suspect a member is committing fraud, contact the Special Investigation Unit in the Department of Health and Human Services:

- Phone number: 402-595-3789
- Email: DHHS.InvestigationsSIU@nebraska.gov

Written complaints may be submitted in Lincoln to:
DHHS Division of Children and Family Services Investigations
1033 O Street, Suite 500
Lincoln, NE 68508

Written complaints may be submitted in Omaha to:
DHHS Division of Children and Family Services Investigations
1215 S 42ND Street
Omaha, NE 68105

What do I do if I suspect another provider is committing fraud?
Medicaid provider fraud is a serious offense. If you suspect a provider is committing fraud, contact the Department of Health and Human Services Medicaid Program Integrity:

- Website: https://dhhs.ne.gov/Pages/Program-Integrity.aspx
    - Anonymous online reporting form: https://mltcmpi-dhhs.ne.gov/
- Email:DHHS.MedicaidProgramIntegrity@nebraska.gov
- Phone: (402) 471-1718

FOR PHARMACY PROVIDERS

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 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.