STATE PLAN UNDER TITLE XIX
OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Nebraska Medical Assistance Program

State/Territory: Nebraska

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State/Territory: Nebraska

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State/Territory: Nebraska

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*Forms Provided

Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURTIY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: Nebraska

Citation

As a condition for receipt of Federal funds under the title XIX of the Social Security Act the

42 CFR
430.10

Nebraska Department of Health and Human Services

(Single State Agency)

submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirement of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

SECTION 1 - SINGLE STATE AGENCY ORGANIZATION

Citation

1.1 Designation and Authority

42 CFR 431.10
AT-79-29

(a) The Nebraska Department of Health and Human Services is the single State agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references In this plan to "the Medicaid agency" mean the agency named in this paragraph.)

ATTACHMENT 1.1-A, is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority under which It administers or supervises administration of the program

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

Sec. 1902 (a)of the Act — 1.1(b) — The State agency that administered or supervised the administration of the plan approved under title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that part of this plan which relates to blind individuals.

☐ Yes. The State agency so designated is _____

This agency has a separate plan covering that portion of the State plan under title XIX for which it is responsible.

☒ Not applicable. The entire plan under title XIX is administered or supervised by the State agency named in paragraph 1.1(a).

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

1.1(c) Waivers of the single State agency requirement which are currently operative have been granted under authority of the Intergovernmental Cooperation Act of 1968.

☐ Yes. ATTACHMENT 1.1-B describes these waivers and the approved alternative organizational arrangements.

☒ Not applicable. Waivers are no longer in effect.

☐ Not applicable. No waivers have ever been granted.

Revision: HCFA-AT-80-38 (BPP) OMB No. 0938-0193

May 22, 1980

State/Territory: Nebraska

Citation

42 CFR 431.10 AT-79-29	1.1(d)	☒	The agency named in paragraph 1.1(a) has responsibility for all determinations of eligibility for Medicaid under this plan.
		☐	Determinations of eligibility for Medicaid under this plan are made by the agency(ies) specified in ATTACHMENT 2.2-A. There is a written agreement between the agency named in paragraph 1.1(a) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

42 CFR 431.10 AT-79-29	1.1(e)	All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a **Professional Standards** Review Organization under title XI of the Act.
	(f)	All other requirements of 42 CFR 431.10 are met.

Citation

1.2 Organization for Administration

42 CFR 431.11
AT-79-29

(a) ATTACHMENT 1.2-A contains a description of the organization and functions of the Medicaid agency and an organization of the agency.

(b) Within the State agency, the Division of Medicaid & Long-Term Care has been designated as the medical assistance unit. ATTACHMENT 1.2-B contains a description of the organization and functions of the medical assistance unit and an organization chart of the unit.

(c) ATTACHMENT 1.2-C contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.

(d) Eligibility determinations are made by State or local staff of an agency other than the agency named in paragraph 1.1(a). ATTACHMENT 1.2-D contains a description of the staff designated to make such determinations and the functions they will perform.

☒ Not applicable. Only staff of the agency named in paragraph 1.1(a) make such determinations.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

1.3 Statewide Operation

42 CFR
431.50(b)
AT-79-29

The plan is in operation on a Statewide basis in accordance with all requirements of 42 CFR 431.50.

☒ The plan is State administered.

☐ The plan is administered by the political subdivisions of the State and is mandatory on them.

Approved OMB#: 0938-1098

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

1.4 State Medical Care Advisory Committee (42 CFR 431.12(b))
There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.

_X_ The State enrolls recipients in MCO, PIHP, PAHP, and/or PCCM programs. The State assures that it complies with 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials.

Tribal Consultation Requirements
Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Please describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Please include information about the frequency, inclusiveness and process for seeking such advice.

The Division of Medicaid and Long-Term Care (MLTC) meets on a quarterly basis or as needed with the tribes (Omaha, Ponca, Santee Sioux and Winnebago) and with the CMS Native American contact to discuss relevant Medicaid/CHIP matters that impact the tribes and to invite discussion and comments for consideration.

Effective September 1, 2010, MLTC implemented a policy regarding seeking consultation from all federally recognized tribes, Indian Health Service and Urban Indian Organizations within the state regarding State Plan Amendments (SPA), proposals for demonstrations, and waivers, including proposed, extensions, amendments and renewals,

(1.4 continued)

which may have an impact on those entities. All proposed SPA's, waivers, and demonstrations will be sent to the Tribes for comment, not just those that we believe will directly impact the tribes. However, purely technical changes that have no impact on the substance of the topic (such as pagination, renumbering of lists, etc.) will not be submitted to the Tribes.

Proposed SPA's, waivers, and demonstrations are routed to the tribes for comment/input prior to submitting to CMS. The Division of Medicaid and Long-Term Care consults with the tribes by notifying designated tribal entities electronically via email with a description of the proposed change(s). The tribal liaison, which is a position designated by the Division of Medicaid and Long-Term Care, is responsible for maintaining a complete list of tribal contacts and their respective email and mailing addresses. The tribal contact list is updated at the tribal consultation meetings and was last updated at the tribal consultation meeting held in November, 2010. The proposed SPA, waiver, or demonstration is submitted to Tribal Clinics, Health Centers, the IHS Hospital, and to the Nebraska Urban Ian Health Coalition for comment. The tribes have 30 days to respond or comment to the proposed SPA, waiver or demonstration from the date the required notice is submitted to the tribes. Following the 30 day period, if no comment is received from the tribes, the Division of Medicaid and Long-Term Care is authorized to submit the SPA, waiver or demonstration to CMS. The CMS Native American Contact is copied in this process by the MLTC to detail our efforts to secure comments/input from the Tribes.

If comments are, in fact, received from the tribes, the same is relayed to the Division Director for further consideration. In situations where comments are received from the tribes, the consultation process time-frame shall extend to a 60 day time period from the date the required notice was submitted to the tribes so that the Division of Medicaid and Long-Term Care can address such comments as set forth below. Following the 60 day period after comments are received from the tribes, the Division of Medicaid and Long-Term Care is authorized to submit the SPA, waiver or demonstration to CMS.

If one tribe has a question or concern about a SPA, waiver amendment, waiver extension, waiver renewal or demonstration proposal, that concern would be communicated and transmitted electronically via e-mail to all other tribes and tribal entities by the tribal liaison. Such communication will specify who raised the concern or comment, the specific nature of the concern or comment, and what the Department proposed to do in response to that concern or comment in an attempt to address or resolve the concern. A management decision is then made as to whether additional action (telephone conferences, meetings, research, etc.) would be appropriate under the circumstances prior to submitting the SPA, waiver or demonstration to CMS.

Comments from the Tribes, or the lack of comments/response, are reported to the CMS Native American Contact, as well as our response/resolution to those comments.

(1.4 continued)

The consultation process established by the Department is based in part on face to face visits and discussions with various tribal entities and the Nebraska Department of Health and Human Services. At the November 29, 2010 meeting, discussions were initiated relating to the proposed SPA consultation process. Tribal Liaison shared the written policy of the Department as it existed at that time regarding the proposed consultation process. Comments from the tribes regarding the process and how it might impact the tribes were noted and later expressed to state Medicaid management. At the November meeting, it was proposed by the Department that the tribes be given notice regarding all proposed SPA's and waivers, not just those that the Department thought might have some impact on the tribes. Some members expressed the Department should indicate to the tribes which SPA's and waivers had a direct impact on the tribes in its opinion. The tribes also expressed that it would be helpful to have a process in place to share comments and Department responses to those comments during the consultation process. These suggestions were discussed with Medicaid administrators and adopted by the Department. Current policy is that if one tribe has a question or concern about a SPA or waiver, that concern will be made known to all the tribal entities by the Department, as well as making it known how the Department attempted to resolve the concern.
In order to facilitate the consultation process, the Department will, in advance of the consultation meeting, provide the tribes with a formal agenda describing the SPA's and waivers that might have relevance to the tribes, as well as other information that will be addressed by the Department. The Department will take minutes of the meeting, which will be available on request, and maintain a record of the same. The Department will ensure that a current roster of participants is kept and maintained, indicating participant's names, addresses, telephone numbers, and with which group they are associated.

Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

Initial Amendment
In January of 2010, the State received guidance from CMS, SMDL# 10-001, that set forth the general requirements expected of States to alert tribal entities to proposed State Plan Amendments, waivers, and demonstrations. On February 18, 2010, a Nebraska State/Tribal Consultation Meeting was held. Attending were representatives from the various Tribes in Nebraska, Indian health providers, the Native American Contact from CMS, the Nebraska Medicaid tribal liaison, and the Nebraska Medicaid Director. The tribal consultation issue was discussed in general terms at the meeting and the Tribes expressed a desire to become involved in the consultation process.

(1.4 continued)

Following this, a written process was developed by Nebraska Medicaid outlining the process for the State to follow to secure consultation with the Tribes prior to the State submitting a SPA, waiver, or demonstration. The proposed process was reviewed and approved by Nebraska Medicaid administration. In June, 2010, the protocol for consultation was shared with Medicaid Division staff and sent to the tribal entities.

In October 2010, the State received additional guidance from CMS regarding the consultation process required with tribal entities prior to submitting a SPA, waiver, or demonstration to CMS. The guidance suggested that states should submit to the Tribes a comprehensible summary of the effect of the proposed SPA, waiver, or demonstration rather than merely submitting the SPA, waiver, or demonstration documents. Nebraska Medicaid revised the protocol for submitting a SPA, waiver, or demonstration and securing tribal consultation and communicated to Medicaid Division staff. On November 2, 2010, the State notified all tribal entities its intent to submit a SPA regarding the tribal consultation process. The letter outlined a summary of the consultation process set forth in the revised protocol.

The tribal consultation issue was discussed in detail at a November 29, 2010 Nebraska State/Tribal Consultation Meeting. Attending were representatives from the various Tribes in Nebraska, Indian health providers, the Native American Contact from CMS, and the Nebraska Medicaid tribal liaison. The tribal consultation issue was discussed in detail at the meeting.

Prior Amendment

A communication was sent to all tribal entities June 2, 2011, advising them of the technical changes and it was also discussed at a meeting with them July 12, 2011.

Current Amendment

A communication was sent to all tribal entities September 7, 2011 advising them that the Department intended to submit a SPA to change the current consultation process, allowing the tribes 30 days to respond to proposed SPA's, waivers or demonstrations and establishing a 60 day time-period for the consultation process if comments were received from the tribes.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1098**. The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Revision: HCFA-PM-94-3 (MB)
April 1994

State/Territory: Nebraska

Citation

1.5 Pediatric Immunization Program

1928 of the Act

1. The State has implemented a program for the distribution of pediatric vaccines to program- registered providers for the immunization of federally vaccine eligible children in accordance with section 1928 as indicated below.

   a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.

   b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program- registered providers.

   c. With respect to any population of vaccine- eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.

   d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h)of the Social Security Act.

   e. The State will assure that no program- registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.

   f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.

   g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.

Revision: HCFA-PM-94-3 (MB)
April 1994

State/Territory: Nebraska

Citation

1928 of the Act

2. The State has not modified or repealed any Immunization Law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.

3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.

4. The State agency with overall responsibility for the Implementation and enforcement of the provisions of section 1928 is:

☐ State Medicaid Agency

☒ State Public Health Agency

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation

2.1 Application, Determination of Eligibility and Furnishing Medicaid

42 CFR Part 435, Subpart J

(a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

Citation

42 CFR 435.914 1902(a) (34) of the Act	2.1	(b)	(1)	Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.
1902(e)(8) and 1905(a) of the Act			(2)	For individuals who are eligible for Medicare cost- sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month which the individual is first determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.
1902(a)(47) and			(3)	Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.
42 CFR 438.6			(c)	The Medicaid agency elects to enter into a risk contract that complies with 42 CFR 438.6, and that is procured through an open, competitive procurement process that is consistent with 45 CFR Part 74. The risk contract is with (check all that apply):

☐ Qualified under Title XIII 1310 of the Public Health Service Act.

☒ A Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2.

☐ A Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2.

☐ A Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2.

☐ Not applicable.

Revision: HCFA-PM-91-6 (MB) OMB No.:
September 1991

State/Territory: Nebraska

Citation

1902(a)(55) of the Act	2.1	(d)	The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described is §1902(a)(10)(A)(i)(IV), (a)(10) (A)(i) (VI), (a)(10)(A)(i)(VII), and (a)(10)(A)(ii)(IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the ADFC form except as permitted by HCFA instructions. Note: Applications may be taken for all eligibility groups.

Citation

2.2 Coverage and Conditions of Eligibility

42 CFR 435.10

Medicaid is available to the groups specified in ATTACHMENT 2.2-A.

☐ Mandatory categorically needy and other required special groups only.

☐ Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.

☐ Mandatory categorically needy, other required special groups, and specified optional groups.

☒ Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(i)(IV), (V), and (VI), 1902(a)(10)(A)(ii)(XI), 1902(a)(10)(E), 1902(1) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.

Citation

2.3 Residence

435.10 and 435.403, and 1902(b) of the Act, P.L. 99-272 (Section 9529)and P.L. 99-509 (Section 9405)

Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.

Citation

2.4 Blindness

42 CFR 435.530(b) 42 CFR 435.531 AT-78-90 AT-79-29	All of the requirements of 42 CFR 435.530 and 42 CFR 435.531are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.

Citation

2.5 Disability

42 CFR 435.121, 435.540(b) 435.541	All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.13.b. of ATTACHMENT 2.2-A of this plan.

Revision: HCFA-PM-92-1 (BPP)
February 1992

State/Territory: Nebraska

Citation

2.6 Financial Eligibility

42 CFR 435.10 and Subparts G & H 1902(a)(10)(A)(i)(III), (IV), (V), (VI), and (VII), 1902(a)(10)(A)(ii)(IX), 1902(a)(10)(A)(ii)(X), 1902(a)(10)(C), 1902(f), 1902(1) and (m), 1905(p) and (s), 1902(r)(2), and 1920

(a) The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6- A.

State/Territory: Nebraska

Citation

2.7 Medicaid Furnished Out of State

431.52 and 1902(b) of the Act, P.L. 99-272 (Section 9529)

Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.

SECTION 3 – SERVICES: GENERAL PROVISIONS

Citation

3.1 Amount, Duration, and Scope of Services

42 CFR Part 440, Subpart B 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

(1) Categorically needy.

Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:

(i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

☐ Not applicable. Nurse-midwives are not authorized to practice in this State.

State/Territory: Nebraska

Citation

3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1902(e)(5) of the Act

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends)and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

☒ (iv) Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.

1902(a)(10), Clause (VII) of the matter following (F) of the Act

(v) Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

Revision: HCFA-AT-92-7 (MB)
October 1992

State/Territory: Nebraska

Citation

3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1902(a)(10)(D) of the Act

(vi) Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.

1902(e)(7) of the Act

(vii) Inpatient services that are being furnished to infants and children described in section 1902(1)(1)(B) -through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.

1902(e)(9) of the Act

(viii) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

1902(a)(52) and 1925 of the Act

(ix) Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.

1905(a)(23) and 1929

(x) Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

State/Territory: Nebraska

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(26) and 1934

X Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 4 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

Citation

3.1 Amount. Duration. and Scope of Services (continued)

42 CFR Part 440, Subpart B

(a) (2) Medically needy.

☒ This State plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided.

Services for the medically needy include:

1902(a)(10)(C)(iv) of the Act
42 CFR 440.220

(i) If services in an institution for mental diseases (42 CFR 440.140 and 440.160) or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1)through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act.

☐ Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.

1902(e)(5) of the Act

(ii) Prenatal care and delivery services for pregnant women.

Revision: HCFA-PM-91 (BPD) OMB No. 0938-1991

State/Territory: Nebraska

Citation

3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

☒ (iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services.

☐ Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

1902(a)(10)(c) (vi) Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.

☒ (vii) Services in an institution for mental diseases for individuals over age 65.

42 CFR 440.140, 440.150, 440.160, Subpart B 442.441, Subpart C 1902(a)(20) and (21) of the Act

☒ (viii) Services in an intermediate care facility for the mentally retarded.

(ix) Inpatient psychiatric services for individuals under age 21.

Citation

3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1902(e)(9) of Act

(x) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

1905(a)(23) and 1929 of the Act

(xi) Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

State/Territory: Nebraska

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)
1905(a)(26) and 1934

X Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 4 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

Citation

3.1 Amount, Duration, and Scope of Services (continued)

	(a)(3)	Other Required Special Groups: Qualified Medicare Beneficiaries
1902(a)(10)(E)(i) and clause (VIII) of the matter following (F), and 1905(p)(3) of the Act		Medicare cost sharing for qualified Medicare beneficiaries described in section1905(p) of the Act is provided only as indicated in item 3.2 of this plan.
1902(a)(10)(E)(ii) and 1905(s) of the Act	(a)(4)(i)	Other Required Special Groups: Qualified Disabled and Working Individuals Medicare Part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E) (ii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act	(ii)	Other Required Special Groups: Specified Low-Income Medicare Beneficiaries Medicare Part B premiums for specified low- income Medicare beneficiaries described in section 1902(a)(10)(E)(iii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10)(E)(iv)(I), 1905(p)(3)(A)(ii), and 1933 of the Act	(iii)	Other Required Special Groups: Qualifying Individuals -1 Medicare Part B premiums for qualifying individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

State/Territory: Nebraska

Citation

1902(a)(10)(E)(iv)(II), 1905(p)(3)(A)(iv)(II), 1905(p)(3) of the Act	(iv)	Other Required Special Groups: Qualifying Individuals -2 The portion of the amount of increase to the Medicare Part B premium attributable to the Home Health provisions for qualifying individuals described in 1902(A)(10)(E)(iv)(II) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.
1925 of the Act	(a)(5)	Other Required Special Groups: Families Receiving Extended Medicaid Benefits Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

State/Territory: Nebraska

Citation

Sec. 245A(h) of the Immigration and Nationality Act

(a)(6) Limited Coverage for Certain Aliens

(i) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they –

(A) Are aged, blind or disabled individuals as defined in section 1614(a)(1) of the Act;

(B) Are children under 18 years of age; or

(C) Are Cuban or Haitian entrants as defined in section 501(e)(1) and (2)(A) of P.L. 96422 in effect on April 1, 1983.

(ii) Except for emergency services and pregnancy- related services, as defined in 42 CFR 447.53(b) aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who are not identified in items 3.1(a)(6)(i)(A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved State plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.

State/Territory: Nebraska

Citation		
1905(a)(9) of the Act	(a)(7)	Homeless Individuals Clinic services furnished to eligible individuals who do reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.
1902(a)(47) of the Act	☒ (a)(8)	Presumptively Eligible Pregnant Women Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.
42 CFR 441.55 50 FR 43654 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act	(a)(9)	EPSDT Services The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) or the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

Citation

3.1 (a)(9) Amount, Duration, and Scope of Services: EPSDT Services (continued)

42 CFR 441.60

The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.

(a)(10) Comparability of Services

42 CFR 440.240 and 440.250

1902(a) and 1902 (a)(10), 1902(a)(52), 1903(v), 1915(g), 1925(b)(4) and 1932, of the Act.

Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915, 1925, and 1932 of the Act, 42 CFR 440.250 and section245A of the Immigration and Nationality Act, permit exceptions:

(i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.

(ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.

(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.

☒ (iv) Additional coverage for pregnancy-related services and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

**Describe here.

The MCO submits monthly encounter data.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

42 CFR Part
440, Subpart B
42 CPR 441.15
AT -78-90
AT-80-34

3.1(b) Home health services are provided in accordance with the requirements of 42 CFR 441.15.

(1) Home health services are provided to all categorically needy individuals 21 years of age or over.

(2) Home health services are provided to all categorically needy individuals under 21 years of age.

☒ Yes

☐ Not applicable. The State plan does not provide for skilled nursing facility services for such individuals.

(3) Home health services are provided to the medically needy:

☒ Yes, to all

☐ Yes, to individuals age 21 or over; SNF services are provided

☐ Yes, to individuals under age 21; SNF services are provided

☐ No; SNF services are not provided

☐ Not applicable; the medically needy are not included under this plan

Citation

3.1 Amount, Duration, and Scope of Services (continued)

42 CFR 431.53 (c)(1) Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-D.

42 CFR 483.10 (c)(2) Payment for Nursing Facility Services

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c) (8) (i).

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

3.1(d) Methods and Standards to Assure Quality of Services

42 CFR 440.260
AT-78-90

The standards established and the methods used to assure high quality care are described in ATTACHMENTS 3.1-C.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

3.1(e) Family Planning Services

42 CFR 441.20 AT-78-90	The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

State/Territory: Nebraska

Citation

3.1(f)(1) Optometric Services

42 CFR 441.30
AT-78-90

Optometric services (other than those provided under §435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

☐ Yes.

☐ No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

☒ Not applicable. The conditions in the first sentence do not apply.

(2) Organ Transplant Procedures

1903(i)(1)
of the Act,
P.L. 99-272
(Section 9507)

Organ transplant procedures are provided.

☐ No

☒ Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.

Citation

3.1 (g) Participation by Indian Health Service Facilities

42 CFR
431.110(b)
AT-78-90

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

(h) Respiratory Care Services for Ventilator-Dependent Individuals

1902(e)(9) of the Act,
P.L. 99-509
(Section 9408)

Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who--

(1) Are medically dependent on a ventilator for life support at least six hours per day;

(2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of--

☐ 30 consecutive days;

☐ ___ days (the maximum number of inpatient days allowed under the State plan);

(3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;

(4) Have adequate social support services to be cared for at home; and

(5) Wish to be cared for at home.

☐ Yes. The requirements of section 1902(e)(9) of the Act are met.

☒ Not applicable. These services are not included in the plan.

Citation

3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

1902(a)(10)(E)(i) and 1905(p)(1) of the Act

(i) Qualified Medicare Beneficiary (QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, through the group premium payment arrangement, unless the agency has a Buy-in agreement for such payment, as indicated below.

Buy-In agreement for:

☐ Part A ☒ Part B

☐ The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

Citation

	(ii)	Qualified Disabled and Working Individual (QDWI)
1902(a)(10)(E)(ii) and 1905(s) of the Act		The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-E, for individuals in the QDWI group defined in item A.26 of ATTACHMENT 2.2-A of this plan.
1902(a)(10)(E)(iii) and 1905(p)(3)(A)(iii) of the Act	(iii)	Specified Low-Income Medicare Beneficiary (SLMB)
		The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of ATTACHMENT 2.2-A of this plan.
1902(a)(10)(E)(iv)(I), 1905(p)(3)(A)(ii), and 1933 of the Act	(iv)	Qualifying Individual - 1 (OI-1)
		The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act.
1902(a)(10)(E)(iv)(II), 1905(p)(3)(A)(ii), and 1933 of the Act	(iv)	Qualifying Individual - 2 (OI-2)
		The Medicaid agency pays the portion of the amount of increase to the Medicare Part B premium attributable to the Home Health Provision to the individuals described in 1902(a)(10)(E)(iv)(II) and subject to 1933 of the Act.

Revision: HCFA-PM-93-2 (MB)
March 1993

State/Territory: Nebraska

Citation

(iv) Other Medicaid Recipients

1843(b) and 1905(a) of the Act and 42 CFR 431.625

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

☒ All individuals who are: a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); b) receiving State supplements under title XVI; or c) within a group listed at 42 CFR 431.625(d)(2).

☐ Individuals receiving title II or Railroad Retirement benefits.

☐ Medically needy individuals (FFP is not available for this group).

(2) Other Health Insurance

1902(a)(30) and 1905(a) of the Act

☒ The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

Revision: HCFA-PM-93-2 (MB)
March 1993

State/Territory: Nebraska

Citation

(b) Deductibles/Coinsurance

(1) Medicare Part A and B

1902(a)(30), 1902(n), 1905(a),and 1916 of the Act

Supplement 1 to ATTACHMENT 4.19-B describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

(i) Qualified Medicare Beneficiaries (QMBS)

Sections 1902 (a)(10)(E)(i) and 1905(p)(3) of the Act

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

(ii) Other Medicaid Recipients

1902(a)(10), 1902(a)(30), and 1905(a) of the Act

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare(subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2(a)(1)(iv),payment is made as follows:

42 CFR 431.625

☒ For the entire range of services available under Medicare Part B

☐ Only for the amount, duration, and scope of services otherwise available under this plan.

1902(a)(10), 1902(a)(30), 1905(a), and 1905(p) of the Act

(iii) Dual Eligible--QMB plus

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).

Citation

(c) Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations

1906 of the Act

The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans.

When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22(h).

1902(a)(10)(F) of the Act

(d) ☐ The Medicaid agency pays premiums for individuals described in item19 of Attachment 2.2-A.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

42 CFR 441.101,
42 CFR 431.620(c)
and (d)
AT-79-29

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

☒ Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620(c) and (d) are met.

☐ Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

3.4 Special Requirements Applicable to Sterilization Procedures

42 CFR 441.252 All requirements of 42 CFR Part 441, Subpart F are met.
AT"78-99

Citation

3.5 Families Receiving Extended Medicaid Benefits

1902(a)(52) and 1925 of the Act

(a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are -

☒ Equal in amount, duration,and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

☐ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:

☐ Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

☐ Medical or remedial care provided by licensed practitioners.

☐ Home health services.

Citation

3.5 Families Receiving Extended Medicaid Benefits (Continued)

- ☐ Private duty nursing services.
- ☐ Physical therapy and related services
- ☐ Other diagnostic, screening, preventive, and rehabilitation services.
- ☐ Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.
- ☐ Intermediate care facility services for the mentally retarded.
- ☐ Inpatient psychiatric services for individuals under age 21.
- ☐ Hospice services.
- ☐ Respiratory care services.
- ☐ Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

Citation

3.5 Families Receiving Extended Medicaid Benefits (Continued)

(c) ☐ The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance—

☐ 1st 6 months ☐ 2nd 6 months

☐ The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.

☐ 1st 6 mos. ☐ 2nd 6 mos.

(d) ☐ (1) The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:

☐ Enrollment in the family option of an employer's health plan.

☐ Enrollment in the family option of a State employee health plan.

☐ Enrollment in the State health plan for the uninsured.

☐ Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

Citation

3.5 Families Receiving Extended Medicaid Benefits (Continued)

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency—

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

☐ (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

SECTION 4 – GENERAL PROGRAM ADMINISTRATION

Citation		
	4.1	Methods of Administration
42 CFR 431.15 AT-79-29		The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

Revision: HCFA RO VII
November 1990

State/Territory: Nebraska

Citation

4.2 Hearings for Applicants and Recipients

42 CFR 431.202
AT-79-29
AT-80-34

The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

1919(e)(3)

With respect to transfers and discharges from nursing facilities, the requirements of 1919(e)(3) are met.

Revision: HCFA-AT-87-9 (BERC) OMB No. 0938-0193
August 1987

State/Territory: Nebraska

Citation

4.3 Safeguarding Information on Applicants and Recipients

42 CFR 431.301
AT-79-29

Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

52 FR 5967

All other requirements of 42 CFR Part 431, Subpart F are met.

Citation

4.4 Medicaid Quality Control

42 CFR 431.800(c)
50 FR 21839
1903(u)(1)(D) of the Act, P.L. 99-509 (Section 9407)

(a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.

(b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h), (j) and (k).

☐ Yes.

☒ Not applicable. The State has an approved Medicaid Management Information System (MMIS).

Revision: HCFA-PM-88-10 (BERC) OMB No. 0938-0193
September 1988

State/Territory: Nebraska

Citation

4.5 Medicaid Agency Fraud Detection and Investigation Program

42 CFR 455.12
AT-78-90
48 FR 3742
52 FR 48817

The Medicaid agency has established and will maintain methods, criteria and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.

State/Territory: Nebraska

Citation

4.5a Medicaid Agency Fraud Detection and Investigation

Section 1902 (a)(64) of the Social Security Act P.L. 105-33	The Medicaid agency has established a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title.

Revision: (Draft)
State/Territory: Nebraska

4.5b Medicaid Recovery Audit Contractor Program

Citation

Section 1902(a)(42)(B)(i) of the Social Security Act

_____ The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan.

__X__ The State is seeking an exception to establishing such program for the following reasons:

Nebraska implemented Heritage Health effective January 1, 2017. Heritage Health combines physical health, behavioral health and pharmacy programs into a single managed care system. More than 99% of Nebraska Medicaid clients are enrolled in Managed Care. A dental benefits manager for dental services was effective October 1, 2017. Neb Rev Stat 68-974(3)(a) excludes Managed Care claims from the scope of the Recovery Audit Contractor. This leaves very few claims for review or recovery from the fee for service program.

Section 1902(a)(42)(B)(ii)(I) of the Act

_____ The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute.

Place a check mark to provide assurance of the following:

_____ The State will make payments to the RAC(s) only from amounts recovered.

_____ The State will make payments to the RAC(s) on a contingent basis for collecting overpayments.

Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act

The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee):

_____ The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register.

Revisions: (Draft)

State/Territory: Nebraska (4.5b Continued)

_____ The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.

_____ The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.

Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act

_____ The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee):
Flat fee to be negotiated

Section 1902 (a)(42)(B)(ii)(III) of the Act

_____ The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).

Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act

_____ The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.

Section 1902(a)(42)(B)(ii)(IV)(bb) of the Act

_____ The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.

Section 1902 (a)(42)(B)(ii)(IV)(cc) Of the Act

_____ Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

4.6 Reports

42 CFR 431.16
AT-79-29

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

4.7 Maintenance of Records

42 CFR 431.17
AT-79-29

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

4.8 Availability of Agency Program Manuals

42 CFR 431.18(b)
AT-79-29

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

4.9 Reporting Provider Payments to Internal Revenue Service

42 CFR 433.37
AT-78-90

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C.6041) with respect to payment for services under the plan.

Revision: HCFA-AT-99-3 (CMSO)
June 1999

State/Territory: Nebraska

Citation

4.10 Free Choice of Providers

42 CFR 431.51
AT-78-90
46 FR 48524
48 FR 23212
1902(a)(23)
P.L. 100-93
(section 8(f)
P.L. 100-203
(Section 4113)

(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including of the Act an organization that provides these services or arranges for their availability on a prepayment basis.

(b) Paragraph (a) does not apply to services furnished to an individual —

(1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph(c), or

(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or

(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act,

Section 1902(a)(23)
Of the Social
Security Act
P.L. 105-33

(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid Services, or

Section 1932(a)(1)
Section 1905(t)

(5) Under an exception allowed under 42 CFR 438.50 or 42 CFR 440.168, subject to the limitations in paragraph (c)

(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1905(t), 1915(a), 1915(b)(1), or 1932(a); or managed care organization, prepaid inpatient health plan, a prepaid ambulatory health plan, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905(a)(4)(c).

Citation

4.11 Relations with Standard-Setting and Survey Agencies

42 CFR 431.610
AT-78-90
AT-80-34

(a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is the Nebraska Department of Health and Human Services.

(b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are): Nebraska Health and Human Services System.

(c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.

State/Territory: Nebraska

Citation

42 CFR 431.610 AT-78-90 AT-89-34	4.11(d)	The Nebraska Department of Health and Human Services, which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

4.12 Consultation to Medical Facilities

42 CFR 431.105(b)
AT-78-90

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105(b).

☐ Yes, as listed below:

☒ Not applicable. Similar services are not provided to other types of medical facilities.

Citation

4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

42 CFR 431.107

(a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.

42 CFR Part 483
1919 of the Act

(b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.

42 CFR Part 483,
Subpart D

(c) For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart DI--are also met.

1920 of the Act

(d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.

☐ Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

Citation

1902(a) (58)
1902(w)

4.13 (e) For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (unless the PAHP excludes providers in 42 CFR 489.102), and health insuring organizations are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights.

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State Law (whether

statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Managed care organizations, health insuring organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (as applicable) at the time of enrollment of the individual with the organization.

(3) Attachment 4.34 A describes law of the State (whether statutory or as Recognized by the courts of the State) concerning advance directives.

☐ Not applicable. No State law or court decision exist regarding advance directives.

State/Territory: Nebraska

Citation

4.14 Utilization/Quality Control

42 CFR 431.60
42 CFR 456.2
50 FR 15312
1902(a)(30)(C) and 1902(d) of the Act,
P.L. 99-509 (Section 9431)

(a) A Statewide program of surveillance and utilization control has implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:

☒ Directly

☐ By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO —

(1) Meets the requirements of §434.6(a);

(2) Includes a monitoring and evaluation plan to ensure satisfactory performance;

(3) Identifies the services and providers subject to PRO review;

(4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and

(5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.

1902(a)(30)(c) and 1902(d) of the Act,
P.L. 99-509 (section 9431)

☒ By undertaking quality and utilization reviews through contracts with utilization review organizations which do peer reviews (PRO-like/non- PRO-like entities). One contract includes hospital services (selected in- patient and selected out-patient services); the other contract includes mental health substance abuse inpatient services

☒ A qualified External Quality Review Organization performs an annual External Quality Review that meets the requirements of 42 CFR 438 Subpart E each managed care organization, prepaid inpatient health plan, and health insuring organizations under contract, except where exempted by the regulation.

Revision: HCFA-PH-85-3 (BERC)
May 1985

State/Territory: Nebraska

Citation

The contracts with the entities —

(1) Meets the requirements of §434.6(a);

(2) Includes a monitoring and evaluation plan to ensure satisfactory performance;

(3) Identifies the services and providers subject to the entity's review-,

(4) Includes a description of the extent to which the entity's determinations are considered conclusive for payment purposes.

42 CFR 456.2
50 FR 15312

4.14 (b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

☐ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

☐ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for.

☐ AII hospitals (other than mental hospitals).

☐ Those specified in the waiver.

☒ No waivers have been granted.

State/Territory: Nebraska

Citation

42 CFR 456.2
30 Fit 15312

4.14(c) The Medicaid agency meets the requirements of 42 CFR Part 456.Subpart D, for control of utilization of inpatient services in mental hospitals.

☐ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

☐ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for-.

☐ All mental hospitals.

☐ Those specified in the waiver

☒ No waivers have been granted.

☐ Not applicable. Inpatient services in mental hospitals are not provided under this plan.

Note: The utilization review entity will not review —

1. Inpatient hospital services in institutions for mental disease (IMD's) for clients age 65 or older; and

2. Treatment Crisis Intervention services for which coverage is limited to a maximum of 7 days.

State/Territory: Nebraska

Citation

42 CFR 456.2 50 FR 15312	4.14(d)	The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

☐ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

☐ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart F for:

- ☐ All skilled nursing facilities.
- ☐ Those specified in the waiver.

☒ No waivers have been granted.

Citation

42 CFR 456.2
50 FR 15312

4.14 ☒ (e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

- ☐ Facility-based review.
- ☒ Direct review by personnel of the medical assistance unit of the State agency.
- ☐ Personnel under contract to the medical assistance unit of the State agency.
- ☐ Utilization and Quality Control Peer Review Organizations.
- ☐ Another method as described in ATTACHMENT 4.14-A.
- ☐ Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

☐ Not applicable. Intermediate care facility services are not provided under this plan.

Revision: HCFA-AT-80-38 (BPP) OMB No. 0938-0193
May 22, 1980

State/Territory: Nebraska

Citation

4.14 Utilization/Quality Control (Continued)

42 CFR 438.356(e)

(f) For each contract, the State must follow an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR part 74 as it applies to State procurement of Medicaid services.

42 CFR 438.354
42 CFR 438.356(b) and (d)

The State must ensure that an External Quality Review Organization and its subcontractors performing the External Quality Review or External Quality Review-related activities meets the competence and independence requirements.

☐ Not applicable.

Revision: HCFA-PM-92-2 (HSQB)
March 1992

State/Territory: Nebraska

Citation

4.15 Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals

42 CFR Part 456 Subpart I, and 1902(a)(31) and 1903(g) of the Act

☐ The State has contracted with a Peer Review Organization (PRO) to perform inspection of care for:

- ☐ ICFs/MR;
- ☐ Inpatient psychiatric facilities for recipients under age 21; and
- ☐ Mental Hospitals.

42 CFR Part 456 Subpart A and 1902(a)(30) of the Act

☒ All applicable requirements of 42 CFR Part456, Subpart I, are met with respect to periodic inspections of care and services.

☐ Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan.

☐ Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan.

☐ Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees

42 CFR 431.615(c)
AT-78-90

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

Revision: HCFA-PM-95-3 (MB)
May 1995

State/Territory: Nebraska

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Citation

4.17 Liens and Adjustments or Recoveries

42 CFR 433.36(c)
1902(a) (18) and
1917(a) and (b) of
the Act

(a) Liens

☐ The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917 (a) of the Act and regulations at 42 CFR 433.36(c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

☐ The State imposes liens on real property on account of benefits incorrectly paid.

☐ The State imposes TEFRA liens 1917(a)(1)(B) on real property of an individual who is an inpatient of nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (Note: If the State indicates in its State plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

Citation

☐ The State imposes liens on both real and personal property of an individual after the individual's death.

(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36(h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

(1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

☒ Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual

(2) ☒ The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917(a)(1)(B) (even if it does not impose those liens).

(3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

☒ In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State plan as listed below:

All Medicaid services provided under the Nebraska Title XIX State Plan for individuals age 55 and over, except for Medicare Cost Sharing as specified at 4.17(b)(3) – Continued.

42 CFR 1396p(b)(1)(B)(ii) (3) (continued)
Limitations on Estate Recovery - Medicare Cost Sharing:

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1,2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.

(ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

1917(b)1(c)	(4)	☒	If an individual covered under a long-term care insurance policy received benefits for which assets or resources were disregarded as provided for in Attachment 2.6-A, Supplement 8c (State Long-Term Care Insurance Partnership), the State does not seek adjustment or recovery from the individuals estate for the amount of assets or resources disregarded.

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

Citation

(c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917(b)(2) of the Act and regulations at 42 CFR §433.36(h) - (i).

(1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.

(2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:

(a) a sibling of the-individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or

(b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.

Citation

(3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

(d) ATTACHMENT 4.17-A

(1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).

(2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).

(3) Defines the following terms:

- estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),

- individual's home,
- equity interest in the home,
- residing in the home for at least 1 or 2 years,
- on a continuous basis,
- discharge from the medical institution and return home, and
- lawfully residing.

(4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.

(5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost- effectiveness.

(6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

State/Territory: Nebraska

Citation

4.18 Recipient Cost Sharing and Similar Charges

42 CFR 447.51 through 447.58

(a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

1916(a) and (b) of the Act

(b) Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan

(2) No deductible, coinsurance, copayment or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

- ☐ Age 19
- ☐ Age 20
- ☐ Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

Individuals age 19 and 20 who are eligible under the -

1. ADC Program;
2. AABD Program;
3. Refugee Resettlement Program; or
4. Ribicoff Program.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

Citation

4 .18(b) (2) (Continued)

42 CFR 447.51 through 447.58

(iii) All services furnished to pregnant women.

☐ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a managed care organization, health insuring organization, prepaid inpatient health plan, or prepaid ambulatory health plan in which the individual is enrolled, unless they meet the requirements of 42 CFR 447.60.

42 CFR 438.108
42 CFR 447.60

☐ Managed care enrollees charged deductibles, coinsurance rates, and copayments in an amount equal to the State Plan service cost sharing.

☒ Managed care enrollees are not charged deductibles, coinsurance rates, and copayments.

1916 of the Act, P.L. 99-272, (Section 9505)

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

Citation

4.18(b) (Continued)

42 CFR 447.51 through 447.48

(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.

☐ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

☐ 18 or older

☒ 19 or older

☐ 20 or older

☐ 21 or older

☒ Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

Individuals age 19 and 20 who are eligible under the -

1. ADC Program;
2. AABD Program;
3. Refugee Resettlement Program; or
4. Ribicoff Program.

Citation

4.18(b)(3) (Continued)

42 CFR 447.51 through 447.58

(iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

(A) Service(s) for which a charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

☒ Not applicable. There is no maximum.

Revision: HCFA-PM-91-4 August 1991 (BPD) OMB No. 0938-

State/Territory: Nebraska

Citation

1916(c) of the Act	4.18(b)(4) ☐	A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.
1902(a)(52) and 1925(b) of the Act	4.18(b)(5) ☐	For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.
1916(d) of the Act	4.18(b)(6) ☐	A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. ATTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.

State/Territory: Nebraska

Citation

4.18(c) ☒ Individuals are covered as medically needy under the plan.

42 CFR 447.51 through 447.58

(1) ☐ An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

447.51 through 447.58

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18,or under—

☒ Age 19

☐ Age 20

☐ Age 21

Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:

Individuals age 19 and 20 who are eligible under the -

1. ADC Program;
2. AABD Program;
3. Refugee Resettlement Program; or
4. Ribicoff Program.

Citation

4.18 (c)(2) (Continued)

42 CFR 447.51 through 447.58

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

(iii) All services furnished to pregnant women.

☐ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

1916 of the Act, P.L. 99-272 (Section 9505)

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

447.51 through 447.58

(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.

☐ Not applicable. No such charges are imposed.

Citation

4.18 (c) (3) Unless a waiver under 42 CFR 431.55(g)applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

☐ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

1. 18 or older
2. 19 or older
3. 20 or older
4. 21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.

Individuals age 19 and 20 who are eligible under the -

1. ADC Program;
2. AABD Program;
3. Refugee Resettlement Program; or
4. Ribicoff Program.

Citation

4.18(c)(3) (Continued)

447.51 through 447.58

(iii) For the medically needy, and other optional groups, ATTACHMENT 4.18C specifies the:

(A) Service(s) for which charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

☒ Not applicable. There is no maximum.

State/Territory: Nebraska

Citation

4.19 Payment for Services

42 CFR 447.252
1902(a)(13)
and 1923 of
the Act

(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

☒ Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

☐ Inappropriate level of care days are not covered.

State/Territory: Nebraska

Citation		
42 CFR 447.201 42 CFR 447.302 52 FR 28648 1902(a)(13)(E) 1903(a)(1) and (n), 1920, and 1926 of the Act	4.19(b)	In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m),the Medicaid agency meets the following requirements: (1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys). (2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan. ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.
1902(a)(10) and 1902(a)(30) of the Act		SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

42 CFR 447.40
AT-78-90

4.19(c) Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

☒ Yes. The State's policy is described in ATTACHMENT 4.19-C

☐ No.

Citation

4.19(d)

42 CFR 447.252
47 FR 47964
48 FR 56046
42 CFR 447.280
47 FR 31518
52 FR 28141
4.19 (d)

☒ (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C. with respect to payments for skilled nursing and intermediate care facility services.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services.

(2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

☒ At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

☐ At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

☐ Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.

(3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

☐ At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

☐ At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

☒ Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

☐ (4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

42 CFR 447.45(c) AT-79-50	4.19(e)	The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims. ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

Revision: HCFA-PM-87-4 March 1987 (BERC) OMB No. 0938-0193

State/Territory: Nebraska

Citation

42 CFR 447.15 AT-78-90 AT-80-34 48 FR 5730	4.19 (f)	The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15. No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

42 CFR 447.201 42 CFR 447.202 AT-78-90	4.19(g)	The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

Revision: HCFA-AT-80-60 (BPP)
August 12, 1980

State/Territory: Nebraska

Citation

42 CFR 447.201 42 CFR 447.203 AT-78-90	4.19(h)	The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

42 CFR 447.201 42 CFR 447.204 AT-78-90	4.19(i)	The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general peculation.

Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
August 1991

State/Territory: Nebraska

Citation

42 CFR 447.201 and 447.205	4.19 (j)	The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.
1903(v) of the Act	(k)	The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: Nebraska

Citation

1903(i)(14) of the Act	4.19 (l)	The Medicaid agency meets the requirements of section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physician to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

Revision: HCFA-PM-94-B (MB)
October 1994

State/Territory: Nebraska

Citation

4.19(m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928(c)(2)(C)(ii) of of the Act.

(i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid the Act reimbursement to providers will be administered as follows.

(ii) The State:

☐ sets a payment rate at the level of the regional maximum established by the DHHS Secretary.

☐ is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

☒ sets a payment rate below the level of the regional maximum established by the DHHS Secretary.

☐ is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

The State pays the following rate for the administration of a vaccine: $10.50

1926 of the Act

(iii) Medicaid beneficiary access to immunizations is assured through the following methodology:

The State will compare -

a. The number of Medicaid pediatric practitioners (including practitioners listed in section 1926(a)(4)(B) of the Act) who are Medicaid-enrolled providers and who have submitted pediatric immunization claims; and

b. The total number of pediatric practitioners providing immunizations to children.

The Medicaid-enrolled providers must have at least one Medicaid pediatric immunization claim per month or an average of 12 claims per year.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services

42 CFR 447.25(b)
AT-78-90

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

☐ Yes, for ☐ physicians' services

☐ dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

☒ Not applicable. No direct payments are made to recipients.

Revision: HCFA-AT-81-34 (BPP)

State/Territory: Nebraska

Citation

4.21 Prohibition Against Reassignment of Provider Claims

42 CFR 447.10(c) AT-78-90 46 FR 42699	Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.

Revision: HCFA-PM-94-1 (MB)
February 1994

State/Territory: Nebraska

Citation

4.22 Third Party Liability

42 CFR 433.137
1902(a)(25)(H) and (I)
of the Act

(a) The Medicaid agency meets all requirements of:
1. 42 CFR 433.138 and 433.139.
2. 42 CFR 433.145 through 433.148.
3. 42 CFR 433.151 through 433.154.
4. Sections 1902(a)(25)(H) and (I) of the Act.

42 CFR 433.138(f)

(b) ATTACHMENT 4.22-A –

(1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;

42 CFR 433.138(g)(1)(ii) and (2)(ii)

(2) Describes the methods the agency uses for meeting the followup requirements contained in §433.138(g)(1)(i) and (g)(2)(i);

42 CFR 433.138(g)(3)(i) and (iii)

(3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources; and

42 CFR 433.138(g)(4)(i) through (iii)

(4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources.

Revision: HCFA-PM-94-1 (MB)
February 1994

State/Territory: Nebraska

Citation

42 CFR 433.139(b)(3)(ii) (A)

(c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.

(d) ATTACHMENT 4.22-B specifies the following:

42 CFR 433.139(b)(3)(ii)(C)

(1) The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(C).

42 CFR 433.139(f)(2)

(2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.

42 CFR 433.139(f)(3)

(3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.

42 CFR 447.20

(e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

Revision: HCFA-PM-94-1 (MB)
February 1994

State/Territory: Nebraska

Citation

4.22 (continued)

42 CFR 433.151(a)

(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

- ☐ State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.
- ☐ Other appropriate State agency(s) _____
- ☐ Other appropriate agency(s) of another State _____
- ☐ Courts and law enforcement officials.

1902(a)(60) of the Act

(g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

- ☐ The Secretary's method as provided in the State Medicaid Manual, Section 3910.
- ☒ The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.

Citation

4.23 Use of Contracts

42 CFR Part 434.4
48 FR 54013

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42CFR Part 434.

☒ Not applicable. The State has such no contracts.

Revision: HCFA-PM-94-2 (BPD)
April 1994

State/Territory: Nebraska

Citation

4.24 Standards for Payments for Nursing Facility and Intermediate Care Facility for the Mentally Retarded Services

42 CFR 442.10
and 442.100
AT-78-90
AT-79-18
AT-80-25
AT-80-34
52 FR 32544
P.L, 100-203
(Sec.4211)
54 FR 5316
56 FR 48826

With respect to nursing facilities and intermediate care facilities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met.

☐ Not Applicable to intermediate care facilities for the mentally retarded; such services are not provided under this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

4.25 Program for Licensing Administrators of Nursing Homes

42 CFR 431.702
AT-78-90

The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431,Subpart N, for the licensing of nursing home administrators.

Revision: HCFA-PM (MB)

State/Territory: Nebraska

Citation

4.26 Drug Utilization Review Programs

1927(g)
42 CFR 456.700

A. 1. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.

1927(g)(1)(A)

2. The DUR program assures that prescriptions for outpatient drugs are:

- Appropriate
- Medically necessary
- are not likely to result in adverse medical results

1927(g)(1)(a)
42 CFR 456.705(b)
and 456.709(b)

B. The DUR program is designed to educate physicians and pharmacist to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as:

- Potential and actual adverse drug reactions
- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Drug disease contraindications
- Drug-drug interactions
- Incorrect drug dosage or duration of drug treatment
- Drug-allergy interactions
- Clinical abuse/misuse

1927(g)(1)(B)
42 CFR 456.703
(d) and (f)

C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia.

- American Hospital Formulary Service Drug Information
- United States Pharmacopeia-Drug Information
- American Medical Association Drug Evaluations

Revision: HCFA-PM- (MB)

State/Territory: Nebraska

Citation

1927(g)(1)(D)
42 CFR 456.703(b)

D. DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never- the-less chosen to include nursing home drugs in:

☒ Prospective DUR
☒ Retrospective DUR.

1927(g)(2)(A)
42 CFR 456.705(b)

E. 1. The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.

1927(g)(2)(A)(i)
42 CFR 456.705(b), (1)-(7)

2. Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to:

- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Drug-interactions with non-prescription or over-the-counter drugs
- Incorrect drug dosage or duration of drug treatment
- Drug allergy interactions
- Clinical abuse/misuse

1927(g)(2)(A)(ii)
42 CFR 456.705 (c) and (d)

3. Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.

1927(g)(2)(B)
42 CFR 456.709(a)

F. 1. The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify:

- Patterns of fraud and abuse
- Gross overuse
- Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.

Revision: HCFA-PM- (MB)

State/Territory: Nebraska

Citation

927(g)(2)(C)
42 CFR 456.709(b)

F. 2. The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:

- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Incorrect drug dosage/duration of drug treatment
- Clinical abuse/misuse

1927(g)(2)(D)
42 CFR 456.711

3. The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.

1927(g)(3)(A)
42 CFR 456.716(a)

G. 1. The DUR program has established a State DUR Board either:

☐ Directly, or
☒ Under contract with a private organization

1927(g)(3)(B)
42 CFR 456.716
(A) AND (B)

2. The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians)with knowledge and experience in one or more of the following:

- Clinically appropriate prescribing of covered outpatient drugs.
- Clinically appropriate dispensing and monitoring of covered outpatient drugs.
- Drug use review, evaluation and intervention.
- Medical quality assurance.

927(g)(3)(C)
42 CFR 456.716(d)

3. The activities of the DUR Board include:

- Retrospective DUR
- Application of Standards as defined in section 1927(g)(2)(C), and
- Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.

Revision: HCFA-PM- (MB) OMB No.

State/Territory: Nebraska

Citation

1927(g)(3)(C) 42 CFR 456.711 (a)-(d)	G.	4.	The interventions include in appropriate instances: - Information dissemination - Written, oral, and electronic reminders - Face-to-Face discussions - Intensified monitoring/review of prescribers/dispensers
1927(g)(3)(D) 42 CFR 456.712 (A) and (B)	H.		The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report.
1927(h)(1) 42 CFR 456.722	I.	1.	The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line: - real time eligibility verification - claims data capture - adjudication of claims - assistance to pharmacists, etc. applying for and receiving payment.
1927(g)(2)(A)(i) 42 CFR 456.705(b)		2.	Prospective DUR is performed using an electronic point of sale drug claims processing system.
1927(j)(2) 42 CFR 456.703(c)	J.		Hospitals which dispense covered outpatient drugs are exempted from the ,drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.

Citation

1902(a)(85) and Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)

Claim Review Limitations

- Prospective safety edits on opioid prescriptions to address days' supply, early refills, duplicate fills and quantity limitations for clinical appropriateness.
- Prospective safety edits on maximum daily morphine milligram equivalents (MME) on opioids prescriptions to limit the daily morphine milligram equivalent (as recommended by clinical guidelines).
- Retrospective reviews on opioid prescriptions exceeding these above limitations on an ongoing basis.
- Retrospective reviews on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on an ongoing periodic basis.

Programs to monitor antipsychotic medications to children: Antipsychotic agents are reviewed for appropriateness for all children including foster children based on approved indications and clinical guidelines.

Fraud and abuse identification: The DUR program has established a process that identifies potential fraud or abuse of controlled substances by enrolled individuals, health care providers and pharmacies.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

4.27 Disclosure of Survey information and Provider or Contractor Evaluation

42 CFR 431.115(c)
AT-78-90
AT-79-74

The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: Nebraska

Citation

4.28 Appeals Process

42 CFR 431.152;
AT-79-18
52 FR 22444;
Secs. 1902(a)(28)(D)(i)
and 1919(e)(7) of
the Act; P.L.
100-203 (Sec. 4211(c))

(a) The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154.

(b) The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.

Revision: HCFA-PM-99-3 (CMSO)
June 1999

State/Territory: Nebraska

Citation

4.29 Conflict of Interest Provisions

1902(a)(4)(C) of the Social Security Act P.L. 105-33	The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the prohibition against acts, with respect to any activity under the plan, that is prohibited by section 207 or 208 of Title 18, United States Code.
1902(a)(4)(D) of the Social Security Act P.L. 105-33 1932(d)(3) 42 CFR 438.58	The Medicaid agency meets the requirements of 1902(a)(4)(D)of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

Citation

4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals

42 CFR 1002.203
AT-79-54
48 FR 3742
51 FR 34772

(a) All requirements of 42 CFR Part 1002, Subpart B are met.

☐ The agency, under the authority of State law, imposes broader sanctions.

State/Territory: Nebraska

Citation

1902(p) of the Act
P.L. 100-93
(secs. 7)

(b) The Medicaid agency meets the requirements of —

(1) Section 1902(p) of the Act by excluding from participation -

(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under Title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).

42 CFR 438.808

(B) An MCO (as defined in section 1903(m) of the Act), or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that —

(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or

(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.

1932(d)(1)
42 CFR 438.610

(2) An MCO, PIHP, PAHP, or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438.610(b)) suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. If the State finds that an MCO, PCCM, PIPH, or PAHP is not in compliance the State will comply with the requirements of 42 CFR 438.610(c).

State/Territory: Nebraska

Citation

1902(a)(39) of the Act
P.L. 100-93
(sec 9/5)

(2) Section 1902(a)(39) of the Act by--

(A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and

(B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

(c) The Medicaid agency meets the requirements of--

1902(a)(41)
of the Act
P.L. 96-272,
(sec. 308(c))

(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and

1902(a)(49) of the Act
P.L. 100-93
(sec. 5(a)(4))

(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

Citation

4.31 Disclosure of Information by Providers and Fiscal Agents

455.103
44 FR 41644
1902 (a) (38)
of the Act

The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106.

P.L. 100-93
(sec. 8(f))
435.940
through 435.960
52 FR 5967
P.L. 100-360
(Sec. 411(k)(15))

4.32 Income and Eligibility Verification System

The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42CFR 435.940 through 435.960.

ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

Revision: HCFA-PM-87-14 (BERC) OMB No. 0938-0193
October 1987

State/Territory: Nebraska

Citation

4.33 Medicaid Eligibility Cards for Homeless Individuals

1902(a)(48)
of the Act,
P.L. 99-510
(Section 11005)
P.L 100-93
(sec. 5(a)(3))

(a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

Revision: Region VII
December 1989

OMB No. 0938-0193

State/Territory: Nebraska

Citation

4.34 Systematic Alien Verification for Entitlements

1137 of the Act
P.L. 99-603 (eec. 121)
P.L. 100-360 (Sec. 411(k)(15))

The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988, except for aliens seeking medical assistance for treatment of emergency medical conditions under Section 1903(v)(2) of the Social Security Act.

☐ The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

☐ The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

- ☐ Total waiver
- ☐ Alternative system
- ☐ Partial implementation

State/Territory: Nebraska

Citation

4.35 Enforcement of Compliance for Nursing Facilities

42 CFR §488.402(f)

(a) Notification of Enforcement Remedies

When taking an enforcement action against a non- State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

(1) nature of noncompliance,
(2) which remedy is imposed,
(3) effective date of the remedy, and
(4) right to appeal the determination leading to the remedy.

42 CFR §488.434

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

42 CFR §488.402(f)(2)

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

42 CFR §488.456(c)(d)

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

(b) Factors to be Considered in Selecting Remedies

42 CFR §488.488.404(b)(1)

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) & (2).

☐ The State considers additional factors. Attachment 4.35-A describes the State's other factors.

Revision: HCFA-PM-95-4 (HSQB)
June 1995

State/Territory: Nebraska

Citation

c) Application of Remedies

42 CFR §488.410

(i) If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.

42 CFR §488.417(b) §1919(h)(2)(C) of the Act.

(ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.

42 CFR §488.414 §1919(h)(2)(D) of the Act.

(iii) The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.

42 CFR §488.408 1919(h)(2)(A) of the Act.

(iv) The State follows the criteria specified at 42 CFR §488.408(c)(2), §488.408(d)(2), and §488.408(e)(2), when it imposes remedies in place of or in addition to termination.

42 CFR §488.412(a)

(v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412(a) are not met.

(d) Available Remedies

42 CFR §488.406(b) §1919(h)(2)(A) of the Act.

(i) The State has established the remedies defined in 42 CFR 488.406(b).

- ☒ (1) Termination
- ☒ (2) Temporary Management
- ☒ (3) Denial of Payment for New Admissions
- ☒ (4) Civil Money Penalties
- ☒ (5) Transfer of Residents; Transfer of Residents with Closure of Facility
- ☒ (6) State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.

Revision: HCFA-PM-95-4 (HSQB)
June 1995

State/Territory: Nebraska

Citation

42 CFR
§488.406(b)
§1919(h)(2)(B)(ii)
of the Act.

(ii) ☐ The State uses alternative remedies. The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406(b).

- ☐ (1) Temporary Management
- ☐ (2) Denial of Payment for New Admissions
- ☐ (3) Civil Money Penalties
- ☐ (4) Transfer of Residents; Transfer of Residents with Closure of Facility
- ☐ (5) State Monitoring.

Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

42 CFR
§488.303(b)
1910(h)(2)(F)
of the Act.

(e) ☐ State Incentive Programs

- ☐ (1) Public Recognition
- ☐ (2) Incentive Payments

Citation

4.36 Required Coordination Between the Medicaid and WIC Programs

1902(a)(11)(C) and 1902(a)(53) of the Act

The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.

Revision: HCFA-PM-91-10 (BPD)
December 1991

State/Territory: Nebraska

Citation

4.38 Nurse Aide Training and Competency Evaluation for Nursing Facilities

42 CFR 483.75;
42 CFR 483 Subpart D;
Secs. 1902(a)(28),
1919(e)(1) and (2),
and 1919(f)(2),
P.L. 100-203 (Sec.
4211(a)(3)); P.L.
101-239 (Secs.
6901(b)(3) and
(4)); P.L. 101-508
(Sec. 4801(a)).

(a) The State assures that the requirements of 42 CFR 483.150(a),which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.

☐ (b) The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).

☐ (c) The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.

☐ (d) The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.

☐ (e) The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.

☐ (f) The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154

Revision: HCFA-PM-91-10 (BPD)
December 1991

State/Territory: Nebraska

Citation

42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239-(Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

(g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.

(h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.

(i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.

(j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.

(k) For program reviews other than the initial review, the State visits the entity providing the program.

(l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).

Revision: HCFA-PM-91-10 (BPD)
December 1991

State/Territory: Nebraska

Citation

42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

(m) The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.

(n) The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.

(o) The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).

(p) The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR483.151(b)(2) or (3).

(q) The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.

(r) The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.

Revision: HCFA-PM-91-10 (BPD)
December 1991

State/Territory: Nebraska

Citation

42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

(s) When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.

(t) The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.

(u) The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.

(v) The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.

(w) Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.

(x) The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).

(y) The State has a standard for successful completion of competency evaluation programs.

Revision: HCFA-PM-91-10 (BPD)
December 1991

State/Territory: Nebraska

Citation

42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(z)	The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
	☐	(aa)	The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).
		(bb)	The State maintains a nurse aide Registry that meets the requirements in 42 CFR 483.156.
	☐	(cc)	The State includes home health aides on the registry.
	☐	(dd)	The State contracts the operation of the registry to a non-State entity.
	☐	(ee)	ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv).
	☐	(ff)	ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).
P.L. 105-15 (Sec. 4132.2(e))	☒	(gg)	The State waives the prohibition of nurse aide training and competency evaluation program offered in (but not by) certain nursing homes if the State determines the facility meets specified exception criteria.

Revision: HCFA-PM-91-10 (BPD)
December 1991

State/Territory: Nebraska

Citation

☒ (hh) The State:

(1) assures there is no other such program offered within a reasonable distance of the facility;

a. the facility must make a diligent effort to locate other approved NATCEPs within a reasonable distance (1/2 hour travel time each way from the facility) unless the facility can demonstrate distance or program availability would create a hardship for program participants.

b. the facility must provide evidence that classes are not currently being offered at an approved site within a reasonable distance.

c. the facility must provide evidence that classes are not currently being offered within a reasonable distance during time frames to meet student and facility needs.

(2) assures, through an oversight effort, an adequate environment exists for operating the program in the facility; and

a. the facility must be in substantial compliance with the Federal requirements for participation in §483.13 Resident Behavior and Facility Practices, §483.15 Quality of Life, §483.25 Quality of Care, and §483.75(f) Proficiency of Nurse Aides.

"Substantial compliance" means compliance with the federal requirements of participation as set forth in 42 CFR §§483.13, 483.15, 483.25 and 483.75(f).

b. the facility must not be determined to be a poor performing facility.

A "poor performing facility" is a facility cited for substandard quality of care on the current standard survey and for substandard quality of care or immediate jeopardy on at least one of the previous two standard surveys. See, Survey and Certification Regional Letter No. 97-02.

Citation

c. employees of the facility cannot function as instructors for the program. If the approved NATCEP is experiencing difficulty in finding qualified instructors, the state may, in limited hardship situations, allow the NATCEP to use facility employees to serve as instructors if they meet the qualifications for instructors and the individual is paid and supervised by the NATCEP.

d. the sponsoring NATCEP must describe the evaluation process used to determine an adequate teaching/learning environment exists for conducting the course (i.e., adequacy of classroom, availability of equipment and oversight of the entire course). The NATCEP is responsible for program administration and assuring program requirements are met.

e. The facility must notify students and the instructor of their right to register any concerns with the state agency at any time during the course and be given information on how to contact the state agency. The state agency may make unannounced visits to any courses offered to determine compliance with the criteria for the waiver or to investigate complaints.

e. The facility and NATCEP instructor/coordinator must have policies for communicating and resolving problems encountered during the course.

g. At the end of the course, the NATCEP instructor/coordinator and all of the students are required to submit an evaluation of the course. The state agency will review and evaluate course evaluations for determination of future waivers.

Citation

(3) provides notice of such determination and assurances to the state long term care ombudsman.

a. The state agency will notify the ombudsman by state agency letter of all facilities granted waivers and oversight efforts to assure compliance with the law.

b. Assurances to the state long term care ombudsman will include:

- The state agency requires the NATCEP to submit the evaluation process used to determine an adequate teaching/learning environment exists for conducting the course and assuring program requirements are met.

- The state agency requires the NATCEP to submit the policies developed for communicating and resolving problems encountered during the course.

- The state agency has the right to make unannounced visits to any courses offered in a facility under waiver. Students or the instructor have the right to register any concerns with the state agency at any time during the program and must be given information on how to contact the agency.

Revision: HCFA-PM-93-1 (BPD)
January, 1993

State/Territory: Nebraska

Citation

4.39 Preadmission Screening and Annual Resident Review in Nursing Facilities

Secs. 1902(a)(28)(D)(i) and 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)); P.L. 101-508 (Sec. 4801(b)).

(a) The Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meet the requirements of 42 (CFR) 431.621(c).

(b) The State operates a preadmission and annual resident review program that meets the requirements of 42 CFR 483.100-138.

(c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or annual resident review until such individuals are screened or reviewed.

(d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as "medical assistance under the State plan" the cost of NF services to individuals who are found not to require NF services.

☒ (e) ATTACHMENT 4.39 specifies the State's definition of specialized services.

☒ (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.

(g) The State describes any categorical determinations it applies in ATTACHMENT 4.39A.

Citation

4.40 Survey & Certification Process

Sections 1919(g)(1) thru (2)and 1919(g)(4) thru (5); of the Act 100-203 (Sec. 4212(a))	(a)	The State assures that the requirements of 1919(g)(1)(A)through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey P.L. and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act, are met.
1919(g)(1)(B) of the Act	(b)	The State conducts periodic education programs for staff and residents (and their representatives). Attachment 4.40-A describes the survey and certification educational program.
1919(g)(1)(C) of the Act	(c)	The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. Attachment 4.40-B describes the State's process.
1919(g)(1)(C) of the Act	(d)	The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency? _____
1919(g)(1)(C) of the Act	(e)	The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.
1919(g)(1)(C) of the Act	(f)	The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.

State/Territory: Nebraska

Citation

1919(g)(2)(A)(i)(I) of the Act	(g)	The State has procedures, as provided for at section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. Attachment 4.40-C describes the State's procedures.
1919(g)(2)(A)(ii) of the Act	(h)	The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.
1919(g)(2)(A)(iii)(I) of the Act	(i)	The State assures that the statewide average interval between standard surveys of nursing facilities does not exceed 12 months.
1919(g)(2)(A)(iii)(II) of the Act	(j)	The State may conduct a special standard or special abbreviated standard survey within two months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.
1919(g)(2)(B) of the Act	(k)	The State conducts extended surveys immediately or, if not practicable, not later than two weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.

Citation

1919(g)(2)(C) of the Act	(l)	The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.
1919(g)(2)(D) of the Act	(m)	The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. Attachment 4.40-D describes the State's programs.
1919(g)(2)(E)(i) of the Act	(n)	The State uses a multidisciplinary team of professionals including a registered professional nurse.
1919(g)(2)(E)(ii) of the Act	(o)	The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or have no personal or familial financial interest in the facility being surveyed.
1919(g)(2)(E)(iii) of the Act	(p)	The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.
1919(g)(4) of the Act	(q)	The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and on-site monitoring. Attachment 4.40-E describes the State's complaint procedures.
1919(g)(5)(A) of the Act	(r)	The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act.

State/Territory: Nebraska

Citation

1919(g)(5)(B) of the Act	(s)	The State notifies the State long-term care ombudsman of the State's finding of noncompliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.
1919(g)(5)(C) of the Act	(t)	If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.
1919(g)(5)(D) of the Act	(u)	The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.

Revision: HCFA-AT-80-38 (HSQB)
May 22, 1980

State/Territory: Nebraska

Citation

4.41 Resident Assessment for Nursing Facilities

Sections 1919(b)(3) and 1919(e)(5); of the Act

(a) The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §1919(b)(3)(A) of the Act.

1919(e)(5)(A) of the Act

(b) The State is using:

☐ the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the State Operations Manual) [§1919(e)(5)(A)]; or

1919(e)(5)(B) of the Act

☒ a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary's approval criteria) [§1919(e)(5)(B)].

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

Citation

4.42 Employee Education About False Claims Recoveries.

1902(a)(68) of the Act, P.L. 109-171 (section 6032)

(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

Citation

health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

Citation

(3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(4) The requirements of this law should be incorporated into each State's provider enrollment agreements.

(5) The State will implement this State Plan amendment on January 1, 2007.

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

State/Territory: Nebraska

Citation		
	4.43	Cooperation with Medicaid Integrity Program Efforts.
1902(a)(69) of the Act, P.L. 109-171 (section 6034)		The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

Citation		
	4.44	Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States
1902(a)(80) of the Social Security Act, P.L. 111-148 (Section 6505)		_X_ The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

4.45 Reserved

Citation

4.46 Provider Screening and Enrollment (Page 1 of 3)

Citation	The State Medicaid agency gives the following assurances:
1902(a)(77) 1902(a)(39) 1902(1c1c); P.L. 111-148 and P.L. 111-152	As per our September 14, 2012, discussion with CMS Regional Representative Sandra Levels and Michael Berger, Nebraska is assuring compliance as per our previously stated implementation issues related to staffing and systems.
42 CFR 455 Subpart E	PROVIDER SCREENING __X__ Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(1c1c) of the Act.
42 CFR 455.410	ENROLLMENT AND SCREENING OF PROVIDERS __X__ Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq. __X__ Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.
42 CFR 455.412	VERIFICATION OF PROVIDER LICENSES __X__ Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.
42 CFR 455.414	REVALIDATION OF ENROLLMENT __X__ Assures that providers will be revalidated regardless of provider type at least every 5 years.
42 CFR 455.416	TERMINATION OR DENIAL OF ENROLLMENT __X__ Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.
42 CFR 455.420	REACTIVATION OF PROVIDER ENROLLMENT __X__ Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

42 CFR 455.422 APPEAL RIGHTS

__X__ Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.

42 CFR 455.432 SITE VISITS

__X__ Assures that pre-enrollment and post-enrollment site visits of providers who are in "moderate" or "high" risk categories will occur.

42 CFR 455.434 CRIMINAL BACKGROUND CHECKS

__X__ Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.

FEDERAL DATABASE CHECKS

42 CFR 455.436 __X__ Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.

NATIONAL PROVIDER IDENTIFIER

42 CFR 455.440 __X__ Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

SCREENING LEVELS FOR MEDICAID PROVIDERS

42 CFR 455.450 __X__ Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.

APPLICATION FEE

42 CFR 455.460 __X__ Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.

42 CFR 455.470

TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS

__X__ Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(a)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1151. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

SECTION 5: PERSONAL ADMINISTRATION

Citation

5.1 Standards of Personnel Administration

42 CFR 432.10 (a)
AT-78-90
AT-79-23
AT-80-34

(a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with Section 208of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900,Subpart F. All requirements of 42 CFR 432.10 are met.

☒ The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

5.2 Reserved

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

5.3 Training Programs; Subprofessional and Volunteer Programs

42 CFR Part 432,
Subpart B
AT-78-90

The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

SECTION 6 FINANCIAL ADMINISTRATION

Citation

6.1 Fiscal Policies and Accountability

42 CFR 433.32
AT-79-29

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.

Revision: HCFA-AT-81 (BPP)

State/Territory: Nebraska

Citation

6.2 Cost Allocation

42 CFR 433.34 47 FR 17490	There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nebraska

Citation

6.3 State Financial Participation

42 CFR 433.33
AT-79-29
AT-80-34

(a) State funds are used in both assistance and administration.

☒ State funds are used to pay all of the non-Federal stare of total expenditures under the plan.

☐ There is local participation. State funds are to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State or an equalization or other basis which, assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.

(b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

SECTION 7: GENERAL PROVISIONS

Citation

7.1 Plan Amendments

42 CFR 430.12(c)

The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

Citation

7.2 Nondiscrimination

45 CFR Parts 80 and 84

In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap.

The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in ATTACHMENT 7.2-A.

Citation

7.3 [Reserved]

Citation

7.4 State Governor's Review

42 CFR 430.12(b)

The Medicaid agency will provide opportunity for the Office of the Governor to review State plan amendments, long range program planning projections, and other periodic reports thereon, excluding periodic, statistical, budget and fiscal reports. Any comments made will be transmitted to the Health Care Financing Administration with such documents.

☒ Not applicable. The Governor -

☒ Does not wish to review any plan material.

☐ Wishes to review only the plan material specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

Nebraska Department of Health and Human Services
(Designated Single State Agency)

Date: 9/18/07

Christine Z. Peterson, Chief Executive Officer
Department of Health and Human Services

-OR-

Vivianne M. Chaumont, Director
Division of Medicaid & Long-Term Care
Department of Health and Human Services

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

_X____ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __X___ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. __X__ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. __X___ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Nebraska Medicaid state plan, as described below:

Nebraska will begin the tribal consultation period concurrently with submission of this SPA to CMS. Nebraska tribes will have 15 calendar days to initiate a tribal consultation in which Nebraska will immediately address any questions.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

Less restrictive resource methodologies:

4. __X___ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. __X___ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. __X___ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

The agency designates entities qualified to make determinations for pregnant women only, as defined in NE 13-0027, to expand to provide determinations for Parent/Caretaker Relatives, Former Foster Care Children, and Children under age 19. The policies and procedures for qualified entities applies to these determinations. There may be no more than one period of presumptive eligibility per pregnancy. Periods of presumptive eligibility are limited to no more than one period within two calendar years for Parent/Caretaker Relatives, Former Foster Care Children, and Children under age 19.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. _____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

   a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

   b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. __X___ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Nebraska Medicaid is offering reimbursement for telephonic evaluation and management for the following beneficiaries seeking care when they are already an established patient or the parent or legal guardian of an established patient:
-Beneficiaries who are actively experiencing mild symptoms of COVID-19 (fever, cough, shortness of breath) prior to going to the emergency department, urgent care, or other health care facility;
-Beneficiaries who need routine, uncomplicated follow up and who are not currently experiencing symptoms of COVID-19; and,
-Beneficiaries requiring behavioral health assessment and management.

The telephonic evaluation and management services must be rendered by a qualified health care professional, defined as a physician, nurse practitioner, or physician assistant actively enrolled in Nebraska Medicaid at the time of service. Telephonic evaluation and management by staff other than those listed should not be submitted for reimbursement and will not be reimbursed. Services are to be rendered only to established patients, and parents or legal guardians of established patients.

Telephonic evaluation and management of services may be utilized by the following behavioral health providers: Psychologist (PhD/PsyD), provisional psychologist (PHD provisional), licensed independent mental health worker (LIHMP), licensed mental health worker (LHMP), provisionally licensed mental health worker (PLMHP), licensed alcohol and drug counselor (LADC), and provisionally licensed alcohol and drug counselor (PLADC).

Home Health: Initial assessments and recertification assessments may be completed by using telehealth for physicians and nurse practitioners. Initial assessments, recertifications, and ongoing visits per individual plan of care may be completed by using telehealth for nurses. Telehealth may be used for supervisory visits for aide services.

Hospice: Initial assessments and recertification assessments may be completed by using telehealth for the appropriate physicians and nurse practitioners. Initial assessments, recertifications, and ongoing visits per individual plan of care may be completed by using telehealth for nurses.

Lactation Counseling Services provided through EPSDT: Comprehensive lactation counseling services may be provided by using telehealth.

Tobacco Cessation Counseling: Tobacco Cessation Counseling services may be provided by using telehealth.

Pediatric Feeding Disorder Outpatient Therapy: Pediatric Feeding Disorder Outpatient Therapy services may be provided by using telehealth.

Community Support: Community Support Services may be done via telehealth. As clinically appropriate, HIPPA compliant two-way real-time interactive audio and video telehealth may be offered to proceed with behavioral health interventions. All visits, regardless of modality of communication, must be clinically necessary to work on treatment goals as outlined in the beneficiaries plan of care. Visit documentation must include the modality of communication, the rationale for that modality and the duration of the intervention.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

   a. ____ Published fee schedules –

      Effective date (enter date of change): _____

      Location (list published location): _____

b. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. _____ The agency increases payment rates for the following services:

Please list all that apply.

a. _____ Payment increases are targeted based on the following criteria:

Please describe criteria.

b. Payments are increased through:

i. ____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

ii. ____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. __X___ For the duration of the emergency, the state authorizes payments for telehealth services that:

    a. __X__ Are not otherwise paid under the Medicaid state plan;

    b. ____ Differ from payments for the same services when provided face to face;

    c. __X__ Differ from current state plan provisions governing reimbursement for telehealth;

Indian Health Services, Tribal Clinics, and Urban Indian Health Centers (ITU's) may bill the encounter rate for telehealth services that would typically have been bill for a non-telehealth encounter. In order to remain in accordance with the four walls rule in federal statute, ITU's may bill encounters via telehealth the same as they would typically bill for a non-telehealth encounter, with the addition of the telehealth modifier to both the encounter and the corresponding procedure codes, as long as either the provider or the client is within the walls of the facility during the time of the visit.

Federally Qualified Health Centers and Rural Health Centers may bill the encounter rate for core services provided via telehealth during the emergency period.

The changes to telehealth described in section D. 5. make use of new rates and new separate billing codes.

Code G2012 is used for a brief communication technology-based service; for example, virtual or telephone communication by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days or not leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion. The rate for this code is $13.82.

Code 99441 is used for telephone evaluation and management service by a physician, nurse practitioner, or physician assistant who may report evaluation and management (E/M) services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days or leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion. The rate for this code is $14.47.

Code 99442 is used for telephone evaluation and management service by a physician, nurse practitioner, or physician assistant who may report E/M services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days or leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion. The rate for this code is $28.71.

Code 99443 is used for telephone evaluation and management service by a physician, nurse practitioner, or physician assistant who may report E/M services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days or leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion. The rate for this code is $46.60.

Code 98966 is used for Telephone assessment and management service provided by an enrolled behavioral health provider to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days not leading to an assessment and management service or procedure with the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion. The rate for this code is $11.75.

Code 98967 is used for telephone assessment and management service provided by an enrolled behavioral health provider to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days not leading to an assessment and management service or procedure with the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion. The rate for this code is $20.67.

Code 98968 is used for telephone assessment and management service provided by an enrolled behavioral health provider to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days not leading to an assessment and management service or procedure with the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion. The rate for this code is $32.42.

Code G0071 is used for Payment for communication technology-based services for 5 minutes or more of a virtual (not face-to-face) communication between an FQHC or RHC practitioner and a FQHC or RHC patient. The rate for this code is $46.40.

d. ____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

ii. ____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. __X__ Other payment changes:

Nebraska Medicaid is also adding new codes and rates associated with COVID-19 that do not appear currently on our fee schedule. These codes and rates are:

U0001 Test Price - $35.92
U0002 Test Price - $51.31
87635 - $51.33

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

    a. ____ The individual's total income

    b. ____ 300 percent of the SSI federal benefit rate

    c. ____ Other reasonable amount: _____

2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

    The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05,

Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

__X___ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __X___ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. __X___ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. __X___ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Nebraska Medicaid state plan, as described below:

Nebraska will begin the tribal consultation period concurrently with submission of this SPA to CMS. Nebraska tribes will have 15 calendar days to initiate a tribal consultation in which Nebraska will immediately address any questions.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

   Income standard: _____

   -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

   Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

   a. _____ The agency uses a simplified paper application.

   b. _____ The agency uses a simplified online application.

   c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. __X___ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

The State waives cost-sharing for testing services (including in vitro diagnostic products), testing-related services, and treatments for COVID-19, including vaccines, specialized equipment and therapies (including drugs), for any quarter in which the temporary increased FMAP is claimed. This state will implement this policy beginning March 1, 2020 through April 30, 2020.

2. __X___ The agency suspends enrollment fees, premiums and similar charges for:

   a. _____ All beneficiaries

   b. __X___ The following eligibility groups or categorical populations:

Premiums are suspended for the following eligibility groups:
Work Incentives Eligibility Group: 1902(a)(10)(A)(ii)(XIII); and
Transitional Medical Assistance: 1902(a)(52)

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. __X___ The agency makes the following adjustments to benefits currently covered in the state plan:

Additional Provider Types Allowed to Prescribe Home Health Services

Nebraska allows for a Nurse Practitioner, Physician's Assistant, Clinical Nurse Specialist, and a Nurse Midwife to order Medicaid Home Health services and certify plan of care as authorized in the COVID-19 Public Health Emergency Medicare interim final rule.

Increasing the Bed Hold Number of Days

Bed hold days for Nursing Facilities will be increased up to 90 days combined for therapeutic and hospital leave provided the sending facility does not fill the resident's bed temporarily during the public health emergency.

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at

1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

   a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

   b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. __X___ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Teledentistry: *Re-evaluation: post-operative visit.*

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

   a. ____ Published fee schedules –

      Effective date (enter date of change): _____

      Location (list published location): _____

   b. ____ Other:

Increases to state plan payment methodologies:

2. _____ The agency increases payment rates for the following services:

Please list all that apply.

   a. _____ Payment increases are targeted based on the following criteria:

Please describe criteria.

   b. Payments are increased through:

      i. ____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

      ii. ____ An increase to rates as described below.

      Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. __X___ For the duration of the emergency, the state authorizes payments for telehealth services that:

   a. __X___ Are not otherwise paid under the Medicaid state plan;

   b. __X___ Differ from payments for the same services when provided face to face;

   c. ____ Differ from current state plan provisions governing reimbursement for telehealth;

D0171 re-evaluation: post-operative visit. The rate for this code is $16.32. *D9995 teledentistry: synchronous; real-time encounter reported in addition to other procedures (e.g. diagnostic) delivered to the patient on the date of service. The rate for this code is $14.47.* *D9999 adjunctive code: to be used for audio only, consultation between dentist and patient. The rate for this code is $0.*

   d. ____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

      i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

      ii. ____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _____ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
   a. ____ The individual's total income
   b. ____ 300 percent of the SSI federal benefit rate
   c. ____ Other reasonable amount: _____
2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

   The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have

comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

__X___ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. _____ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. ___X__ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. ___X__ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Nebraska Medicaid state plan, as described below:

Nebraska will begin the tribal consultation period concurrently with submission of this SPA to CMS. Nebraska tribes will have 15 calendar days to initiate a tribal consultation in which Nebraska will immediately address any questions.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. __X___ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Nebraska Medicaid will suspend all cost sharing for all eligibility groups effective May 1, 2020.

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. _____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

   a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

   b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

   a. ____ Published fee schedules –

      Effective date (enter date of change): _____

      Location (list published location): _____

b. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. _____ The agency increases payment rates for the following services:

Please list all that apply.

a. _____ Payment increases are targeted based on the following criteria:

Please describe criteria.

b. Payments are increased through:

i. ____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

ii. ____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

    a. ____ Are not otherwise paid under the Medicaid state plan;

    b. ____ Differ from payments for the same services when provided face to face;

    c. ____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

    d. ____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

        i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

        ii. ____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _____ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

    a. ____ The individual's total income

    b. ____ 300 percent of the SSI federal benefit rate

    c. ____ Other reasonable amount: _____

2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

    The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

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