STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT ATTACHMENT 1.1-A
MEDICAL ASSISTANCE PROGRAM

State of Nebraska

ATTORNEY GENERAL'S CERTIFICATION

I certify that:

The Nebraska Department of Health and Human Services is the single State agency responsible for:

☒ administering the plan

The legal authority under which the agency administers the plan on a Statewide basis is Sections 68-901 through 68-926. Laws 2006 LB 1248 Section 1.

(statutory citation)

☐ supervising the administration of the plan by local political subdivisions.

The legal authority under which the agency supervises the administration of the plan on a Statewide basis is contained in _____
(statutory citation)

The agency's legal authority to make rules and regulations that are binding on the political subdivisions administering the plan is _____
(statutory citation)

9/25/07
Date

Jon Bruning
Attorney General

By _____
(Signature)

Jon Bruning, Nebraska Attorney General

(Name and Title)

State of Nebraska

WAIVER(S) OF THE SINGLE STATE AGENCY REQUIREMENT GRANTED
UNDER THE INTERGOVERMENTAL COOPERATION ACT OF 1968

WAIVER #1. [1]

a. Waiver was granted on _____
(date)

b. The organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to _____, and the resources and/or
(name of agency)
services of such agency to be utilized in administration of the plan are described below:

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[1] (Information on any additional waivers which have been granted is contained in attached sheets.)

c. The methods for coordinating responsibilities among the several agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

ORGANIZATION AND FUNCTIONS OF THE MEDICAID AGENCY

The Nebraska Department of Health and Human Services is organized into Operations and six Divisions: the Division of Behavioral Health, the Division of Children & Family Services, the Division of Developmental Disabilities, the Division of Medicaid & Long-Term Care, the Division of Public Health, and the Division of Veteran's Homes The Division of Medicaid & Long-Term Care manages the development and approval of Medicaid policy so that all Divisions operate using the same policies

Operations includes Human Resources, Communications & Legislative Services, Financial Services Information Systems &Technology Regulatory Analysis & Integration

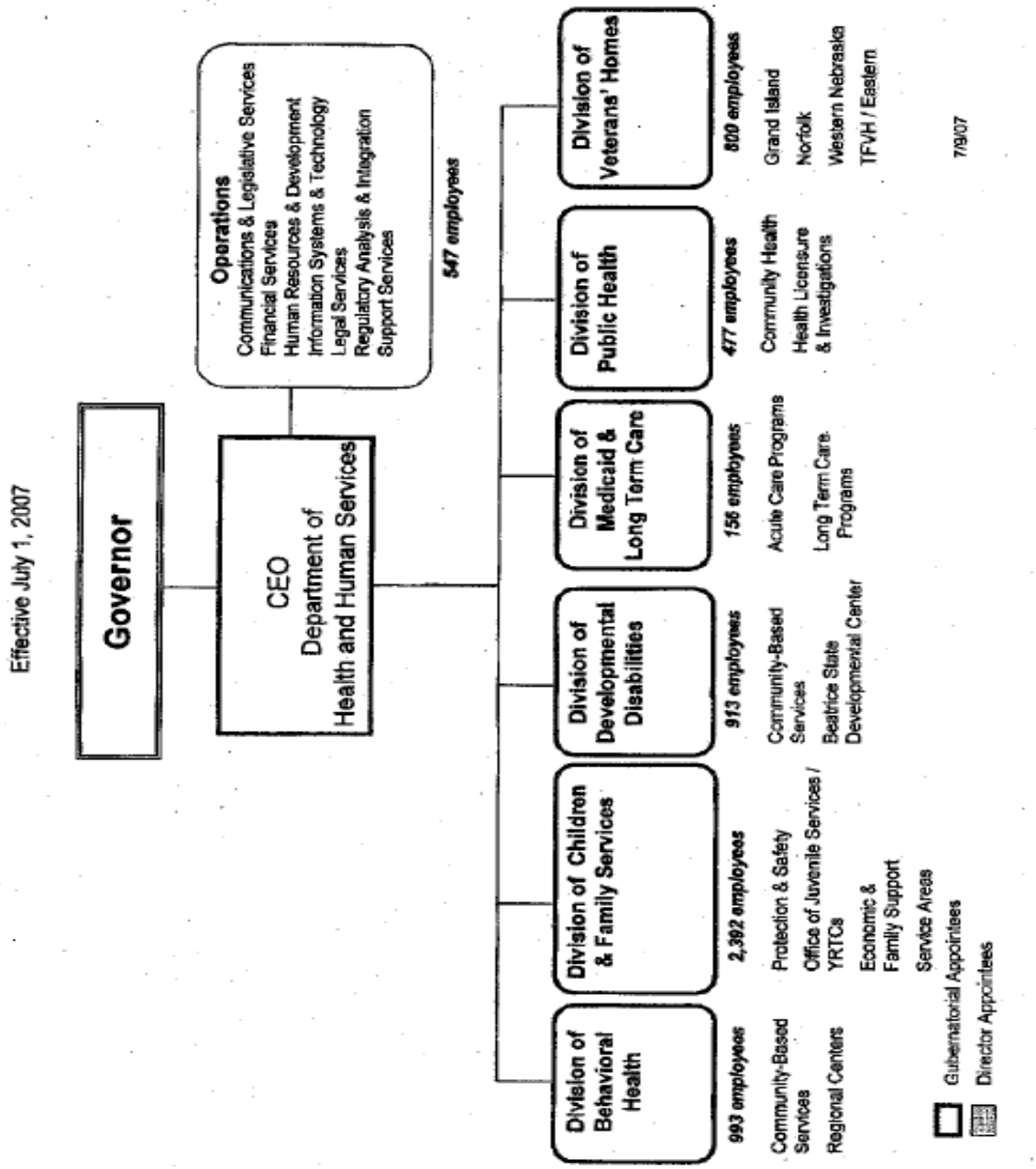
The Division of Behavioral Health provides funding, oversight and technical assistance to the six local Behavioral Health Regions. The Regions contract with local programs to provide public inpatient, outpatient, and emergency services and community mental health, substance abuse and gambling services.

The Division of Children & Family Services includes the areas of child abuse, foster care, adoption, domestic violence, Employment First, ADC, Medicaid eligibility, refugee resettlement, energy assistance, child care subsidy, child support enforcement, food stamps, economic assistance, Integrated Care Coordination Units, resource development, quality assurance and parole and community-based juvenile services.

The Division of Developmental Disabilities The Division of Developmental Disabilities administers the Beatrice State Developmental Center and publicly-funded community-based developmental disability services.

The Division of Medicaid & Long-Term Care encompasses the Medicaid Program, Home and Community Services for Aging and Persons with Disabilities and the State Unit on Aging.

The Division of Veterans' Homes includes administration of the state Veterans' Homes located in Bellevue, Norfolk, Grand Island and Scottsbluff


Effective July 1, 2007
Governor
CEO
Department of
Health and Human Services
Operations
Communications & Legislative Services
Financial Services
Human Resources & Development
Information Systems & Technology
Legal Services
Regulatory Analysis & Integration
Support Services
547 employees
Division of Behavioral Health
993 employees
Community-Based Services
Regional Centers
Division of Children & Family Services
2,392 employees
Protection & Safety
Office of Juvenile Services / YRTCs
Economic & Family Support
Service Areas
Division of Developmental Disabilities
913 employees
Community-Based Services
Beatrice State Developmental Center
Division of Medicaid & Long Term Care
156 employees
Acute Care Programs
Long Term Care Programs
Division of Public Health
477 employees
Community Health
Health Licensure & Investigations
Division of Veterans' Homes
809 employees
Grand Island
Norfolk
Western Nebraska
TFVH / Eastern
Gubernatorial Appointees
Director Appointees
7/9/07

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Nebraska

ORGANIZATION AND FUNCTIONS OF THE MEDICAL ASSISTANCE UNIT

The Division of Medicaid & Long-term Care within the Department of Health and Human Services is composed of two sections - the Acute Care Programs Section and the Long-Term Care Programs Section. The Director of the Division of Medicaid & Long-Term Care has administrative authority over the operations and functions of the Medicaid program including the issuance of policies.

The Acute Care Programs Section is managed by an Administrator. The Section is organized into four units: Behavioral Health and Managed Care Unit, Medicaid Claims Payment Unit, Operations Unit, and Physical Health Services Unit.

The Behavioral Health, Pharmacy, and Ancillary Services Unit is responsible for the pharmacy program; the behavioral health program; and ancillary services such as transportation and durable medical equipment and supplies.

The Medicaid Claims Unit is responsible for provider enrollment; claims payment; coordination of benefits; data entry; screening; and electronic data interchange (EDI).

The Operations Unit is responsible for the Health Insurance Premium Payment (HIPP) program; the Medicaid Management Information System (MMIS); estate recovery and third party liability (TPL); the program integrity office; school-based contracts, and project management.

The Physical Health Services Unit is responsible for practitioner services such as dental, physician, visual, therapies, etc.; hospital policy and reimbursement development; disability determinations; and. administration of the Nebraska Health Connection, Nebraska's Medicaid Managed Care program under approved 1915(b) waivers Payment methodology is developed, maintained, and monitored by unit staff. This unit is responsible for formulating the request for proposal (RFP) for the program and well as negotiating contracts with the final selected contractors. The unit is also responsible for submittal of appropriate waivers. Quality assurance functions and contract monitoring are ongoing functions of this unit.

The Long-Term Care Section is managed by an Administrator. The Section is organized into four units: Long-Term Care State Plan Services; Home &Community Based Waiver Services; Safety & Independence Supports Unit; and the State Unit on Aging.

The Long-Term Care State Plan Services unit is responsible for hospice/home health/private duty nursing services; nursing facilities; ICF/MR facilities; personal assistance services; and the Money Follows the Person Grant.

The Home & Community Based Waiver Services unit is responsible for waiver policy; quality assurance; and clinical review.

The Safety &Independence Supports Unit is responsible for the Social Services Block Grant (SSBG) & Federal Grants; Disabled Persons and Family Support (DPFS), Medically Handicapped Children's Program (MHCP) and the Disabled Children's Program (DCP); Adult Protective Services; Early Development Network; and Respite Network/Subsidy.

The State Unit on Aging is responsible for aging services and the Long Term Care Ombudsman Program.

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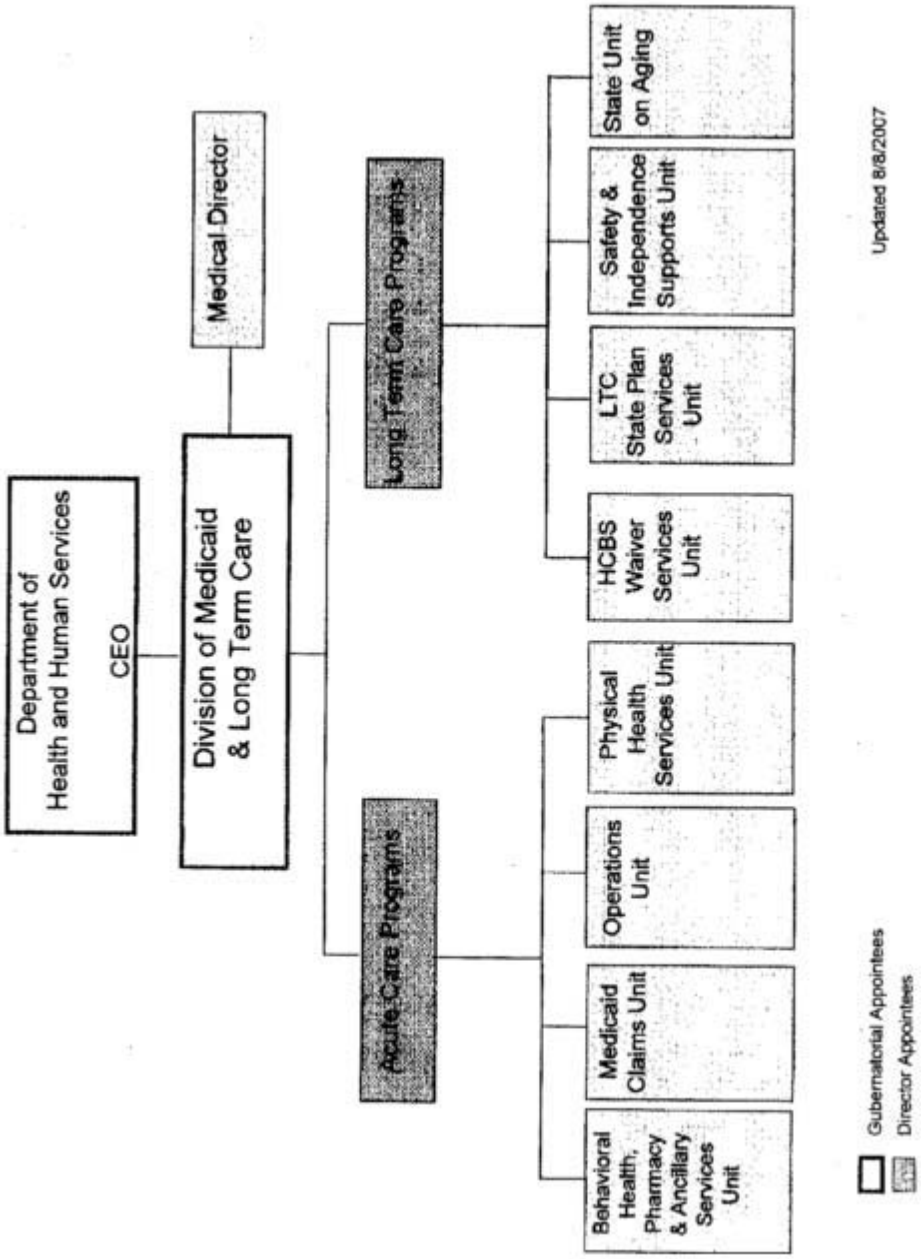
[1] TN No. should read 07-05 and supersedes TN No. 95-14


Department of Health and Human Services
CEO
Division of Medicaid & Long Term Care
Medical Director
Acute Care Programs
Long Term Care Programs
Behavioral Health, Pharmacy & Ancillary Services Unit
Medicaid Claims Unit
Operations Unit
Physical Health Services Unit
HCBS Waiver Services Unit
LTC State Plan Services Unit
Safety & Independence Supports Unit
State Unit on Aging
Gubernatorial Appointees
Director Appointees
Updated 8/8/2007

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

MEDICAL PROFESSIONALS INVOLVED IN THE ADMINISTRATION OF THE MEDICAL ASSISTANCE PROGRAM

Employees:

Employees include a part-time physician, the Medical Director for the Medicaid program, who assists with utilization review, quality of care, and policy development and interpretation. The Medical Director works closely with staff in developing and monitoring quality health policy. This physician also confers with program and payment staff on questions involving the establishment of reasonable reimbursement rates and in determining the appropriateness of medical claims payments and compliance with agency regulations. The Medical Director confers with medical professionals to assure appropriate medical input and oversight of programs. The physician is involved with medical reviews for the State Disability Program.

Three pharmacists are responsible for administering the pharmacy program. They set policy, oversee the payment process and payment vendor, and maintain contacts with providers to ensure program quality.

Eleven registered nurses on staff administer sections of the Medicaid program and provide significant medical input into policy and payment decisions. They also consult with the Program Integrity section. A nurse administrator is responsible for the S-CHIP program and oversees operational issues such as estate recovery, HIPP, program integrity, TPL, school based services, contracting process, and the state plan. Nurse program specialists are located throughout the Medicaid program areas and are responsible for the following service areas: physician, hospital, nursing facilities, mental health and substance abuse, home health nursing, vision, anesthesia, chiropractor, podiatry, rural health clinics, FQHC, lab and radiology. Two nurses assigned to Medicaid waivers also consult on issues involving home health care, hospice, and special needs in long term care facilities.

A social worker/licensed mental health practitioner administers the area responsible for mental health and substance abuse, DME, pharmacy, and transportation services.

Under Contract:

One psychologist and one family therapist serve as consultants to the mental health and substance abuse program, assuring quality care for all levels of behavioral health services. There is a pool of psychiatrists under contract who consult with Medicaid on psychiatric issues.

Three dentists, one podiatrist, one optometrist, and one audiologist, consult with their respective service area. One registered nurse consults with the DME and home health programs. All consultants have input into policy making and claims processing determinations as well as quality of care and utilization review.

Numerous registered nurses, many in local health departments, serve under contracts with local health departments to do Medicaid - particularly EPSDT - outreach; they also work with Medicaid clients regarding such things as barriers to keeping appointments, finding and maintaining a medical home, and using health care resources such as the emergency room appropriately.

Attachment 1.2-D

Not Applicable to Nebraska

see State Plan Section 1.2 – part (d)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered

The following groups are covered under this plan.

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups

IV-A 42 CFR 435.110

1. Recipients of AFDC

The approved State AFDC plan includes:

☒ Families with an unemployed parent for the mandatory 6-month period and an optional extension of N/A months. No time limit.

☒ Pregnant women with no other eligible children

☒ AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

The standards for AFDC payments are listed in Supplement 1 of ATTACHMENT 2.6-A.

IV-A 42 CFR 435.115

2. Deemed Recipients of AFDC

a. Individuals denied a title IV-A cash payment solely because the amount would be less than $10

* Agency that determines eligibility for coverage

State/Territory: Nebraska

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups
IV-A		2. Deemed Recipients of AFDC.
	1902(a)(10)(A)(i)(I) of the Act	b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e)(6) of the Act.
	402(a)(22)(A) of the Act	c. Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds
	406(h) and 1902(a)(10)(A)(i)(I) of the Act	d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.
	1902(a) of the Act	e. Individual deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

* Agency that determines eligibility for coverage

State/Territory: Nebraska

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups
IV-A		3. Qualified Family Members
407(b), 1902 (a)(10)(A)(i) and 1905(m)(l) of the Act		Effective October 1, 1990, qualified family member who would be eligible to receive AFDC under section 407 of the Act because the principal wage earner is unemployed.
		☒ Qualified family members are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.
IV-A 1902(a)(52) and 1925 of the Act		4. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitle up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998)

* Agency that determines eligibility for coverage

State/Territory: Nebraska

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups
IV-A	42 CFR 435.113	5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are: a. Families denied AFDC solely because of income and resources deemed to be available from – (1) Stepparents who are not legally liable for support of stepchildren under a State law of general applicability; (2) Grandparents; (3) Legal guardians; and (4) Individual alien sponsors (who are not spouses of the individual or the individual's parent); b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit. c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.

* Agency that determines eligibility for coverage

State/Territory: Nebraska

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups
42 CFR 435.114		6. Individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.
		☐ Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group included in this state's August 1972 plan).
		☐ Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).
		☐ Not applicable with respect to intermediate care facilities: State did or does not cover this service.
1902(a)(10)(A)(i)(III) and 1905(n) of the Act		7. Qualified Pregnant Women and Children
		a. A pregnant woman whose pregnancy has been medically verified who--
		(1) Would be eligible for an AFDC cash payment if the child had been born and was living with her;

* Agency that determines eligibility for coverage

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
	7. a. (2) Is member of a family that would be eligible for aid to families with dependent children of unemployed parents if the State had an AFDC-unemployed parents program; or
	(3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved plan.
1902(a)(10)(A)(i)(III) and 1905(n) of the Act	b. Children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.
	☐ Children born after _____ (specify optional earlier date) who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
1902(a)(10)(A)(i)(IV) and 1902(l)(1)(A) and (B) of the Act	8. Pregnant women and infants under 1 year of age with family incomes up to 133 percent of the Federal poverty level who are described in section 1902(a)(10)(A)(i)(lV) and 1902(l)(1)(A) and (B) of the Act. The income level for this group is specified in Supplement 1 to Attachment 2.6-A. ☒ The State uses a percentage greater than 133 but not more than 185 percent of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.
	9. Children:
1902(a)(10)(A)(i)(VI) 1902(l)(1)(C) of the Act	a. who have attained 1 year of age but have not attained 6 years of age, with family incomes at or below 133 percent of the Federal poverty levels.
1902(a)(10)(A)(i)(VII) and 1902(l)(1)(D) of the Act	b. born after April 30, 1979, who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.
	Income levels for these groups are specified in Supplement 1 to ATTACHMENT ·2.6A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
1902(e)(5) of the Act	10. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.
1902(e)(6) of the Act	b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
1902(e)(4) of the Act	12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains or would remain eligible if still pregnant and the child remains in the same household as the mother.
42 CFR 435.120	13. Aged, Blind and Disabled Individuals Receiving Cash Assistance ☒ a. Individuals receiving SSI. This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act. ☒ Aged ☒ Blind ☒ Disabled

State/Territory: Nebraska

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
435.121 1619(b)(1) of the Act		13. ☐ b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons, who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section l619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.) ☐ Aged ☐ Blind ☐ Disabled The more restrictive categorical eligibility criteria are described below: (Financial criteria are described in ATTACHMENT 2.6-A).

*Agency that determines eligibility for coverage.

State/Territory: Nebraska

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
XIX	1902(a)(10)(A)(i)(II) and 1905(q) of the Act	14. Qualified severely impaired blind and disabled individuals under age 65, who-- a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or b. For the month of June 1987, considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must- (1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled; (2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits; (3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

*Agency that determines eligibility for coverage.

State/Territory: Nebraska

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and

(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

☐ Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

*Agency that determines eligibility for coverage.

State/Territory: Nebraska

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
1619(b)(3) of the Act		☐ The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.

*Agency that determines eligibility for coverage.

State/Territory: Nebraska

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
XIX	1634(c) of the Act	15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who – a. Are least 18 years of age; b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long they would be eligible for SSI, absent their OASDI eligibility. ☐ c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility. ☐ d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.
XIX	42 CFR 435.122	16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under-§435.230), because of requirements that do not apply under title XIX of the Act.
XIX	42 CFR 435.130	17. Individuals receiving mandatory State supplements.

*Agency that determines eligibility for coverage.

State/Territory: Nebraska

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
	42 CFR 435.131	18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment: ☐ In December 1973, Medicaid coverage of the essential spouse limited to the following group(s): ☐ Aged ☐ Blind ☐ Disabled ☒ Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

*Agency that determines eligibility for coverage.

State/Territory: Nebraska

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
XIX	42 CFR 435.132	19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they-- a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and b. Remain institutionalized; and c. Continue to need institutional care.
XIX	42 CFR 435.133	20. Blind and disabled individuals who— a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and b. Were eligible for Medicaid in December 1973 as blind or disabled; and c. For each consecutive month after December 1973 continue to meet December 1973 eligibility· criteria.

*Agency that determines eligibility for coverage.

State/Territory: Nebraska

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
XIX	42 CFR 435.134	21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.
		☐ Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).
		☐ Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).
		☐ Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

*Agency that determines eligibility for coverage.

State/Territory: Nebraska

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
XIX	42 CFR 435.135	22. Individuals who –

a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and

b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

☐ Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.

☐ Not applicable because the State applies more restrictive eligibility requirements than those under SSI.

☐ The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

*Agency that determines eligibility for coverage.

State/Territory: Nebraska

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
1634 of the Act		23. Disabled widowers would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act. ☐ Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients. ☐ The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equalling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

*Agency that determines eligibility for coverage.

State/Territory: Nebraska

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
1634(d) of the Act		24. Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A.

☐ The State applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.

☐ In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in 1634(d)(1)(A) in determining the income of the individual, but does not disregard any more of this income than would reduce the individual's income to the SSI income standard.

☐ In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in §1634(d)(1)(A) in determining the income of the individual, which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to disregarded is specified in Supplement 4 to Attachment 2.6-A.

☒ In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in § 1634(d)(1)(A) in determining the income of the individual.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
1902(a)(10(E)(i) and 1905(p) of the Act		25. Qualified Medicare beneficiaries – a. Who are entitled to hospital insurance benefits under Medicare Part At (but not pursuant to an enrollment under section 1BIBA of the Act). b. Whose income does not exceed 100 percent of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index. (Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan)
1902(a) (10) (E)(ii), 1905(s) and 1905(p) (3) (A) (i) of the Act		26. Qualified disabled and working individuals – a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act; b. Whose income does not exceed 200 percent of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index. d. Who are not otherwise eligible for medical assistance under Title XIX of the Act. (Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
	1902(a)(10)(E)(ii) and 1905(p)(3)(A)(ii) of the Act	27. Specified low-income Medicare beneficiaries-- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act); b. Whose income for calendar years 1993 and 1994 exceeds the income level in 25. b., but is less than 110 percent of the Federal poverty level, and whose income for calendar years beginning 1995 is less than 120 percent of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index. (Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)
		28. Qualifying individuals – a. Who are entitled to hospital insurance benefits Under Medicare Part A (but not pursuant to an Enrollment under section 1818A of the Act); b. Whose income is at least 120 percent but does not exceed 135 percent of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the Increase In the consumer price index. (Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy
42 CFR 435.210 1902(a)(10)(A)(ii) and 1905(a) of the Act		☐ 1. Individuals described below who meet the income and resource requirements of AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, but who do not receive cash assistance. ☐ The plan covers all individuals as described above. ☐ The plan covers only the following group or groups of individuals: ☐ Aged ☐ Blind ☐ Disabled ☐ Caretaker relatives ☐ Pregnant women
42 CFR 435.211		☐ 2. Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

*Agency that determines eligibility for coverage.

State/Territory: Nebraska

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
	42 CFR 435.212 & 1902(e)(2) of the Act, P.L.. 99-272 (section 9517) P.L. 101-508 (section 4732)	☐ 3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act or a managed care organization (MCO), or a primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act. ☒ The State elects not to guarantee eligibility. ☐ The State elects to guarantee eligibility. The minimum enrollment period is ____months (not to exceed six). The State measures the minimum enrollment period from: ☐ The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility. ☐ The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment. ☐ The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
	1932(a)(4) of Act	The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible. ☐ Disenrollment rights are restricted for a period of months (not to exceed 12 months). During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment. ☒ No restrictions upon disenollment rights.
	1903(m)(2)(H) 1902(a)(52) of the Act P.L. 101-508 42 CFR 438.56(g)	In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to re-enroll those individuals in the same entity if that entity still has a contract. ☒ The agency elects to re-enroll the above individuals who are eligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost. ☐ The agency elects not to re-enroll above individuals into the same entity in which they were previously enrolled.

*Agency that determines eligibility for coverage.

State/Territory: Nebraska

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.
42 CFR 435.217	☒	4.	A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the Waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.
	☒		This includes PACE enrollees who reside in the community who are eligible using institutional rules.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
	1902(a)(10)(A)(ii)(VII) of the Act	5. Individuals would be eligible for Medicaid under the plan if they were in a medical institution, who were terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

☐ The State covers all individuals as described above.

☐ The State covers only the following group or groups of individuals:

- ☐ Aged
- ☐ Blind Disabled
- ☐ Individuals under the age of--
  - ☐ 21
  - ☐ 20
  - ☐ 19
  - ☐ 18
- ☐ Caretaker relatives
- ☐ Pregnant women

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
42 CFR 435.220		☒ 6. Individuals who would be eligible for AFDC if their work-related child care costs were paid from earnings rather than by a State agency as a service expenditure. The State's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC. ☒ The State covers all Individuals as described above. ☐ The State covers only the following group or groups of individuals: ☐ Individuals under the age of-- ☐ 21 ☐ 20 ☐ 19 ☐ 18 ☐ Caretaker relatives ☐ Pregnant women
1902(a)(10) (A) (ii) and 1905(a) of the Act		
42 CFR 435.222 1902(a)(10) (A) (ii) and 1905(a)(i) of		7. ☒ a. All individuals who are not described in section 1902(a)(10)(A)(i) of the Act, who meet the income and resource requirements the Act of the AFDC State plan, and who are under the age of 21 or younger as indicated below. ☐ 20 ☒ 19 ☐ 18

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
	42 CFR 435.222	☒ b. Reasonable classifications of individuals described in (a) above, as follows:
		☐ (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:
		☐ (a) In foster homes (and are under the age of ____)
		☐ (b) In private institutions (and are under the age of ___).
		☐ (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ____)
		☐ (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of ____)
		☐ (3) Individuals in NF's (who are under the age of ____). NF services are provided under this plan.
		☐ (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of ____)

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

☒ (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of 21). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

☒ (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(10)(A)(ii)(VIII) of the Act

☒ 8. A child for whom there is in effect a State adoption assistance agreement (other than under title IV-E of the Act), who, as determined by the State adoption agency, cannot be place for adoption without medical assistance because the child has special need for medical or rehabilitative care, and who before execution of the agreement-

a. Was eligible for Medicaid under the State's approved Medicaid plan; or

b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies.

The State covers individuals under the age of –

- ☐ 21
- ☐ 20
- ☒ 19
- ☐ 18

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
42 CFR 435.223		☐ 9. Individuals described below who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under title IV-A:
1902(a)(10)(A)(ii) and 1905(a) of the Act		☐ Individuals under the age of - ☐ 21 ☐ 20 ☐ 19 ☐ 18
		☐ Caretaker relatives
		☐ Pregnant women

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
42 CFR 435.230		☐ 10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act. The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is-- a. Based on need and paid in cash on a regular basis. b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement. - c. Available to all individuals in the State. d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income. ☐ (1) All aged individuals. ☐ (2) All blind individuals. ☐ (3) All disabled individuals.

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
	42 CFR 435.230	☐ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
		☐ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
		☐ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
		☐ (7) Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
		☐ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
		☐ (9) Individuals in additional classifications approved by the Secretary as follows:

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

☐ Yes.

☐ No.

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
42 CFR 435.230 435.121 1902(a)(10) (A)(ii)(XI) of the Act		☒ 11. Section 1902(f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act. The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is-- a. Based on need and paid in cash on regular basis. b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement. c. Available to all individuals in each classification and available on a statewide basis. d. Paid to one or more of the classifications of individuals listed below: ☒ (1) All aged individuals. ☒ (2) All blind individuals. ☒ (3) All disabled individuals.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

☒ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

☒ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

☒ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

☐ (7) Individuals receiving a federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

☒ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

☒ (9) Individuals in additional classifications approved by the Secretary as follows:

Board and Room

Adult Family

Residential Care Facility

Group Home for Children or Child Caring Agency

Center for the Developmentally Disabled

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

☐ Yes

☒ No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
42 CFR 435.231 1902(a)(10) (A)(ii)(V) of the Act		☐ 12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement I to ATTACHMENT 2.6-A. ☐ The State covers all individuals as described above. ☐ The State covers only the following group or groups of individuals:
1902(a)(10)(A) (ii) and 1905(a) of the Act		☐ Aged ☐ Blind ☐ Disabled ☐ Individuals under the age of-- ☐ 21 ☐ 20 ☐ 19 ☐ 18 ☐ Caretaker relatives ☐ Pregnant women

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
1902 (e) (3) of the Act		☒ 13. Certain disabled children 18 or under who are living home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act. *See Below Supplement 3 to Attachment 2.2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.
1902(a)(10)(A)(ii)(IX) and 1902(l) of the Act		☒ 14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in Supplement 1 to Attachment 2.6-A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to Attachment 2.6-A: a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and b. Infants under one year of age.

* Certain disabled children are those 18 and younger who meet the definition of clients with special needs: ventilator-dependent, pulmonary, and/or special needs.

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
1902(a)(10)(A)(ii)(IX) and 1902(l)(1)(D) of the Act		☐ 15. The following individuals who not mandatory categorically needy, who have income that does not exceed the income level (established at an amount up to 100 percent of the Federal poverty level) specified in Supplement 1 of ATTACHMENT 2.6-A for a family of the same size. Children who are born after September 30, 1983 and who have attained 6 years of age but have not attained – ☐ 7 years of age; or ☐ 8 years of age.

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
1902(a)(10)(A)(ii)(X) and 1902(m)(1) and (3) of the Act		☒ 16. Individuals-- a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group. b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in ATTACHMENT 2.6-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	B. Optional Groups Other Than the Medically Needy (Continued)
1902(a)(47) and 1920 of the Act	☒ 17. Pregnant women who are determined by a "qualified provider" (as defined in §1920(b)(2) of the Act) based on preliminary information, to meet the highest applicable income criteria in this plan under ATTACHMENT 2.6-A and are therefore determined to be presumptively eligible during presumptive eligibility period in accordance with §1920 of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	B. Optional Groups Other Than the Medically Needy (Continued)
1906 of the Act	18. Individuals required to enroll in cost-effective employer-based group health plan remain eligible for a minimum enrollment period of 0 months.
1902(a(10)(F) 1902(u)(1) of the Act	19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent set of services. See Supplement 11 to Attachment 2.6-A.
1902(a)(10)(A)	☒ 20. Optional Targeted Low Income Children who: a. are not eligible for Medicaid under any other optional or mandatory eligibility group or eligible as medically needy (without spenddown liability); b. would not be eligible for Medicaid under the policies in the State's Medicaid plan as in effect on April 15, 1997 (other than because of the age expansion provided for in 1902(l)(2)(D));

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	c. are not covered under a group health plan or other group health insurance (as such terms are defined in 2791 of the Public Health Service Act coverage) other than under a health insurance program in operation before July 1, 1997 offered by a State which receives no Federal funds for the program.
	d. have family income at or below: 200% of the Federal poverty level for the size family involved, as revised annually in the Federal Register; or A percentage of the Federal poverty level, which is in excess of the "Medicaid applicable income level" (as defined in 2110(b)(4) of the Act) but by no more than 50 percentage points. The State covers: ☒ All children described above who are under 19 with family income at or below 200 percent of the Federal poverty level. ☐ The following reasonable classifications of children described above who are under age ____ with family income at or below the percent of the Federal poverty level specified for the classification.
1902(e)(12) of the Act	☒ 21. A child under age 19 who has been initially determined eligible is deemed to be eligible for a total of 6 months regardless of changes in circumstances other than attainment of the maximum age state above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)		Groups Covered
1920A of the Act	☐	22. Children under age 19 who are determined by a "qualified entity" (as defined in 1920A(b)(3)(A)) based on preliminary information, to meet the highest applicable income criteria specified in this plan. The presumptive period begins on the day that the determination is made. If an application for Medicaid is filed on the child's behalf by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on the day that the State agency makes a determination of eligibility based on that application. If an application is not filed on the child's behalf by the last day of the month following the month the determination of presumptive eligibility was made, the presumptive period ends on that last day.
1902(a)(10)(A)	☒	23. Working disabled individuals whose net family income is below 250 percent of the Federal poverty level for a family of the size involved and who, except for earned income meet all criteria for receiving benefits under the SSI program. See page 12c of Attachment 2.6A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

CITATION GROUP COVERED

B. Optional Coverage Other Than the Medically Needy (Continued)

1902 (a) (10) (A)

(ii) (XVIII) of the Act ___ [24]. Women who:

a. Have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix;

b Are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act;

c. Are not eligible for Medicaid under any mandatory categorically needy eligibility group; and

d.. Have not attained age 65.

1920B of the Act ___[25]. Women who are determined by a "qualified entity" (as defined in 1920B (b) based on preliminary information, to be a woman described in 1902 (aa) the Act related to certain breast and cervical cancer patients.

The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.

State/Territory: Nebraska

Agency*	Citation(s)	Groups Covered
		C. Optional Coverage of the Medically Needy
42 CFR 435.301		This plan includes the medically needy.
		☐ No.
		☒ Yes. This plan covers:
		1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.
1902(e) of the Act		2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.
1902(a)(10)(C)(ii)(I) of the Act		3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.

State/Territory: Nebraska

Agency*	Citation(s)	Groups Covered
		C. Optional Coverage of the Medically Needy (Continued)
1902(e)(4) of the Act		4. Newborn children born on or after October 1, 1984 to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as the woman remains eligible and the child is a member of the woman's household.
42 CFR 435.308		☒ 5. a. Financially eligible individuals who are not described in section C.3 above and who are under the age of – ☐ 21 ☐ 20 ☒ 19 ☐ 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training ☒ b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below: ☐ (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are: ☐ (a) In foster homes (and are under the age of _____) ☐ (b) In private institutions (and are under the age of ____)

State/Territory: Nebraska

Agency*	Citation(s)	Groups Covered

C. Optional Coverage of the Medically Needy (Continued)

☐ c. In addition to the group under b. (1)(a) and (b), individuals place in foster homes or private institutions by private, nonprofit agencies (and are under the age of ____)

☐ (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of _____).

☐ (3) Individuals in NFs (who are under the age of ____).NF services are provided under this plan.

☐ (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of _____).

☒ (5) Individuals receiving active treatment as – inpatients psychiatric facilities or programs (who are under the age of 21). Inpatient psychiatric services for individuals underage 21 are provided under this plan.

☒ (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

State/Territory: Nebraska

Agency*	Citation(s)	Groups Covered
		C. Optional Coverage of the Medically Needy (Continued)
42 CFR 435.310		☒ 6. Caretaker relatives.
42 CFR 435.320 and 435.330		☒ 7. Aged individuals.
42 CFR 435.322 and 435.330		☒ 8. Blind individuals.
42 CFR 435.324 and 435.330		☒ 9. Disabled individuals.
42 CFR 435.326		☐ 10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.
435.340		11. Blind and disabled individuals who: a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; b. Were eligible as medically needy in December 1973 as blind or disabled; and c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.

State/Territory: Nebraska

Citation(s)	Groups Covered
	C. Optional Coverage of the Medically Needy (Continued)
1906 of the Act	12. Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of 0 months.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Agency*	Citation(s)	Groups Covered
	1935(a) and 1902(a)(66)	The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act.
	42 CFR 423.774 and 423.904	1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act; 2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined; 3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

REASONABLE CLASSIFICATIONS OF INDIVIDUALS UNDER
THE AGE OF 21, 20, 19, AND 18

Young adults age 18, 19, or 20 who were former wards of the State of Nebraska and regularly attend a school, college, or university or regularly attend a course of vocation al or technical training designed to prepare such a person for gainful employment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

Method for Determining Cost Effectiveness of Caring for
Certain Disabled Children at Home

The child must first meet the criteria as defined under Special Needs. The cost of the child's in-home care is compared to the cost of the child's acute hospital care. A determination is made that the cost of providing in-home care will not exceed the cost of acute hospital care.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	A. General Conditions of Eligibility
	Each individual covered under the plan:
42 CFR Part 435, Subpart G	1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.
42 CFR Part 435, Subpart F	2. Meets the "applicable non-financial eligibility conditions.
	a. For the categorically needy:
	(i) Except as specified under items A.2.a.(ii) and (iii) below, for AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program.
	(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.
1902(l) of the Act	(iii) For financially eligible pregnant women, infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act, meets the non-financial criteria of section 1902(l) of the Act.
1902(m) of the Act	(iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.

State of Nebraska

Citation(s)	Condition or Requirement
	b. For the medically needy, meets the non-financial eligibility Conditions of 42 CFR Part 435.
1905(p) of the Act	c. For financially eligible qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(I) of the Act, meets the non-financial criteria of section 1905(p) of the Act.
1905(s) of the Act	d. For financially eligible qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, Meets the non-financial criteria of section 1905(a).
1905(p)(3)(A)(ii) of the Act	e. For financially eligible specified low income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, meets the non-financial criteria under 1905(p)(3)(A)(ii) of the Act.
42 CR 435.406	3. Is residing in the United States and--
	a. Is a citizen or national of the United States;
	b. Is a qualified alien (QA) as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) as amended, and the QA's eligibility is required by section 402(b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended;
	c. Is a qualified alien subject to the 5-year bar as described in section 403 of PRWORA, so that eligibility is limited to treatment of an emergency medical condition as defined in section 401 of PRWORA;
	d. Is a non-qualified alien, so that eligibility is limited to treatment of an emergency medical condition as defined in section 401 of PRWORA;

Citation(s)	Condition or Requirement
	e. Is a QA whose eligibility is authorized under section 402(b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended. _X_ State covers all authorized QAs. ___ State does not cover authorized QAs. f. State elects CHIPRA option to provide full Medicaid coverage to otherwise eligible pregnant women or children as specified below who are aliens lawfully residing in the United States; including the following: (1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641); (2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission; (3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings; (4) An alien who belongs to one of the following classes: (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively); (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. § 1254a), and pending applicants for TPS who have been granted employment authorization; (iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

Citation(s)	Condition or Requirement
	(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended; (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President; (vi) Aliens currently in deferred action status; or (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status; (5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the NA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days; (6) An alien who has been granted withholding of removal under the Convention Against Torture; (7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J)); (8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or (9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa. __X__ Elected for pregnant women. __X__ Elected for children under age _19_.

Citation(s)	Condition or Requirement
	a. _X__ The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA section 214 option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.
42 CFR 435.403 1902(b) of the Act	4. Is a resident of the State, regardless of whether or not the individual maintains the residence permanently or maintains it at a fixed address. ☐ State has interstate residency agreement with the following States: ☐ State has open agreement(s). ☐ Not applicable; no residency requirement.

Citation(s)	Condition or Requirement
435.1008	5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, nursing facilities and intermediate care facilities for the mentally retarded, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
42 CFR 435.1008 1905(a) of the Act	b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program. ☐ Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.
433.145 435.604 1912 of the Act	6. Is required, as a condition of eligibility, to assign rights to medical support and to payments for medical care from any third party, to cooperate in obtaining such support and payments, and to cooperate in identifying and providing information to assist in pursuing any liable third party. The assignment of rights obtained from an applicant or recipient is effective only for services that are reimbursed by Medicaid. The requirements of 42 CFR 433.146 through 433.148 are met. An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902(l)(1)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

Citation(s)	Condition or Requirement
	(6. continued) An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate. ☒ Assignment of rights is automatic because of State law.
42 CFR 435.910	7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number); except for aliens seeking medical assistance for the treatment of an emergency medical condition under Section 1903(v)(2) of the Act.

State of Nebraska

Citation(s)	Condition or Requirement
1902(c)(2)	8. Is not required to apply for AFDC benefits under title IV-A as a condition of applying for, or receiving, Medicaid if the individual is a pregnant woman, infant, or child that the State elects to cover under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.
1902(e)(10)(A) and (B) of the Act	9. Is not required, as an individual child or pregnant woman; to meet requirements under section 402(a)(43) of the Act to be in certain living arrangements. (Prior to terminating AFDC individuals who do not meet such requirements under a State's AFDC plan, the agency determines if they are otherwise eligible under the State's Medicaid plan.)
	10. Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).

State: Nebraska

Citation	Condition or Requirement
	B. Posteligibility Treatment of Institutionalized Individuals' Incomes
	1. The following items are not considered in the posteligibility process:
1902(o) of the Act	a. SSI and SSP benefits paid under §1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital, nursing home, SNF, or ICF.
Bondi v. Sullivan (SSI)	b. Austrian Reparation Payments (pension (reparation) payments made under §500 - 506 of the Austrian General Social Insurance Act). Applies only if State follows SSI program rules with respect to the payments.
1902(r)(1) of the Act	c. German Reparations Payments (reparation payments made by the Federal Republic of Germany).
105/206 of P. L. 100-383	d. Japanese and Aleutian Restitution Payments.
1. (a) of P.L. 103-286	e. Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II
10405 of P.L. 101-239	f. Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent orange product liability litigation, M.D.L. No.381 (E.D.N.Y.)
6(h)(2) of P.L. 101-426	g. Radiation Exposure Compensation.
12005 of P. L. 103-66	h. VA pensions limited to $90 per month under 38 U.S.C. 5503.

Citation	Condition or Requirement
1924 of the Act 435.725 435.733 435.832	2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care: Personal Needs Allowance (PNA) of not less than $30 For Individuals and $60 For Couples For All Institutionalized Persons. a. Aged, blind, disabled: Individuals $ 50 Couples $ 100 For the following persons with greater need: ▪ Individuals with a guardian or conservator ▪ Individuals in an ICF-MR (ICF-ID) who participate in a sheltered workshop Supplement 15 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. b. AFDC related: Children $ 50 Adults $ 50 For the following persons with greater need: ▪ Individuals with a guardian or conservator ▪ Individuals in an ICF-MR (ICF-ID) who participate in a sheltered workshop Supplement 15 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. c. Individual under age 21 covered in the plan as specified in Item B. 7. of Attachment 2.2-A. $ 50

Citation	Condition or Requirement
	For the following persons with greater need: ▪ Individuals with a guardian or conservator ▪ Individuals in an ICF-MR (ICF-ID) who participate in a sheltered workshop Supplement 15 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.
1924 of the Act	3. In addition to the amounts under item 2, the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse: a. The monthly income allowance for the community spouse, calculated using the formula in §1924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in § 1924 (d)(3)(C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance. __X_ The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level. ____ The poverty level component is calculated using a percentage greater than the applicable percentage, equal to ___%, of the official poverty level (still subject to maximum maintenance needs standard). ____ The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C). Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court-ordered support.

Citation	Condition or Requirement
	In determining any excess shelter allowance, utility expenses are calculated using: __X_ the standard utility allowance under §5(e) of the Food Stamp Act of 1977 or ____ the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges. b. The monthly income allowance for other dependent family members living with the community spouse is: __X_ one-third of the amount by which the poverty level component (calculated under §1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in §1924(d)(3)(B)) exceeds the dependent family member's monthly income. ____ a greater amount calculated as follows: The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924 (d)(1): c. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party: (i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments. (ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to ATTACHMENT 2.6-A.)

Citation	Condition or Requirement
435.725 435.733 435.832	4. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple. a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the: o AFDC level or o Medically needy level: (Check one) _____ AFDC level sin Supplement 1 __X__ Medically needy level in Supplement 1 _____ Other: $ b. Amounts for health care expenses described below that have not been deducted under 3.c. above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple, and are not subject to the payment by a third party: (i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments. (ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amount are described in Supplement 3 to ATTACHMENT 2.6-A.)
435.725 435.733 435.832	5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an institutionalized couple: A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period: ___ No. _X_ Yes (the applicable amount is shown on page 5a.)

State: Nebraska

Citation	Condition or Requirement
	___ Amount for maintenance of home is: $_____.
	_X_ Amount for maintenance of home is the actual maintenance costs not to exceed $281.
	___ Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individual's home and the community spouse's home are different.
	_X_ Amount for maintenance of home is not deductible when countable income is determined under §1924(d)(1) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.711 435.721, 435.831	C. Financial Eligibility For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified below. For individuals who are not AFDC or SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply. Supplement 1 to ATTACHMENT 2.6-A specifies the income levels for mandatory and optional categorically needy groups of individuals, including individuals with incomes related to the Federal income poverty level--pregnant women and infants or children covered under sections 1902(a)(10)(A)(i)(IV), . 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act and aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act--and for mandatory groups of qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act.

State of Nebraska

Citation(s)	Condition or Requirement
	☐ Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.
	☐ Supplement 7 to ATTACHMENT 2.6-A specifies the income levels for categorically needy aged, blind and disabled· persons who are covered under requirements more restrictive than SSI.
	☐ Supplement 4 to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
	☐ Supplement 5 to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
	☒ Supplement 8a to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.
	☒ Supplement 8b to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(r)(2) of the Act	1. Methods of Determining Income a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children) (1) In determining countable income for AFDC-related individuals, the following methods are used: ☒ (a) The methods under the approved AFDC plan only; or ☐ (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8a to Attachment 2.6-A. (2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
1902(e)(6) the Act	(3) Agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.721 435.831, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act	b. Aged individuals. In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902(m)(1) of the Act, the following methods used: ☐ The methods of the SSI program only. ☒ The methods of the SSI program and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

State of Nebraska

Citation(s)	Condition or Requirement
	☐ For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
	☒ For institutional couples, the methods specified under section 1611(e)(5) of the Act.
	☐ For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to Attachment 2.6-A.
	☒ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--
	☐ SSI methods only.
	☒ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to Attachment 2.6-A.
	☐ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to Attachment 2.6-A.
	In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

State of Nebraska

Citation(s)	Condition or Requirement
42 CFR 435.721 and 435.831 1902(m)(1) (B), (m) (4), and 1902(r) (2). of the Act	c. Blind individuals. In determining countable income for blind individuals, the following methods are used: ☐ The methods of the SSI program only. ☒ SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A ☐ For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A, and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ☒ For institutional couples, the methods specified under section 1611(e)(5) of the Act. ☐ For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A. ☒ For optional .State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements-- ☐ SSI methods only. ☒ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. ☐ Methods more restrictive and/ or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

State of Nebraska

Citation(s)	Condition or Requirement
	In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
42 CFR 435.721 and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	d. Disabled individuals. In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in section 1902(m) of the Act the following methods are used: ☐ The methods of the SSI program. ☒ SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ☒ For institutional couples: the methods specified under section l6l1(e)(5) of the Act. ☐ For optional State supplement recipients under §435.230: income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A. ☐ For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

State of Nebraska

Citation(s)	Condition or Requirement

☒ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements—

☐ SSI methods only.

☒ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.

☐ Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902(m)(1) of the Act. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(l)(3)(E) and 1902(r)(2) of the Act	e. Poverty level pregnant women, infants, and children. For pregnant women and infants or children covered under the provisions of sections 1902(a)(10)(A)(i)(IV), (VI), and (VII), and 1902(a)(10)(A)(ii)(IX) of the Act-- (1) The following methods are used in countable income: ☒ The methods of the State's approved AFDC plan. ☐ The methods of the approved title IV-E plan. ☐ The methods of the approved AFDC State plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. . ☐ The methods of the approved title IV-E plan ,and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
1902(e)(6) of the Act	(3) The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.
1905(p)(1), 1902(m)(4), and 1902(r)(2) of the Act	f. Qualified Medicare beneficiaries. In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the following methods are used:
	☐ The methods of the SSI program only.
	☒ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A
	☒ For institutional couples, the methods specified under section 1611(e)(5) of the Act.

State of Nebraska

Citation(s)	Condition or Requirement
	If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level. For individuals with tile II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period. For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.
1905(s) of the Act	g. (1) Qualified disabled and working individuals. In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.
1905(p) of the Act	(2) Specified low-income Medicare beneficiaries. In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.

* U.S.G.P.O.: 1993-342-239:80032

State of Nebraska

Citation(s)	Condition or Requirement
1902(u) of the Act	(h) COBRA Continuation Beneficiaries In determining countable income for COBRA continuation beneficiaries, the following disregards are applied: ☐ The disregards of the SSI program; ☐ The agency uses methodologies for treatment of income more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A Note: For COBRA continuation beneficiaries specified at 1902(u)(4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612(b)(4)(B)(ii).

State/Territory: Nebraska

Citation(s)	Groups Covered
1902(a)(10)(A)(ii)(XIII) of the Act	(i) Working Disabled Who Buy Into Medicaid In determining countable income and resources for Working Disabled individual who buy into Medicaid, the following methodologies are applied: ☐ The methodologies of the SSI program. ☐ The agency uses methodologies for the treatment of income and resources more restrictive than the SSI Program. Those more restrictive methodologies are described in Supplement 4 to Attachment 2.2-A. ☒ The agency uses more liberal income and/or resources methodologies than the SSI Program. More liberal income methodologies are described in Supplement 8a to Attachment 2.6-A. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A. ☒ The agency requires individuals to pay premiums or other cost sharing charges. The premium or other cost sharing charges and how they are applied are described in Attachment 2.6-A page 12d.

State/Territory: Nebraska

STATE PLAN UNDER TITLE XIS OF THE SOCIAL SECURITY ACT

ESTABLISHMENT AND APPLICATION OF A PREMIUM OR OTHER COST SHARING CHARGES

☐ Section 1902(f) State ☒ Non-Section 1902(f) State

1. A working disabled individual who receives Medicaid benefits may be subject to cost sharing. The following premium or cost sharing procedures are utilized:

   (a) The amount of the individual's cost share shall be based on a progressive rate dependent on adjusted income (any unearned income plus any earned income less any allowable disregards) in excess of 200 percent of the Federal Poverty Level. The minimum rate is 2 percent and the maximum rate is 10 percent.

State of Nebraska

Citation(s)	Condition or Requirement
1902(k) of the Act 1917(d)	2. Medicaid Qualifying Trusts In the case of a Medicaid qualifying trust described in 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded. The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship. Supplement 10 of ATTACHMENT 2.6-A specifies what constitutes an undue hardship. Effective October 1, 1993 the Medicaid agency complies with Section 1917 (d) of the Act as amended by the Omnibus Budget Reconciliation Act of 1993.
1902(a)(10) of the Act	3. Medically needy income levels (MNILs) are based on family size. Supplement 1 to ATTACHMENT 2.6-A specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, Supplement 1 so indicates.

State of Nebraska

Citation(s)	Condition or Requirement
42 CFR 435.732, 435.831	4. Handling of Excess Income - Spend-down for the Medically Needy in All States and the Categorically Needy in 1902(f) States Only a. Medically Needy (1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for period of 6 months to determine the amount of excess countable income applicable to the cost of medical care and services. (2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order: (a) Health insurance premiums, deductibles and coinsurance charges. (b) Expenses for necessary medical and remedial care not included in the plan. (c) Expenses for necessary medical and remedial care included in the plan. ☐ Reasonable limits on amounts of expenses deducted from income under a.(2)(a) and (b) above are listed below. See page ~~14a~~ *14b (per MS-91-29) NS*
1902(a)(17) of the Act	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

State of Nebraska

Citation(s)	Condition or Requirement
	a. Medically Needy (Continued)
1903(f)(2) of the Act	☐ (3) If countable income exceeds the MNIL standard,the agency deducts spenddown payments made to the State by the individual.

State of Nebraska

Citation(s)	Condition or Requirement
	Under (2)(b) above, the difference between the State Supplemental payment level for board and room and the State Supplemental payment level (consolidated standard of need) for the alternate care facilities specified below is an allowable excess income obligation when that amount is being applied towards necessary medical and remedial services. The necessity for medical and remedial services is recognized in the following types of alternate care facilities: Licensed Domiciliary Facility Certified Adult Family Home Licensed Residential Care Facility Licensed Group Home for the Mentally Retarded Licensed Center for the Developmentally Disabled Subsistence to obtain medical care: a limit of $12 per day for meals is allowed for the client, and the same for an attendant if one is necessary.

State of Nebraska

Citation(s)	Condition or Requirement
42 CFR 435.732	b. Categorically Needy - Section 1902 (f) States The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income: (1) Any SSI benefit received. (2) Any State supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act. (3) Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section. (4) Other deductions from income described in this plan at Attachment 2.6-A, Supplement 4. (5) Incurred expenses for necessary medical and remedial services recognized under State law.
1902(a)(17) of the Act, P.L. 100-203	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

State of Nebraska

Citation(s)	Condition or Requirement
	4.b. Categorically Needy - Section 1902(f) States Continued
1903(f)(2) of the Act	☐ (6) Spenddown payments made to the State by the individual. NOTE: FFP will be reduced to the extent State is paid spenddown payment by the individual.

State of Nebraska

Citation(s)	Condition or Requirement

5. Methods for Determining Resources

a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).

(1) In determining countable resources for AFDC-related individuals, the following methods are used:

(a) The methods under the State's approved AFDC plan; and

☒ (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A

(2) In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

State of Nebraska

Citation(s)	Condition or Requirement
	5. Methods for Determining Resources
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r) of the Act	b. Aged individuals. For aged individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, the agency used the following methods for treatment of resources: ☐ The methods of the SS1 program. ☒ SSI methods and/or anymore liberal methods described in Supplement 8b to ATTACHMENT 2.6-A ☐ Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.

State of Nebraska

Citation(s)	Condition or Requirement
	In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and 1902(r) of the Act	c. Blind individuals. For blind individuals the agency uses the following methods for treatment of resources: ☐ The methods of the SSI program. ☒ SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A. ☐ Methods that are more restrictive and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describe the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specify the more liberal methods. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

State of Nebraska

Citation(s)	Condition or Requirement
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and (C), and 1902(r)(2) of the Act	d. Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act. The agency uses the following methods for the treatment of resources: ☐ The methods of the SSI program. ☒ SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ☐ Methods that are more restrictive (except for individuals described In section 1902(m)(1) of the Act) and/or more liberal that those under the SSI program. More restrictive methods are described in Supplement 5 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8b to ATTACHMENT 2.6-A. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(l)(3) and 1902(r)(2) of the Act	e. Poverty level pregnant women covered under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX)(A) of the Act. The agency uses the following methods in the treatment of resources. ☐ The methods of the SSI program only. ☐ The methods of the SSI program and/or any more liberal methods described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.

State of Nebraska

Citation(s)	Condition or Requirement
	☐ Methods that are more liberal than those of SSI. The more liberal methods are specified in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A. ☒ Not applicable. The agency does not consider resources in determining eligibility. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(l)(3) and 1902(r)(2) of the Act	f. Poverty level infants covered under section 1902(a)(10)(A)(i)(IV) of the Act. The agency uses the following methods for the treatment of resources: ☐ The methods of the State's approved AFDC plan.
1902(l)(3)(C) of the Act	☐ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(l)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A.
1902(r)(2) of the Act	☐ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A. ☒ Not applicable. The agency does not consider resources in determining eligibility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(l)(3) and 1902(r)(2) of the Act	g. 1. Poverty level children covered under section 1902(a)(10)(A)(i)(VI) of the Act. The agency uses the following methods for the treatment of resource: ☐ The methods of the State's approved AFDC plan.
1902(1)(3)(C) of the Act	☐ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(l)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A.
	☐ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8b to ATTACHMENT 2.6-A.
1902(r)(2) of the Act	☒ Not applicable. The agency does not consider resources in determining eligibility. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(l)(3) and 1902(r)(2) of the Act	g. 2. Poverty level children under section 1902(a)(10)(A)(i)(VII) The agency uses the following methods for the treatment of resources: ☐ The methods of the State's approved AFDC plan. ☐ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as specified in Supplement 5a of ATTACHMENT 2.6-A.
1902(1)(3)(C) of the Act	☐ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8a to ATTACHMENT 2.6-A.
1902(r)(2) of the Act	☒ Not applicable. The agency does not consider resources in determining eligibility. In determining relative responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

State of Nebraska

Citation(s)	Condition or Requirement
1905(p)(1) (C) and (D) and 1902(r)(2) of the Act	5. h. For Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act the agency uses the following methods for treatment of resources: ☒ The methods of the SSI program only. ☐ The methods of the SSI program and/or more liberal methods as described in Supplement 8b to ATTACHMENT 2.6-A.
1905(s) of the Act	i. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.
1902(u) of the Act	j. For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources: ☐ The methods of the SSI program only. ☐ More restrictive methods applied under section 1902(f) of the Act as described in Supplement 5 to Attachment 2.6-A.

State of Nebraska

Citation(s)	Condition or Requirement
1902(a)(10)(E)(iii) of the Act	k. Specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act-- The agency uses the same method as in 5.h. of Attachment 2.6-A. 6. Resource Standard - Categorically Needy a. 1902(f) States (except as specified under items 6.c. and d. below).for aged, blind and disabled-individuals: ☐ Same as SSI resource standards. ☐ More restrictive. The resource standards for other individuals are the same as those in the related cash assistance program. b. Non-1902(f) States (except as specified under items 6.c. and d. below) The resource standards are the same as those in the related cash assistance program. Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(l)(3)(A) (B) and (C) of the Act	c. For pregnant women and infants covered under the provisions of section 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act, the agency applies resource standard. ☐ Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which, for pregnant women, is no more restrictive than the standard under the SSI program; and for infants is no more restrictive than the standard applied in the State's approved plan. ☒ No. The agency does not apply resource standard to these individuals.
1902(l)(3)(A) and (C) of the Act	d. For children covered under the provisions of section 1902(a)(10)(A)(i)(VI) of the Act, the agency applies a resource standard. ☐ Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the state's approved AFDC plan. ☒ No. The agency does not apply a resource standard to these individuals.

State of Nebraska

Citation(s)	Condition or Requirement
1902(m)(1)(C) and (m)(2)(B) of the Act	e. For aged and disabled individuals described in section 1902(m)(1) of the Act who are covered under section 1902(a)(10)(A)(ii)(X) of the Act, the resource standard is: ☐ Same as SSI resource standards. ☒ Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy). Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.

State of Nebraska

Citation(s)	Condition or Requirement
	7. Resource Standard - Medically Needy
1902(a)(10)(C)(i) of the Act	a. Resource standards are based on family size.
	b. A single standard is employed in determining resource eligibility for all groups.
	☐ c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for - ☐ Aged ☐ Blind ☐ Disabled Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 so indicates.
1905(p) (1) (D) and (p) (2) (B) of the Act	8. Resource Standard - Qualified Medicare Beneficiaries Specified Low-Income Medicare Beneficiaries, and Qualifying Individuals For qualified Medicare beneficiaries covered under Section 1902(a)(10)(E)(i) of the Act, specified low-income Medicare beneficiaries covered under Section 1902(a)(10)(E)(iii) of the Act, and Qualifying Individuals covered under Section 1902(a)(10)(E)(iv) of the Act, the resource standard is equal to the amount defined under Section 1905(p)(1)(C) of the Act.
1905(s) of the Act	9. Resource Standard-Qualified Disabled and Working Individuals For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is twice the SSI resource standard.

State of Nebraska

Citation(s)	Condition or Requirement
1902(u) of the Act	9. 1 For COBRA continuation beneficiaries, the resource standard is: ☐ Twice the SSI resource standard for an individual. ☐ More restrictive standard for as applied under section 1902(f) of the Act as described in Supplement 8 to Attachment 2.6-A.

State of Nebraska

Citation(s)	Condition or Requirement
1902(u) of the Act	10. Excess Resources a. Categorically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries Any excess resources make the individual ineligible. b. Categorically Needy Only ☐ This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources. c. Medically Needy Any excess resources make the individual ineligible.

State of Nebraska

Citation(s)	Condition or Requirement
42 CFR 435.914	11. Effective Date of Eligibility

a. Groups Other Than Qualified Medicare Beneficiaries

(1) For the prospective period.

coverage Is available for the full month if the following individuals are eligible at any time during the month.

☒ Aged, blind, disabled.
☒ AFDC-related.

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

☐ Aged, blind, disabled.
☐ AFDC-related.

(2) For the retroactive period.

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:

☐ Aged, blind, disabled.
☐ AFDC-related.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied..

☒ Aged, blind, disabled.
☒ AFDC-related.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1920(b)(1) of the Act	☒ (3) For a presumptive eligibility period for pregnant women only. Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider determines that a woman meets any of the income eligibility levels specified in ATTACHMENT 2.6-A of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the State agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day.
1902(e)(8) and 1905(a) of the Act	☒ b. For qualified Medicare beneficiaries defined in section 1905(p)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905(p)(1).The eligibility determination is valid for ☒ 12 months ☐ 6 months ☐ __ months (no less than 6 months and nor more than 12 months)

State of Nebraska

Citation(s)	Condition or Requirement
1902(a)(18) and 1902(f) of the Act	12. Pre-OBRA 93 Transfer of Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources. Disposal of resources at less than fair market value affects eligibility for certain services as detailed in Supplement 9 to Attachment 2.6-A.
1917(c)	13. Transfer of Assets - All eligibility groups The agency complies with the provisions of section 1917(c) of the Act, as enacted by OBRA 93, with regard to the transfer of assets. Disposal of assets at less than fair market value affects eligibility for certain services as detailed in Supplement 9(a) to ATTACHMENT 2.6-A, except in instances where the agency determines that the transfer rules would work an undue hardship.
1917(d)	14. Treatment of Trusts - All eligibility groups The agency complies with the provisions of section 1917(d) of the Act, as amended by OBRA 93, with regard to trusts. ☐ The agency uses more restrictive methodologies under section 1902(f) of the Act, and applies those methodologies in dealing with trusts: ☐ The agency meets the requirements in section 1917(d)(f)(B) of the Act for use of Miller trusts. The agency does not count the funds in a trust in any instance where the agency determines that the transfer would work an undue hardship, as described in Supplement 10 to ATTACHMENT 2.6-A.

State: Nebraska

Citation	Condition or Requirement
1924 of the Act	15. The agency complies with the provisions of § 1924 with respect to income and resource eligibility and post eligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community. When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is: ___ the maximum standard permitted by law; _X_ the minimum standard permitted by law; or $___ a standard that is an amount between the minimum and the maximum.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY

1. AFDC-Related Groups Other Than Poverty Level Pregnant Women and Infants:

Family Size	Need Standard	Payment Standard	Maximum Payment Amounts
1	222	222	222
2	293	293	293
3	364	364	364
4	435	435	435
5	506	506	506
6	577	577	577
7	648	648	648
8	719	719	719
9	790	790	790
10	861	861	861

2. For pregnant women and infants under Section 1902(a)(10)(i)(IV) of the Act (women during pregnancy and infants under one year of age) the income eligibility level is 150 percent of the Federal Poverty level (as revised annually in the Federal Register) for the size family involved.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY (Continued)

3. For children under Section 1902(a)(10)(i)(VI) of the Act (children who have attained age 1 but have not attained 6), the income eligibility level is 133 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

4. For children under Section 1902(a)(10)(i)(VII) of the Act (children who were born after September 30, 1983 and have attained age 6 but have not attained age 19), the income eligibility level is 100 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

INCOME ELIGIBILITY LEVELS (Continued)

B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women and Infants

The levels for determining income eligibility for optional groups of pregnant women and infants under the provisions of sections 1902(a)(10)(A)(ii)(IX) and 1902(l)(2) of the Act are as follows:

Based on 150 percent of the official Federal income poverty level (no less than 133 percent and no more than 185 percent) for the size of the family involved.

Family Size	Income Level
1	$
2	$
3	$
4	$
5	$

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

(Reserved)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

INCOME ELIGIBILITY LEVELS (Continued)

3. Aged and Disabled individuals

For aged and disabled individuals described in Section 1902(m)(1) of the Act, the income edibility level is 100 percent of the Federal Poverty level (as revised annually in the Federal Register) for the size family involved.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of section 1905(p)(2)(A) of the Act are as follows:

1. NON-SECTION 1902(f) STATES

a. Based on the following percent of the official Federal income poverty level:

Eff. Jan 1, 1989:	☒	85 percent	☐	____ percent (no more than 100)
Eff. Jan 1, 1990:	☒	90 percent	☐	____ percent (no more than 100)
Eff. Jan 1, 1991:		100 percent		
Eff. Jan 1, 1992:		100 percent		

b. Levels

For Qualified Medicare Beneficiaries described in 1905(p)(1) of the Act, the income eligibility level is 100 percent of the Federal Poverty Level (as revised annually in the Federal Register) for the size family involved.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

2. SECTION 1902(f) STATES WHICH AS OF JANUARY 1, 1987 USED INCOME STANDARDS MORE RESTRICTIVE THAN SSI

a. Based on the following percent of the official Federal income poverty level:

Eff. Jan 1, 1989: ☐ 80 percent ☐ _____ percent (no more than 100)
Eff. Jan 1, 1990: ☐ 85 percent ☐ _____ percent (no more than 100)
Eff. Jan 1, 1991: ☐ 90 percent ☐ _____ percent (no more than 100)
Eff. Jan 1, 1992: 100 percent

b. Levels:

Family Size	Income Levels
1	$ _____
2	$ _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

INCOME ELIGIBILITY LEVELS (Continued)

D. MEDICALLY NEEDY

☒ Applicable to all groups.

☐ Applicable to all groups except those specified below. Excepted group income levels are also listed on an attached page 3.

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for 6 months ☐ urban only ☒ urban & rural	Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007[1]	Net income level for persons living in rural areas for ___ months	Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007[1]
1	$ 2,352	$	$	$
2	$ 2,352	$	$	$
3	$ 2,952	$	$	$
4	$ 3,504	$	$	$
For each additional person add:	$ 546	$	$	$

[1] The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

INCOME ELIGIBILITY LEVELS (Continued)

D. MEDICALLY NEEDY

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for 6 months ☐ urban only ☒ urban & rural	Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007[1]	Net income level for persons living in rural areas for ___ months	Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007[1]
5	$ 4,050	$	$	$
6	$ 4,650	$	$	$
7	$ 5,202	$	$	$
8	$ 5,802	$	$	$
9	$ 6,354	$	$	$
10	$ 6,900	$	$	$
For each additional person add:	$ 546	$	$	$

[1] The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

RESOURCE LEVELS

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women

a. Mandatory Groups

☐ Same as SSI resources levels

☐ Less restrictive than SSI resource levels and is as follows:

Family Size	Resource Level
1	
2	

b. Optional Groups

☐ Same as SSI resources levels

☐ Less restrictive than SSI resource levels and is as follows:

Family Size	Resource Level
1	
2	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

2. Infants

a. Mandatory Group of Infants

☐ Same as resource levels in the State's approved AFDC plan.

☐ Less restrictive than the AFDC levels and are as follows.

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

a. Optional Group of Infants

☐ Same as resource levels in the State's approved AFDC plan.

☐ Less restrictive than the AFDC levels and are as follows.

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

3. Children

a. Mandatory Group of Children under Section 1902(a)(10)(i)(VI) of the Act.
(Children who have attained age 1 but have not attained age 6)

☐ Same as resource levels in the State's approved AFDC plan.

☐ Less restrictive than the AFDC levels and are as follows.

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

b. Mandatory Group of Children under Section 1902(a)(10)(i)(VII) of the Act. (Children born after September 30, 1983 who have attained age 6 but have not attained age 19)

☐ Same as resource levels in the State's approved AFDC plan.

☐ Less restrictive than the AFDC levels and are as follows.

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

3. Aged and Disabled Individuals

☐ Same as SSI resource levels.

☐ More restrictive than SSI levels and are as follows.

Family Size	Resource Level
1	
2	
3	
4	
5	

☒ Same as medically needy resource levels (applicable only if State has a medically needy program.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

B. MEDICALLY NEEDY

Applicable to all groups-

☐ Except those specified below under the provisions of section 1902(f) of the Act.

Family Size	Resource Level
1	$4,000
2	6,000
3	6,025
4	6,050
5	6,075
6	6,100
7	6,125
8	6,150
9	6,175
10	6,200
For each additional person	25

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

NOT APPLICABLE

11/08 decision by CMS & DHHS to leave this page in State Plan

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

METHODS FOR TREATMENT OF INCOME THAT
DIFFER FROM THOSE OF THE SSI PROGRAM

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section 1902(r)(2) of the Act. Use Supplement 8a for section 1902(r)(2) methods.)

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

MORE RESTRICTIVE METHODS OF TREATING RESOURCES
THAN THOSE OF THE SSI PROGRAM – Section 1902(f) States only

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS
WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r)(2) methods.)

N/A

Standards for Optional State Supplementary Payments

Payment Category (Reasonable Classification)	Administered By Federal/State	Net Income Level		Income Disregards Employed
		One Person	Couple	
(1)	(2)	(3)	(4)	(5)
Available to all aged, blind and disabled individuals with varying payment levels dependent on the following living arrangements:	State			SSI Standards
Own or rent a home	State	$361 $227*	$583 $291*	
Patient in a nursing home, regional center, state institution for the mentally retarded, or receiving chronic or convalescent hospital care	State	$50	$100	
In room and board situation (not licensed home) or boarding home (licensed or unlicensed if board and room is provided)	State	$506	$1012	
In certified adult family home	State	$737	$1,474	
In licensed assisted living facility In licensed mental health center	State	$1,017	$2,034	
Assisted Living Waiver	State	$579	$1,158	
In licensed group home for children and/or child caring agency	State	$673	$1,346	
In licensed centers for the developmentally disabled	State	$576	$1,152	

* Maximum for shelter allowance

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

INCOME LEVELS FOR 1902(f) STATES - CATEGORICALLY NEEDY WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nebraska

RESOURCE STANDARDS FOR 1902(f) STATES CATEGORICALLY NEEDY

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

MORE LIBERAL METHODS OF TREATING INCOME AND RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT*

☐ Section 1902(f) State ☒ Non-Section 1902(f) State

1. For the qualified pregnant women and children (1902)(a)(10)(A)(i)(III), the poverty level pregnant women and children (1902(a)(10)(A)(i)(IV), (VI) and (VII)), the optional groups of children under age 21 and caretaker relatives (1902(a)(10)(A)(ii)(I)), and pregnant women under 1902(a)(10)(A)(ii)(IX) and 1902(l)(1)(A), declared winnings, interest, and dividends of less than $10 per month are excluded as income.

2 For the qualified pregnant women and children (1902)(a)(10)(A)(i)(III), the poverty level pregnant women and children (1902(a)(10)(A)(i)(IV), (VI) and (VII)), the optional groups of children under age 21 and caretaker relatives (1902(a)(10)(A)(ii)(I)), and pregnant women under 1902(a)(10)(A)(ii)(IX) and 1902(l)(1)(A), and the medically needy (1902(a)(10)(C)(i)(III), effective November 1, 2002, disregard $100 of gross earned income per working individual as a work-related expense deduction in determining countable income.

3 For Working Disabled individuals as defined in Section (1902)(a)(10)(A)(ii)(XIII) of the Act, the following income standard applies:

Disregard all earnings plus unearned income contingent upon a trial work period (such as a Social Security Trial Work Periods). In determining eligibility for SSI in the individual eligibility determination required under Section 4733 of the Balanced Budget Act.

4. For pregnant women under 1902(a)(10)(A)(ii)(IX) and 1902 (l)(1)(A) of the Act, disregard the amount of income between 150% FPL and 185% FPL.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

MORE LIBERAL METHODS OF TREATING INCOME AND RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT*

☐ Section 1902(f) State ☒ Non-Section 1902(f) State

3. Treatment of Excess Resources Under 1902(r)(2) for Medicaid Working Disabled

For Working Disabled individuals as defined in Section 1902(a)(10)(A)(iii)(XIII) of the Act, the following more liberal resource methodology applies:

Disregard an additional $2,000 per individual for a total of $4,000 per individual and an additional $3,000 per couple for a total of $6,000 per couple. The purpose of this additional resource disregard is to aid in achieving self-sufficiency.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LESS RESTRICTIVE METHODS OF TREATING INCOME UNDER SECTION 1902(r)(2) OF THE ACT

☒ For all eligibility groups subject to 1902(r)(2) and not subject to the limitations on payment explained in 1903(f) of the Act: All otherwise countable income deposited in an IDA account funded under the Assets for Independence Act is excluded.

☐ For all eligibility groups subject to 1902(r)(2) and not subject to the limitations on payment explained in 1903(f) of the Act: All otherwise countable income deposited in an IDA account authorized under Section 404 is excluded.

☒ For all eligibility groups subject to 1902(r)(2) and not subject to the limitations on payment explained in 1903(f) of the Act: All interest earned on an IDA account funded under the Assets for Independence Act is excluded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

☐ Section 1902(f) State ☒ Non-Section 1902(f) State

TREATMENT OF EXCESS RESOURCES UNDER 1902(r)(2)

Excess resources make the individual ineligible. Once the excess resources have been reduced to the allowable limit, eligibility may begin –

1. The first day of the month in which the resources are actually reduced to or below the allowable limit if the resources were not used to pay bills incurred in a prior month. The resources may be reduced by paying any bills or by purchasing any items of need.

2. The first day of the month in which the most recent bill (s) for maintenance or medical was incurred which was paid to reduce the excess resources. Maintenance needs include items such as food, shelter, clothing, transportation and personal comfort items. Qualifying bills would be those incurred by the client, the client's spouse or dependent child(ren).

   Example

Medicaid Bills Incurred	Application Made	Bills Paid
Jan. 1, Feb. 3, Mar. 5, Mar. 25	March Excess Resources	April Below Resources

If bills from Jan. 1 and Feb.3 were used to reduce resources, eligibility would begin Feb. 1 even though the bills were not actually paid until April.

This methodology would apply to all eligibility groups except deemed cash recipients and Qualified Medicare Beneficiary's.

All of the requirements of 1917(c)(4) are met for individuals who dispose of resources for less than fair market value.

Eligibility will never begin before the third month before the month of application.

From the date of determination of eligibility for Medicaid, an applicant has 90 days in which to spend down excess resources to become retroactively eligible for Medicaid.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITYACT

State: Nebraska

LESS RESTRICTIVE METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

☒ For all eligibility groups subject to 1902(r)(2) of the Act: All funds in IDA accounts funded under the Assets for independence Act are excluded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

STATE LONG-TERM CARE INSURANCE PARTNERSHIP

1902(r)(2)
1917(b)(1)(C)

The following more liberal methodology applies to individuals who are eligible for medical assistance under one of the following eligibility groups:

1902(a)(10)(A)(ii)(I), 1902(a)(10)(A)(ii)(X), 1902(a)(10)(C) - (Section 1905(a)(iii), Section 1905(a)(iv) & Section 1905(a)(v))

An individual who is a beneficiary under a long-term care insurance policy that meets the requirements of a "qualified State long-term care insurance partnership" policy (partnership policy) as set forth below, is given a resource disregard as described in this amendment. The amount of the disregard is equal to the amount of the insurance benefit payments made to or on behalf of the individual. The term "long-term care insurance policy" includes a certificate issued under a group insurance contract.

☒ The State Medicaid Agency (Agency) stipulates that the following requirements will be satisfied in order for a long-term care policy to qualify for a disregard. Where appropriate, the Agency relies on attestations by the State Insurance Commissioner (Commissioner) or other State official charged with regulation and oversight of insurance policies sold in the state, regarding information within the expertise of the State's Insurance Department.

- The policy is a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986.

- The policy meets the requirements of the long-term care insurance model regulation and long-term care insurance model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) as those requirements are set forth in section 1917(b)(5)(A) of the Social Security Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

STATE LONG-TERM CARE INSURANCE PARTNERSHIP

- The policy was issued no earlier than the effective date of this State plan amendment.

- The insured individual was a resident of a Partnership State when coverage first became effective under the policy. If the policy is later exchanged for a different long-term care policy, the individual was a resident of a Partnership State when coverage under the earliest policy became effective.

- The policy meets the inflation protection requirements set forth in section 1917(b)(1)(C)(iii)(IV) of the Social Security Act.

- The Commissioner requires the issuer of the policy to make regular reports to the Secretary that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

- The State does not impose any requirement affecting the terms or benefits of a partnership policy that the state does not also impose on non-partnership policies.

- The State Insurance Department assures that any individual who sells a partnership policy receives training, and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

- The Agency provides information and technical assistance to the Insurance Department regarding the training described above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: 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.

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 individual's estate for the amount of assets or resources disregarded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

TRANSFER OF RESOURCES

1917(c) The agency provides for the denial of eligibility by reason of disposal of resources for less than fair market value.

A. Transfer of resources of an individual who is an inpatient in a medical institution or nursing facility.

1. The agency provides for a period of ineligibility in the case of an institutionalized individual who at any time during the 30 month period immediately preceding the individuals application for medical assistance, disposed of resources for less than fair market value. The period of ineligibility shall begin with the month in which the resources were transferred and the number of months will be equal to the less of 30 months, or the total uncompensated value of the transferred resources divided by the average cost to a private patient at the time of application, of nursing facility services.

B. Transfer of the home of an individual who is an inpatient in a medical institution or nursing facility.

1. A period of ineligibility is not imposed if the resource transferred were a home and title to the home was transferred to-

a. the spouse of the individual,

b. a child of the individual who is under age 21, or is blind or disabled,

c. a sibling of such individual who has an equity interest in the home and who was residing in the home for a period of at least one year immediately preceding the date of the individuals admission to the medical institution or nursing facility, or

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

TRANSFER OF RESOURCES

d. a son or daughter who was residing in the home for a period of two years immediately preceding the individuals admission to the medical institution or nursing facility, and who provided care to the individual which permitted him/her to reside at home rather than in the institution or facility.

C. A period of ineligibility for transfer of resources will not be imposed if the individual can show that s/he intended to dispose of the resource for fair market value or for other valuable consideration, the transfer was not made to qualify for assistance, or that denial of assistance would cause undue hardship

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

TRANSFER OF ASSETS

1917(c) The agency provides for the denial of certain Medicaid services by reason of disposal of assets for less than fair market value.

1. Institutionalized individuals may be denied certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

   The agency withholds payment to institutionalized individuals for the following services:

   Payments based on a level of care in a nursing facility;

   Payments based on a nursing facility level of care in a medical institution;

   Home and community-based services LInder a 1915 waiver.

2. Non-institutionalized individuals:

   ☒ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

   The agency withholds payment to non-institutionalized individuals for the following services:

   Home health services (section 1905(a)(7));

   Home and community care for functionally disabled and elderly adults (section 1905(a)(22));

   Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

   ☒ The following other long-term care services for which medical assistance is otherwise under the agency plan:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

TRANSFER OF ASSETS

3. Penalty Date--
The beginning date of each penalty period imposed for an uncompensated transfer of assets is:

☒ the first day of the month in which the asset was transferred;

☐ the first day of the month following the month of transfer.

4. Penalty Period - Institutionalized Individuals--
In determining the penalty for an institutionalized individual, the agency uses:

☐ the average monthly cost to a private patient of nursing facility services in the agency;

☒ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized.

5. Penalty Period-Non-institutionalized Individuals--
The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

☐ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

State: Nebraska

TRANSFER OF ASSETS

6. Penalty period for amounts of transfer less than cost of nursing facility care -

   a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency:

      ☒ does not impose a penalty;

      ☐ imposes a penalty for less than a full month, based on the proportion of the agency's private nursing facility rate that was transferred.

   b. Where an individual makes a series of transfers, each less than the private nursing facility rate for a month, the agency:

      ☐ does not impose a penalty;

      ☒ imposes a series of penalties, each for less than a full month.

7. Transfers made so that penalty periods would overlap -
   The agency:

   ☒ totals the value of all assets transferred to produce a single penalty period;

   ☐ calculates the individual penalty periods and imposes them sequentially.

8. Transfers made so that penalty periods would not overlap -
   The agency:

   ☒ assigns each transfer its own penalty period;

   ☐ uses the method outlined below:

State: Nebraska

TRANSFER OF ASSETS

9. Penalty periods - transfer by a spouse that results in a penalty period for the individual -

   a. The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

   b. If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

10. Treatment of income as an asset -
When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

   ☒ The agency will impose partial month penalty periods.

   When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

   ☒ For transfers of individual income payments, the agency will impose partial month penalty periods.

   ☒ For transfers of the right to an income stream, the agency will use the actuarial value of all payments transferred.

   ☐ The agency uses an alternate method to calculate penalty periods, as described below:

State: Nebraska

TRANSFER OF ASSETS

11. Imposition of a penalty would work an undue hardship--
The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determinations:

a. The client will be sent a notice that their Medicaid case is being closed or application rejected due to a gratuitous transfer, the length of the penalty period and notification that they can claim undue hardship.

b. The client must then file for an administrative hearing within 90 days from this notice to follow-up on their claim of undue hardship.

c. The client and/or their representative must present their claim and supporting documentation.

d. A decision/finding is issued within 45 days.

The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:

Factors that would be considered would include but are not limited to: whether the client's health or life would be endangered; whether the application of a penalty would deprive the client or financially dependent family members of food, clothing, or shelter; whether the individual made a reasonable attempt to recover the assets.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

TRANSFER OF ASSETS

1917(c) FOR TRANSFERS OF ASSETS FOR LESS THAN FAIR MARKET VALUE MADE ON OR AFTER FEBRUARY 8, 2006, the agency provides for the denial of certain Medicaid services.

1. Institutionalized individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

   The agency does not provide medical assistance coverage for institutionalized individuals for the following services:

   Nursing facility services;

   Nursing facility level of care provided in a medical institution;

   Home and community-based services under a 1915(c) or (d) waiver.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

TRANSFER OF ASSETS

2. Non-institutionalized individuals:

☐ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a) (7));

Home and community care for functionally disabled elderly adults (section 1905(a) (22);

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a) (24).

☐ The following other long-term care services for which payment for medical assistance is otherwise made under the agency plan:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

TRANSFER OF ASSETS

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is the later of:

- the first day of a month during or after which assets have been transferred for less than fair market value;

  ☐ The State uses the first day of .the month in which the assets were transferred

  ☒ The state uses the first day of the month after the month in which the assets were transferred

  or

- the date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level care services described in paragraphs 1 and 2 that, were it not for the imposition of the penalty period, would be covered by Medicaid;

  AND

  which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

TRANSFER OF ASSETS

4. Penalty Period Institutionalized Individuals--
In determining the penalty for an institutionalized individual, the agency uses:

☐ the average monthly cost to a private patient of nursing facility services in the State at the time of application;

☒ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized at the time of application.

5. Penalty Period - Non-institutionalized Individuals--
The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

☐ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

6. Penalty period for amounts of transfer less than cost of nursing facility care -

☒ Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.

☒ The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility, that begins on the earliest date that would otherwise apply if the transfer had been made in single lump sum.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

TRANSFER OF ASSETS

7. Penalty periods - transfer by a spouse that results in a penalty period for the individual -

   (a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

   (b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

8. Treatment of a transfer of income--

   When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

   When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

   ☒ For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above.

   ☒ For transfers of the right to an income stream, the agency will base the penalty period on the combined actuarial value of all payments transferred.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

TRANSFER OF ASSETS

9. Imposition of a penalty would work an undue hardship--

The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would work an undue hardship. The agency will use the following criteria in making undue hardship determinations:

Application of a transfer of assets penalty would deprive the individual:

(a) Of medical care such that the individual's health or life would be endangered; or

(b) Of food, clothing, shelter, or other necessities of life.

10. Procedures for Undue Hardship waivers

The agency has established a process under which hardship waivers may be requested that provides for:

(a) Notice to a recipient subject to a penalty that an undue hardship exception exists;

(b) A timely process for determining whether an undue hardship waiver will be granted; and

(c) A process, which is described in the notice, under which an adverse determination can be appealed.

These procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the individual's personal representative.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

TRANSFER OF ASSETS

11. Bed Hold Waivers For Hardship Applicants

The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:

☒ Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed 30 days (may not be greater than 30).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

The agency does not apply the trust provisions in any case in which the agency determines that such application would work an undue hardship.

The following criteria will be used to determine whether the agency will not count assets transferred because doing so would work an undue hardship:

Criteria would include but are not limited to: whether application of the provisions would deprive the client of medical care such that his/her health or life would be endangered; whether the application of the transfer provisions would deprive a financially dependent family member of food, clothing, or shelter; whether the client or client's representative has made a reasonable effort to recover the assets.

Under the agency's undue hardship provisions, the agency exempts the funds in an irrevocable burial trust.

The maximum value of the exemption for an irrevocable burial trust is $ 30,000.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

Citation(s)	Condition or Requirement
	COST EFFECTIVENESS METHODOLOGY FOR COBRA CONTINUATION BENEFICIARIES
1902(u) of the Act	Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods: ☐ The methodology as described in SMM section 3598. ☐ Another cost-effective methodology as described below.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The state covers low-income families and children under section 1931 of the Act.

The following groups were included in the AFDC State Plan effective July 16, 1996.

☒ Pregnant women with no other eligible children

☒ AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

☐ In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996, without modification.

☐ In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996, with the following modifications

☐ The agency applies lower income standards which are no lower than the AFDC standards in effect on May 1, 1988, as follows:

NA

☐ The agency applies higher income standards than those in effect as of July 16, 1996, increase by no more than the percentage increases in the CPI-U since July 16, 1996 as follows:

NA

☐ The agency applies higher resource standards than those in effect as of July 16, 1996, increase by no more than the percentage increases in the CPI-U since July 16, 1996 as follows:

NA

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

☒ The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996 as follows:

1. For purposes of the 185% gross income test, all income in excess of 185% of the Standard of Need will be disregarded, effective 10-1-97.

2. When determining resources eligibility an additional $3,000 for a one person ADC unit and $5,000 for two or more shall be disregarded to assist families to become self-sufficient effective 7-1-97.

3. When determining countable resources, the total value of one car used for employment or medical transportation will be disregarded effective 7-1-97.

4. When determining countable resources, the cash value of Life insurance policies will be disregarded effective 7-1-97.

5. When determining available income up to $10 interest income per month, per source, per individual, will be disregarded effective 7-1-97.

6. When determining available income, disregard any grant, scholarship, or work study to a student of any age effective 7-1-97.

7. Lump sums are considered resources in the month of receipt or report and resources thereafter, with the exception of the benefit payments listed below which are disregarded for six months and counted as resources thereafter, unless it is to the client's benefit to treat these payments under the previous methodologies. The benefit payments are: Black Lung; Civil Service Pension; Disability Benefits – Employer/Insurance; Retirement Pension – Employment; Military Retirement; Railroad Retirement; Social Security; Veterans Pension/Compensation; and Workers Compensation.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

8. For Grandparent deeming, subtract 300% of the Federal Poverty Level for the family size before deeming income to the minor parent effective 7-1-97.

9. Earnings of children working are disregarding effective 7-1-97.

10. Effective July 1, 2003, disregard earned income as follows: the first 20% of gross earnings, child care as billed or paid up to earned income, and earned income equal to the following for the corresponding family size:

Family Size	Earned Income Disregarded
1	$179
2	201
3	223
4	245
5	267
6	289
7	311
8	262
9	355
10	377

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The income and/or resource methodologies that the less restrictive methodologies replace are as follows:

NA

☒ The agency terminates medical assistance (except for certain pregnant women and children) for individuals who fail to meet TANF work requirements.

☐ The agency continues to apply the following waivers of provisions of Part A of Title IV in effect as of July 16, 1996, or submitted prior to August 22, 1996 and approved by the Secretary on or before July 1, 1997.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as follows:

☒ All otherwise countable income deposited in an IDA account funded under the Assets for Independence Act is excluded from income.

☒ All interest earned on an IDA account funded under the Assets for Independence Act is excluded from income.

☒ All funds in IDA accounts funded under the Assets for Independence Act are excluded from resources.

☐ All otherwise countable income deposited in an IDA account funded under Section 404 of the Social Security Act is excluded from income

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Family Size	Additional income disregard as a percent of FPL for family of the applicable size
1	133%
2	138%
3	140%
4	142%
5	143%
6	144%
7	145%
8	145%
9	146%
10	146%

Child care shall be disregarded from earnings.

For those families with income above 100% of FPL the State shall charge a premium that equal to 3% of the families gross income. The premium shall be administered in accordance with Section 1925(5) of the Social Security Act as in effect September 2002.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY

STATE: Nebraska

SECTION 1924 PROVISIONS

A. Income and resource eligibility policies used to determine eligibility for institutionalized individuals who have spouses living in the community are consistent with Section 1924 of the Act.

B. In the determination of resource eligibility, the State resource standard is $15,804.

C. The definition of undue hardship for purposes of determining if institutionalized spouses receive Medicaid in spite of having excess countable resources is described below:

Imminent eviction from the institution.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY

State: Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
QUALIFIED DISABLED AND WORKING INDIVIDUALS

The income standard for Qualified Disabled and Working Individuals (QDWI's) is 200 percent of the official federal poverty line as defined by the Executive Office of Management and Budget.

The resource standard for QDWI's is $4,000 for an individual and $6,000 for a married couple.

The same income disregards and resource exclusions that apply to other categorically needy groups apply to QDWI's.

A QDWI must also meet the federal non-financial eligibility requirements for medical assistance, such as the filing of an application for Medicaid, obtaining a Social Security number, citizenship, residency, and assignment of rights.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

An individual considered incompetent to handle his/her own affairs is allowed an additional $10 per month for guardianship/conservator fees and additional amount as approved by the court for annual accounting and bonding fees.

For an individual in an ICF-MR (ICF-ID) who participates in a sheltered workshop, an additional amount up to $65 plus one-half of the remainder of earned income may be retained.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEBRASKA

DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY

1917(f) The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State plan for an individual who does not have a spouse, child under 21 or adult disabled child residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:

☒ $500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

☐ An amount that exceeds $500,000 but does not exceed $750,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

The amount chosen by the State is _____

☐ This higher standard applies statewide.

☐ This higher standard does not apply statewide. It only applies in the following areas of the State:

☐ This higher standard applies to all eligibility groups.

☐ This higher standard only applies to the following eligibility groups:

The State has a process under which this limitation will be waived in cases of undue hardship.

State: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided: ☐ No limitations ☒ With limitations*

2. a. Outpatient hospital services.

Provided: ☐ No limitations ☒ With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State Plan)

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with sec. 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Provided: ☐ No limitations ☒ With limitations*

3. Other laboratory and x-ray services.

Provided: ☐ No limitations ☒ With limitations*

* Description provided on attachment

State: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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

Provided: ☐ No limitations ☒ With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

Provided: ☐ No limitations ☒ With limitations*

c. Family planning services and supplies for individuals of child-bearing age.

Provided: ☐ No limitations ☒ With limitations*

d. 1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

☒ (i) By or under supervision of a physician;

☒ (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; or

☐ (iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.)
*describe if there are any limits on who can provide these counseling services.

2) Face-to-Face Tobacco Cessation counseling Services Benefit Package for Pregnant Women

Provided: ☒ No limitations ☐ With limitations*

*Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period (eight (8) per year) should be explained below.

Please describe any limitations:

State: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: ☐ No limitations ☒ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the act).

Provided: ☐ No limitations ☒ With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by state law.

a. Podiatrists' services.

Provided: ☐ No limitations ☒ With limitations*

* Description provided on attachment

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

c. Chiropractors' services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

d. Other practitioners' services.

☒ Provided: Identified on attached sheet with description of
☐ Not Provided limitations.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

☒ Provided: ☐ No limitations ☒ With limitations*

b. Home health aide services provided by a home health agency.

☒ Provided: ☐ No limitations ☒ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

☒ Provided: ☐ No limitations ☒ With limitations*

* Description provided on attachment.

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

8. Private duty nursing services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

* Description provided on attachment.

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

10. Dental Services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

11. Physical therapy and related services.

a. Physical therapy

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

b. Occupational therapy.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

*Description provided on attachment

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Proscribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

b. Dentures.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

c. Prosthetic devices

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

d. Eyeglasses

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other that those provided elsewhere in the plan.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not Provided

*Description provided on attachment

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

c. Preventive services

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not Provided

d. Rehabilitative services

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

14. Services for individual age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

b. Skilled nursing facility services

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

c. Intermediate care facility services

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

*Description provided on attachment

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

_X_ Provided __ No limitations

_X_ With limitations* __ Not Provided:

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

_X_ Provided __ No limitations

_X_ With limitations* __ Not Provided:

16. Inpatient psychiatric facility services for individuals under 22 years of age.

_X_ Provided _X_ No limitations __ With limitations*

__ Not Provided:

17. Nurse-midwife services

_X_ Provided __ No limitations _X_ With limitations*

__ Not Provided:

18. Hospice care (in accordance with section 1905(o) of the Act).

_X_ Provided __ No limitations _X_ Provided in accordance with section 2302 of the Affordable Care Act

_X_ With limitations* __ Not Provided:

*Description provided on attachment

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACTMENT 3.1-A (in accordance witH section 1905(a)(19) or section 1915(g) of the Act.)

☒ Provided: ☒ With limitations*
☐ Not Provided

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

☐ Provided: ☐ With limitations*
☒ Not Provided

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

☐ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

☐ Additional coverage ++

Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not Provided

23. Certified pediatric or family nurse practitioners' services.

☐ Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law specified by the Secretary.

a. Transportation.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

b. Services of Christian Science nurses.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not Provided

c. Care and services provide in Christian Science sanatoria

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not Provided

d. Nursing facility services for patients under 21 years of age

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

e. Emergency hospital services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

*Description provided on attachment

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. 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.

☒ Provided: ☐ Not provided

26. Personal assistance services are those services provided to a Medicaid client who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, institution for mental disease, or prison, which are authorized on a written service plan according to individual needs identified in a written assessment.

Personal assistance services are A) authorized by a Social Services Worker or designee, B) provided by qualified providers who are not legally responsible relatives, and C) are furnished inside the home, and outside the home with limitations.

☒ Provided:
- ☒ State Approved (Not Physician) Service Plan Allowed
- ☒ Services Outside the Home Also Allowed
- ☒ Limitations Described on Attachment

☐ Not Provided

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

_X_ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

___ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Center

Provided: ☐ No limitations ☒ With limitations ☐ None licensed or approved

Please describe any limitations:
Facilities must:
(a) Be specifically approved by Department of Health and Human Services, Division of Public Health to provide birthing center Services.
(b) Maintain standards of care required by Department of Health and Human Services, Division of Public Health for licensure.

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ☐ No limitations ☒ With limitations (please describe below)
☐ Not Applicable (there are no licensed or State approved Freestanding Birth Centers

Please check all that apply:

☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e. physicians and certified nurse midwives).

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife).*

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

Telehealth Service means any contact between a patient and a health care practitioner relating to health care diagnosis or treatment of such patient through telehealth but does not include a telephone conversation, electronic mail message, or facsimile transmission between a health care practitioner and a patient or a consultation between two health care providers.

Health care practitioners must:

1. act within their scope of practice;
2. be enrolled with NMAP; and
3. be appropriately licensed, certified, or registered by Nebraska HHS Regulation and Licensure for the service for which they bill Medicaid.

All state plan prior authorization requirements must be met to be covered as a telehealth service. Prior authorization requests must state the intent to provide the service as a telehealth service.

Medicaid services covered under the State Plan but specifically excluded from telehealth coverage are:

1. Medical equipment and supplies provided by DME (Durable Medical Equipment) suppliers and pharmacies;
2. Orthotics and prosthetics provided by DME suppliers and pharmacies;
3. Personal Care Aide (PCA) services;
4. Home Health Aide services;
5. Pharmacy services for prescribed drugs;
6. Home and Community Based Waiver services provided by persons that do not meet the standards for practitioner of telehealth services;
7. Mental health, substance abuse, and psychiatric rehabilitation services provided by persons that do not meet the standards for practitioner of telehealth services;
8. Medical transportation services, including ambulance services;
9. Federally Qualified Health Center core services billed as an "encounter" service;
10. Rural Health Clinic core services billed as an "encounter" service;
11. Physician visits to clients in nursing facilities required on the specific periodic schedule for nursing facility certification;
12. Tribal 638 clinic core services billed as an "encounter" service;
13. Services requiring "hands on" professional services such as eye glass fittings and hearing aid fittings;
14. Services provided in public schools by staff who are not licensed, certified, or registered with Nebraska HHS - Regulation and Licensure; and
15. Ambulatory room and board services.

Services provided via telecommunications are not covered if the client has access to a comparable service within 30 miles of his/her place of residence.

This requirement does not apply:

1. In emergency or urgent medical situations;

2. When accessing the appropriate service at a distance less than 30 miles poses a significant hardship on the client due to a medical condition or disability; or

3. To clients residing in nursing facilities who require transportation to the appropriate service via ambulance.

A telehealth service is not covered when the service delivered via telecommunication technology is deemed to be investigational or experimental. Even though a service is covered when provided in-person to a client, the service may be deemed investigational/experimental for Medicaid payment purposes when provided via telecommunications technology.

Transmission costs are not covered when the telehealth service provided by the health care practitioner is not a covered state plan service.

Services that require direct physical contact with a client by a health care practitioner and that cannot be delegated to another health care practitioner at the site where the client is located are not covered.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - INPATIENT HOSPITAL SERVICES

Reimbursement for inpatient hospital care of patients whose primary care needs are psychiatric in nature are limited to a hospital or distinct part of a hospital that -

1. Is maintained for the care and treatment of patients with primary psychiatric disorders;
2. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, or if the hospital is located in another state, the officially designated authority for standard-setting in that state;
3. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, or by any other accrediting organization with comparable standards, that is recognized by the State; or
4. Meets the requirements for participation in Medicare for psychiatric hospitals; and
5. Has in effect a utilization review plan applicable to all Medicaid clients.

Inpatient Subacute Hospital Services for Individuals Age 21 and Above

This service is covered under 42 CFR 440.10 Subpart A. In addition to the acute inpatient hospital services for clients age 21 and above, Medicaid considers reimbursement for subacute inpatient hospital psychiatric services when the primary care needs are psychiatric in nature and services are limited to a hospital or distinct part of a hospital that is –

1. Maintained for the care and treatment of patients with a primary psychiatric disorder;
2. Licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health or if the hospital is located in another state, the officially designated authority for standard-setting in that state;
3. Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA);
4. Meets the requirements for participation in Medicare for psychiatric hospitals;
5. Has in effect a utilization review plan applicable to all Medicaid clients.
6. Has medical records that are sufficient to determine the degree and intensity of the treatment furnished to a client;
7. Meets staffing requirements effective to carry out an active treatment program;
8. Encourages the involvement of family members in assessment treatment planning, treatment delivery and discharge, unless prohibited through legal action or the client or because of federal confidentiality laws;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – INPATIENT HOSPITAL SERVICES

9. Has the flexibility to meet the schedules of families, guardians and caretakers as necessary; and
10. Documents the attempts to involve family in treatment.

Subacute inpatient psychiatric hospital programs must have adequate staff to provide:

1. Comprehensive assessments including a biopsychosocial assessment, psychiatric diagnostic evaluations by an attending psychiatrist, nursing assessments, substance abuse assessments as needed, laboratory radiology or other diagnostic tests as necessary.
2. Physical examination and the ability to meet the basic medical needs of the patient.
3. Individual, group, and family psychotherapy by a licensed practitioner. Medication initiation and management services by a psychiatrist.
4. An organized, supervised milieu, psycho-educational services and other support services appropriate.

Subacute inpatient psychiatric programs must have adequate staff to meet the needs of the patients served. Essential positions available to the program are:

1. A clinical/program director;
2. Nursing services;
3. Psychotherapy services by a licensed practitioner;
4. Licensed addiction and drug abuse services as needed and appropriate by a licensed individual skilled and trained to treat substance abuse issues;
5. Psycheducational services as necessary;
6. Case Management services.

Providers of subacute inpatient hospital services must consider the following conditions to be determine the necessity for treatment.

1. Can the patient benefit from longer term evaluation, stabilization, and treatment services?
2. Is the client moderate to high risk to harm self or others?
3. Does the client have symptoms consistent with a current version of the DSM diagnosis?
4. Does the client have the ability to respond to intensive structured intervention services?
5. Is the client of moderate to high risk to relapse or have symptom reoccurrence?
6. Does the client have a high need of professional structure and intervention services?
7. Can the client be treated with short term intervention services?

All subacute inpatient psychiatric services must be prior authorized by the Department or by the Department's contracted Peer Review Organization or management designee.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS -INPATIENT HOSPITAL SERVICES

NMAP covers medical transplants including donor services that are medically necessary and defined as non-experimental by Medicare. If no Medicare policy exists for a specific type of transplant, the appropriate staff in the Medicaid Division shall determine whether the transplant is medically necessary and non-experimental.

Notwithstanding any Medicare policy on liver or heart transplants, the Nebraska Medical Assistance Program covers liver or heart transplantation when the written opinions of two physicians specializing in transplantation state that -

1. No other therapeutic alternatives exist; and

2. The death of the patient is imminent.

NMAP requires prior authorization of all transplant services before the services are provided.

NMAP covers medically necessary services for the NMAP-eligible donor to an NMAP-eligible client. The services must be directly related to the transplant.

NMAP covers laboratory tests for NMAP-eligible prospective donors. The tests must be directly related to the transplant.

NMAP covers medically necessary services for the NMAP-ineligible donor to an NMAP-eligible client. The services must be directly related to the transplant and must directly benefit the NMAP transplant client. Coverage of treatment of complications is limited to those that are reasonably medically foreseeable.

NMAP covers laboratory tests for NMAP-ineligible prospective donors that directly benefit the NMAP transplant client. The tests must be directly related to the transplant.

NMAP does not cover services provided to an NMAP-ineligible donor that are not medically necessary or that are not directly related to the transplant.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS -INPATIENT HOSPITAL SERVICES

Telehealth:

Inpatient hospital services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS -INPATIENT HOSPITAL SERVICES

ABORTIONS:

Payment for abortions under the Nebraska Medical Assistance Program is limited to those abortions for which FFP is currently available.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS – OUTPATIENT HOSPITAL

All psychiatric testing and evaluations must be performed by a licensed psychologist or under the supervision of a licensed psychologist.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS – OUTPATIENT HOSPITAL

Drugs, medical supplies and services not utilized in the emergency or outpatient facility are not a covered outpatient or emergency service.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS – OUTPATIENT HOSPITAL SERVICES

Abortions are covered when a physician certifies that the pregnancy was a result of rape or incest, or the woman suffers from a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS – OUTPATIENT HOSPITAL

Telehealth:
Outpatient hospital services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS – OUTPATIENT HOSPITAL

PSYCHIATRIC PARTIAL HOSPITALIZATION SERVICES

Psychiatric Partial Hospitalization services are diagnostic, therapeutic, treatment and rehabilitation services provided in a outpatient hospital setting under the direction of a licensed physician, preferably a psychiatrist, enrolled with Nebraska Medicaid.

Services are provided in a facility licensed as a hospital by Health and Human Services, Division of Public Health or if the service is provided in another state, the state agency assigned this responsibility. The facility must have achieved and maintained national accreditation by the Joint Commission on Accreditation of healthcare Organizations or by the American Osteopathic Association. The provider must be enrolled as a hospital with Nebraska Medicaid. Services are provided at a level of intensity that meets the client's mental health/substance abuse treatment needs but less than a 24-hour period. Services are available a minimum of three hours per day and may be provided a full day of 6 or more treatment hours. Services must be available a minimum of 5 days per week but may be available 7 days per week.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS – RURAL HEALTH CLINIC SERVICES

Rural Health Clinic Services

The rural health clinic must be certified by HCFA for participation in the Medicare program. Covered services are limited to those defined in 42 CFR 440.20(b).

Telehealth:

Rural health clinic services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Core services billed as "encounter" services are excluded from coverage when provided via telehealth.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS – FEDERALLY-QUALIFIED HEALTH CENTERS

To be considered a federally-qualified health center (FQHC) for the Nebraska Medical Assistance Program, as allowed by section 6404 of P.L. 101-239, a health center must furnish proof that the United States Public Health Service has determined that it is qualified under Sections 329, 330, or 340 of the Public Health Service Act, or that it qualifies by meeting other requirements established by the Secretary of Health and Human Services.

Telehealth:

FQHC services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Core services billed as "encounter" services are excluded from coverage when provided via telehealth.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – OTHER LABORATORY AND X-RAY SERVICES

PRIOR AUTHORIZATION: NMAP requires prior authorization for certain radiology services. Prior authorization must be obtained before the service is provided. All non-emergency outpatient computerized tomography (CT) scans, magnetic resonance angiogram (MRA) scans, magnetic resonance imaging (MRI) scans, magnetic resonance spectroscopy (MRS) scans, nuclear medicine cardiology scans, positron emission tomography (PET) scans, and single photon emission computed tomography (SPECT) scans will require prior authorization. These prior authorization requirements apply for all Medicaid clients enrolled in fee-for-service programs and must be completed prior to the scan being performed. These requirements do not apply to these scans when performed during an inpatient hospitalization or for treatment of an emergency medical condition through the hospital's emergency room.

Telehealth:

Other laboratory and x-ray services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS -ASSESSMENTS OF DEVELOPMENTALLY DISABLED PERSONS IN SNF

Individuals having a developmental disability who currently reside in a non-MR facility shall, when identified as appropriate by the Medical Review Team, have an initial and subsequent annual independent assessment for functional living skills. Assessment of functional living skills shall be given to only clients identified by the Medical Review Team as appropriate for assessment based on the developmental disability criteria in order to:

1. Identify the most appropriate services to meet the identifying needs based on the principle of normalization, the least restrictive alternatives, and the client's needs.

2. The evaluation shall include actual observation/interview with the client and identify the sources of information including the staff persons who have supplied assessor with information relative to the assessment.

3. The assessment shall be an assessment of independent functioning of the individual. The assessment shall include recommendations for further evaluation and/or consultation in specific areas. Recommendations shall be incorporated into the individual's overall plan of care by the facility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS - EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

This section applies to EPSDT services provided on or after April 1, 1990.

HEALTH SCREENING SERVICES are provided at intervals stated in the American Academy of Pediatrics Periodicity schedule and at other intervals indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions. This periodicity schedule was selected based on meetings and/or written correspondence with the Nebraska Chapter of the American Academy of Pediatrics, the Nebraska Chapter of the Academy of Family Physicians, and the Chairman of the University of Nebraska Medical Center's Department of Pediatrics.

Health screening services include, at a minimum,-

1. A comprehensive health and developmental history (including assessment of both physical and mental health development);

2. A comprehensive unclothed physical exam;

3. Appropriate immunizations according to age and health history;

4. Appropriate laboratory tests (including lead blood level assessment appropriate for age and risk factors); and

5. Health education (including anticipatory guidance).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS - EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

VISION SERVICES are provided at the following intervals, and at other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition:

Birth to 3 years	Screening through history taking and observation at intervals that follow the Health Screening periodicity schedule
Age 3 to 21 years	Screening by standard testing method yearly through age six and thereafter to follow the Health Screening periodicity schedule

This periodicity schedule was selected based on input from meetings and/or written correspondence with the Nebraska Chapter of the American Academy of Pediatrics, the Nebraska Chapter of the American Academy of Family Physicians, the American Optometrist Association (AOA), and the HHS visual care consultant.

Vision services include, at a minimum, diagnosis and treatment for defects in vision, including eyeglasses.

DENTAL SERVICES are provided at the following intervals, and at other intervals, indicated as medically necessary to determine the existence of a suspected illness or condition:

Birth to 21 years	At six month intervals, dental screening is to be obtained from a dentist as recommended by AAP's "Recommendations For Preventive Pediatric Health Care." Visual inspection of the mouth for very young children is Recommended as part of each Health Screening examination.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS - EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

This periodicity schedule was established based on input from written correspondence with the Nebraska Dental Association. The schedule for EPSDT dental exams is based on the NDA's recommendations.

Dental services include, at a minimum, relief of pain and infections, restoration of teeth, and maintenance of dental health.

HEARING SERVICES are provided at the following intervals, and at other intervals indicated as medically necessary, to determine the existence of a suspected illness or condition:

Birth to 3 years	Screening through history taking and observation at intervals that follow Health Screening periodicity schedule
Age 3 to 21 years	Screening by standard testing method yearly through age six and thereafter to follow the Health Screening periodicity schedule

This periodicity schedule was established based on input from meetings and written correspondence with the Nebraska Chapter of the American Academy of Pediatrics, the Nebraska Chapter of the Academy of Family Physicians, the DSS audiological consultant as well as a position paper by the American Speech and Hearing Association.

Hearing services include, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS - EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

SERVICES DESCRIBED IN SECTION 1905(a) of the Social Security Act that are not covered under Nebraska State Plan for Medical Assistance are covered for treatment when the condition is disclosed in an EPSDT exam, health screen, dental screen, vision screen, or hearing screen. These services are considered EPSDT follow-up services and are covered under the following conditions:

1. The service is required to treat the condition (i.e., to correct or ameliorate defects and physical or mental illnesses or conditions) identified during a HEALTH CHECK (EPSDT) screening examination;

2 The provider of services is a Medicaid-enrolled provider and is authorized to provide the service within the scope of practice under applicable federal and state law;

3. The service is consistent with applicable federal and state laws that govern the provision of health care;

4. The service must be medically necessary, safe and effective, and not considered experimental/investigational;

5. Services not covered under the plan must be prior authorized by the Medicaid Division, Department of Health and Human Services Finance and Support. The screening practitioner shall submit the request which must include -

   a. A copy of the screening exam from or the name of the screening practitioner and the date of the screening exam which identified the condition; and

   b. A plan of care which includes -

      (1) History of the condition;
      (2) Physical findings and other signs and symptoms, including appropriate laboratory data;
      (3) Recommended service/procedure, including (if known) the potential provider of service;
      (4) Estimated cost, if available; and
      (5) Expected outcomes.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS - EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

The Medical Director or designee shall make a decision on each request in an expeditious manner. Appropriate health care professionals may be consulted during the decision-making process. If the initial request is denied, additional information may be sent for reconsideration.

EPSDT follow-up services include -

- Dental sealants: Application is covered if applied to permanent teeth within three years of eruption. Sealant application is covered only for permanent teeth numbered 2, 3, 4, 5, 12, 13, 14, 15, 18, 19, 20, 21, 28, 29, 30, and 31.

- Orthodontic treatment for individuals age 20 and younger: NMAP requires prior authorization of all orthodontic treatment except diagnostic evaluation procedures. Total payment of prior-authorized orthodontic treatment is made upon approval of the treatment plan and submittal of an ADA dental claim form.

- Well child cluster visits: The cluster visit is a well-child visit in a group setting with parent-child pairs of the same age, offering the opportunity for the provision of extended physician parent/child time with a focus on psychosocial aspects as well as physical aspects of well-child care. The cluster visit must include a complete EPSDT exam.

- Nutritional counseling: Nutritional counseling is provided by the screening physician, screening physician auxiliary staff, physician-contracted staff, outpatient hospital-based registered dietitian for nutritional disorders or licensed medical nutritional therapist. The diagnostic finding from the EPSDT exam must indicate that a nutritional problem or condition of such severity exists that nutritional counseling beyond that normally expected as part of the standard medical management is warranted.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS - EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

- Risk reduction services: These services include the basic six to seven week series of prepared childbirth sessions, early pregnancy sessions, refresher childbirth sessions, caesarean birth sessions, breast-feeding session, and infant care sessions when provided by licensed practitioners approved by Health and Human Services Finance and Support, Medicaid Division. The services are covered for EPSDT participants when comparable services are not available in the community at no cost. Risk reduction services also include a pediatric prenatal visit between the expectant parent(s) and the prospective primary care provider of the infant's health care.

- Weight management clinics as allowed in 471 NAC 33-006.

NMAP does not limit providers of EPSDT services to those who are qualified to provide all components of the EPSDT screen. A provider who is qualified under the plan to furnish one or more (but not all) of the services and items is considered qualified to provide the items and services as part of early and periodic screening, diagnosis and treatment services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES COVERED UNDER EPSDT:

Medicaid covers certain mental health and substance abuse (MH/SA) services as part of the HEALTHCHECK (EPSDT) benefit.

Licensed Mental Health Practitioner (LMHP) - 42 CFR 440.60 - Other Licensed Practitioners

The following mental health and substance abuse practitioners who are licensed in the State of Nebraska to diagnose and treat mental illness or substance abuse acting within the scope of all applicable state laws and their professional license may be enrolled as an individual provider of mental health/substance abuse services. The following individuals are licensed to practice: Licensed Alcohol and Drug Counselor who is an individual licensed by the Nebraska Health and Human Services.

Prior authorization is required for some services while other services have an initial authorization for level of benefit and must receive authorization prior to service delivery for medically necessary outpatient psychotherapy or substance abuse treatment services which exceed any established service limit. All services provided while a person is a resident of an IMD are considered content of the institutional service and not otherwise reimbursable by Medicaid.

Medicaid and/or its designee does not permit separate billing of mileage and conference fees for home-based family therapy providers of outpatient psychiatric services. Those costs are assumed to be covered in the rates. For the purposes of this section, Medicaid agency designee will be a contractor designated by the agency to conduct prior authorization and utilization review.

Telehealth:
Services provided by licensed mental health and substance abuse practitioners via telehealth technologies are covered subject to the limitations as set forth in state regulations.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES COVERED UNDER EPSDT:

Rehabilitation Services - 42 CFR 440.130(d)

The following explanation and limitations apply to the mental health and substance abuse rehabilitation services provided by unlicensed direct care staff listed below:

- Day Treatment/Intensive Outpatient Service
- Community Treatment Aide
- Professional Resource Family Care
- Therapeutic Group Home

These rehabilitation services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid EPSDT eligibles with significant functional impairments resulting from an identified mental health or substance abuse diagnosis. The recommendation of medical necessity for these rehabilitative services shall be determined by a licensed psychologist, licensed independent mental health practitioner (LIMHP) or physician who is acting within the scope of his/her professional license and applicable state law, to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level according to an individualized treatment plan, which addresses the child's assessed needs.

The activities included in the rehabilitation service shall be intended to achieve the identified Medicaid eligible client's treatment plan goals or objectives. Components that are not provided to or directed exclusively toward the treatment of the Medicaid eligible individual are not eligible for Medicaid reimbursement. All services are directed exclusively towards the treatment of the Medicaid eligible.

Medicaid and/or its designee shall prior authorize the number of hours of treatment per client need and periodically review the medical need for continued treatment services. For the purposes of this section, Medicaid agency designee will be a contractor designated by the agency to conduct prior authorization and utilization review. This prior authorization includes Evidence-Based Practices (EBPs), which require fidelity reviews on an on-going basis as determined necessary by Medicaid and/or its designee. Only one rehabilitation service may be prior authorized or provided to a single child on any given day (e.g., a child cannot receive both CTA and Intensive Outpatient on the same day).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

Services shall be medically necessary and shall be recommended by a psychologist, LIMHP or physician according to an individualized treatment plan, which addresses the eligible individual's assessed needs. A Pretreatment Assessment (PTA) is a comprehensive assessment that identifies the clinical need for treatment and the most effective treatment intervention/level of care to meet the medical necessity needs of the client. The PTA is completed prior to service provision and the PTA documentation accompanies the referral information to the rehabilitation program provider. The recommendations of the licensed supervising practitioner following the Initial Diagnostic Interview serves as the treatment plan until the comprehensive treatment plan is developed.

The treatment plan shall specify the frequency, amount and duration of services. The treatment plan shall be signed by the psychologist, licensed mental health practitioner or physician responsible for developing the plan. The plan will specify a timeline for reevaluation of the plan that is at least an annual redetermination. A new treatment plan with a different rehabilitation strategy shall be developed if there is no measureable reduction of disability or restoration of functional level.

Agencies and practitioners shall maintain case records that include a copy of the treatment plan, the name of the individual, dates of services provided, nature, content and units of rehabilitation services provided, and progress made toward functional improvement and goals in the treatment plan.

Rehabilitation services shall meet the following requirements:

- If provided at a work site, the rehabilitation service shall not be job tasks oriented.
- Any services or components of services which the basic nature is to supplant housekeeping, homemaking, or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, child care, and laundry services) are not covered.
- Services shall not be provided in an Institution for Mental Disease (IMD).
- Room and board is excluded from any services or rates provided in a residential setting.
- Transportation of children is not included in rehabilitation services or rates.
- Education services are not included in or eligible for payment by the Medicaid Program, and do not apply toward the hours of minimum treatment activities for any service in this section. Practitioners shall be familiar with each youth's IEP and coordinate with the youth and the youth's school to achieve the IEP. Education services may not be the primary reason for rehabilitation admission or treatment. Academic education services, when required by law, shall be available.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

Rehabilitation services shall be offered to all EPSDT eligibles who need them regardless of their living arrangements, including foster care status. EPSDT eligibles covered by Medicaid, including their parents and guardians, shall be able to choose any willing and qualified provider of services (e.g., not limited to foster care parents). Medically necessary rehabilitation services for an EPSDT eligible shall be provided by qualified Medicaid providers distinct from placement and excluding room and board. For all EPSDT services, the practitioner shall include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination shall be documented in the youth's medical record. Rehabilitation services may not include reimbursement for other services to which an eligible individual has been referred, including foster care programs and services such as, but not limited to, the following:

(1) Research gathering and completion of documentation required by the foster care program
(2) Assessing adoption placements
(3) Recruiting or interviewing potential foster care parents
(4) Serving legal papers
(5) Home investigations
(6) Providing transportation
(7) Administering foster care subsidies
(8) Making placement arrangements

Definitions:
The mental health and substance abuse rehabilitation services provided by unlicensed direct care staff are defined as follows:

1. Treatment in Day Treatment and Intensive Outpatient Service (IOP) by Unlicensed Direct Care Staff

Day Treatment and Intensive Outpatient services are part of a continuum of care to prevent inpatient services and/or to facilitate the movement of the client from an-inpatient setting (in a hospital or PRTF) service to a status in which the client is capable of functioning within the community with less frequent contact with the mental health or substance abuse provider. These services shall lead to an attainment of specific goals through a group of individualized treatment interventions and services.

Individualized treatment shall provide the basis for transitioning an EPSDT eligible to a less intense level of care if additional services are clinically necessary. Individualized treatment is based upon an active treatment plan reviewed every 30 days after it is finalized and a specific plan for discharge from Day Treatment when the treatment goals have been met.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

Treatment services may be appropriately used to transition a client from higher levels of care and may be provided for clients at risk of needing more intensive care than traditional weekly outpatient treatment services. Medicaid covers only treatment by unlicensed direct care staff. For these specific rehabilitation services, the comprehensive specialized psychiatric program, Medicaid covers only treatment by unlicensed direct care staff. Unlicensed direct care staff perform the following functions:

A. Provide psychoeducational activities and interventions to support the EPSDT eligible in developing social, therapeutic, and other independent living skills as appropriate. Psychoeducational therapy services may include:

(1) Crisis Intervention Plan and Aftercare Planning - This service is provided in a group or individual session and assists the client in understanding crisis planning and supports the client in developing their individualized plan for crisis intervention.
(2) Social Skills Building - This service is a behavioral health intervention used to support the psychotherapy provided by a licensed person that assist the client in learning better relationship skills with other individuals around him/her. The service is provided by a skilled and trained, unlicensed individual under the supervision of a licensed practitioner.
(3) Life Survival Skills - These are interactions either in the group setting or the individual session which develop better interaction skills in the community. These services are led and provided by a skilled and trained unlicensed direct care staff person under the supervision of a licensed practitioner.
(4) Substance Abuse Prevention Intervention - This service provides substance abuse education and is provided by a skilled and trained unlicensed direct care staff person under the supervision of a licensed practitioner.
(5) Self-care services - These are interventions to assist the client in coping and managing in their environment. These services are led and provided by a skilled and trained unlicensed direct care staff under the supervision of a licensed practitioner.
(6) Medication education and medication compliance groups - These are treatment interventions either in a group setting or an individual session that assists the client in understanding the purpose of medication, assists in identifying side effects, and assists in helping the client maintain compliance. Services are provided by a registered nurse.
(7) Health care issues group (may include nutrition, hygiene, personal wellness) - This is a psychoeducational group service, generally provided by a licensed nurse, that provides assistance to the client in learning how to better manage their health issues.

These activities (1 through 7) are rehabilitative skill building provided by a skilled and trained unlicensed direct care staff or by a licensed nurse, when indicated, who has proven competency in delivering these psychosocial activities.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

B. Implement the treatment plan and discharge plan for each EPSDT eligible
C. Provide continual care to the EPSDT eligibles in the program
D. Report all crisis or emergency situations to the program/clinical director or to the program's designee in the absence of the program/clinical director
E. Understand the program's philosophy regarding behavior management and apply its philosophy in daily interactions with the clients in care

Provider Qualifications:
Agencies shall be certified by Medicaid and/or its designee. Agencies shall be licensed by the State of Nebraska for substance abuse service delivery if substance abuse treatment is delivered. Each agency will employ program/clinical directors to supervise unlicensed direct care staff consistent with State licensure, accreditation, and regulations including co-occurring conditions. The program shall identify an on-call system of licensed practitioners available for crisis management when the client is not in the program's scheduled hours and/or the program is not in session. Programs shall identify a coverage Supervising Practitioner to serve the program in the unforeseen absence of the designated Supervising Practitioner due to illness or vacations.

Practitioners providing substance abuse or mental health services must meet the training requirements outlined by Medicaid and/or its designee, in addition to any required scope of practice license required for the facility or agency to practice in the State of Nebraska. The unlicensed direct care staff shall have a bachelor's degree or higher in psychology, sociology, or related human service field, but two years of course work in the human services field and two years experience/training with demonstrated skills and competencies in treatment of youth with mental illness is acceptable. These requirements for unlicensed direct care staff become effective for staff hired on or after the effective date of this policy. Unlicensed direct care staff:

(1) Shall complete the initial program training and successfully complete the agency's competency check. In addition, each staff shall have demonstrated skill and competency in the treatment of clients with mental health and substance abuse disorders prior to delivery of services.
(2) Shall pass child abuse check, Adult abuse registry and motor vehicle screens
(3) Shall complete specific training for behavioral management and update the training as required by the program
(4) Shall understand de-escalation techniques and demonstrate the ability to implement those techniques effectively

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

Unit of Service: 15-minute unit for unlicensed direct care staff. A unit of service is defined according to the HCPCS approved code set.

Limitations:
Agency providers cannot receive Medicaid reimbursement for treatment services provided to clients who live in any institution and are transported to the program. When a Medicaid beneficiary is receiving Therapeutic Group Home, Professional Resource Family Care, hospital or PRTF services, the client may not participate in day treatment or Intensive Outpatient Services.

The service definition does not include activities or reimbursement for the following clients:

(1) Living in institutions
(2) With social or educational needs met through a less structured program
(3) Wtih primary diagnosis and functional impairment acutely psychiatric in nature and an unstable condition which will not benefit from the program
(4) With disruptive and/or harmful behavior to other program participants or staff members
(5) With behaviors due to a primary developmental disorder needing applied behavioral analysis (ABA)
(6) Where referral information supports that the client cannot benefit from services

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

The overall program may generally only bill for 6 hours a day for day treatment and 3 hours per day for intensive outpatient services. The number of hours per day shall be determined by the specific clinical needs of the client and by the level of acuity of the client. Medicaid and/or its designee may prior authorize treatment in excess of these guidelines if medically necessary.

Licensed practitioners will provide services and bill separately from unlicensed practitioners for the time spent in direct therapy per direct therapy coding under the Other Licensed Practitioner Section of the State Plan (e.g., unbundled). Licensed and unlicensed practitioners may not bill for the same time. Clinica supervision costs for unlicensed practitioners are build into the unlicensed direct care practitioner service and reimbursement.

Day Treatment Direct Care Staff time may only be provided in an office-based facility with a well organized supportive therapeutic environment for EPSDT eligibles in order that EPSDT eligibles can apply the goals of their individualized, active treatment plan and achieve progress in accomplishing those goals. Clients whose symptoms includes uncontrolled disruptive behavior shall have de-escalation and anger management identified in the initial treatment plan and measures shall be taken to aggressively enforce and manage those behaviors at the earliest time possible. Day Treatment workers shall be aware of safety issues unique to each EPSDT eligible and provide safety intervention within the milieu. Procedures such as seclusion and restraint to manage the treatment milieu are not permitted in Day Treatment programs. Treatment Plans shall be developed within 10 days of admission to the Day Treatment program.

Intensive Outpatient Direct Care Staff time may only be provided in an office-based facility providing group-based, non-residential, intensive outpatient mental health/substance abuse treatment services in conjunction with psychotherapy services and substance abuse counseling services provided by licensed practitioners. Treatment Plans shall be developed within 14 days of admission to the IOP program.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

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2. Community Treatment Aide (CTA)

Community Treatment Aide (CTA) services are supportive, and psycho-educational interventions provided primarily in the client's natural environment. Natural environment primarily is the client's home but may also include a foster home, school, or other appropriate community locations conducive for the delivery of CTA services per the service. CTA services shall be expected to improve the client's level of functioning within their environment to enhance the client and caregiver's ability to manage the client's primary mental health and substance abuse related symptoms. The service is delivered by a highly skilled, educated and trained non-licensed (paraprofessional) staff person under the direction and supervision of a licensed practitioner who simultaneously provides family and individual therapy on a regular basis to the client and the client's caregiver/family. Community Treatment Aide (CTA) services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. Services may be provided in the community or in the individual's place of residence as outlined in the Plan of Care.

The intent of CTA is to restore the fullest possible integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention. CTA is a face-to-face intervention with the individual present. Services may be provided individually and in a family setting. A majority of CTA contacts shall occur in community locations where the person lives, works, attends school, and/or socializes. A CTA provider performs the following functions:

(A) Provides training and rehabilitation of basic personal care and activities of daily living through training the EPSDT eligibles and the usual caregiver (such as the biological family, foster family) etc. This function provides basic education and encouragement to clients with mental health issues to develop personal grooming habits which assists in better personal relationships and assists the client to provide better daily organization.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

(B) Promotes improvement in the EPSDT eligible's social skills and relationship skills through training and education of the EPSDT eligibles and the usual caregiver -This rehabilitative service assists the client in learning acceptable social behavior to improve relationships with family members, peer groups and community.

(C) Teaches and instructs the caregiver in crisis and de-escalation techniques - This is a rehabilitative function provided individually or in a group setting that assists the client in managing emotions, particularly understanding anger and healthy releases and outlets for emotions.

(D) Teaches and models appropriate behavioral treatment interventions and techniques for the EPSDT eligible and the caregiver - This rehabilitative function assists the caregiver and client in understanding appropriate interactions through the use of role playing techniques and modeling appropriate behaviors.

(E) Teaches and models appropriate coping skills to manage dysfunctional behavior for the caregiver - This rehabilitative function assists the client in understanding methods of healthy coping of stress to reduce and eliminate dysfunctional behavior.

(F) Provides information about medication compliance and relapse prevention and reports to her/his supervising licensed mental health practitioner - This rehabilitative function assists the client/caregiver with resolving any medication compliance issues by CTA reporting any medication problems to his/her immediate supervisor to assist in bringing these issues to the physician.

(G) Teaches and models proper and effective parenting practice - This rehabilitative function assists the immediate caregiver and client in learning more effective parenting techniques in relation to managing mental health and substance abuse symptoms.

These activities (A through G) are rehabilitative skill building provided by a skilled and trained unlicensed staff person who has proven competency in delivering these activities.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

Provider Qualifications:
Agencies shall be certified by Medicaid and/or its designee. Each agency will employ licensed program/clinical directors to supervise unlicensed direct care staff consistent with State licensure. Practitioners providing substance abuse or mental health services must meet the training requirements outlined by Medicaid and/or its designee, in addition to any required scope of practice license required for the facility or agency to practice in the State of Nebraska. CTA staff shall have a bachelor's degree in psychology, social work, child development or related field and equivalent of one year of full-time work experience or graduate studies in direct child/adolescent services or mental health and/or substance abuse services or high school degree and two years post high school education in the human services field and have two years full time work experience in direct child/adolescent services or mental health and/or substance abuse services. The CTA staff shall be employed/contracted within the same agency as the therapist/licensed practitioner providing psychotherapy services to the client and the client's family. The CTA staff shall be certified in the State of Nebraska to provide the service, which includes criminal, abuse/neglect registry and professional background checks, and completion of a state approved standardized basic training program.

The CTA staff person of the CTA agency shall receive regularly scheduled clinical supervision from a licensed Program/Clinical Director meeting the qualifications of a licensed mental health practitioner, registered nurse (RN), APRN, LIMHP, or a psychologist with experience regarding this specialized mental health service. A licensed practitioner which may include a licensed psychiatrist, psychologist, LIMHP, LMHP and APRN (large agency CTA programs may also include provisionally licensed psychologists and provisionally licensed mental health practitioners as therapists) shall be available at all times for supervision of the CTA staff, guiding the active treatment plan implementation in the home/living environment, co-signing all CTA progress notes and continuous and ongoing assessment of the active treatment plan to assure that the clinical needs of the EPSDT eligible/parent/caregiver are met. This includes transitioning the client to other treatment and care settings as necessary.

Unit of Service: 15 minute unit for unlicensed direct care staff. A unit of service is defined according to the HCPCS approved code set.

Limitations:
Limit of 750 hours of CTA per calendar year that can be exceeded when medically necessary through prior authorization.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

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3. Professional Resource Family Care

Professional Resource Family Care is intended to provide short-term and intensive supportive resources for the EPSDT eligible and his/her family. The intent of this service is to provide a crisis stabilization option for the family in order to avoid psychiatric inpatient and institutional treatment of the EPSDT eligible by responding to potential crisis situations through the utilization of a co-parenting approach provided in a surrogate family setting. The goal will be to support the EPSDT eligible and family in ways that will address current acute and/or chronic mental health needs and coordinate a successful return to the family setting at the earliest possible time. During the time the professional resource family is supporting the EPSDT eligible, there is regular contact with the family to prepare for the EPSDT eligible's return and his/her ongoing needs as part of the family. It is expected that the EPSDT eligible, family and professional resource family are integral members of the EPSDT eligible's individual treatment team. A professional resource family performs the following functions:

(A) Promotes improvement in the EPSDT's social skills and family and peer relationship skills through training and education of the EPSDT eligible and the biological parents/primary caregiver
(B) Teaches and instructs the caregiver in crisis and de-escalation techniques
(C) Teaches and models appropriate behavioral treatment interventions and techniques for the EPSDT eligible and the biological parents/primary caregiver
(D) Teaches and models appropriate coping skills to manage dysfunctional behavior for the biological parents/primary caregiver
(E) Teaches and models proper and effective parenting practice to biological parents/primary caregiver
(F) Provides information about medication compliance and relapse prevention and reports to her/his supervising licensed mental health practitioner
(G) Provides training and rehabilitation of basic personal care and activities of daily living through training the EPSDT eligible and the usual biological parents/primary caregiver
(H) Assists the EPSDT eligible to develop positive peer relationships
(I) Works with the biological parents/primary caregiver to explore community resources in the EPSDT eligible's natural setting

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

Provider Qualifications:
Agencies shall be licensed by the State of Nebraska as a Child Placing Agency and accredited by a national accrediting body. Each agency will employ licensed program/clinical directors to supervise unlicensed direct care staff consistent with State licensure. PRFC service staff shall receive ongoing and regular clinical supervision through a Child Placing Agency by a person meeting the qualifications of a psychiatrist or psychologist with experience regarding this specialized mental health service, and such supervision shall be available at all times to provide back up, support, and/or consultation.

Practitioners providing substance abuse or mental health services must meet the training requirements outlined by Medicaid and/or its designee, in addition to any required scope of practice license required for the facility or agency to practice in the State of Nebraska. The agency will also employ Professional Resource Families Care staff with the following qualifications:

(1) Have a high school diploma or equivalent for all staff and a bachelor's degree in a human service field for specialists
(2) Be 21 years of age and have a minimum of 2 years experience working with children, 2 years education in the human service field or a combination of work experience and education with one year of education substituting for one year of experience
(3) Complete training according to a curriculum approved by State prior to providing the service
(4) Pass child abuse check, Adult abuse registry and motor vehicle screens
(5) Each surrogate family setting shall have a Foster Family license by the State. Each PRFC practitioner shall be supported by a Child Placing Agency with appropriate clinical supervision, training and staffing.
(6) Understand de-escalation techniques and demonstrate the ability to implement those techniques effectively

Unit of Service: Day unit for unlicensed direct care staff. A unit of service is defined according to the HCPCS approved code set.

Limitations: PRFC services require prior authorization. The duration of services is prior authorized. Additional days can be authorized with prior approval from Medicaid and/or its designee. Each unlicensed direct care staff may only care for one EPSDT eligible in treatment unless an exception is granted by Medicaid and/or its designee.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

PRFC services may not be provided simultaneously with ThGH care and do not duplicate any other Medicaid State Plan Service or service otherwise available to recipient at no cost as charity care. Treatment Plans shall be developed within 7 days of admission to the PRFC program and reviewed every 14 days thereafter.

Direct care by licensed staff is billed separately from the PRFC services per diem treatment rate for unlicensed practitioners (e.g., unbundled) which does not include room and board.

4. Therapeutic Group Home

Therapeutic Group Homes (ThGHs) provide a community-based residential service in a home-like setting of no greater than eight beds under the supervision and program oversight of a psychiatrist or psychologist. The treatment should be targeted to support the development of adaptive and functional behaviors that will enable the EPSDT eligible to remain successfully in his/her community, and to regularly attend and participate in work, school or training. ThGHs deliver an array of clinical and related services within the ThGH including psychiatric supports, integration with community resources and skill-building taught within the context of the home-like setting. ThGH treatment shall target reducing the severity of the behavioral health issue that was identified as the reason for admission. Most often, targeted behaviors will relate directly to the EPSDT eligible's ability to function successfully in a home setting and school environment (e.g., compliance with reasonable behavioral expectations; safe behavior and appropriate responses to social cues and conflicts).

Treatment shall:

(A) Focus on reducing the behavior and symptoms of the psychiatric disorder that necessitated the removal of the EPSDT eligible from his/her usual living situation
(B) Decrease problem behavior and increase developmentally-appropriate, normative and pro-social behavior in EPSDT eligibles who are in need of out-of-home placement
(C) Transition EPSDT eligible from therapeutic group home to home or community based living with outpatient treatment (e.g., individual and family therapy) if necessary.

ThGH services are utilized when less intensive levels of treatment shall have been determined to be unsafe, unsuccessful or unavailable. The EPSDT eligible shall require active treatment on an individualized active treatment plan that would not be able to be provided at a less restrictive level of care is being provided on a 24-hour basis with licensed program/clinical directors supervising the behavioral health staff. The treatment plan shall be developed within 7 days of admission and reviewed every 14 days thereafter.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

The setting shall be ideally situated to allow ongoing participation of the EPSDT eligible's family. The EPSDT eligible shall attend a school in the community (e.g., a school integrated with children not from the institution and not on the institution's campus). In this setting, the EPSDT eligible remains involved in community-based activities and may attend a community educational, vocational program or other treatment setting.

ThGHs provide twenty-four hours/day, seven days/week structured and supportive living environment. Care coordination is provided to plan and arrange access to a range of educational and therapeutic services. Psychotropic medications should be used with specific target symptoms identification, with medical monitoring and 24-hour medical availability, when appropriate and relevant. Physicians and Advanced Practice Registered Nurses administer and monitor the psychotropic medications. Screening and assessment is required upon admission and every 14 days thereafter to track progress and revise the treatment plan to address any lack of progress and to monitor for current medical problems and concomitant substance use issues.

The individualized, strengths-based services and supports:

(1) Are identified in partnership with the EPSDT eligible and the family and support system, to the extent possible, and if developmentally appropriate
(2) Are based on both clinical and functional assessments
(3) Are clinically monitored and coordinated, with 24-hour availability
(4) Are implemented with oversight from a licensed mental health professional
(5) Assist with the development of skills for daily living and support success in community settings, including home and school

The ThGH is required to coordinate with the EPSDT eligible's community resources, with the goal of transitioning the EPSDT eligible out of the program as soon as possible and appropriate. Discharge planning begins upon admission with concrete plans for the EPSDT eligible to transition back into the community beginning within the first week of admission with clear action steps and target dates outlined in the treatment plan. The treatment plan shall include behaviorally-measurable discharge goals.

For treatment planning, the program shall use a standardized assessment and treatment planning tool such as the Child and Adolescent Needs and Strengths. The assessment protocol shall differentiate across life domains, as well as risk and protective factors, sufficiently so that a treatment plan can be tailored to the areas related to the presenting problems of each EPSDT eligible and their family in order to ensure targeted treatment. The tool should also allow tracking of progress over time. The specific tools and approaches used by each program shall be specified in the program description and are subject to approval by the State. In addition, the program shall ensure that requirements for pretreatment assessment are met prior to treatment commencing.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

For service delivery, the program shall incorporate at least two research-based approaches including either Evidence-Based Practices (EBPs) or ASAM pertinent to the sub-populations of ThGH clients to be served by the specific program. The specific research-based models to be used should be incorporated into the program description and submitted to the State for approval. All research-based programming in ThGH settings must be approved by the State.

Annually, facilities shall submit documentation demonstrating compliance with fidelity monitoring for at least two research-based approaches (e.g., EBP and/or ASAM). The State shall approve the auditing body providing the fidelity monitoring. ThGH facilities may specialize and provide care for sexually deviant behaviors, substance abuse, or dually diagnosed individuals. If a program provides care to any of these categories of populations, the program shall submit documentation regarding the appropriateness of the research-based approaches. For milieu management, all programs should also incorporate some form of research-based, trauma-informed programming and training, if the primary research-based treatment model used by the program does not.

Provider Qualifications: A Therapeutic Group Home shall be nationally accredited and licensed as a mental health center or substance abuse treatment center by the Nebraska Health and Human Services System and may not exceed eight beds unless grandfathered. Practitioners providing substance abuse or mental health services must meet the training requirements outlined by Medicaid and/or its designee, in addition to any required scope of practice license required for the facility or agency to practice in the State of Nebraska. ThGH staff shall be supervised by a licensed psychiatrist or psychologist (supervising practitioner) with experience in the research-based treatments used in the facility. Unlicensed direct care staff includes paraprofessional, master's and bachelor's level staff supervised by a psychologist or psychiatrist. At least 21 hours of active treatment per week for each EPSDT eligible is required to be provided by qualified staff (e.g., having a certification in the EBPs selected by the facility and/or licensed practitioners operating under their scope of practice in Nebraska and meeting ThGH licensure requirements), consistent with each EPSDT eligible's treatment plan and meeting assessed needs. All staff not licensed shall have provider qualifications meeting at least the following:

(1) Have a high school diploma or equivalent
(2) Be 21 years of age and have a minimum of 2 years experience working with children, 2 years education in the human service field or a combination of work experience and education with one year of education substituting for one year of experience
(3) Complete training according to a curriculum approved by the State prior to providing the service
(4) Pass child abuse check, Adult abuse registry and motor vehicle screens
(5) Be certified in: First Aid, CPR, Crisis Prevention / Management
(6) Understand de-escalation techniques and demonstrate the ability to implement those techniques effectively

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

Staffing schedules shall reflect overlap in shift hours to accommodate information exchange for continuity of treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix and the consistent presence and availability of professional staff. In addition, staffing schedules should ensure the presence and availability of professional staff on nights and weekends, when parents are available to participate in family therapy and to provide input on the treatment of their EPSDT eligible.

Unit of Service: Day unit for unlicensed direct care staff. A unit of service is defined according to the HCPCS approved code set.

Limitations:
All licensed staff including psychiatrists, psychologists, Licensed Independent Mental Health Practitioners, Licensed Mental Health Practitioners, Provisionally Licensed Mental Health Practitioners, Advanced Practice Registered Nurses, and Licensed Alcohol and Drug Counselors bill for their services separately under the approved State Plan for Other Licensed Practitioners, Item 6d or EPSDT Other Licensed Practitioners. A psychiatrist or psychologist shall be the supervising practitioner and shall provide twenty-four (24) hour, on-call coverage seven (7) days a week. The psychologist or psychiatrist shall see the client at least once, prescribe the type of care provided, and, if the services are not time-limited by the prescription, review the need for continued care every 14 days. Although the psychologist or psychiatrist does not have to be on the premises when his/her client is receiving covered services, the supervising practitioner shall assume professional responsibility for the services provided and assure that the services are medically appropriate. Therapy (individual, group and family, whenever possible) and ongoing psychiatric assessment and intervention (by a psychiatrist) are required of ThGH, but provided and billed separately by licensed practitioners for direct time spent.

ThGHs are located in residential communities in order to facilitate community integration through public education, recreation and maintenance of family connections. The facility is expected to provide recreational activities for all residents but not use Medicaid funding for payment of such non-Medicaid activities.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

ThGHs may not be Institutions for Mental Disease. Each organization owning Therapeutic Group Homes shall ensure that the definitions of institutions are observed and that in no instance does the operation of multiple ThGH facilities constitute operation of an Institution of Mental Disease. All new construction, newly acquired property or facility or new provider organization shall comply with facility bed limitations not to exceed eight beds. Existing facilities may not add beds if the bed total would exceed eight beds in the facility. A waiver up to a maximum of 16 beds may be granted for existing facilities of greater than eight beds at the existing capacity not to exceed 16 beds in the institution until alterations of the existing facility are made. Any physical plant alterations of existing facilities shall be completed in a manner to comply with the eight bed per facility limit (i.e., renovations of existing facilities exceeding eight beds shall include a reduction in the bed capacity to eight beds).

Average Length of stay ranges from 14 days to 6 months. ThGH programs focusing on transition or short-term crisis are typically in the 14 to 30 day range. Discharge will be based on the EPSDT eligible no longer making adequate improvement in this facility (and another facility is being recommended) or the EPSDT eligible no longer having medical necessity at this level of care. Continued ThGH stay should be based on a clinical expectation that continued treatment in the ThGH can reasonably be expected to achieve treatment goals and improve or stabilize the EPSDT eligible's behavior, such that this level of care will no longer be needed and the EPSDT eligible can return to the community. Transition should occur to a more appropriate level of care (either more or less restrictive) if the EPSDT eligible is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care (e.g., EPSDT eligible's behavior and/or safety needs requires a more restrictive level of care, or alternatively, EPSDT eligible's behavior is linked to family functioning and can be better addressed through a family/home-based treatment).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS - PHYSICIANS SERVICES

PAYMENT RESTRICTION-DRUGS AND MEDICAL PROCEDURES:
Payment may not be authorized for any drugs or medical procedures which may be considered experimental or which are not generally employed by the medical profession. Payment may not be authorized for:
Reversal of tubal ligation;
Reversal of vasectomy; or
Sex change operations.

INFLUENZA INJECTIONS IN NURSING HOMES:
As the services of a nurse to give injections are included in the compensation of ICF-I Nursing Homes, no remuneration will be paid to a physician giving influenza injections in these facilities.

ABORTIONS:
Payment for abortions under the Nebraska Medical Assistance Program is limited to those abortions for which FFP is currently available. Therapeutic abortions are covered only in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed; therapeutic abortions are also covered in cases of rape or incest.

PSYCHIATRIC SERVICES:
Prior authorization is not required for medically necessary outpatient psychotherapy services. Testing and evaluations must be performed by a licensed psychologist or supervised by a licensed psychologist. NMAP does not cover mileage and conference fees for home-based family therapy providers of outpatient psychiatric services for individuals age 21 and older.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS - PHYSICIANS SERVICES

Transplants:

NMAP covers medical transplants including donor services that are medically necessary and defined as non-experimental by Medicare. If no Medicare policy exists for a specific type of transplant, the appropriate staff in the Medicaid Division shall determine whether the transplant is medically necessary and non-experimental.

Not withstanding any Medicare policy on liver or heart transplants, the Nebraska Medical Assistance Program covers liver or heart transplantation when the written opinions of two physicians specializing in transplantation state that -

1. No other therapeutic alternatives exist; and
2. The death of the patient is imminent.

NMAP requires prior authorization of all transplant services before the services are provided.

NMAP covers medically necessary services for the NMAP-eligible donor to an NMAP-eligible client. The services must be directly related to the transplant.

NMAP covers laboratory tests for NMAP-eligible prospective donors. The tests must be directly related to the transplant.

NMAP covers medically necessary services for the NMAP-ineligible donor to an NMAP-eligible client. The services must be directly related to the transplant and must directly benefit the NMAP transplant client. Coverage of treatment of complications is limited to those that are reasonably medically foreseeable.

NMAP covers laboratory tests for NMAP-ineligible prospective donors that directly benefit the NMAP transplant client. The tests must be directly related to the transplant.

NMAP does not cover services provided to an NMAP-ineligible donor that are not medically necessary or that are not directly related to the transplant.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS - PHYSICIANS SERVICES

TOBACCO CESSATION COUNSELING

NMAP covers up to two tobacco cessation sessions in a 12-month period. A tobacco cessation session includes (a) visits to the primary practitioner for evaluation, particularly for any contraindications for drug product(s) and to obtain prescription(s) if tobacco cessation products are needed, and (b) up to a total of four tobacco cessation counseling visits with a physciain or pharmacist tobacco cessation counselor. These visits may be a combination of intermediate and intensive counseling.

Telehealth:

Physicians services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX-OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - PODIATRISTS' SERVICES

NMAP covers medically necessary podiatry services within the scope of the podiatrists' licensure and within NMAP program guidelines.

ORTHOTIC DEVICES AND ORTHOTIC FOOTWEAR: NMAP covers orthotic devices, orthopedic footwear, shoe corrections, and other items for the feet if medically necessary for the client's condition.

PALLIATIVE FOOT CARE: Palliative foot care includes the cutting or removal of corns or callouses; the trimming of nails; other hygienic and preventive maintenance care or debridement, such as cleaning and soaking the feet and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory clients; and any services performed in the absence of localized illness, injury, or symptoms involving the foot. Coverage of palliative footcare is limited to one treatment every 90 days for non-ambulatory clients and one treatment every 30 days for ambulatory clients.

Telehealth:

Podiatrists' services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Services requiring "hands on" professional care are excluded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - OPTOMETRISTS' SERVICES

See Item 12d.

Telehealth:

Optometrists' services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Services requiring "hands on" professional care, such as eyeglass fittings, are excluded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - CHIROPRACTIC SERVICES

NMAP limits coverage of chiropractic services specifically to treatment of the spine by means of manual manipulation (i.e., by use of hands only) and spinal x-rays.

The following guidelines outline the maximum number of treatments NMAP may consider for payment:

1. For clients age 21 and older, manual manipulation of the spine is limited to 12 treatments per calendar year.
2. For clients age 20 and younger, manual manipulation of the spine is limited to 18 treatments during the initial five-month period from the date of initiation of treatment for the reported diagnosis. A maximum of one treatment per month is covered thereafter if needed for stabilization care.
3. No more than one treatment per client per day is covered.

For clients who are eligible for HEALTHCHECK (EPSDT), additional visits may be approved if medically necessary.

Coverage of spinal x-rays is limited to one set of spinal x-rays for a client in a twelve-month period.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - OTHER PRACTITIONERS SERVICES

MENTAL HEALTH/SUBSTANCE ABUSE PRACTITIONERS

The following licensed mental health and substance abuse practitioners who are licensed in the State of Nebraska to diagnose and treat mental illness or substance abuse acting within the scope of all applicable state laws and their professional license may be enrolled as an individual provider of mental health/substance abuse services. The following individuals are licensed to practice independently and may act as a supervising practitioner:

- Licensed psychologist
- Licensed Independent Mental Health Practitioner (LIMHP)

The following individuals are licensed to practice under supervision or direction:

- Licensed Mental Health Practitioner (LMHP)

Supervision must be provided by a person who is eligible to provide Medicaid services and who is licensed at the clinical level under State law as eligible to provide supervision or is a physician.

The following individuals who are licensed to practice in the State of Nebraska and treat mental illness or substance abuse, acting within the scope of all applicable state laws and their professional license, may be enrolled as a provider of mental health/substance abuse services. These individuals may not act as a supervising practitioner.

- Advanced Practice Registered Nurses (APRN-NP) with a specialty in mental health or family practice nursing.

All services have an initial authorization level of benefit. Prior authorization is required prior to service delivery for medically necessary outpatient psychotherapy services which exceed the limitation of the initial authorization. All services provided while a person is a resident of an IMD are considered content of the institutional service and not otherwise reimbursable by Medicaid.

A unit of service is defined according to the CPT and HCPCS approved code set unless otherwise specified.

Testing and evaluations must be performed by a licensed clinical psychologist or supervised by a licensed psychologist.

NMAP does not cover mileage and conference fees for home-based family therapy providers of outpatient psychiatric services for individuals age 21 and older.

Telehealth:
Services provided by licensed mental health and substance abuse practitioners via telehealth technologies are covered subject to the limitations as set forth in state regulations.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - OTHER PRACTITIONERS SERVICES

CERTIFIED REGISTERED NURSE ANESTHETISTS

The Nebraska Medical Assistance Program covers the services of certified registered nurse anesthetists (CRNAs) and anesthesia assistants (AAs), for services provided on or after August 1, 1989.

A certified registered nurse anesthetist is a registered nurse who is licensed by the Department of Health and Human Services Regulation and Licensure and is currently certified by the Council on Certification of Nurse Anesthetists or Council on Recertification of Nurse Anesthetists, or has graduated since August 1987 from a nurse anesthesia program that meets the standards of the Council on Accreditation of Nurse Anesthesia Educational Programs and is awaiting initial certification.

An anesthesia assistant is a person who is allowed by state law to administer anesthesia and who has successfully completed a six-year program for AA's, of which two years consist of specialized academic and clinical training on anesthesia.

Telehealth:

Services provided by CRNAs and AAs via telehealth technologies are covered subject to the limitations as set forth in state regulations, as amended. Services requiring "hands on" professional services are excluded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - OTHER PRACTITIONERS SERVICES

TOBACCO CESSATION COUNSELING

NMAP covers tobacco cessation counseling only when provided by licensed pharmacists who have completed a Department-approved tobacco cessation counseling training and maintain current training as a tobacco cessation counselor. The counseling must be separate and distinct from Prospective Drug Use Review (ProDur) counseling required under Section 1927. [42 U.S.C. 1396r-8] of the Social Security Act and as amended, and must not be related to the dispensing of a drug product. The counseling must be ordered by the primary practitioner with feedback required from the pharmacist to the ordering practitioner.

NMAP covers up to two tobacco cessation sessions in a 12-month period. A tobacco cessation session includes (a) visits to the primary practitioner for evaluation, particularly for any contraindications for drug product(s) and to obtain prescription(s) if tobacco cessation products are needed, and (b) up to a total of four tobacco cessation counseling visits with a physician or pharmacist tobacco cessation counselor. These visits may be a combination of intermediate and intensive counseling.

Telehealth: other Practitioner Services for tobacco cessation counseling are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - HOME HEALTH NURSING SERVICES

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1. Payment for home health agency services must be authorized by the Medicaid Division.

2. All home health agency services are subject to the guidelines for coverage listed in 471 NAC 9-002.06.
3. If the client receives multiple home health agency services in the home, the Department averages the HHA expenses over a three-month period. If the average exceeds the appropriate nursing facility per diem, the Department will recommend nursing facility care for the client.
4. NMAP does not cover skilled nursing visits provided by student nurses who are enrolled in a school of nursing and are not employed by the home health agency unless the student is accompanied by a registered nurse who is an employee of the home health agency.
5. NMAP limits skilled nursing visits for teaching and training on an individual basis, based on medical necessity and the ability of the client, parent or caregiver to perform the task independently. The client must have a medical condition which has been diagnosed and treated by a physician. There must be a physician's order for the specific teaching and training.
6. Payment for supplies normally carried in the nursing bag and incidental to the nursing visit is included in the per visit rate. Medical supplies not normally carried in the nursing bag are provided by pharmacies or medical suppliers who bill NMAP directly. Under extenuating circumstances, the home health agency may bill for a limited quantity of supplies.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - HOME HEALTH NURSING SERVICES

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7. Medical necessity for a second visit on the same day must be well documented.
8. NMAP recognized enterostomal therapy visits as a skilled nursing service.
9. NMAP applies the following limitations to nursing services (RN and LPN) for adults age 21 and older:
    a. Per diem reimbursement for nursing services for the care of ventilator-dependent clients shall not exceed the average ventilator per diem of all Nebraska nursing facilities which are providing that service. This average shall be computed using nursing facility's ventilator interim rates which are effective January 1 of each year, and are applicable for that calendar year period.

    b. Per diem reimbursement for all other in-home nursing services shall note exceed the average case-mix per diem for the Extensive Special Care 2 case-mix reimbursement level. This average shall be computed using the Extensive Special Care 2 case-mix nursing facility interim rates which are effective January 1 of each year, and applicable for that calendar year period.

    Under special circumstances, the per diem reimbursement may exceed this maximum for a short period of time - for example, a recent return from a hospital stay. However, in these cases, the 30-day average of the in-home nursing per diems shall not exceed the maximum above. (The 30 days are defined to include the days which are paid in excess of the maximum plus those days immediately following, totaling 30.)

II. Telehealth: Home health nursing services are covered via telehealth technologies subject to the limitations as set forth in state regulations, as amended. "Hands on" professional services are excluded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - HOME HEALTH NURSING SERVICES – HOME HEALTH AIDE SERVICES

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1. Home health aide services must be:
    a. Necessary to continuing a medical treatment plan;
    b. Prescribed by a licensed physician;
    c. Recertified by the licensed physician at least every 60 days; and
    d. Supervised by a registered nurse.
2. Payment for home health agency services must be authorized by the Medicaid Division.
3. Prefilling syringes with insulin for a blind diabetic is reimbursed only as a home health nursing service. Home health agencies will not be reimbursed for prefilling insulin syringes for a blind diabetic by a home health aide.
4. Skilled nursing visits are not a prerequisite for the provision of home health aide services.
5. Telehealth: Home health aide services are not covered when provided via telehealth technologies.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – MEDICAL SUPPLIES, EQUIPMENT, AND APPLIANCES
SUITABLE FOR USE IN THE HOME

The Nebraska Medical Assistance Program covers the purchase or rental of durable medical equipment, medical supplies that meet program guidelines when prescribed by a physician or other licensed practitioner whose licensure allows prescribing these items (M.D., D.O., D.P.M.). To qualify as a covered service under NMAP, the item must be medically necessary and must meet the definitions in state regulations.

NMAP does not cover items that primarily serve personal comfort; convenience; or educational, hygienic, safety, or cosmetic functions; or new equipment of unproven value and/or equipment of questionable current usefulness or therapeutic value.

Home health agencies may provide durable medical equipment and oxygen only.

Durable medical equipment and supplies providers shall complete and sign the Medical Assistance Provider Agreement, and submit the completed form to the Department for approval. Providers shall meet any applicable state and federal laws governing the provision of their services. NMAP enrolls, as providers of durable medical equipment, medical supplies, orthotics, or prosthetics, only those providers who are involved in the direct provision of services or items to the client.

Durable medical equipment is equipment which:

1. Withstands repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an illness or injury; and
4. Is appropriate for use in the client's home. This generally does not include long term care facilities.

Coverage conditions for individual services are listed with the procedure code descriptions.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – MEDICAL SUPPLIES, EQUIPMENT, AND APPLIANCES SUITABLE FOR USE IN THE HOME

NMAP covers medical supplies listed in the coverage criteria and procedure code list when prescribed for medical care in the client's home. Items not specifically listed may not be covered by NMAP. Coverage for medical supplies does not generally include clients residing in nursing facilities or ICF/MR's.

NMAP does not cover, as medical supplies, personal care items such as non-medical mouthwashes, deodorants, talcum powders, bath powders, soaps, dentifrices, eye washes, contact solutions, etc. NMAP does not cover, as medical supplies, oral or injectable over-the-counter drugs and medications.

NMAP covers orthotic devices when medically necessary and prescribed to support a weak or deformed body member or restrict or eliminate motion in a diseased or injured part of the body. Coverage includes braces, orthopedic shoes and shoe corrections, lumbar supports, hernia control devices, and similar items. NMAP covers prosthetic devices when medically necessary and prescribed to replace a missing body part. Orthotics and prosthetics are covered for clients residing in nursing facilities and ICF/MR's. NMAP does not cover external powered prosthetic devices.

NMAP covers only one pair of orthopedic shoes at the time of purchase. Except when size change is necessary due to growth and/or when diagnosis indicates excessive wear, NMAP allows only one pair of shoes in a one-year period. Orthopedic shoes and shoe corrections are not covered for flexible or congenital flat feet.

Prior authorization is required of payment of rental and purchase of the items listed in state regulations as requiring prior authorization.

Telehealth: Medical equipment, supplies, orthotics and prosthetics furnished by durable medical equipment suppliers and pharmacies are not covered when provided via telehealth technologies.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
LIMITATIONS - HOME HEALTH SERVICES – PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH PATHOLOGY AND AUDIOLOGY

To be eligible for home health services, the attending physician shall certify that the client cannot receive the services in an outpatient/physician office setting.

Services for Individuals Age 21 and Older: The Nebraska Medical Assistance Program (NMAP) covers occupational therapy, physical therapy, and speech, hearing, and language therapy services for individuals age 21 and older as a Home Health Agency service only when the following criteria is met. The services must:

1. Be prescribed by a physician;
2. Be performed by, or under the direct supervision of, a licensed physical therapist; and
3. Meet one of the following criteria:
    a. The services must be restorative when there is a medically appropriate expectation that the patient's condition will improve significantly in a reasonable period of time;
    b. The services must be reasonable and medically necessary for the treatment of the client's illness or injury;
    c. The services must have been recommended in a Department-approved individual program plan (IPP); or
    d. The services must have been recommended in an individual education plan (IEP) or an individual family service plan (IFSP).

These therapies for adults (age 21 and older) are a Home Health Agency Service only when there is no other method for the client to receive the service. Services must be prior authorized by Central Office staff. Substantiating documentation must be attached to the claim.

Services for Individuals Age 20 and Younger: The Nebraska Medical Assistance Program (NMAP) covers occupational therapy, physical therapy, and speech, hearing, and language therapy services for individuals birth to age 20 as a Home Health Agency service when the following criteria is met. The services must:

1. Be prescribed by a physician;
2. Be performed by, or under the direct supervision of, a licensed physical therapist; and
3. Meet one of the following criteria:
    a. The services must be reasonable and medically necessary for the treatment of the client's illness or injury;
    b. The services must have been recommended in a Department-approved IPP; or
    c. The services must have been recommended in an individual's education plan (IEP) or an individual family service plan (IFSP).

Telehealth: Home health physical therapy, occupational therapy, speech pathology and audiology services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Services requiring "hands on" professional services are excluded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – PRIVATE DUTY NURSING SERVICES

NMAP applies the following limitations to nursing services (RN and LPN) for adults age 21 and older:

1. Per diem reimbursement for nursing services for the care of ventilator-dependent clients shall not exceed the average ventilator per diem of all Nebraska nursing facilities which are providing that service. This average shall be computed using nursing facility's ventilator interim rates which are effective January 1 of each year, and are applicable for that calendar year period.

2. Per diem reimbursement for all other in-home nursing services shall not exceed the average case-mix per diem for the Extensive Special Care 2 case-mix reimbursement level. This average shall be computed using the Extensive Special Care 2 case-mix nursing facility interim rates which are effective January 1 of each year and applicable for that calendar year period.

Under special circumstances, the per diem reimbursement may exceed this maximum for a short period of time - for example, a recent return from a hospital stay. However, in these cases, the 30-day average of the in-home nursing per diems shall not exceed the maximum above. (The 30 days are defined to include the days which are paid in excess of the maximum plus those days immediately following, totaling 30.)

3. Telehealth: Private duty nursing services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Services requiring "hands on" professional services are excluded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – CLINIC SERVICES

Community mental health centers must be licensed and approved by the Joint Commission on Accreditation of Healthcare Organizations (JACHO), the Council on Accreditation of Services for Families and Children, the Commission on Accreditation of Rehabilitation Facilities, the American Osteopathic Association, or by any other accrediting organization with comparable standards, that is recognized by the State.

Services provided by community mental health centers are limited to medically necessary acute psychiatric services.

Day treatment services are limited to a half-day or full-day rate, established on the basis of each facility's cost report which is reviewed annually. (For age 20 and under, additional day treatment hours may be added up to 9.)

Prior authorization is not required for medically necessary outpatient psychotherapy services.

Testing and evaluations must be performed by a licensed psychologist or under the supervision of a licensed psychologist.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – CLINIC SERVICES

Services Provided in Ambulatory Surgical Centers: NMAP covers facility services provided in ambulatory surgical centers (both free-standing and hospital-affiliated) under the following limitations.

The "facility fee" includes payment for services and items provided by an ASC in connection with a covered surgical procedure.

Covered surgical procedures include the procedures on Nebraska's list of covered ASC procedures, which includes tubal ligations, vasectomies, and certain dental services.

The ASC may also provide services other than those included under the facility fee. These services are limited under the appropriate category (durable medical equipment, medical supplies, ambulance services, etc.) listed elsewhere in the Title XIX Plan.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of licensed Ambulatory Surgical Centers and any annual/periodic adjustments to the fee schedule are published at http://www.hhs.state.ne.us/med/medindex.htm (Division of Medicaid and Long-Term Care website). The agency's rates were set as of January 1, 2008 and are effective for services on or after that date”

Upper Payment Limit: Aggregate payment for hospital-affiliated ASCs located within Nebraska may not exceed the reasonable estimate of the amount that would be paid for such services under Medicare payment principles. The upper limit of aggregate payments to hospitals pursuant to 42 CFR §447.321 shall be determined using the hospital's latest audited filed cost report and claims data corresponding with the period to determine the reasonable costs in accordance with Medicare principles of reimbursement.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - CLINIC SERVICES

ABORTIONS:

Payment for abortions under the Nebraska Medical Assistance Program is limited to those abortions for which FFP is currently available.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – CLINIC SERVICES

Telehealth: Clinic services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – CLINIC SERVICES

Comprehensive Treatment of Pediatric Feeding Disorders Through Interdisciplinary Treatment.

NMAP covers evaluation and treatment of infants and children who fail to eat and/or drink a sufficient quantity or variety of foods or liquids to meet their nutritional and/or hydration needs.

Comprehensive interdisciplinary treatment means the collaboration of medicine, psychology, nutrition science, speech therapy, occupational therapy, social work, and other appropriate medical and behavioral disciplines in an integrated program.

The service may be provided by hospital affiliated clinics or free-standing clinics.

Day treatment is defined as daily therapy (M-F) from approximately 8:30 am to 5 pm.

Outpatient is defined as therapy 1 to 2 times per week for 1-3 hours per day.

Prior authorization is required of all services before the services are provided.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - DENTAL SERVICES

PRIOR AUTHORIZATION: NMAP requires prior authorization for certain dental services. Prior authorization must be obtained before the service is provided. Diagnostic services, as defined in state regulations, and routine corrective dental care, do not require prior authorization. Prepayment authorization for emergencies and other circumstances beyond the provider's control (insurance coverage, etc.) will be reviewed by Medicaid Division staff.

COVERED SERVICES: NMAP defines dental services as any diagnostic, preventive, or corrective procedures provided by or under the supervision of a licensed dentist. Covered procedures are specified in state regulations.

For clients age 21 and older, dental coverage is limited to $1,000 per fiscal year.

DIAGNOSTIC DENTAL SERVICES: NMAP covers diagnostic dental services as defined in state regulations, as amended. This includes exams, radiology, prophylaxis, topical application of fluoride, and diagnostic casts. Exams are covered once each year on a routine basis for clients age 21 and older. For clients who are eligible for HEALTH CHECK (EPSDT), exams are allowed every 6 months or more often if medically necessary. Interperiodic dental exams will also be considered appropriate to determine the existence of suspected conditions. When a patient is referred to another dentist or specialist, NMAP covers one exam by the second dentist or specialist.

ORAL SURGERY: Oral surgery, as defined by HCPCS, is covered as a physician service.

HOSPITALIZATION FOR DENTAL SERVICES: Dental services must be provided at the least expensive appropriate place of service.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - DENTAL SERVICES

COSMETIC SERVICES: NMAP does not cover cosmetic dental services.

RADIOLOGY: NMAP covers a maximum dollar amount for any combination of the following radiographs: Intraoral complete series, intraoral periapical films, extraoral films, bitewings, or panoramic films. A intraoral complete series is covered once every three years.

ENDODONTIA: NMAP covers endodontia for anterior and posterior permanent teeth when the prior authorization request of submitted x-rays substantiates medical necessity.

PERIODONTAL TREATMENT: All periodontal treatment must be prior authorized by the Medicaid Division. Covered periodontal services include those procedures necessary for the treatment of the tissues supporting the teeth.

ORTHODONTICS: NMAP covers orthodontic treatment for clients age 20 and younger. Orthodontic treatment is covered when the client has a handicapping malocclusion defined as (1) Craniofacial birth defect that is affecting the occlusion; or (2) Mutilated or severe occlusion.

Telehealth: Dental services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Services requiring “hands on" professional care are excluded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – PHYSICAL THERAPY

NMAP covers physical therapy services when the following conditions are met:

1. The services must be prescribed by a physician;
2. The services must be performed by, or under the direct supervision of, a licensed physical therapist;
3. The services must be restorative; and
4. There must be a medically appropriate expectation that the patient's condition will improve significantly in a reasonable period of time or the services are recommended in a Department-approved individual program plan (IPP).

NMAP does not cover physical therapy if the expected restoration potential is insignificant in relation to the extent and duration of the services required to achieve the potential.

Exception: NMAP covers physical therapy services for EPSDT eligibles when the following conditions are met:

1. The services must be prescribed by a physician;
2. The services must be performed by, or under the direct supervision of, a licensed physical therapist; and
3. There must be a medically appropriate expectation that the patient's condition will improve significantly in a reasonable period of time or the services are recommended in a Department-approved individual program plan (IPP).

For clients age 21 and older, NMAP covers a combined total of 60 therapy sessions per fiscal year, physical therapy, occupational therapy and speech therapy.

Telehealth: Physical therapy services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Services requiring “hands on” professional care are excluded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – OCCUPATIONAL THERAPY

NMAP covers occupational therapy services provided by independent therapists under the following conditions.

The therapist must be licensed by the Nebraska Department of Health and Human Services Regulation and Licensure. If services are provided by an OT assistant under the supervision of an OT, the assistant must be licensed by the Nebraska Department of Health and Human Services Regulation and Licensure. If services are provided outside Nebraska, the provider must be licensed in that state.

Occupational therapy is defined as improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation; improving ability to perform tasks for independent functioning when functions are impaired or lost; or preventing, through early intervention, initial or further impairment or loss of function.

NMAP covers OT services when the following conditions are met. The services must be:

1. Prescribed by a physician;
2. Performed by a licensed occupational therapist or a licensed occupational therapy assistant under the supervision of a licensed occupational therapist;
3. Restorative; and
4. Reasonable and medically necessary for the treatment of the client's illness or injury.

NMAP covers orthotic appliances or devices when medically necessary for the client's condition. NMAP does not reimburse an occupational therapist for orthotic devices or appliance which do not require customized fabrication by the therapist.

Exception: NMAP covers occupational therapy services for EPSDT eligibles when the following conditions are met. The services must be:

1. Prescribed by a physician;
2. Performed by a licensed occupational therapist or a licensed occupational therapy assistant under the supervision of a licensed occupational therapist; and
3. Reasonable and medically necessary for the treatment of the client's illness or injury.

For clients age 21 and older, NMAP covers a combined total of 60 therapy sessions per fiscal year (physical therapy, occupational therapy, and speech therapy).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – OCCUPATIONAL THERAPY

Telehealth: Occupational therapy services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Services requiring "hands on" professional care are excluded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – SERVICES FOR INDIVIDUALS WITH SPEECH, HEARING, AND LANGUAGE DISORDERS

To be covered by NMAP, speech pathology and audiology services must be prescribed by a licensed physician and performed by a licensed speech pathologist or audiologist in accordance with 42 CFR §440.110. The speech pathologist or audiologist must be in constant attendance. The physician's orders must be for no more than 30 days, with documentation of the patient's progress and a recertification of the physician's order every 30 days or more frequently if the patient's condition necessitates. In addition, the services must meet at least one of the following conditions:

1. The services must be an evaluation;
2. The services must be restorative speech pathology with a medically appropriate expectation that the patient's condition will improve significantly within a reasonable period of time; or
3. The services must have been recommended in a Department-approved individual program plan (IPP); or
4. The services must be necessary for an individual with an augmentative communication device.

NMAP covers speech pathology and audiology services when the following conditions are met:

1. The services must be prescribed by a physician;
2. The services must be performed by, or under the supervision of, a licensed speech pathologist or audiologist;
3. The services must be restorative; and
4. There must be a medically appropriate expectation that the patient's condition will improve significantly in a reasonable period of time or the services are recommended in a Department-approved individual program plan (IPP).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – SERVICES FOR INDIVIDUALS WITH SPEECH, HEARING, AND LANGUAGE DISORDERS

NMAP does not cover speech pathology and audiology services when the expected restoration potential is insignificant in relation to the extent and duration of the services required to achieve the potential.

Exception: NMAP covers speech pathology and audiology services for EPSDT eligibles when the following conditions are met:

1. The services must be prescribed by a physician (Exception: Audiology screening services for EPSDT eligibles do not require a physician's prescription);
2. The services must be performed by, or under the supervision of, a licensed speech pathologist or audiologist; and
3. There is a medically appropriate expectation that the patient's condition will improve significantly in a reasonable period of time or the services are recommended in a Department-approved individual program plan (IPP).

For clients age 21 and older, NMAP covers a combined total of 60 therapy sessions per fiscal year (physical therapy, occupational therapy, and speech therapy.

LIMITATIONS – HEARING AIDS

To be covered by the Nebraska Medical Assistance Program, hearing aids, hearing aid repairs, hearing aid rental, assistive listening devices, and other hearing aid services must be prescribed by a physician and meet medical necessity criteria.

- For clients age 20 and younger, NMAP covers hearing aids when required by medical necessity.

- For clients age 21 and older, NMAP covers hearing aids limited to not more than one aid per ear every four years and then only when required by medical necessity.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – SERVICES FOR INDIVIDUALS WITH SPEECH, HEARING, AND LANGUAGE DISORDERS

NMAP requires a complete audiogram (pure tone, air bone, masking, speech) for a hearing aid or assistive listening device, and a Form DM-5H "Physician's Report on Hearing Loss" to be filled out by the examining physician and either the examiner or the hearing aid dispenser.

NMAP requires that a client be evaluated by an E.N.T. when any of the following criteria is met:

1. The client has a conductive hearing loss;
2. The client has a unilateral hearing loss; or
3. The client is age 16 or younger.

NMAP covers standard in-the-ear, behind the ear, or body hearing aids. Bone conduction aids will be approved with Ear, Nose and Throat (E.N.T.) Specialist approval.

NMAP covers hearing aid batteries.
Exception: NMAP does not cover hearing aid batteries for residents of a nursing facility except with the initial fitting

NMAP does not cover accessories which are for convenience and not medically necessary, or in-the-canal (ITC) or completely in the canal (CIC) hearing aids.

Telehealth: Speech pathology and audiology services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Services requiring “hands on” professional care, such as hearing aid fittings, are excluded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – PRESCRIBED DRUGS

The Nebraska Medicaid Program covers outpatient drugs, in accordance with Sections 1902(a)(54) and 1927 of the Social Security Act, which are covered by a national or State agreement, with the following restrictions or exceptions (as indicated by checkmark).

☒ A. Prior authorization program which complies with Section 1927(d)(5) of the Social Security Act.

☒ B. The following drugs are covered, or restricted, as indicated by the checkmark:

☒ 1. Certain drugs are not covered if the prescribed use is not for a medically accepted indication, as defined by Section 1927(k)(6)

☒ 2. Drugs subject to restrictions pursuant to an agreement between a manufacturer and this State authorized by the Secretary under 1927(a)(1) or 1927(a)(4).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency Nebraska

MEDICAID PROGRAM: REQUIREMENTS RELATING TO COVERED OUTPATIENT DRUGS FOR BOTH THE CATEGORICALLY NEEDY AND MEDICALLY NEEDY

12.a. Prescribed Drugs: Description of Service Limitation

Citation(s)	Provision(s)
1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.
1927(d)(2) and 1935(d)(2)	The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare prescription Drug Benefit –Part D. **X The following excluded drugs are covered:** *("All" drugs categories covered under the drug class)* ☐ *("Some" drugs categories covered under the drug class* X *-List the covered common drug categories not individual drug products directly under the appropriate drug class)* *("None" of the drugs under this drug class are covered)* ☐ X (a) agents when used for anorexia, weight loss, weight gain (limited to weight gain only) ☐ (b) agents when used to promote fertility ☐ (c) agents when used for cosmetic purposes or hair growth X (d) agents when used for the symptomatic relief of cough and colds

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency Nebraska

MEDICAID PROGRAM: REQUIREMENTS RELATING TO COVERED OUTPATIENT DRUGS FOR BOTH THE CATEGORICALLY NEEDY AND MEDICALLY NEEDY
12.a. Prescribed Drugs: Description of Service Limitation

Citation(s)		Provision(s)
	X	(e) prescription vitamins and mineral products, except prenatal vitamins and fluoride
	X	(f) nonprescription drugs (All drugs in this category are potential benefits, subject to medical necessity). Covered over the counter (OTC) classes include analgesics, anesthetics, anti-inflammatory products, anti-asthmatics, antihistamines, anti-infectives, cough and cold preparations, eye, ear and nose preparations, gastrointestinal products, hypoglycemic, smoking deterrents, and topicals.
	X	(g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)
	X	(h) barbiturates **(Except for dual eligible individuals effective January 1, 2013 when used in the treatment of epilepsy, cancer or a chronic mental health disorder as Part D will cover those indications)**
	X	(i) benzodiazepines **(Except for dual eligible individuals effective January 1, 2013 as Part D will cover all indications)**
	X	(j) smoking cessation drugs (Except for dual eligible individuals as Part D will cover these drugs); Agents when used to promote smoking cessations. (Restricted

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency Nebraska

MEDICAID PROGRAM: REQUIREMENTS RELATING TO COVERED OUTPATIENT DRUGS FOR BOTH THE CATEGORICALLY NEEDY AND MEDICALLY NEEDY
12.a. Prescribed Drugs: Description of Service Limitation

Citation(s)		Provision(s)
		to the prescription drugs, bupropion and varenicline, and over-the-counter nicotine patches and nicotine gum. Prescription drugs are covered for Medicaid recipients who are not full-benefit dual eligible individuals. Over-the-counter drugs are covered for all populations. Coverage of all prescription and over-the-counter agents is available to only those Medicaid recipients that are enrolled with and actively participating in the Nebraska Tobacco-free Quitline.)
	X	(k) the Medicaid agency will provide coverage of prescription and over-the-counter (OTC) tobacco/smoking cessation covered outpatient drugs for pregnant women as recommended in "Treating Tobacco Use and Dependence: 2008 Update: Clinical Practice Guideline" published by the Public Health Service in May 2008 or any subsequent modification of such guideline.

Telehealth: Pharmacy services for prescribed drugs are not covered when provided via telehealth technologies

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – PRESCRIBED DRUGS

Supplemental Rebate Program:

The state is in compliance with Section 1927 of the Social Security Act. Based on the requirements of Section 1927 of the act, the state has the following policies for the supplemental rebate program for Medicaid recipients:

a) All covered drugs of federal participating manufacturers remain available to the Medicaid program but may require prior authorization.
b) CMS has authorized the State of Nebraska to enter into the TOP$sm, *The Optimal PDL $olution* ("TOP$sm") multi state pooling agreement to collect supplemental rebates through the TOP$sm program. The Supplemental Drug Rebate Agreement was submitted to CMS on July 15, 2013 and has been authorized by CMS, effective October 1, 2013.
c) Any contracts not authorized by CMS will be submitted to CMS for authorization.
d) Any changes to the contracts for the TOP$SM program will be submitted to CMS for approval.
e) All drugs covered by this program irrespective of a supplemental agreement, will comply with the provisions of the National Drug Rebate Agreement.
f) The State will negotiate supplemental rebates in addition to federal rebates provided for in Title XIX.
g) Supplemental rebates received by Nebraska in excess of those required under the National Drug Rebate Agreement will be shared with the federal government on the same percentage basis as applied under the National Drug Rebate Agreement.
h) The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification, in accordance with Section 1927(b)(3)(D).
i) Rebates paid under the CMS-authorized TOP$sm for the Nebraska Medicaid population do not affect AMP or best price under the Medicaid program.
j) The CMS-authorized TOP$sm Agreement for the Nebraska Medicaid population only covers supplemental rebates for Medicaid programs. It does not cover non-Medicaid programs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - DENTURES

DENTURES & PARTIALS: NMAP covers the following prosthetic appliances when coverage criteria is met: (1) Dentures (immediate, replacement/complete, or interim/complete); (2) Resin base partial dentures; (3) Flipper partials; and (4) cast metal framework with resin denture base partials for clients age 20 and younger.

Replacement prosthetic appliances are covered when:

1. The client's dental history does not show that previous prosthetic appliances have been unsatisfactory to the client; and
2. The client does not have a history of lost prosthetic appliances; and
3. A repair will not make the existing denture or partial wearable; or
4. A reline will not make the existing denture or partial wearable; or
5. A rebase will not make the existing denture or partial wearable;

NMAP covers partial dentures for clients that do not have adequate occlusion. Adequate occlusion is defined as first molar to first molar, or a similar combination of anterior and posterior teeth on the upper or lower arch in occlusion.

NMAP prior authorizes replacement/complete dentures, maxillary resin base partials, and flipper partials.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – PROSTHETIC DEVICES

The Nebraska Medical Assistance Program covers the purchase or rental of durable medical equipment, medical supplies, orthotics, and prosthetics that meet program guidelines when prescribed by a physician or other licensed practitioner whose licensure allows prescribing these items (M.D., D.O., D.P.M.). To qualify as a covered service under NMAP, the item must be medically necessary and must meet the definitions in state regulations.

NMAP does not cover items that primarily serve-personal comfort; convenience; or educational, hygienic, safety, or cosmetic functions; or new equipment of unproven value and/or equipment of questionable current usefulness or therapeutic value.

NMAP does not generally enroll hospitals, hospital pharmacies, long term care facilities; rehabilitation services or centers, physicians, physical therapists, speech therapists, or occupational therapists as providers of durable medical equipment, medical supplies, or orthotics and prosthetics.

Durable medical equipment is equipment which:

1. Withstands repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an illness or injury; and
4. Is appropriate for use in the client's home. This generally does not include long term care facilities.

Coverage conditions for individual services are listed with the procedure code descriptions.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – PROSTHETIC DEVICES

NMAP covers medical supplies listed in the coverage criteria and procedure code list when prescribed for medical care in the client's home. Items not specifically listed may not be covered by NMAP. Coverage for medical supplies does not generally include clients residing in nursing facilities or ICF/MR's.

NMAP does not cover, as medical supplies, personal care items such as non-medical mouthwashes, deodorants, talcum powders, bath powders, soaps, dentifrices, eye washes, contact solutions, etc. NMAP does not cover, as medical supplies, oral or injectable over-the-counter drugs and medications.

NMAP covers orthotic devices when medically necessary and prescribed to support a weak or deformed body member or restrict or eliminate motion in a diseased or injured part of the body. Coverage includes braces, orthopedic shoes and shoe corrections, lumbar supports, hernia control devices, and similar items. NMAP covers prosthetic devices when medically necessary and prescribed to replace a missing body part. Orthotics and prosthetics are covered for clients residing in nursing facilities and ICF/MR's. NMAP does not cover external powered prosthetic devices.

NMAP covers only one pair of orthopedic shoes at the time of purchase. Except when size change is necessary due to growth and/or when diagnosis indicates excessive wear, NMAP allows only one pair of shoes in a one-year period. Orthopedic shoes and shoe corrections are not covered for flexible or congenital flat feet.

Prior authorization is required of payment of rental and purchase of the items listed in state regulations as requiring prior authorization.

Telehealth: Orthotics and prosthetics furnished by durable medical equipment suppliers and pharmacies are not covered when provided via telehealth technologies.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – EYE GLASSES

The Nebraska Medical Assistance Program covers eye examinations, diagnostic services, and other treatment services within program guidelines when medically necessary and appropriate to diagnose or treat a specific eye illness, symptom, complaint, or injury.

NMAP covers annual eye examinations for clients age 20 and younger. More frequent exams will also be covered if needed to determine existence of suspected conditions. Eye examinations are recommended beginning at approximately age three.

NMAP covers eye examinations for clients age 21 and older once every 24 months. More frequent eye examinations will also be covered when reasonable and appropriate.

NMAP covers eyeglass frames under the following conditions:

1. The client's first pair of prescription eyeglasses; or
2. Size change due to growth; or
3. A prescribed lens change only if new lenses cannot be accommodated by the current frame; or
4. The client's current frame is no longer usable due to irreparable wear/damage; breakage or loss. Replacement of frames is limited to one per year for clients 21 years and older.

A pair of eyeglasses is covered for adults (21 and older) when one of the above conditions is met within a 24-month period.

NMAP covers eyeglass lenses under the following conditions:

1. The client's first pair of prescription eyeglasses; or
2. Change in size due to growth; or

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – EYE GLASSES

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3. When new lenses are required due to a new prescription when the refraction correction meets one of the following criteria:

    a. A change of 0.50 diopters in the meridian of greatest change when placed on an optical cross;
    b. A change in axis in excess of 10 degrees for 0.50 cylinder, five degrees for 0.75 cylinder; or
    c. A change of prism correction of 1/2 prism diopter vertically or two prism diopters horizontally or more.

For persons 21 and older, NMAP covers a pair of lenses within a 24 month period when anyone of the above medical reasons exist.

Lenses must meet the specifications for eyeglass lenses and coverage criteria listed in state regulations.

NMAP covers contact lens services only when prescribed for correction of keratoconus, monocular aphakia, or other pathological conditions of the eye when useful vision cannot be obtained with eyeglasses. NMAP does not cover contact lenses when prescribed for routine correction of vision.

NMAP does not cover:

1. Sunglasses;
2. Multiple pairs of eyeglasses for the same individual (for example, two pairs of eyeglasses in lieu of bifocals or trifocals in single vision frame);
3. Non-spectacle mounted aids, hand-held or single lens spectacle mounted low vision aids, and telescopic and other compound lens systems (including distant vision telescopic, near vision telescopes, and compound microscopic lens systems); and
4. Replacement insurance.

Telehealth: Services requiring “hands on” professional care, such as eye glass fittings, are not covered when provided via telehealth technologies.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – SCREENING SERVICES

NMAP covers mammograms and annual gynecological examinations when provided based on a medically necessary diagnosis. In the absence of a diagnosis, NMAP covers mammograms and annual gynecological examinations provided according to the American Cancer Society's periodicity schedule.

Telehealth: Mammograms are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – REHABILITATIVE SERVICES

Community-Based Comprehensive Psychiatric Rehabilitation and Support Services Program

The following rehabilitative psychiatric services are covered for adult clients who have been diagnosed with severe and persistent major mental illness:

1. Community Support;
2. Day Rehabilitation; and
3. Psychiatric Residential Rehabilitation.

The services must be medically necessary. These services are designed to rehabilitate individuals who are experiencing severe and persistent mental illness in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or nursing facility.

Clients must be assessed by a Nebraska licensed mental health practitioner who can diagnose major mental illness prior to referral, prior authorization and prior to admission to these services. Based on the assessment, the licensed mental health practitioner of the program will complete a biopsychosocial assessment and supervise the development of a treatment, recovery and rehabilitation plan that identifies rehabilitative and mental health/substance abuse services needed by the client.

Licensed Mental Health Practitioners in the program must meet the requirements of a Nebraska Licensed Mental Health Practitioner as identified by DHHS Division of Public Health, Licensure Unit. Non licensed staff must prove competency in the treatment of individuals with a mental health diagnosis. Non licensed staff must meet the requirements for education and experience as defined in each service.

Psychiatric Rehabilitation Agencies must have acquired accreditation by a national accrediting agency such as Joint Commission of Accreditation of Hospitals Organizations (JCAHO), Commission on Accreditation (COA), or Commission on Accreditation of Rehabilitation Facilities (CARF).

The State assures that rehabilitative services are not provided in institutions for mental diseases (IMD).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – REHABILITATIVE SERVICES

Community Support

Community Support is a rehabilitation recovery service delivered by a skilled, trained community support worker under the supervision of a licensed mental health practitioner to individuals suffering from Severe and Persistent Mental Illness (SPMI). The service is delivered through a mental health agency that has achieved and maintained national accreditation by JCAHO, COA, or CARF.

Community-Support is designed to:

1. Provide/develop the necessary services and supports to enable clients to reside in the community;
2. Maximize the client's community participation, community and daily living skills, and quality of life;
3. Facilitate communication and coordination between mental health rehabilitation providers that serve the same client; and
4. Decrease the frequency and duration of hospitalization.

Community Support Program components:

1. A Comprehensive Biopsychosocial Assessment including a strength based assessment within 30 days of admission by a licensed mental health practitioner/clinical supervisor.
2. A Treatment Recovery and Rehabilitation Plan developed within 30 days of admission and with updates of the plan every 90 days and reviewed and approved by a licensed mental health practitioner/clinical supervisor.
3. Individualized rehabilitation and recovery services provided by a community support worker according to the plan.
4. Supervision of the community support worker's services delivery by a licensed mental health practitioner.
5. Staff training supervised by the agency's licensed mental health practitioner at the time of initial employment and on an ongoing basis.

Community Support services:

1. Assist in coordination of a medical and mental health service.
2. Coordination of all communication with community based supports, including family, education, prevocational and social outlets.
3. Monitor medication adherence and report any barriers.
4. Understand and support use of client's relapse prevention plan.
5. Assist in development of problem solving skills and age appropriate independence

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – REHABILITATIVE SERVICES

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6. Assist in accessing medical and mental health care.
7. Assist and encourage relationship building and use of social activities and interests.
8. Teach daily living skills in the client's home environment.
9. Assist client with money management and finances.

Staff ratio: One full-time community support worker to 20 clients. One licensed mental health practitioner to complete all of the essential responsibilities of a clinical supervisor, including review of each client's individualized treatment recovery and rehabilitation plan monthly.

Community support workers (non licensed) must hold a Bachelor's degree or higher in psychology, sociology, or a related human services field or two years of coursework in the human services field and two years experience /training or two years recovery experience with demonstrated competencies and skills in treatment of individuals with mental health diagnosis.

Day Rehabilitation

Day Rehabilitation is a program that provides a structured, organized therapeutic milieu for multiple hours per day. The agency providing the service must achieve and maintain national accreditation with JCAHO, COA, or CARF.

Day Rehabilitation is designed to:

1. Enhance and maintain the client's ability to function in community settings;
2. Decrease the frequency and duration of hospitalization.
3. Develop prevocational services, including services designed to rehabilitate and develop the general skills and behaviors needed to prepare the client to be employed and/or engage in other related substantial gainful activity. The program does not provide training for a specific job or assistance in obtaining permanent competitive employment positions for clients;
4. Develop community living skills and daily living skills development;
5. Assist client skills development for self-administration of medication, as well as recognition of signs of relapse and control of symptoms;
6. Assist in planned socialization and skills training and recreation activities focused on identified rehabilitative needs;
7. Encourage skill-building in the use public transportation when appropriate; and

Program Availability:

Services must be available for clients for a minimum of three hours but up to five hours per day, five days per week. Specific services may be offered on weekends and evenings according to client need.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – REHABILITATIVE SERVICES

Day Rehabilitation Program components:

1. Review of the diagnostic assessment completed by a community based mental health practitioner who can diagnose major mental illness. The Diagnostic Assessment is the clinical information used to refer the client into the program and is reviewed by the program's licensed mental health practitioner.
2. A licensed mental health practitioner (clinical supervisor) completes a comprehensive Biopsychosocial Assessment within 30 days of admission.
3. The licensed mental health practitioner completes the treatment, recovery and rehabilitation plan in the first 30 days following admission which is reviewed and updated every 90 days.
4. Rehabilitation services are delivered in the therapeutic milieu at least 3 hours to 5 hours of services per day. Service availability includes weekend and evening activity as the client's rehabilitative needs are identified.

Day Rehabilitation services:

1. Assist in building daily living skills and time management.
2. Coordinate a prevocational activities to encourage ability for employment
3. Teaching social skills through planned activities.
4. Teaching medication management and it's effectiveness.
5. Assisting in health care access and assist in understanding health care insurance.
6. Skill building in the use of public transportation.
7. Teach money management and financial issues.

Direct Care Staff (non licensed) must have a high school diploma at a minimum and have demonstrated skills and competencies in the treatment of individuals with mental health disorders. Direct care staff are directly supervised by individuals licensed as a Licensed Mental Health Practitioner.

Residential Rehabilitation

Residential Rehabilitation is a 24-hour program that allows a client suffering from severe and persistent mental illness to recover in a rehabilitative setting which includes 20 hours of on-site rehabilitation services and 25 hours off-site services. The agency providing the service must have acquired and maintain national accreditation such as JCAHO, COA, CARF, and be licensed as a Mental Health Center. Room and board are not included in the service.

Residential Rehabilitation Program components:

1. A community-based diagnostic assessment by a licensed practitioner who can diagnose major mental illness as a referral into the program. Prior authorization is required for admission.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – REHABILITATIVE SERVICES

2. A Biopsychosocial Assessment within 30 days of admission into the program.
3. The development of a treatment, recovery and rehabilitation plan developed within 30 days of admission, reviewed and approved by the clinical supervisor who is a licensed mental health practitioner.
4. Service delivery provided by trained direct care staff under the supervision of a licensed clinical supervisor (licensed mental health practitioner). One direct care staff must be available per each 10 clients.

Specific rehabilitation services are:

1. Assist in arranging medical and psychiatric care and management of appointments.
2. Teaching relapse prevention skills and revisiting the relapse plan with the client.
3. Teaching time management and daily living skills.
4. Social skill development through encouraging healthy relationship building and social activities.
5. Teaching survival skills, such as meal preparation, nutrition, housekeeping activities and other daily management.
6. Money management and budgeting.
7. Prevocational skill development.

Psychiatric Residential Rehabilitation is designed to:

1. Increase the client's functioning so that s/he can eventually live successfully in the residential setting of his/her choice, capabilities, and resources; and
2. Decrease the frequency and duration of hospitalization.

Non licensed staff must hold a Bachelor's degree or higher in psychology, sociology, or a related field or two years of coursework in the human services field or two years recovery experience with demonstrated competencies and skills in treatment of individuals with mental health diagnosis. Non licensed staff are supervised by a Nebraska Licensed Mental Health Practitioner who is the Program Supervisor.

Secure Psychiatric Residential Rehabilitation Services

Secure Psychiatric Residential Rehabilitation Services is a service provided to individuals who have psychiatric symptoms and dysfunctions which cause severe disability. The target population is unable to live outside a high level of 24-hour care. These individuals require a secure setting at times for safety of self and others.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – REHABILITATIVE SERVICES

A secure psychiatric residential rehabilitation provider must be licensed as a mental health center by Nebraska Department of Health and Human Services, Division of Public Health and enrolled as a psychiatric rehabilitation provider with Nebraska Medicaid. The provider must have acquired accreditation from a national accrediting agency. The maximum capacity for this facility must not exceed 16 beds. A facility considered an Institution for Mental Disease (IMD), as defined by the Centers for Medicaid and Medicare, will not be enrolled as a provider. The provider of services must develop a treatment rehabilitation and recovery program that meets the individual rehabilitation and treatment needs of the client. The services are provided in a community-based setting in an organized therapeutic environment. The provider must have acquired national accreditation of the Joint Commission on Accreditation for Healthcare Organizations (JCAHO), Council for Accreditation (COA), or Commission on Accreditation of Rehabilitation Facilities and must maintain that accreditation.

Services consist of psychiatric assessment by a psychiatrist. Treatment planning by a multi-disciplinary treatment team supervised by the psychiatrist, rehabilitation and treatment services delivered by licensed professionals and paraprofessionals within their scope of practice, training and competency.

Staff consist of a board certified, Nebraska enrolled psychiatrist who is a licensed physician, a program manager who is a licensed mental health therapist with administrative ability and licensed therapists to provide therapy and rehabilitation interventions. Direct care staff provide interventions consistent with the rehabilitative plan.

Secure psychiatric residential rehabilitation services are designed to assist severely psychiatrically impaired individuals live in a more community-based setting where they can achieve a level of success in the least restrictive level of care. These services also prevent individuals with severe psychiatric illnesses from being institutionalized if they can live in a secure community based environment. The goal of this service is to prevent or decrease the frequency and duration of psychiatric hospitalization. It is intended that the service would lessen and/or eliminate symptoms and prevent reoccurrence of acute episodes and exacerbation of illness. Goals include improving client ability to develop more self-care activities, manage psychiatric symptoms through adherence to medication administration, and develop social skills to adapt to a less secure community setting.

Telehealth:

Rehabilitative services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – REHABILITATIVE SERVICES

ASSERTIVE COMMUNITY TREATMENT

Assertive Community Treatment is a service-delivery model for providing comprehensive community-based psychiatric treatment and rehabilitation services and is intended for individuals with psychiatric illnesses that are most severe and persistent. The service is a multidisciplinary and mobile mental health team who functions interchangeably to provide the rehabilitation and treatment services designed to enable the consumer to live successfully in the community in an independent or semi-independent arrangement. With the same team providing treatment and rehabilitation services, the complex interaction of symptoms and psychosocial functioning are addressed more efficiently and effectively across time. The content, amount, timing and kinds of service provided vary among clients and for each client across time. Team service intensity is individualized based upon continual assessment of need and adjustment to the treatment plan.

The services must be medically and/or biopsychosocially necessary.· These services are designed to rehabilitate individuals who are experiencing severe and persistent mental illness in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or nursing facility. Rehabilitative psychiatric services do not include treatment for a primary diagnosis of substance abuse.

Assertive Community Treatment services must be recommended by a licensed mental health professional prior to receiving these services. An assessment must be completed to receive the service(s). The licensed mental health professional will develop service need recommendations that identify rehabilitative and mental health services needed by the client. The completed service needs assessment and service recommendations will be reviewed and approved by a supervising mental health practitioner (psychiatrist or licensed psychologist).

Provider Qualifications: Providers of rehabilitative psychiatric services must be licensed/ certified by the Nebraska Department of Health and Human Services as providers of community-based comprehensive psychiatric rehabilitation and support services. Providers must be under contract with the Nebraska Health and Human Service System through the Regional Governing Boards as defined in Neb. Rev. Stat. §83-158.01 to §83-169 and §71-5001 to §71-5052 to provide one or more of the covered services and must demonstrate the capacity to fulfill and abide by all contractual requirements. The provider must complete a Medicaid provider agreement and obtain a Medicaid approved provider number. Providers are required to meet all applicable licensure and certification requirements, hold a current license/certification and adhere to scope of practice definitions of licensure/certification boards.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – REHABILITATIVE SERVICES

Assertive Community Treatment teams shall provide a comprehensively staffed team including a psychiatrist, peer/family support staff (licensed mental health practitioner), program assistants, and clinical staff (mental health practitioners and registered nurses). Team members must be appropriately licensed.

Limitation on Services: Covered services are available only to Medicaid eligible recipients with a written service plan containing the recommended necessary psychiatric rehabilitation and support services. Services must be pre-authorized by the Department or its agent, and are subject to continuing stay review. Each service has an authorized level of benefit as determined by the Department or its agent. Limitations may also be imposed on days and/or hours of total benefits provided to a client during a given time period. Services are excluded to any recipient who is a resident of an IMD.

Assertive Community Treatment is designed to:

1. Provide comprehensive community based treatment and rehabilitation services through a self-contained clinical team to clients living in independent or semi-independent living situations.
2. Provide services to severely impaired clients who are resistant to more traditional interventions or unable to remain stable with the maximum use of traditional community resources including other psychiatric rehabilitative service.
3. To increase the client's functioning so that s/he can live successfully in the community setting of his/her choice, capabilities, and resources;
4. Decrease the frequency and duration of hospitalization;
5. To lessen or eliminate debilitating symptoms and to prevent or minimize recurrent acute episodes of illness;
6. To improve social skills, self-care, symptom management, and medication adherence; and
7. Provide a frequency and duration of services that allows the client to achieve continuous stability in all functional areas. Involvement with the team is over an extended period of time to maintain consumer functional level and progress.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - REHABILITATIVE SERVICES

Assertive Community Treatment includes the following components:

1. Completion of a comprehensive assessment of client need and the development of an appropriate treatment, rehabilitation and service plan;
2. Direct and provide needed treatment and rehabilitation services in a culturally sensitive and competent manner. The mandatory treatment and rehabilitative interventions include:

   a) Treatment and Service Plan Coordination: An individualized treatment and service plan developed by the treatment team to diagnose, treat, and rehabilitate the client's medical symptoms and remedial functional impairments;
   b) Crisis Assessment and Management: Immediate medical interventions to assess and treat an acute exacerbation of medical symptoms and/or remedial functional impairments;
   c) Symptom Assessment and Management: Initial and ongoing biopsychosocial assessment of the client's medical symptoms and remedial functional impairments. The assessment includes, but is not limited to, relevant history, previous treatment, current medical conditions and medications;
   d) Individual Contacts: Staff interventions with the client or their family to facilitate communication and client skill building necessary to support the client in the community and minimize the adverse effects of the illness. The specific focus of family contact is to facilitate the effective treatment and rehabilitation of the client;
   e) Active Treatment Interventions: Active treatment interventions include individual therapy, group therapy, family therapy and substance abuse counseling;
   f) Medication Prescription, Administration and Monitoring;
   g) Activities of Daily Living: Medical and remedial services designed to rehabilitate and develop the general skills and behaviors needed for the client to engage in substantial gainful activity and use of daily living skills. These include problem solving, individualized assistance and support and skill training;
   h) Social Interpersonal Relationship and Leisure Time Skill Training: Remedial interventions (problem solving, role playing, modeling and support, etc.) designed to minimize the adverse effects of severe mental illness (examples: isolation, poor peer selection, poor decision making, depression, substance abuse, anxiety). Interventions include activities required to help the client improve communication skills, develop assertiveness, increase self esteem, develop social skills and meaningful personal relationships, plan appropriate

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - REHABILITATIVE SERVICES

and productive use of leisure their use of such opportunities. All social and recreational activities are in support of the client's treatment plan and not purely social or recreational in nature;

3. Provide services in home and community based settings with an emphasis on assertive outreach to clients. Community based settings include, but are not limited to, clinics, libraries, grocery stores, and other locations available to the general public;

4. Provide multiple service contacts per week and per day according to client need. Programs have the capacity to immediately increase service intensity to a client when status requires it. The program has shifts staffed for at least 12 hours per day on weekdays and eight hours per day on weekends and holidays;

5. Provide for active psychiatrist involvement as a member of the treatment team;

6. Provide for a licensed and/or certified interdisciplinary team including a psychiatrist, registered nurse, mental health practitioner, substance abuse specialist and peer/family specialist. Provider qualifications are ensured by compliance with requirements and standards of national accreditation and/or State certification; and

7. Conduct daily organization staff meetings to review the status of the team's clients and the schedule of upcoming interventions.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – SERVICES FOR INDIVIDUALS AGE 65 OR OLDER IN INSTITUTIONS FOR MENTAL DISEASES – INPATIENT HOSPITAL SERVICES

Telehealth:

Inpatient hospital services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – SERVICES FOR INDIVIDUALS AGE 65 OR OLDER IN INSTITUTIONS FOR MENTAL DISEASES – SKILLED NURSING FACILITY SERVICES

Telehealth:

Skilled nursing facility services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Physician visits to clients required on the specific periodic schedule for nursing facility certification are excluded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – SERVICES FOR INDIVIDUALS AGE 65 OR OLDER IN INSTITUTIONS FOR MENTAL DISEASES – INTERMEDIATE CARE FACILITY SERVICES

Telehealth:

Intermediate care facility services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – ICF/MR SERVICES

ICF/MR Level of Care Criteria

The Department applies the following criteria to determine the appropriateness of ICF/MR services on admission and at each subsequent review:

1. The individual has a diagnosis of mental retardation or a related condition which has been confirmed by prior diagnostic evaluations/standardized tests and sources independent of the ICF/MR; and

2. The individual can benefit from "active treatment" as defined in 42 CFR 483.440(a) and 471 NAC 31-001.02. "Benefit from active treatment" means demonstrable progress in reducing barriers to less restrictive alternatives; and

3. In addition, the following criteria shall apply in situations where -

   a. The individual has a related condition and the independent QMRP assessment identifies that the related condition has resulted in substantial functional limitations in three or more of the following areas of major life activity:

      (1) self-care;
      (2) receptive and expressive language;
      (3) learning;
      (4) mobility;
      (5) self-direction; or
      (6) capacity for independent living;

      These substantial functional limitations indicate that the individual needs a combination of individually planned and coordinated special interdisciplinary care, a continuous active treatment program, treatment, and other services which are lifelong or of extended duration; and/or

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - ICF/MR SERVICES

b. A Medicaid-eligible individual has a dual diagnosis of mental retardation or a related condition and a mental illness (i.e., mental retardation and schizophrenia). The mental retardation or related condition has been verified as the primary diagnosis by both an independent QMRP and a mental health professional (i.e., psychologist, psychiatrist); and

(1) Historically there is evidence of missed developmental stages, due to mental retardation or a related condition;

(2) There is remission in the mental illness and/or it does not interfere with intellectual functioning and participation in training programs, i.e., the individual does not have active hallucinations nor exhibit behaviors which are manifestations of mental illness; and

(3) The diagnosis of mental retardation or related condition takes precedence over the diagnosis of mental illness.

Inappropriate Level of Care: The following examples are not appropriate for ICF/MR services:

1. Mental illness is the primary barrier to independent living within a normalized environment; or

2. The ICF/MR level of care is not the least restrictive alternative, e.g., the client –

a. Exhibits skills and needs comparable to those of persons with similar needs living independently or semi-independently in the community;

b. Exhibits skills and needs comparable to those of persons at NF level of care; or

c. Is able to function with little supervision or in the absence of a continuous active treatment program.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - ICF/MR SERVICES

QMRP Approval Criteria: Under 42 CFR 483.430, a qualified mental retardation professional is a person who has at least one year of experience working directly with persons with mental retardation or related conditions and is one of the following:

1. A doctor of medicine or osteopathy;
2. A registered nurse;
3. An individual who holds at least a bachelor's degree or is licensed, certified, or registered and provides professional services in Nebraska in one of the following professional categories:
    a. An occupational therapist;
    b. A physical therapist;
    c. A psychologist;
    d. A social worker;
    e. A speech-language pathologist or audiologist;
    f. A professional recreation staff member;
    g. A professional dietitian; or
    h. A human services professional.

The Department uses these standards to approve individuals who conduct independent QMRP assessments.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - ICF/MR SERVICES

Standards for a QMRP: To be approved by the Department to complete Independent QMRP Assessments, an individual shall submit the following information to the Department of Health and Human Services:

1. Proof of QMRP designation by an outside agency or program; or
2. Verification of -
   a. Education/degree (transcript);
   b. Licensure, registration, or certification. as applicable to the profession (copy); and
   c. One year's experience in working directly with persons with mental retardation. The individual shall indicate the following skills related to his/her job experience in a mental retardation facility/program:
      (1) Assessing the need for specific goals and objectives;
      (2) Writing behaviorally-stated goals and objectives in training programs;
      (3) Conducting or carrying out training programs; and
      (4) Evaluating, documenting. and summarizing training programs.

Department staff shall review the submitted information and, if approved, shall issue a formal letter of approval to the applicant.

The Department may withdraw approval of any QMRP who has been advised by Nebraska Department of Health and Human Services that his/her assessments are lacking in quality and/or completeness.

Telehealth: ICF/MR services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER AGE 21

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – NURSE-MIDWIFE SERVICES

To participate in the Nebraska Medical Assistance Program, the nurse-midwife must be certified by the Department of Health and Human Services Regulation and Licensure. The practice agreement between nurse-midwife and the physician with whom s/he has a practice agreement must be on file with the Department of Health and Human Services Regulation and Licensure. The nurse- midwife is approved for enrollment in NMAP under an independent provider agreement or the provider agreement of the physician with whom s/he has a practice agreement.

NMAP covers nurse-midwife services that are medically necessary and are concerned with the management of the care of mothers and newborns throughout the maternity cycle. The maternity cycle includes pregnancy, labor, birth, and the immediate postpartum period (up to six weeks), including care of the newborn. To be covered, the services must be provided by a certified nurse- midwife according the terms of the practice agreement between the nurse-midwife and the physician.

NMAP does not cover any other services provided by nurse-midwives.

Telehealth:

Nurse-midwife services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Services requiring "hands on" professional care are excluded.

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

STATE OF NEBRASKA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

LIMITATION ON THE AMOUNT, DURATION AND SCOPE OF CERTAIN ITEMS OF PROVIDED MEDICAL AND REMEDIAL CARE AND SERVICES ARE DESCRIBED AS FOLLOWS.

Medical and Remedial Care and Services-Item 18

Citation
1905(o) of the Social Security Act

42 CFR Part 418

Hospice Care

The Nebraska Medical Assistance Program will provide reimbursement for hospice care for Medicaid clients that are terminally ill. Terminally ill means that the client is diagnosed with a medical prognosis that his/her life expectancy is six months or less if the illness runs its normal course.

Hospice services are provided in accordance with the guidance specified in sections 4305-4308 of the State Medicaid Manual.

Election Statement
An election statement must be filed with a specific hospice for the client who meets the requirements. An election to receive hospice care will be considered to continue through the initial certification period and the subsequent election periods without a break in care as long as the client remains in the care of the hospice and does not revoke the election.

Dually eligible (Medicare and Medicaid) clients must elect and revoke hospice care simultaneously under both the Medicare and the Medicaid program.

Election Period
A client may elect to receive hospice care during one or more of following election periods;

1. an initial 90-day period;
2. a subsequent 90-dayperiod;
3. an initial 60-day period;
4. a subsequent 60-day period;
5. a third 60-day period.

Additional 60-day benefit periods must be approved as an exception under the Prior Authorization provision.

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

STATE OF NEBRASKA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

LIMITATION ON THE AMOUNT, DURATION AND SCOPE OF CERTAIN ITEMS OF PROVIDED MEDICAL AND REMEDIAL CARE AND SERVICES ARE DESCRIBED AS FOLLOWS.

Certification of Terminal Illness

The client must be certified as terminally ill with a six-month life expectancy by the Hospice medical director and the attending physician at the beginning of the first benefit period and by the Hospice medical director for all subsequent benefit periods. The hospice provider must obtain written certification of the terminal illness for each certification period even when a single election continues in effect for two or more periods.

Plan of Care

A written plan of care must be established and maintained for each client admitted to a hospice program. The care provided to a client must be consistent with the plan and be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions. The plan of care must be established before services are provided.

Waiver of Payment for Other Services

A client waives all rights to Medicaid payments for the duration of the election of hospice care for the following services:

Hospice care provided by a hospice other than the hospice designated by the client; and

For adult clients, any Medicaid services that are related to the treatment of the terminal condition for which hospice care elected or a related condition or that are equivalent to hospice care except for services provided:

by the designated hospice; or

the client's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – PREGNANCY-RELATED AND POSTPARTUM SERVICES FOR 60 DAYS AFTER THE PREGNANCY ENDS

NMAP covers pregnancy-related and postpartum services for 60 days after the pregnancy ends or at the end of the month in which the 60th day falls, based on medical necessity.

Telehealth:

Pregnancy-related and postpartum services are provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – SERVICES FOR ANY OTHER MEDICAL CONDITIONS THAT MAY COMPLICATE PREGNANCY

NMAP covers medical services for any other medical conditions that may complicate pregnancy, based on medical necessity.

Telehealth:

Medical services for medical conditions that may complicate pregnancy are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – CERTIFIED PEDIATRIC OR FAMILY NURSE PRACTITIONERS' SERVICES

Telehealth:

Certified pediatric or family nurse practitioners' services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - TRANSPORTATION

AMBULANCE

NMAP covers medically necessary ambulance services required to transport a client during an emergency or required to obtain medical care. Emergency ambulance transports to a physician or practitioner's office, clinic or therapy center are covered. Non-emergency ambulance transports to a physician or practitioner's office, clinic or therapy center are covered when -

1. The client is bed confined before, during, and after transport; and
2. The services cannot or cannot reasonably be expected to be provided at the client's residence (including a nursing facility or ICF/MR).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – TRANSPORTATION

AMBULATORY ROOM AND BOARD

NMAP covers ambulatory room and board services as a travel-related expense under 42 CFR 440.170(a)(3)(ii) and (iii). Ambulatory room and board is defined as meals and lodging determined to be necessary by Medicaid Division staff to secure NMAP-coverable services for a Medicaid client.

This may include meals and lodging for an attendant.

NMAP covers ambulatory room and board services only when:

1. The client is receiving NMAP-coverable services;
2. Travel time or distance to the medical provider and receipt of medical services are expected to require the client to be away from his/her home for 12 hours or longer;
3. An out-of-town overnight stay is necessary while receiving NMAP-coverable services; and
4. Ambulatory room and board is a cost effective level of care that provides an alternative to inpatient admission or extended outpatient care.

Ambulatory room and board services may be covered for up to one day before or after receiving NMAP-coverable services, if extensive travel is necessary to receive NMAP-coverable services. Ambulatory room and board for an attendant to accompany the client may be covered when the client is physically or mentally unable to travel or wait alone while receiving NMAP-coverable services.

To be eligible to receive NMAP payment for ambulatory room and board services, each hospital providing those services must be approved by the Medicaid Division as a provider of ambulatory room and board services before providing these services to NMAP clients and/or attendants.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – TRANSPORTATION

Telehealth:

Medical transportation services, including ambulance services and ambulatory room and board, are not covered when provided via telehealth technologies.

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

State/Territory: Nebraska

SECTION 3 – SERVICES: GENERAL PROVISIONS

3.1 Amount, Duration, and Scope of Services

Medicaid is provided in accordance with the requirements of sections 1902(a), 1902(e), 1903(i), 1905(a), 1905(p), 1905(r), 1905(s), 1906, 1915, 1916, 1920, 1925, 1929, and 1933 of the Act; section 245A(h) of the Immigration and Nationality Act; and 42 CFR Parts 431, 440, 441, 442, and 483.

A. Categorically Needy

28. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary (in accordance with section 1905(a)(28) of the Social Security Act and 42 CFR 440.170).

a. Transportation (provided in accordance with 42 CFR 440.170 as an optional medical service) excluding "school-based" transportation.

☐ Not Provided:

☐ Provided without a broker as an optional medical service: (If state attests "Provided without a broker as an optional medical service" then insert supplemental information.)

Describe below how the transportation program operates including types of transportation and transportation related services provided and any limitations. Describe emergency and non-emergency transportation services separately. Include any interagency or cooperative agreements with other Agencies or programs.

☒ Non-emergency transportation is provided through a brokerage program as an optional medical service in accordance with 1902(a)(70) of the Social Security Act and 42 CFR 440.170(a)(4). (If state attests that non-emergency transportation is being provided through a brokerage program then insert information about the brokerage program.)

☒ The State assures it has established a non-emergency medical transportation program in accordance with 1902(a)(70) of the Social Security Act in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(i).

State/Territory: Nebraska

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a);

☐ (1) state-wideness (indicate areas of State that are covered)
☐ (10)(B) comparability (indicate participating beneficiary groups)
☒ (23) freedom of choice (indicate mandatory population groups)

(2) Transportation services provided will include:
☒ wheelchair van
☒ taxi/commercial carrier
☐ stretcher car
☒ bus passes

☒ tickets
☐ secured transportation
☒ other transportation (if checked describe below other transportation)
- Individual volunteer
- Medical escort

☒ (3) The State assures that transportation services will be provided under a contract with a broker who:
(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs:
(ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely and transport personnel are licensed qualified, competent and courteous:
(iii) is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services:
(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate.)

State/Territory: Nebraska

(4) The broker contract will provide transportation to the following categorically needy mandatory populations:

- ☒ Low-income families with children (section 1931)
- ☒ Deemed AFCD-related eligibles
- ☒ Poverty-level related pregnant women
- ☒ Poverty-level infants
- ☒ Poverty-level children 1 through 5
- ☒ Poverty-level children 6 – 18
- ☒ Qualified pregnant women AFDC – related
- ☒ Qualified children AFDC – related
- ☒ IV-E foster care and adoption assistance children
- ☒ TMA recipients (due to employment) (section 1925)
- ☒ TMA recipients (due to child support)
- ☒ SSI recipients

(5) The broker contract will provide transportation to the following categorically needy optional populations:

- ☒ Optional poverty-level - related pregnant women
- ☒ Optional poverty-level - related infants
- ☒ Optional targeted low income children
- ☒ Non IV-E children who are under State adoption assistance agreements
- ☒ Non IV-E independent foster care adolescents who were in foster care on their 18th birthday
- ☒ Individuals who meet income and resource requirements of AFDC or SSI
- ☒ Individuals who would meet the income & resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency

- ☐ Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law
- ☐ Children aged 15-20 who meet AFDC income and resource requirements
- ☒ Individuals who would be eligible for AFDC or SSI if they were not in a medical institution
- ☐ Individuals infected with TB
- ☒ Individuals screened for breast or cervical cancer by CDC program
- ☐ Individuals receiving COBRA continuation benefits
- ☐ Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income standard

State/Territory: Nebraska

- ☒ Individuals receiving home and community based waiver services who would only be eligible under State plan if in a medical institution (the broker will provide NEMT only to 1905(a) services)
- ☐ Individuals terminally ill if in a medical institution and will receive hospice Care
- ☒ Individuals aged or disabled with income not above 100% FPL
- ☐ Individuals receiving only an optional State supplement in a 209(b) State
- ☒ Individuals working disabled who buy into Medicaid (BBA working disabled group)
- ☐ Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group
- ☒ Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids).

(6) Payment Methodology

(A) The State will pay the contracted broker by the following method:

- ☐ (i) risk capitation
- ☐ (ii) non-risk capitation
- ☒ (iii) other (e.g., brokerage fee and direct payment to providers) (If checked describe any other payment methodology)

The State shall pay the contracted broker a uniform fee-for-service administration rate per completed trip for all trips. A Completed Trip is defined as a transportation service scheduled, arranged and prior authorized for payment by the broker. The administrative fee rate to the broker is established for each contract year in the contract.

For dates of service on or after May 1, 2011, Medicaid pays for non-emergency medical transportation services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Except as otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates, which are the same for both governmental and private providers of non-emergency

State/Territory: Nebraska

transportation services. The agency's rates were set as of May 1, 2011, and are effective for services rendered on or after that date. The fee schedule is subject to annual/periodic adjustment. All rates, including current and prior rates, are published and maintained on the agency's website. Specifically, the fee schedule and any annual/periodic adjustments to the fee schedule are published at http://www.dhhs.ne.gov/med/practitioner_fee_schedule.htm.

(B) Who will pay the transportation provider?

☒ (i) Broker
☒ (ii) State
☐ (iii) other

The broker will pre-purchase public transit passes, and commercial bus, airline and train tickets on behalf of the beneficiary when determined to be necessary and will not bill the state until the pre-purchased ticket/pass is actually dispersed or used by the beneficiary. Public transit passes shall be administered pursuant to the CMS letter to State Medical Directors, issued December 2, 1996. The Medicaid beneficiary is not reimbursed mileage for use of their personal vehicle by the broker, nor the state.

(C) What is the source of the non-Federal share of the transportation payments? Describe the source of the non-Federal share of the transportation payments proposed under the State plan amendment. If more than one source exists to fund the non-Federal share of the transportation payment, please separately identify each source of non-Federal share funding.

State General Funds

☒ (D) The State assures that no agreement (contractual or otherwise) exists between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). This assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.

State/Territory: Nebraska

☒ (E) The State assures that payments proposed under this State plan amendment will be made directly to transportation providers and that the transportation provider payments are fully retained by the transportation providers and no agreement (contractual or otherwise) exists between the State or local government and the transportation provider to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly).

☒ (7) The broker is a non-governmental entity:

☒ The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial relationship as described at 45 CFR 440.170(4)(ii).

☐ The broker is itself a provider of transportation or subcontracts with or
refers to an entity with which it has a prohibited financial relationship and:

☐ transportation is provided in a rural area as defined at 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

☐ transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

☐ the availability of other non-governmental Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.

☐ (8) The broker is a governmental entity

☐ The broker provides transportation itself or refers to or subcontracts with another governmental entity for transportation. The governmental broker will:

☐ Maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.

☐ Document that with respect to each individual beneficiary's specific transportation needs, the government provider is the most appropriate and lowest cost alternative.

☐ Document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public para-transit services than the rate charged to other State human services agencies for the same service.

State/Territory: Nebraska

(9) Please describe below how the NEMT brokerage program operates. Include the services that will be provided by the broker. If applicable, describe any services that will not be provided by the broker and name the entity that will provide these services.

The broker shall be responsible for and perform all administrative brokerage functions to include: establish and monitor Medicaid program compliance of a transportation network; receive NET service requests through a customer service call center for at least nine (9) consecutive hours during the hours of 9:00 a.m. though 7:00 p.m. Central Standard Time, Monday through Friday, and on-call representative for urgent care trips; verify client Medicaid eligibility, and their requested medical service provider is an active Medicaid provider through a daily batch interface to the broker's system; screen client need for service and mobility status for the most appropriate mode of transportation; approve and arrange the least expensive transport to the closest appropriate Medicaid provider; prior-authorize completed services in MMIS for direct provider payment from the State. The broker provides oversight to assure services through:

a. Client Surveys;
b. Random pre-transportation validation checks prior to approving the NET service request to a covered medical service provider for no fewer than ten (10%) percent of the NET services received in a month for contract year one, with annual re-evaluation for percentage determination in subsequent years. The broker shall contact the medical service provider and verify the client has an appointment for a covered medical service. The State may require pre-transportation validation checks of trips to specific program services, such as non-routine out-of-state medical care. The broker shall determine that the client is requesting NET medical services to a qualified, enrolled, medical service provider who is willing to accept the client, within the travel standards established by the State; and
c. Random post-transportation validation checks prior to submitting a prior-authorization for payment to a NET service provider for no fewer than ten (10%) percent of the NET service public/commercial transportation referrals, and one hundred (100%) percent of Individual Transportation and Escort Provider referrals, in a month to ensure that all NET provider supporting documentation is maintained and matches the prior-authorization, and that the trips actually occurred in accordance to Nebraska Medicaid regulations.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – NURSING FACILITY SERVICES FOR PATIENTS UNDER 21 YEARS OF AGE

Telehealth:

Nursing facility services for patients under 21 years of age are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Physician visits to client in nursing facilities required on the specific periodic schedule for nursing facility certification are excluded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - EMERGENCY HOSPITAL SERVICES

Telehealth:

Emergency hospital services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

ATTACHMENT 3.1-A
Item 24f
Applies to both
Categorically and
Medically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – CRITICAL ACCESS HOSPITALS

Critical access hospital services as defined in 42 CFR 440.170(g) are a covered service by Nebraska Medicaid.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – PERSONAL ASSISTANCE SERVICES

NMAP covers personal assistance services, which are a defined range of human assistance that enable persons with disabilities and chronic conditions of all ages to accomplish tasks that they would normally do for themselves if they did not have a disability; chosen and directed by the individual or designee.

NMAP generally limits personal assistance services to 40 hours per client per seven-day period, subject to utilization review. Medicaid Division approval must be obtained for services authorized in excess of 40 hours per week.

Personal assistance services may not be provided at a client's worksite except when the client is engaged in competitive integrated employment. Personal assistance services may only be provided at a client's worksite to the extent the authorized task might otherwise be needed in the home and community.

Personal assistance service may not be provided to individuals residing in residential facilities where personal assistance services are required under the licensing requirements.

Telehealth:

Personal assistance services are not covered when provided via telehealth technologies.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

PROVIDER QUALIFICATIONS – PERSONAL ASSISTANCE SERVICES

NMAP reimburses personal assistance services providers who meet requirements that include being age 19 or older; being capable of recognizing signs of distress in client and knowing how to access available emergency resources if a crisis situation occurs; keeping current any state or local license/certification required for service provision; understanding and accepting responsibility for the client's safety and property; and having the knowledge, experience, and/or skills necessary to perform the task(s). To be considered and reimbursed by NMAP as a "specialized" personal assistance services provider, the applicant must provide proof that s/he has successfully completed a basic aide training course that has been approved by the Nebraska Department of Health and Human Services; has passed the Nurse Aide Equivalency test; is a licensed R.N. or L.P.N.; or has a total of 4,160 hours of experience (24 months at an average of 40 hours per week) as a personal assistance service provider.

Personal Assistance Services will be provided in accordance with, and meet the requirements of 42 CFR 440.167.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – FREESTANDING BIRTH CENTER SERVICES

The facility fee is based on a review of Medicaid fees paid by other states. Under this State Plan, birthing centers are limited to those licensed by the State of Nebraska or other legally authorized licensing authority under applicable state laws, to provide a level of service commensurate with the professional skills of a physician (MD or DO) or a certified nurse-midwife (CNM) who acts as birth attendant. The center, the physician, and CNM must be licensed at the time and place the services are provided. The birthing center must be enrolled and approved by the state agency or its designee for participation in the Nebraska Medical Assistance Program. The center must have a written agreement for emergency care with a hospital that provides obstetrical services. Admission to the facility must be restricted to low-risk vaginal delivery patients. Caesarean section procedures are prohibited. Each mother and newborn must be discharged within 24 hours after admission, in a condition which will not endanger the well-being of either. If the condition of mother or newborn does not allow discharge within 24 hours, then transfer to a hospital must occur.

Coverage of birthing center facility services is limited to certain birthing services provided by the center and determined by the attending physician or CNM to be necessary for the care of the mother and live newborn child following the mother's normal, uncomplicated pregnancy. Reimbursable services are limited to facility services provided during the labor, delivery and postpartum periods. Birthing center facility services furnished prior to or after the above described period are not considered birthing center facility services and are not covered or reimbursed as such under this state plan. Services provided by a physician or CNM are not considered to be birthing center facility services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

CASE MANAGEMENT SERVICES

A. Target Group:

Mandatory and optional groups covered as aged, blind, or disabled under Nebraska's Medicaid state plan (with the exception of persons covered in Nebraska's approved case management amendment for persons with mental retardation).

B. Areas of State in which services will be provided:

☒ Entire State.

☐ Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

☐ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Case management services are defined as –

1. Assessment of individual needs level and requirement for supports and services;

2. Development of individual support and service goals; and

3. Coordination of personal, agency, non-agency, and professional resources to develop and attain individual support and service goals and access needed medical, social, habilitation, education, employment, housing and other services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

CASE MANAGEMENT SERVICES

Case management activities designed to assist Medicaid-eligible clients include the following:

1. Client assessment

   a. Receive referrals or client request for case management services.
   b. Conduct information gathering and assessment interviews.
   c. Conduct an assessment to determine client's needs for individual support and services.
   d. Arrange for additional specialized needs assessment as required to provide a full assessment of clients' needs for individual support and services.

2. Service Planning

   a. Together with the client or his/her representative develop a plan which includes types of services to be provided to meet the client's needs, resources selected to provide the services, frequency and duration of service provision, etc.
   b. Arrange for support and services identified in the plan, consistent with Section 1902(a)(23) of the Social Security Act.
   c. Contact, coordinate, and confirm the client's service provision with providers of service.
   d. Provide follow-up, ongoing monitoring of service delivery, and periodic reviews to assess suitability of client's plan.

3. Accessing Resources

   a. Determine appropriate resources to meet the client's needs
   b. Assist clients in applying for appropriate programs within the Department of Social Services (e.g., Low Income Energy Assistance Program, Child Support, Food Stamps) and outside of the Department (e.g., community action, housing authority, legal aid, public health nurses, social security administration, veterans administration, vocational rehabilitation). This may include assisting the client to make an appointment or arranging transportation to the resources.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

CASE MANAGEMENT SERVICES

c. Coordinate services from all available sources to insure that client needs are met
d. Assist clients in locating appropriate living arrangements, based upon the philosophy of least restrictive services.
e. Assist client to arrange for and receive appropriate medical care and counseling.
f. Assist clients to locate appropriate employment or training.

4. Resource Recruitment

a. Recruit or locate service providers that would be consistent with the client's plan and consistent with Section 1902(a)(23) of the Social Security Act.

Conditions of Provision

1. The following conditions must be met in order for case management service to be provided:

a. The client/guardian must freely accept case management services.
b. The client and case manager must work together to achieve a plan.
c. The client must no reside in an institutional setting.

2. The following conditions must be met in order for case management services to be reimbursed under Medicaid:

a. The case manager must conduct a face-to-face interview with the client in order to determine client needs and develop approaches to meet the needs.
b. The case manager with the client or client's representative, must develop a plan which is documented in the case record.
c. The case manager must reevaluate the plan when necessary but at that minimum annually.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

CASE MANAGEMENT SERVICES

d. The case manager must provide narrative documentation to supplement the paln which includes:
   (1) Information supporting the approaches selected;
   (2) Information supporting case management decisions and action;
   (3) Documentation of communication with the client;
   (4) Documentation of referrals to resources; and
   (5) Other factual information relevant to the case.

E. Qualification of Providers:

Because of the nature of the services for which coordination is to be provided, the provider agency must have a written referral agreement with Nebraska Title XX agency.

Case management services will be provided by or under the supervision of a person with at least three years of experience in case management.

Qualifications

Case Manager

Knowledge of : Principles and practices of social work; theories and strategies of provider services to persons with special needs; public and private medical, social, educational, and other resources available in the community; agency philosophy, procedures, and programs; techniques of interviewing to obtain necessary information; and regulations and standards pertaining to service delivery.

Ability to: Interact with clients from a variety of socio-economic and cultural backgrounds and clients with functional limitations caused by physical or mental disabilities or advanced age; work well with people and exercise good judgment in evaluating situations and making decisions; assess client needs; translate needs assessment into individual client plan to provide proper services; develop working relationships with other individuals, groups, and agency representatives; communicate both orally and in writing; mobilize resources to meet client needs.

Education/Experience

Each case manager must have experience in a human services field where the required knowledge, skills, and abilities have been successfully applied.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

CASE MANAGEMENT SERVICES

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

CASE MANAGEMENT SERVICES

A. Target Group:

Mandatory and optional groups covered as AFDC-related in Nebraska's Medicaid state plan.

B. Areas of State in which services will be provided:

☒ Entire State.

☐ Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

☐ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Case management services are defined as –

1. Assessment of individual needs level and requirement for supports and services;
2. Development of individual support and service goals; and
3. Coordination of personal, agency, non-agency, and professional resources to develop and attain individual support and service goals and access needed medical, social, habilitation, education, employment, housing, and other services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

CASE MANAGEMENT SERVICES

Case management activities designed to assist Medicaid-eligible clients include the following:

1. Client assessment

   a. Receive referrals or client requests for case management services.
   b. Conduct information gathering and assessment interviews.
   c. Conduct an assessment to determine client's needs for individual support and services.
   d. Arrange for additional specialized needs assessment as required to provide a full assessment of clients' needs for individual support and services.

2. Service Planning

   a. Together with the client or his/her representative develop a plan which includes types of services to be provided to meet the client's needs, resources selected to provide the services, frequency and duration of service provision, etc.
   b. Arrange for support and services identified in the plan, consistent with Section 1902(a)(23) of the Social Security Act.
   c. Contact, coordinate, and confirm the client's service provision with providers of service.
   d. Provide follow-up, ongoing monitoring of service delivery, and periodic reviews to assess suitability of client's plan.

3. Accessing Resources

   a. Determine appropriate resources to meet the client's needs.
   b. Assist clients in applying for appropriate programs within the Department of Social Services (e.g., Low Income Energy Assistance Program, Child Support, Food Stamps) and outside of the Department (e.g., community action, housing authority, legal aid, public health nurses, social security administration, veterans administration, vocational rehabilitation). This may include assisting the client to make an appointment or arranging transportation to the resource.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

CASE MANAGEMENT SERVICES

c. Coordinate services from all available sources to insure that client needs are met.
d. Assist clients in locating appropriate living arrangements, based upon the philosophy of least restrictive services.
e. Assist client to arrange for and receive appropriate medical care and counseling.
f. Assist clients to locate appropriate employment or training.

4. Resource Recruitment

a. Recruit or locate service providers that would be consistent with the client's plan and consistent with Section 1902(a)(23) of the Social Security Act.

Conditions of Provision

1. The following conditions must be met in order for case management services to be provided:

a. The client/guardian must freely accept case management services.
b. The client and case manager must work together to achieve a plan.
c. The client must not reside in an institutional setting.

2. The following conditions must be met in order for case management services to be reimbursed under Medicaid:

a. The case manager must conduct a face-to-face interview with the client in order to determine client needs and develop approaches to meet these needs.
b. The case manager with the client or client's representative, must develop a plan which is documented in the case record.
c. The case manager must reevaluate the plan when necessary but at a minimum annually.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

CASE MANAGEMENT SERVICES

d. The case manager must provide narrative documentation to supplement the plan which includes:
   (1) Information supporting the approaches selected;
   (2) Information supporting case management decisions and actions;
   (3) Documentation of communication with the client;
   (4) Documentation of referrals to resources; and
   (5) Other factual information relevant to the case.

E. Qualification of Providers:

Because of the nature of the services for which coordination is to be provided, the provider agency must have a written referral agreement with Nebraska's Title XX agency.

Case management services will be provided by or under the supervision of a person with at least three years of experience in case management.

Qualifications

Case Manager

Knowledge of: Principles and practices of social work; theories and strategies of providing services to persons with special needs; public and private medical, social, education, and other resources available in the community; agency philosophy, procedures, and programs; techniques of interviewing to obtain necessary information; and regulations and standards pertaining to service delivery.

Ability to: Interact with clients from a variety of socio-economic and cultural backgrounds and clients with functional limitations caused by physical or mental disabilities or advanced age; work well with people and exercise good judgment in evaluating situations and making decisions; assess client needs; translate needs assessment into individual client plan to provide proper services; develop working relationships with other individuals, groups, and agency representatives; communicate both orally and in writing; and mobilize resources to meet client needs.

Education/Experience

Each case manager must have experience in a human services field where the required knowledge, skills, and abilities have been successfully applied.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

CASE MANAGEMENT SERVICES

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

CASE MANAGEMENT SERVICES

A. Target Groups

Persons with developmental disabilities. Developmental disabilities being mental retardation or related conditions, other than mental illness. Eligible individuals must not be residing in institutions or receiving services under Medicaid waivers other than the Nebraska home and community-based waiver for persons with mental retardation or related conditions or the waiver for children with mental retardation and their families.

B. Areas of State in which services will be provided:

☒ Entire State.

☐ Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

☐ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Case management services are defined as -

1. Assessment (or arrangement for assessment) of individual or family needs level and requirement for supports and services;
2. Development of individual and family support and service goals; and
3. Coordination of personal, agency, non-agency, and professional resources to develop and attain individual support and service goals and access needed medical, social, habilitation, education, employment, housing, and other services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

CASE MANAGEMENT SERVICES

Case management activities designed to assist Medicaid-eligible clients include the following.

1. Client Assessment

   a. Receive referrals or client requests for case management services.
   b. Conduct information gathering and assessment interviews.
   c. Conduct an assessment to determine client's and, as appropriate, family's needs for support and services.
   d. Arrange for additional needs assessment as required to provide a full assessment of client's, and, as appropriate, family's needs for support and services.

2. Service Planning

   a. Together with the client or his/her representative, the client's family as appropriate, and members of an interdisciplinary team, composed of workers from various disciplines or fields as well as the client as a team member, develop a plan which includes types of services to be provided to achieve the client's goals, resources selected to provide service, frequency and duration of service provision, etc.
   b. Arrange for support and services identified in the plan.
   c. Contact, coordinate, and confirm the client's service provision with providers of service.
   d. Provide follow-up, ongoing monitoring of service delivery, and periodic reviews to assess suitability of client's plan.

3. Accessing Resources

   a. Determine appropriate resources to meet the client's needs.
   b. Assist clients in applying for appropriate programs within the Department of Health and Human Services System (HHS) (e.g., Low Income Energy Assistance Program, Child Support, Food Stamps) and outside of Health and Human Services (e.g., community action, housing authority, legal aid, public health nurses, Social Security Administration, Veterans Administration, vocational rehabilitation). This may include assisting the client to make an appointment and to gather the information required for program application, arranging transportation to the resource or accompanying the client.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

c. Coordinate services from all available sources to ensure that client needs are met.
d. Assist clients in locating appropriate living arrangements, based upon the philosophy of most appropriate services.
e. Assist clients to arrange for and receive appropriate medical care and counseling.
f. Assist clients to locate appropriate employment or training.

4. Resource Recruitment

a. Recruit or locate service providers that would be consistent with the client's plan and consistent with Section 1902(a)(23) of the Social Security Act.

Conditions of Provisions

1. The following conditions must be met in order for case management services to be provided:

a. The client, the client's family as appropriate, the client's legal representative, and case manager must work together to achieve a plan.
b. The client must not reside in an institutional setting.

2. The following conditions must be met in order for case management services to be reimbursed under Medicaid:

a. The case manager must conduct a face-to-face interview with the client in order to determine client needs and develop approaches to meet these needs.
b. The case manager with an interdisciplinary team including the client or client's representative, must develop a plan which is documented in the case record.
c. The case manager must reevaluate the plan when necessary but at a minimum annually.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

d. The case manager must provide documentation to supplement the plan which includes:

(1) Information supporting goal selection;
(2) Information supporting short term objectives;
(3) Information supporting the approaches selected;
(4) Information supporting case management decisions and actions;
(5) Documentation of communication with the client;
(6) Documentation of referrals to resources; and
(7) Other factual information relevant to the case.

Unit of Service

A unit of case management services is a month.

E. Qualifications of Providers:

In order to ensure that the case managers for persons with developmental disabilities are capable of ensuring that such persons receive needed services, providers will be limited to the Health and Human Services Developmental Disabilities Service Coordinators.

Case Manager

Knowledge of: the policies and practices of the agency which relate to habilitation services delivery; the goals, objectives, and philosophy of the agency; the legal system and laws pertaining to persons with disabilities; knowledge of medications; the theories and strategies of providing habilitation services to persons with mental retardation or related conditions.

Ability to: evaluate client needs by scheduling, chairing and serving as team member for the plan development meetings with all involved persons to plan for implementation and coordination of necessary services and supports; serve as liaison between all persons involved with the client to coordinate services and promote cooperation; and monitor services received by the client to insure the implementation of the plan.

Job Preparation Guidelines: (Entry knowledge's, abilities, and/or skills may be acquired through, but are not limited to the following coursework/training and/or experience.) Post-high school coursework in education, psychology, social work, sociology, or related field plus one year current experience within a specialized, developmental disabilities service system in delivery of habilitation or developmental disabilities service coordination OR bachelor's degree in education, psychology, social work, sociology, or a related field.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. _X_ The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

1902(a)(10)(A)(ii)(XI) of the Act
1902(a)(10)(A)(ii)(X) and 1902(m)(1) and (3) of the Act
42 CFR 435.310
42 CFR 435.320
42 CFR 435.322
42 CFR 435.324

The State will use the actual maximum monthly allowable Special Needs Nursing Facility rate to reduce an individual's income to an amount at or below the medically needy income limit (MNIL) for persons who are medically needy with a Share of Cost.

B. ___ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.

C. _X_ The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

D. _X__ Spousal impoverishment eligibility rules are being applied.

Regular Post Eligibility

1. _X_ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

1. Allowances for the needs of the:
   (A.) Individual (check one)
      1. ___ The following standard included under the State plan (check one):
         (a) _____ SSI
         (b) _____ Medically Needy
         (c) _____ The special income level for the institutionalized
         (d) _____ Percent of the Federal Poverty Level: ____
         (e) _____ Other (specify):_____

      2. ___ The following dollar amount: $_____
      Note: If this amount changes, this item will be revised.

      3. _X__ The following formula is used to determine the needs allowance:
         (a) For waiver clients receiving Assisted Living Services: The State protects the SSI standard.
         (b) For clients receiving waiver services in other eligible living arrangements: The State protects the medically needy income standard.

   Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

   (B.) Spouse only (check one):
      1 .___ SSI Standard
      2. ___ Optional State Supplement Standard
      3. ___ Medically Needy Income Standard
      4. ___ The following dollar amount: $_____
      Note: If this amount changes, this item will be revised.
      5. ___ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
      6. ___ The amount is determined using the following formula:
      7. _X_ Not applicable (N/A)

   (C.) Family (check one):
      1. ___ AFDC need standard
      2. _X_ Medically needy income standard

   The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

3. ___ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4. ___ The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.
5. ___ The amount is determined using the following formula:
6. ___ Other
7. ___ Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

2. ___ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) 42 CFR 435.735--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
(A.) Individual (check one)
1. __ The following standard included under the State plan (check one):
(a) __ SSI
(b) __ Medically Needy
(c) __ The special income level for the institutionalized
(d) __ Percent of the Federal Poverty Level: _____%
(e) __ Other (specify):_____
2. ___ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
3. ___ The following formula is used to determine the needs allowance:

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):
1. __ The following standard under 42 CFR 435.121:
2. __ The Medically needy income standard
3. __ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

4. __ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
5. __ The amount is determined using the following formula:
6. __ Not applicable (N/A)

(C.) Family (check one):
1. __ AFDC need standard
2. __ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. __ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4. __ The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.
5. __ The amount is determined using the following formula:
6. __ Other
7. __ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3. X State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:
1. Individual (check one)
(A). __ The following standard included under the State plan (check one):
1. __ SSI
2. __ Medically Needy
3. __ The special income level for the institutionalized
4. __ Percent of the Federal Poverty Level: ____
5. __ Other (specify):_____

(B). __ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

(C). _X_ The following formula is used to determine the needs allowance:
(1) For waiver clients receiving Assisted Living Services: The State protects the SSI standard.
(2) For clients receiving waiver services in other eligible living arrangements: The State protects the medically needy income standard.

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_____
_____
_____

II. Rates and Payments

A. The State assures that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1. __ Rates are set at a percent of fee-for-service costs
2. ___ Experience-based (contractors/State's cost experience or encounter date)(please describe)
3. ___ Adjusted Community Rate (please describe)
4. _X_ Other (please describe) Rates are set at a percent of Upper Payment Limits.

The State contracts with an actuarial company to develop PACE Upper Payment Limits (UPLs). The UPLs are developed based on historical Nebraska Medicaid fee-for-service (FFS) costs for individuals aged 55 and over who were either nursing home residents or eligible for HCBS waiver services based on meeting nursing facility level of care criteria. Projection factors are applied to the UPLs to reflect utilization changes, historical and prospective Medicaid program changes, and provider rate changes. The UPLs are then summarized into rate cells by eligibility category and defined geographic area. The State ensures that rates paid to PACE provider organizations are less than the cost in FFS by negotiating a rate for each rate cell set at 95% of the UPL for that cell.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

The State contracted with Milliman, Inc., to develop its initial UPLs for calendar year 2012. The initial UPLs were developed by Shelly S. Brandel, FSA, MAAA, Actuary, and David F. Ogden, FSA, MAAA, Principal and Consulting Actuary. The UPLs are an estimate of what costs would have been to Nebraska Medicaid for PACE participants if they had not enrolled in PACE. Within each eligibility category (dually Medicaid and Medicare eligible, Medicaid only, and dually Medicaid and Medicare (Part B only) eligible), Milliman developed separate UPLs for nursing home residents and HCBS waiver participants who meet nursing facility level of care criteria (aka PACE eligibles) by geographic area. Milliman then weighted these UPLS by the estimated distribution of individuals in each service category (based on the distribution of 2009 eligible months) to calculate the overall UPLs. The distribution of individuals for Part B only eligibles was assumed to be the same as for dual eligibles.

Data Reliance and Important Caveats

In developing the UPLs, Milliman relied on data and other information provided by the State. Since the source of the data was the State's Medicaid Management Information System (MMIS), the State takes responsibility for the accuracy and validity of the base data. The following data and information was used:

- Medicaid claims and eligibility data for individuals ages 55 and older, including a description of each data field and its potential use in classifying individuals into eligibility groupings of service use and Medicare eligibility;
- Summary of Medicaid fee and program changes in SFY 2008 and later; and
- Quarterly CMS-64 Medicaid Administrative Cost reports for SFY 2010.

Base Data and Adjustments

The State provided claims and eligibility data for Medicaid individuals ages 55 and over for the period January 1, 2007, through the most recent date available at the time, August, 2010.

1. Excluded Data

Milliman excluded the following data:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

- Managed care enrollees;
- Partial Medicare eligibility: Claims and eligibility data for individuals with partial Medicare eligibility (Part A or Part B only) were excluded. (Note: Milliman developed UPLs for Part B only eligibles based on the projected results for Medicaid only and dual eligibles due to a small number of individuals in the data with Part B only eligibility.)
- Individuals with claims but no eligibility; and
- Claims and eligibility for individuals for whom the county of residence was outside the State of Nebraska.

2. UPL Categories

Milliman separated the data into eligibility groupings or "cells" as follows:

- Dual eligible versus Medicaid only;
- Nursing home residents versus HCBS waiver participants; and
- Urban versus rural geographic areas.

Regarding Medicare eligibility, individuals with full Medicare coverage (Part A and B) or no Medicare coverage were included in the analysis. As noted above, individuals with partial Medicare coverage (Part A or Part B only) were excluded from the analysis (Part B only UPL projections are based on the UPL results for Medicaid only and dual eligibles due to the small number of Part B only individuals in the data.)

Nursing home residents were flagged as such for each month within each individual's total eligibility segment(s) if the total nursing home payments for the month were greater than $0.00. If an individual was identified as both a nursing home resident and a HCBS waiver participant for a given month, the individual was classified by Milliman as a nursing home resident for purposes of their analysis.

Milliman classified data as "rural" or "urban" based on the county of residence in the eligibility file as follows:

Urban: Douglas, Lancaster, Gage, Otoe, Saline, Sarpy, Saunders, Seward, and Washington counties (counties surrounding Omaha and Lincoln, Nebraska); and

Rural: Remaining counties in Nebraska.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

3. Data Adjustments

The following were taken into consideration regarding the claims and eligibility data, and adjustments were made as appropriate:

- Disproportionate Share Hospital (DSH) payments;
- Critical Access Hospitals;
- Graduate Medical Education (GME);
- Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) payments;
- Third Party Liability (TPL);
- Copayments;
- Organ Transplants;
- Prescription Drug Rebates;
- Historical Program Changes: The base experience data was adjusted to reflect historical Medicaid program changes that became effective during the experience period. The program changes include:
    - CHIP eligibility to 100% of the Federal Poverty Limit (9/1/2009
    - Hospital Inpatient DRG Reimbursement Structure (10/1/2009); and
    - Radiology Management (11/1/2009); and
- Claims Completion Factors.

PACE UPL Development

Milliman used 2009 experience as a base to project a UPL for CY 2012. They applied the following projection factors to project 2009 experience for each rate category to CY 2012:

- Trend factors;
- Prospective Nebraska Medicaid program changes;
- Prospective provider rate changes; and
- PACE administrative costs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

1. Trend Factors

Milliman developed the trend factors by reviewing the following information:

- Historical trends from 2007 to 2009 for the PACE eligibles in the data;
- Information about changes in the Nebraska Medicaid program (historical and projected) to better understand provider fee and program changes during the experience period to interpret non-fee based trends; and
- Knowledge about Medicaid trends in other states and Medicare trends for representative service categories.

2. Prospective Medicaid Program Changes

Milliman adjusted the PACE UPLs to reflect the impact of Nebraska Medicaid program changes taking place between the experience period (CY 2009) and the projection period (CY 2012). They relied on Mercer's Data Book dated December 1, 2009, to estimate the appropriate adjustment for each program change which includes:

- Facility/Non-Facility pricing; and
- Outpatient Hospital Cost Ratio decrease.

3. Prospective Provider Rate Changes

The PACE UPL projections reflect the following anticipated future changes to Nebraska Medicaid provider payment rates:

- A 0.5% rate increase for all services effective for SFY 2011 beginning on July 1, 2010).
- A 5% rate decrease for all services except primary care for SFY 2012 and SFY 2013.

Note the following regarding future Medicaid provider rate changes:

- Milliman assumed that Medicaid provider rate changes would have no impact on pharmacy costs. Therefore, the provider rate change factor for pharmacy services was 1.000.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

- Although the FFS data did not indicate primary care versus specialty care services, Milliman expected the level of primary care services in the PACE population to be very small given the amount of chronic care services. Therefore they did not make an adjustment to the SFY 2012 and SFY 2013 Medicare rate decreases to exclude primary care services.
- For dual eligibles, the impact of Medicaid provider rate changes is difficult to predict since a significant amount of costs for many services are paid by Medicare. Milliman assumed the Medicaid provider rate change increases would be dampened by a factor of ½ for dual eligibles for the following services: inpatient hospital; outpatient hospital; physician; other practitioner; radiology and laboratory; clinic; DME/supplies; and transportation.

4. PACE Administrative Costs

Milliman added a 3.9% allowance (as a percentage of projected 2012 claims) for PACE administrative services based on the CMS-64 data the State provided for SFY 2010. The CMS 64 reports reflect the State's current Medicaid administrative costs as a percentage of claim payments. School-based administrative costs were excluded from the calculation.

There were very few individuals in the FFS with Part B only Medicare eligibility, therefore the historical data was not credible for purposes of UPL development. Milliman calculated the Part B only UPLs by setting the projected 2012 UPL for each service category equal to either the dual eligible UPL or the Medicaid only UPL. They linked the following service categories to the dual eligible UPL (meaning they expected that Medicare coverage would decrease the expected costs PEPM for Part B eligibles): outpatient hospital; physician; other practitioner; radiology and laboratory; clinic; pharmacy; DME/supplies; and transportation. All other service categories were linked to the Medicaid only UPL.

C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

The following ambulatory services are provided.

Rural health clinic services
Other laboratory and x-ray services
Early and Periodic Screening. Diagnosis. and Treatment
Family planning services
Physicians' services
Podiatrists' services
Optometrists' services
Chiropractors' services
Other practitioners' services
Home health services
Private duty nursing services
Clinic services
Dental services
Physical therapy and related services
Prescribed drugs. dentures. and prosthetic devices
Eyeglasses
Transportation
Personal care services
Nurse Practitioner Services
Freestanding Birth Center Services

*Description provided on attachment.

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All Groups

1. Inpatient hospital services other than those provided in an institution for mental diseases.

☒ Provided ☐ No limitations ☒ With Limitations*

2. a. Outpatient hospital services.

☒ Provided ☐ No limitations ☒ With Limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State Plan)

☒ Provided ☐ No limitations ☒ With Limitations*

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with sec. 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

☒ Provided ☐ No limitations ☒ With Limitations*

3. Other laboratory and x-ray services.

☒ Provided ☐ No limitations ☒ With Limitations*

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

☒ Provided ☐ No limitations ☒ With Limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

☒ Provided ☐ No limitations ☒ With Limitations*

c. Family planning services and supplies for individuals of child-bearing age.

☒ Provided ☐ No limitations ☒ With Limitations*

*Description provided on attachment

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All Groups

d. 1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

☒ (i) By or under supervision of a physician;

☒ (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; or

☐ (iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.) *describe if there are any limits on who can provide these counseling services.

2) Face-to-Face Tobacco Cessation counseling Services Benefit Package for Pregnant Women

Provided: ☒ No limitations ☐ With limitations*

*Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period (eight (8) per year) should be explained below.

Please describe any limitations:

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

☒ Provided ☐ No limitations ☒ With Limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the act).

☒ Provided ☐ No limitations ☒ With Limitations*

* Description provided on attachment.

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All covered groups

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6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by state law.

   a. Podiatrists' services.

   ☒ Provided ☐ No limitations ☒ With Limitations*

   b. Optometrists' services.

   ☒ Provided ☐ No limitations ☒ With Limitations*

   c. Chiropractors' services:

   ☒ Provided ☐ No limitations ☒ With Limitations*

   d. Other practitioners' services.

   ☒ Provided ☐ No limitations ☒ With Limitations*

7. Home Health Services

   a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

   ☒ Provided ☐ No limitations ☒ With Limitations*

   b. Home health aide services provided by a home health agency.

   ☒ Provided ☐ No limitations ☒ With Limitations*

   c. Medical supplies, equipment, and appliances suitable for use in the home.

   ☒ Provided ☐ No limitations ☒ With Limitations*

   d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

   ☒ Provided ☐ No limitations ☒ With Limitations*

"Description provided on attachment.

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All covered groups

8. Private duty nursing services
☒ Provided ☐ No limitations ☒ With Limitations*

9. Clinic services
☒ Provided ☐ No limitations ☒ With Limitations*

10. Dental services
☒ Provided ☐ No limitations ☒ With Limitations*

11. Physical therapy and related services.

a. Physical therapy
☒ Provided ☐ No limitations ☒ With Limitations*

b. Occupational therapy
☒ Provided ☐ No limitations ☒ With Limitations*

c. Services for individuals with speech, hearing. and language disorders provided by or under the supervision of a speech pathologist or audiologist.
☒ Provided ☐ No limitations ☒ With Limitations*

12. Prescribed drugs. dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs
☒ Provided ☐ No limitations ☒ With Limitations*

b. Dentures
☒ Provided ☐ No limitations ☒ With Limitations*

*Description provided on attachment.

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All covered groups

c. Prosthetic devices

☒ Provided ☐ No limitations ☒ With Limitations*

d. Eyeglasses

☒ Provided ☐ No limitations ☒ With Limitations*

13. Other diagnostic. screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

☐ Provided ☐ No limitations ☐ With Limitations*
☒ Not Provided

b. Screening services.

☒ Provided ☐ No limitations ☒ With Limitations*

c. Preventive services.

☐ Provided ☐ No limitations ☐ With Limitations*
☒ Not Provided

d. Rehabilitative services.

☒ Provided ☐ No limitations ☒ With Limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

☒ Provided ☐ No limitations ☒ With Limitations*

b. Skilled nursing facility services.

☒ Provided ☐ No limitations ☒ With Limitations*

*Description provided on attachment.

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED
TO THE MEDICALLY NEEDY

c. Intermediate care facility services.

_X_ Provided __ No limitations _X_ With limitations*

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

_X_ Provided __ No limitations _X_ With limitations*

b. Including such services in a public institution (or district part thereof) for the mentally retarded or persons with related conditions.

_X_ Provided __ No limitations _X_ With limitations*

16. Inpatient psychiatric facility services for individuals under 22 years of age.

_X_ Provided _X_ No limitations __ With limitations*

17. Nurse-midwife services.

_X_ Provided __ No limitations _X_ With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

_X_ Provided __ No limitations _X_ Provided in accordance with section 2302 of the Affordable Care Act

_X_ With limitations*

*Description provided on attachment -

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All covered groups

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19. Case management services and Tuberculosis related services

    a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

    ☒ Provided ☒ With Limitations*
    ☐ Not Provided

    b. Special tuberculosis (TB) related services under section 1902 (z) (2) (F) of the Act.

    ☐ Provided ☐ With Limitations*
    ☒ Not Provided

20. Extended services for pregnant women

    a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

    ☒ Provided ☐ Additional coverage ++

    b. Services for any other medical conditions that may complicate pregnancy.

    ☒ Provided ☐ Additional coverage ++ ☒ Not provided

Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

    ☒ Provided ☐ No limitations ☒ With Limitations*
    ☐ Not Provided

*Description provided on attachment.

State/Territory: Nebraska

Major Categories of Services That Are Available As
Pregnancy-Related services or Services For Any
Other Condition That May Complicate Pregnancy

The Nebraska Medical Assistance Program covers the following major categories of services as pregnancy-related services or services for a condition that may complicate pregnancy:

1. All services covered under the Title XIX Plan are available when pregnancy-related or for a condition that may complicate pregnancy; and
2. The same limitations listed in Attachment 3.1-A are applied to pregnancy-related services or services for a condition that may complicate pregnancy.

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All covered groups

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22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

☐ Provided ☐ No limitations ☐ With Limitations*
☒ Not Provided

23. Certified pediatric or family nurse practitioners' services.

☒ Provided ☐ No limitations ☒ With Limitations*

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary:

a. Transportation.

☒ Provided ☐ No limitations ☒ With Limitations*

b. Services of Christian Science nurses.

☐ Provided ☐ No limitations ☐ With Limitations*
☒ Not Provided

c. Care and services provided in Christian Science sanitoria.

☐ Provided ☐ No limitations ☐ With Limitations*
☒ Not Provided

d. Nursing facility services for patient under 21 years of age.

☒ Provided ☐ No limitations ☒ With Limitations*

e. Emergency hospital services.

☒ Provided ☐ No limitations ☒ With Limitations*

*Description provided on attachment.

State/Territory: Nebraska

24. Pediatric or family nurse practitioners' services as defined in Section 1905(a)(21) of the Act (added by Section 6405 of OBRA'89):

☒ Provided ☒ No limitations ☐ With Limitations*

* Description provided on attachment.

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All groups

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25. 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.

☒ Provided ☐ Not Provided

26. Personal assistance services are those services provided to a Medicaid client who is not an inpatient or resident of a hospital, nursing facility, intermediate cafe facility for the mentally retarded, institution for mental disease, or prison, which are authorized on a written service plan according to individual needs identified in a written assessment.

Personal assistance services are A) authorized by a Social Services Worker or designee, B) provided by qualified providers who are not legally responsible relatives, and C) are furnished inside the home, and outside the home with limitations

☒ Provided
☐ Not Provided

☒ State Approved (Not Physician) Service Plan Allowed
☒ Services Outside the Home Also Allowed*
☒ Limitations Described on Attachment

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

_X_ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

__ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: ☐ No Limitations ☒ With Limitations ☐ None licensed or approved
☐ Not Applicable (there are no licensed or State approved Freestanding Birth Centers

Please describe any limitations:
Facilities must:
(a) Be specifically approved by Department of Health and Human Services, Division of Public Health to provide birthing Center Services, and
(b) Maintain standards of care required by Department of Health and Human Services, Division of Public Health for licensure.

* Exception described on attachment

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All groups

28. (ii) Licensed or Otherwise Sate-Recognized covered professionals providing services in the Freestanding Birth Centers

Provided: ☐ No Limitations ☒ With Limitations (please describe below)

Please check all that apply:

☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the Sate plan (i.e., physicians and certified nurse midwives.

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife).*

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

Telehealth Service means any contact between a patient and a health care practitioner relating to health care diagnosis or treatment of such patient through telehealth but does not include a telephone conversation, electronic mail message, or facsimile transmission between a health care practitioner and a patient or a consultation between two health care providers.

Health care practitioners must:

1. act within their scope of practice;
2. be enrolled with NMAP; and
3. be appropriately licensed, certified, or registered by Nebraska HHS Regulation and Licensure for the service for which they bill Medicaid.

All state plan prior authorization requirements must be met to be covered as a telehealth service. Prior authorization requests must state the intent to provide the service as a telehealth service.

Medicaid services covered under the State Plan but specifically excluded from telehealth coverage are:

1. Medical equipment and supplies provided by DME (Durable Medical Equipment) suppliers and pharmacies;
2. Orthotics and prosthetics provided by DME suppliers and pharmacies;
3. Personal Care Aide (PCA) services;
4. Home Health Aide services;
5. Pharmacy services for prescribed drugs;
6. Home and Community Based Waiver services provided by persons that do not meet the standards for practitioner of telehealth services;
7. Mental health, substance abuse, and psychiatric rehabilitation services provided by persons that do not meet the standards for practitioner of telehealth services;
8. Medical transportation services, including ambulance services;
9. Federally Qualified Health Center core services billed as an "encounter" service;
10. Rural Health Clinic core services billed as an "encounter" service;
11. Physician visits to clients in nursing facilities required on the specific periodic schedule for nursing facility certification;
12. Tribal 638 clinic core services billed as an "encounter" service;
13. Services requiring "hands on" professional services such as eye glass fittings and hearing aid fittings;
14. Services provided in public schools by staff who are not licensed, certified, or registered with Nebraska HHS - Regulation and Licensure; and
15. Ambulatory room and board services.

Services provided via telecommunications are not covered if the client has access to a comparable service within 30 miles of his/her place of residence.

This requirement does not apply:

1. In emergency or urgent medical situations;
2. When accessing the appropriate service at a distance less than 30 miles poses a significant hardship on the client due to a medical condition or disability; or
3. To clients residing in nursing facilities who require transportation to the appropriate service via ambulance.

A telehealth service is not covered when the service delivered via telecommunication technology is deemed to be investigational or experimental. Even though a service is covered when provided in-person to a client, the service may be deemed investigational/experimental for Medicaid payment purposes when provided via telecommunications technology.

Transmission costs are not covered when the telehealth service provided by the health care practitioner is not a covered state plan service.

Services that require direct physical contact with a client by a health care practitioner and that cannot be delegated to another health care practitioner at the site where the client is located are not covered.

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All covered groups

The limitations to services listed in Attachment 3.1-B are the same as the limitations for services listed in Attachment 3.1-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

STANDARDS AND METHODS OF ASSURING HIGH QUALITY CARE

The following is a description of the standards established and the methods that will be used to assure that the medical and remedial care and services are of high quality.

1. Medical care and services are provided in accordance with the overall objectives of maintaining good health, preventing disease and disability, curing and mitigating disease, and rehabilitating the individual.

2. Plans for medical care are integrated with social planning.

3. Medical care and service must be provided within the licensure of the provider.

4. Insofar as possible, medical care and services must permit the recipient to exercise free choice in the selection of his/her provider.

5. The amount and kind of medical care and service is determined by the professional opinion of the practitioner.

6. Care for intraocular or chronic eye disease must be provided by a physician, M.D.

7. Medical care and services not provided by a licensed professional person must be recommended or prescribed by a licensed professional person.

8. Care in Homes for the Aged or Infirm or hospitals must be provided in a facility licensed to provide the required care.

9. The State Agency will establish processes of utilization review for each item of care and service included in the medical assistance program. The Division of Medical Services will be responsible for all utilization review plans and activities in the program.

10. Costs of other medical care and service is provided within reasonable maximums set by the Central Office related to the type of care.

11. NDSS provides a regular program of medical review (including medical evaluation of each patient's need for skilled nursing facility care and periodic review and reevaluation of recipients in intermediate care facilities as to the need for their placement) and in the case of individuals in mental hospitals, the need for care in a mental hospital, including, where applicable, evaluation of a written plan of care and a plan of rehabilitation prior to admissions. Periodic inspections will be made in all skilled nursing homes and mental institutions within the state by one or medical review teams (composed of physicians and other appropriate health and social service personnel) and in all intermediate care facilities (by review teams composed of R. N.'s and other appropriate health or social service personnel) of the care being provided in those nursing homes.

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and mental institutions, to persons receiving assistance under the State Plan with respect to each of the patients receiving that care. The review will determine the adequacy of the services available in particular nursing homes or institutions to meet the current health needs and promote the maximum physical well-being of patients receiving care in the homes or institutions; the necessity and desirability of the continued placement of such patients in such nursing homes or institutions; and the feasibility of meeting their health care needs through alternate institutional or noninstitutional services. Further, the team or teams will make full and complete reports of the findings resulting from the inspections together with any recommendations to the State Agency administering or supervising the administration of the State Plan.

12. Public or private skilled nursing facilities are licensed by the Nebraska Department of Health and in addition, meet the requirements for skilled nursing facilities as specified in 42 CFR 405, Subpart K.

13. Public or private intermediate care facilities are licensed by the Nebraska Department of Health and in addition meet the requirements for intermediate care facilities as specified in 42 CFR 442, Subparts E, F, G.

State Nebraska

ASSURANCE OF TRANSPORTATION

NMAP enrolls individual and agency providers to provide appropriate medical transportation to Medicaid-eligible clients.

NMAP covers medically necessary ambulance services that are provided during an emergency or while the client is receiving emergency medical care (see Item 23a of Attachment 3.1-A).

Payment for transportation for non-emergency medical services may be included as a special requirement in the budget for an AABD client.

State/Territory: Nebraska

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

The Nebraska Medical Assistance Program covers transplants that are medically necessary and defined as non-experimental by Medicare. For transplants that may be covered by Medicare, NMAP uses Medicare standards as listed in the Medicare Coverage Issues Manual to determine coverage. If no Medicare policy exists for a specific type of transplant, the Medical Director of the Medical Services Division shall determine whether the transplant is medically necessary or non-experimental.

Notwithstanding any Medicare policy on liver or heart transplants, NMAP covers liver or heart transplants using the following standards:

1. Facility Standards: The facility must have a valid provider agreement to participate in the Nebraska Medical Assistance Program. The facility must have certificate of need approval if required by the State in which the facility is located.

2. Patient Selection Criteria: Before providing transplant services to be covered by NMAP, the facility is required to submit its patient selection criteria, including medical-physical indications and contra-indications and psycho-social criteria, to the Medical Services Division for review.

3. Before the service is approved for payment, Medical Services staff review documentation submitted by the patient's physicians to verify that the transplant candidate meets the facility's previously submitted patient selection criteria. The documentation, submitted by two physicians that specialize in transplantation, must include the following:

    a. The screening criteria used in determining that this patient is an appropriate candidate for a liver or heart transplant;
    b. The results of that screening for this patient describing how the patient meets the facility criteria (i.e., the patient is eligible to be placed on the "waiting list" in which the only remaining criteria is organ availability); and
    c. A statement by each physician -
        (1) Recommending the transplant; and
        (2) Certifying and explaining why a transplant is medically necessary as the only clinical, practical, and viable alternative to prolong the client's life in a meaningful, qualitative way and at a reasonable level of functioning.

State: Nebraska

Citation	Condition or Requirement

1932(a)(1)(A) A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Nebraska enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

_X_ i. MCO
____ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

___ i. fee for service; for the Enhanced PCCM
_X_ ii. capitation; for the MCOs
___ iii. a case management fee; for the Enhanced PCCM
___ iv. a bonus/incentive payment; for the Enhanced PCCM
___ v. a supplemental payment, or
___ vi. other. (Please provide a description below).

Citation	Condition or Requirement
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met. If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). ___ i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. ___ ii. Incentives will be based upon specific activities and targets. ___ iii. Incentives will be based upon a fixed period of time. ___ iv. Incentives will not be renewed automatically. ___ v. Incentives will be made available to both public and private PCCMs. ___ vi. Incentives will not be conditioned on intergovernmental transfer agreements. ___ vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)* The State has in place a public process which complies with the requirements of Section 1902(a)(1 3)(A) of the Social Security Act. Public notice will be published in the Nebraska Register which is available to the public on a weekly basis. In addition ongoing public input is solicited through the Nebraska Medicaid Advisory Committee.

Citation	Condition or Requirement
1932(a)(1)(A)	5. The state plan program will _X_/will not ___ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory __ for the MCO program/ voluntary ___ for the Enhanced PCCM program, enrollment will be implemented in the following county/area(s): i. county/counties (mandatory) ii. county/counties (voluntary)_____ iii. area/areas (mandatory)_____ iv. area/areas (voluntary):_____
	C. State Assurances and Compliance with the Statute and Regulations. If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1. _X__ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. ___ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. _X_ The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.

Citation	Condition or Requirement
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4. _X_ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5. _X_ The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. _X_ The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7. ____ The state assures that all applicable requirements of for 42 CFR 447.362 payments under any nonrisk contracts will be met.
45 CFR 74.40	8. _X_ The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	D. Eligible Groups
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis. Families, children, and pregnant women eligible for Medicaid under Section 1931 of the Social Security Act or related coverage groups; recipients eligible for Medicaid through the Medicaid expansion under the State Child Health Insurance Program (CHIP); AABD Adults
	2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50. Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.

Citation	Condition or Requirement
1932(a)(2)(B) 42 CFR 438(d)(1)	i. ___ (for the Enhanced PCCM only) Recipients who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of enrollment:
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. ___ Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. ___ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. ___ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. ___ Children under the age of 19 years who are in foster care or other out-of-the home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. ___ Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. ___ Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

Citation	Condition or Requirement

D. Identification Of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*

Enrollment in the Early Development Network program.

1932(a)(2)
42 CFR 438.50(d)

2. Place a check mark to affirm if the state's definition of title V children is determined by:

_X_ i. program participation,
___ ii. special health care needs, or
___ iii. both

1932(a)(2)
42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

_X_ i. yes
___ ii. no

1932(a)(2)
42 CFR 438.50 (d)

4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)*

i. Children under 19 years of age who are eligible for SSI under title XVI;

Eligibility system-use of aid codes

ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

Eligibility system-use of a special indicator code.

Citation	Condition or Requirement
	iii. Children under 19 years of age who are in foster care or other out-of-home placement; Eligibility system-use of aid codes
	iv. Children under 19 years of age who are receiving foster care or adoption assistance. Eligibility system-use of aid codes
1932(a)(2) 42 CFR 438.50(d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)* Nebraska has 1915(b) waiver authority to mandatory enroll special needs children.
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self-identification)* i. Recipients who are also eligible for Medicare. Eligibility system use of a separate Medicare table. The eligibility system receives the Medicare status from the SSA system.

Citation	Condition or Requirement
	ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. Self-identification from the eligibility system. Nebraska has the authority to mandatorily enroll this group.
42 CFR 438.50	F. <u>List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</u> a) Clients with Medicare coverage pursuant to 471 NAC 3-000; b) Clients residing in nursing facilities and receiving custodial care pursuant to 471 NAC 12-000; c) Clients residing in intermediate care facilities for the mentally retarded (ICFIMR) pursuant to 471 NAC 31-000; d) Clients who are residing out of state (i.e. Children placed with relatives out of state, and who are designated as such by HHSS personnel); e) Aliens who are eligible for Medicaid for an emergency condition only pursuant to Titles468, 469,477, and 479 NAC; f) Clients participating in the refugee resettlement program/ medical pursuant to Title 470 NAC; g) Clients receiving services through the following home and community based waivers pursuant to Title 480 NAC for: 1. Adults with mental retardation or other related conditions; 2. Aged persons, adults or children, with disabilities; 3. Children with mental retardation and their families; 4. Clients receiving Developmental Disability Targeted Case Management Services; and 5. Any other group for whom which the Nebraska HHS System has received approval of a 1915(c) waiver of the Social Security Act. h) Clients who have excess income (i.e. spenddown - met or unmet) pursuant to 471 NAC 3000.

Citation	Condition or Requirement
	i) Clients participating in the Subsidized Adoption Program, including those receiving subsidy from another state pursuant to Title 469 NAC. j) Clients participating in the State Disability Program pursuant to Title 469 NAC. k) Clients eligible during the period of presumptive eligibility pursuant to 471 NAC 28- 000. l) Transplant recipients pursuant to 471 NAC 10-000. m) Clients who have received a specific disenrollment/waiver of enrollment from the Nebraska Medicaid Managed Care program. n) American Indians and Alaskan Natives (Nebraska uses the 1915(b) Waiver Authority to mandate enrollment into managed care). o) Clients who have an eligibility program that is only retro-active. p) Clients receiving Medicaid hospice services. q) Clients that are participating in the Breast and Cervical Cancer Prevention and Treatment Act of 2000.
42 CFR 438.50	G. List all other eligible groups who will be permitted to enroll on a voluntary basis
	H. Enrollment process.
1932(a)(4) 42 CFR 438.50	1. Definitions i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience or through contact with the recipient.

Citation	Condition or Requirement
	ii. A provider is considered to have "traditionally served" Medicaid recipients if the provider has experience in serving the Medicaid population.
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. Describe how the state's default enrollment process will preserve: i. the existing provider-recipient relationship (as defined in H.1.i). The default enrollment process will look back 2 years for a previous assignment with a MCO health plan and enroll the client with the MCO health plan. ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

Citation	Condition or Requirement
	The default enrollment process will assign the client with a MCO health plan that is in the zip code range of the client. Providers that have traditionally served Medicaid recipients will be located in a zip code range that is close to the Medicaid client. Also, providers that have traditionally served Medicaid recipients will not have an "established only" indicator which means the client would not be assigned to these providers unless there is an existing provider-recipient relationship.
	iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*
	The default enrollment algorithm is built so that there is an equal distribution of recipients into each of the two MCO health plans.

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

Citation	Condition or Requirement
	vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)* Quarterly reports generated by the enrollment broker.
1932(a)(4) 42 CFR 438.50	I. State assurances on the enrollment process Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment. 1. _X_ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program. 2. _X_ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3). 3. ____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs. _X_ This provision is not applicable to this 1932 State Plan Amendment. 4. ___ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.) _X_ This provision is not applicable to this 1932 State Plan Amendment.

Citation	Condition or Requirement
	1. _X_ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less. ___ This provision is not applicable to this 1932 State Plan Amendment.
1932(a)(4) 42 CFR 438.50	J. Disenrollment 1. The state will _X__/will not ___ use lock-in for managed care. 2. The lock-in will apply for __12_ _ months (up to 12 months). 3. Place a check mark to affirm state compliance. _X_ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c). 4. Describe any additional circumstances of “cause” for disenrollment (if any). None. K. Information requirements for beneficiaries Place a check mark to affirm state compliance.

Citation	Condition or Requirement
1932(a)(5) 42 CFR 438.50 42 CFR 438.10	__X_ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)
1932(a)(5)(D) 1905(t)	L. List all services that are excluded for each model For the MCO program: a. Pharmacy b. Dental c. HCBS Waiver services d. Mental Health/Substance services e. Hospice services f. Nursing Facility services-custodial level of care g. ICF/MR services h. School-based services covered under Medicaid in Public Schools i. Non-Home Health Agency Approved Personal Care Aide Services (PAS) j. Optional targeted case management services k. Non-emergency transportation
1932 (a)(1)(A)(ii)	M. Selective contracting under a 1932 state plan option To respond to items #1 and #2, place a check mark. The third item requires a brief narrative. 1. The state will __X__/will not_____ intentionally limit the number of entities it contracts under a 1932 state plan option. 2. __X__ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

Citation	Condition or Requirement
	3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)* Nebraska uses a competitive procurement process and ensures that qualifying MCO contracts comply with federal procurement requirements and 45 CFR Section 92.36. The Department requires all participating MCOs to be licensed by the Nebraska Department of Commerce, Insurance Division. The Department sets the capitation rates and any contracting MCO must accept those rates for the respective Medicaid covered services. 4. ____ The selective contracting provision is not applicable to this state plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

COORDINATION OF TITLE XIX WITH PART B OF TITLE XVIII

The following method is used to provide the entire range of benefits under Part B of title XVIII to the groups of Medicare-eligible individuals indicated.

☒ A. Buy-in agreements with the Secretary of HHS. This agreement covers:

1. ☒ Individuals receiving SSI under title XVI or State supplementation, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   ☒ Yes ☐ No

2. ☒ Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State's approved title IV-A plan, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   ☒ Yes ☐ No

3. ☐ All individuals eligible under the State's approved title XIX plan.

☒ B. Group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:
Aged
Blind
Disabled

☒ C. Payment of deductible and coinsurance costs. Such payments are made in behalf of the following groups:
Aged
Blind
Disabled

This relates only to comparability of devices – benefits under XVIII to what groups – not how XIX pays. If …State has buy-in (which covers premium), it does not check #3 for same group-only if it does #3 for another group, e.g. does #1 for money payment receipts and #3 for non-$-receipts. How it handles deductibles and coinsurance for money payment receipts is a matter for reimbursement attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

a. 175 NAC 9 – Health Care Facilities and Services Licensure.

b. 153 NAC 1 – Nebraska State Fire Code Regulations, State Fire Marshall.
156 NAC 1-12 – Nebraska Accessibility Requirements, State Fire Marshall.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

RELATIONS WITH STATE HEALTH AND VOCATIONAL REHABILITATION AGENCIES AND TITLE V GRANTEES

The State Health and Title V Grantees are within, and administered and supervised by, the Department of Health and Human Services, the Medicaid agency.

The Vocational Rehabilitation agency is located within the Department of Education, and is responsible for assuring the following functions: where and how to apply for services, the appropriate services are provided, reciprocal referrals, liaison staff, confidentiality of information, non-discrimination, funding and limitations, exchange of services reports, and reviews.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

LIENS AND ADJUSTMENTS OR RECOVERIES

1. The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:

   The Department requires either a physician's statement indicating that the individual is unable to return to their home or the recipient's residence in a medical institution for a period of 6 months, whichever occurs first. Notice is given to the recipient when they enter the medical institution and he/she may appeal the Department's determination within 90 days in accordance with the procedures 465 Nebraska Administrative Code.

2. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR §433.36(f):

   N/A as the State does not impose TEFRA liens.

3. The State defines the terms below as follows:

   - Estate means all real and personal property and other assets included within the individuals estate as defined for, purposes of State probate law.
   - Individual’s home: N/A as the State does not impose TEFRA liens
   - Equity interest in the home: N/A as the State does not impose TEFRA liens.
   - Residing in the home for at least one or two years on a continuous basis: N/A as the State does not impose TEFRA liens.
   - Lawfully residing: N/A as the State does not impose TEFRA liens.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

4. Anyone of the following situations may constitute an undue hardship:

(1) An heir of the recipient resided in the recipient's home on a continuous basis for two years prior to the recipient's entry into a nursing home and the heir provided the type of unreimbursed care that delayed the recipient's entry into a nursing home;

(2) An heir of the recipient resided in the recipient's home for two years prior to the recipient's of recoverable medical services and the heir provided unreimbursed care that' delayed the recipient's receipt of those services;

(3) Payment of the Department's claim would cause heirs of the deceased recipient to be eligible for public assistance;

(4) Waiver of the Department's claim would allow an heir to discontinue eligibility for public assistance for a substantial time period; or

(5) Other compelling circumstances.

Any heir of the estate of a Medicaid recipient may apply for waiver of the estate recovery claim based on undue hardship. Any claim may be waived by the Department, partially or fully.

The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective:

A waiver applicant must be an heir of the estate and must apply for a waiver in writing within thirty days from the creditor's claim filing deadline or ninety days from the recipient's date of death if the estate is not probated. The written application must include:

(1) A written statement of the applicant's relationship to the recipient with supporting documentation; and

(2) A written statement of the basis for the hardship waiver under 471 NAC 38-004.02 with supporting documentation.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

The Department must review each application and issue a written decision within ninety days after the Department's receipt of the application. The Department's written decision must advise the applicant of the procedure for requesting an administrative hearing should the applicant want to appeal the Department's decision.

5. Recovery is not cost-effective when the cost of collection exceeds the amount of the Department's claim.

6. The State uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):

   The Department evaluates cases for potential estate recovery via local caseworker referrals, attorney referrals and creditor's notices filed in probate proceedings. If the estate is being probated, the Department files a claim and follows the appropriate procedures as defined in the Nebraska Probate Code. If the estate is not being probated, the Department works with the family, attorney, guardian, or other person handling the recipient's estate, to obtain reimbursement of its claim. Waivers based on undue hardship are defined and granted, as stated above.