Citation	Condition or Requirement

1932(a)(1)(A)

5. The state plan program will X *(for the MCO)* /will not X *(for the Enhanced PCCM)* implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory ___ for the MCO program/ voluntary X for the Enhanced PCCM program, enrollment will be implemented in the following county/area(s):

   i. county/counties (mandatory)

   ii. county/counties (voluntary)_____

   iii. area/areas (mandatory)_____

   iv. area/areas (voluntary): The Enhanced PCCM program operates in Buffalo and Dawson counties. Any Medicaid eligible choosing to receive services through the Enhanced PCCM, regardless of county of residence is eligible to enroll.

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. X The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. X The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

1932(a)(1)(A)
42 CFR 438.50(c)(3)

3. X The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.

Revised Submission
7.9.12

Citation	Condition or Requirement

i) Clients participating in the Subsidized Adoption Program, including those receiving subsidy from another state pursuant to Title 469 NAC.
j) Clients participating in the State Disability Program pursuant to Title 469 NAC.
k) Clients eligible during the period of presumptive eligibility pursuant to 471 NAC 28- 000.
l) Transplant recipients pursuant to 471 NAC 10-000.
m) Clients who have received a specific disenrollment/waiver of enrollment from the Nebraska Medicaid Managed Care program.
n) American Indians and Alaskan Natives (Nebraska uses the 1915(b) Waiver Authority to mandate enrollment into managed care).
o) Clients enrolled in another Medicaid Managed Care Program (only applies when enrolled in the Enhanced PCCM Program)
p) Clients who have an eligibility program that is only retro-active.
q) Clients receiving Medicaid hospice services.
r) Clients that are participating in the Breast and Cervical Cancer Prevention and Treatment Act of 2000.

42 CFR 438.50

G. List all other eligible groups who will be permitted to enroll on a voluntary basis

All groups described as eligible in Section 2.2 of Nebraska's approved State Medicaid Plan will be permitted to enroll on a voluntary basis into the Enhanced PCCM program.

H. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience or through contact with the recipient.

Revised Submission 8.9.12

Citation	Condition or Requirement

ii. A provider is considered to have "traditionally served" Medicaid recipients if the provider has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

i. the existing provider-recipient relationship (as defined in H.1.i).

For the MCO program:
The default enrollment process will look back 2 years for a previous assignment with a MCO health plan and enroll the client with the MCO health plan.

For the Enhanced PCCM program:
There is no default enrollment process, but there will be a look-back at paid claims for the past 12 months for the pilot enhanced PCCM for selected Evaluation and Management and Preventive Visit codes for Established Patients. If the client is currently Medicaid eligible, the enhanced PCCM with the most visits with a specific client will receive the attribution and the PMPM payment and enhanced FFS (if applicable) for that client for the month. If there is a tie between enhanced PCCMs, the client will be attributed to the enhanced PCCM that provided care for the last/most recent visit in the 12-month period. The attribution will be re-assessed on a monthly basis for a rolling twelve months (i.e. each month, the oldest month will be dropped and the newest month added).

ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

Revised Submission 8.9.12

Citation	Condition or Requirement

For the MCO program:
The default enrollment process will assign the client with a MCO health plan that is in the zip code range of the client. Providers that have traditionally served Medicaid recipients will be located in a zip code range that is close to the Medicaid client. Also, providers that have traditionally served Medicaid recipients will not have an "established only" indicator which means the client would not be assigned to these providers unless there is an existing provider-recipient relationship.

For the Enhanced PCCM program:
There is no default enrollment process but selected Enhanced PCCM providers are chosen based upon evidence of traditionally serving Medicaid recipients.

iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

For the MCO program:
The default enrollment algorithm is built so that there is an equal distribution of recipients into each of the two MCO health plans.

For the Enhanced PCCM program:
There is no default enrollment process but the distribution of enrollees is based on the client's choice of providers as demonstrated through utilization of services with providers that have traditionally served Medicaid recipients, using the fee-for-service experience.

Revised Submission
8-9-12

Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	3. As part of the state's discussion on the default enrollment process, include the following information: Items 3.1-3.vi below apply only to the State's MCO program. The Enhanced PCCM program is voluntary and therefore does not utilize a default enrollment process i. The state will _X_/will not __ use a lock-in for managed care. ii. The time frame for recipients to choose a health plan before being auto-assigned will be 15 days. iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)* State generated correspondence iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)* State generated correspondence MCO enrollment packet v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)* The auto-assignment algorithm gives priority to recipient relationship, proximity, and MCO health plan (within the service area of the MCO health plan, will attempt to maintain family members with the same MCO health plan, with an equal distribution of recipients into the two MCO health plans.

Citation	Condition or Requirement

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

__X__ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)

1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

For the MCO program:

a. Pharmacy
b. Dental
c. HCBS Waiver services
d. Mental Health/Substance services
e. Hospice services
f. Nursing Facility services-custodial level of care
g. ICF/MR services
h. School-based services covered under Medicaid in Public Schools
i. Non-Home Health Agency Approved Personal Care Aide Services (PAS)
j. Optional targeted case management services
k. Non-emergency transportation

For the Enhanced PCCM program:
No services are excluded for the Enhanced PCCM program.

1932 (a)(1)(A)(ii)

M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will __X__/will not_____ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. __X__ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.