

State: Nebraska

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Citation Condition or Requirement

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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) and/or primary care case managers (PCCMs)) 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)

1. 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

- 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
- 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).

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Citation	Condition or Requirement
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	<p>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.</p> <p>If applicable to this state plan, place a check mark to affirm the state has met <b>all</b> 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)).</p> <ul style="list-style-type: none"><li><input checked="" type="checkbox"/> 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.</li><li><input checked="" type="checkbox"/> ii. Incentives will be based upon specific activities and targets.</li><li><input checked="" type="checkbox"/> iii. Incentives will be based upon a fixed period of time.</li><li><input checked="" type="checkbox"/> iv. Incentives will not be renewed automatically.</li><li><input checked="" type="checkbox"/> v. Incentives will be made available to both public and private PCCMs.</li><li><input checked="" type="checkbox"/> vi. Incentives will not be conditioned on intergovernmental transfer agreements.</li><li><input type="checkbox"/> vii. Not applicable to this 1932 state plan amendment.</li></ul>
CFR 438.50(b)(4)	<p>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. (<i>Example: public meeting, advisory groups.</i>)</p> <p>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.</p>

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1932(a)(1)(A)	<p>5. The state plan program will___/will not <u>X</u> implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory <u>X</u> for the MCO program/ voluntary <u>X</u> for the Enhanced PCCM program, enrollment will be implemented in the following county/area(s):</p> <ol style="list-style-type: none"><li>1. county/counties (mandatory):Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Sarpy, Saunders, Seward, Washington for the MCO program</li><li>2. county/counties (voluntary)_____</li><li>3. area/areas (mandatory)_____</li><li>4. area/areas (voluntary): The Enhanced PCCM program operates in Buffalo and Dawson counties. Any Medicaid eligible choosing to receive services through the Enhanced PCCM, regardless of county of residence is eligible to enroll.</li></ol>
1.	<p><u>State Assurances and Compliance with the Statute and Regulations.</u></p> <p>If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.</p>
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	<p>1. <u>X</u> The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.</p>
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	<p>2. <u>X</u> The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.</p>
1932(a)(1)(A) 42 CFR 438.50(c)(3)	<p>3. <u>X</u> 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.</p>

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Citation	Condition or Requirement
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C)	4. <u>X</u> 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. <u>X</u> 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. <u>X</u> 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. <u>    </u> 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. <u>X</u> The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

2. 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.

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Citation	Condition or Requirement
1932(a)(2)(B) 42 CFR 438(d)(1)	i. <u>X</u> (for the Enhanced PCCM only) Recipients who are also eligible for Medicare.  If enrollment is voluntary, describe the circumstances of enrollment:  Clients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled.
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. <u>X</u> (for the Enhanced PCCM only) 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. <u>X</u> (for the Enhanced PCCM only) 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. <u>X</u> (for the Enhanced PCCM only)_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. <u>X</u> (for the Enhanced PCCM only) 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. <u>X</u> (for the Enhanced PCCM only) 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. <u>X</u> (for the Enhanced PCCM only) 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.

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3. 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:

- 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.

- 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*)

1. Children under 19 years of age who are eligible for SSI under title XVI;

For the MCO program only:  
Eligibility system-use of aid codes

2. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

For the MCO program only:  
Eligibility system-use of a special indicator code.

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3. Children under 19 years of age who are in foster care or other out-of-home placement;
- For the MCO program only:  
Eligibility system-use of aid codes
4. Children under 19 years of age who are receiving foster care or adoption assistance.
- For the MCO program only:  
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*)
1. 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.

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2. 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. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

For the MCO program only:

1. Clients with Medicare coverage pursuant to 471 NAC 3-000;
2. Clients residing in nursing facilities and receiving custodial care pursuant to 471 NAC 12-000;
3. Clients residing in intermediate care facilities for the mentally retarded (ICFIMR) pursuant to 471 NAC 31-000;
4. 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);
5. Aliens who are eligible for Medicaid for an emergency condition only pursuant to Titles 468, 469, 477, and 479 NAC;
6. Clients participating in the refugee resettlement program/ medical pursuant to Title 470 NAC;
7. 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.
8. Clients who have excess income (i.e. spenddown - met or unmet) pursuant to 471 NAC 3000.

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	<ol style="list-style-type: none"><li>9. Clients participating in the Subsidized Adoption Program, including those receiving subsidy from another state pursuant to Title 469 NAC.</li><li>10. Clients participating in the State Disability Program pursuant to Title 469 NAC.</li><li>11. Clients eligible during the period of presumptive eligibility pursuant to 471 NAC 28- 000.</li><li>12. Transplant recipients pursuant to 471 NAC 10-000.</li><li>13. Clients who have received a specific disenrollment/waiver of enrollment from the Nebraska Medicaid Managed Care program.</li><li>14. American Indians and Alaskan Natives (Nebraska uses the 1915(b) Waiver Authority to mandate enrollment into managed care).</li><li>15. Clients having other "qualified" insurance.</li><li>16. Clients enrolled In another Medicaid Managed Care Program (except the PHP program).</li><li>17. Clients who have an eligibility program that is only retro-active.</li><li>18. Clients receiving Medicaid hospice services.</li><li>19. Clients that are participating in the Breast and Cervical Cancer Prevention and Treatment Act of 2000.</li></ol>

42 CFR 438.50      G. List all other eligible groups who will be permitted to enroll on a voluntary basis

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

1. Enrollment process.

1932(a)(4)  
42 CFR 438.50

1. Definitions

1. 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.

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1932(a)(4) 42 CFR 438.50	<p data-bbox="594 396 1357 495">2. A provider is considered to have "traditionally served" Medicaid recipients if the provider has experience in serving the Medicaid population.</p> <p data-bbox="532 531 1105 564">2. State process for enrollment by default.</p> <p data-bbox="587 598 1308 661">Describe how the state's default enrollment process will preserve:</p> <p data-bbox="587 695 1390 758">1. the existing provider-recipient relationship (as defined in H.1.i).</p> <p data-bbox="667 800 964 833"><u>For the MCO program:</u></p> <p data-bbox="667 833 1422 932">The default enrollment process will look back 2 years for a previous assignment with a doctor and health plan and enroll the client with the doctor and health plan.</p> <p data-bbox="667 968 1122 1001"><u>For the Enhanced PCCM program:</u></p> <p data-bbox="667 1001 1435 1465">There is no default enrollment process, but there will be a look-back at paid claims for the past 12 months for the pilot enhanced PCCM for selected Evaluation and Management and Preventive Visit codes for Established Patients. If the client is currently Medicaid eligible, the enhanced PCCM with the most visits with a specific client will receive the attribution and the PMPM payment and enhanced FFS (if applicable) for that client for the month. If there is a tie between enhanced PCCMs, the client will be attributed to the enhanced PCCM that provided care for the last/most recent visit in the 12-month period. The attribution will be re-assessed on a monthly basis for a rolling twelve months (i.e. each month, the oldest month will be dropped and the newest month added).</p> <p data-bbox="587 1503 1338 1566">2. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).</p>

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For the MCO program:

The default enrollment process will assign the client with a provider that is in the zip code location of the client. It will expand the zip code search but the zip code search will be based on the client's location. Providers that have traditionally serviced Medicaid recipients will be located in a zip code range that is close to the Medicaid client. Also, providers that have traditionally served Medicaid recipients will not have an "established only" indicator which means the client would not be assigned to these providers unless there is an existing provider-recipient relationship.

For the Enhanced PCCM program:

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

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

For the MCO program:

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

For the Enhanced PCCM program:

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

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1932(a)(4)  
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

Items 3.1-3.vi below apply only to the State's MCO program. The Enhanced PCCM program is voluntary and therefore does not utilize a default enrollment process

1. The state will X/will not    use a lock-in for managed care.
2. The time frame for recipients to choose a health plan before being auto-assigned will be 15 days.
3. Describe the state's process for notifying Medicaid recipients of their auto-assignment. (*Example: state generated correspondence.*)

State generated correspondence

4. 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

5. 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 provider-recipient relationship, proximity, will attempt to maintain family members with the same PCP, and MCO health plan, and will assign the recipient to a provider that is in the zip code range of the client with an equal distribution of recipients into the two MCO health plans.

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6. 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.  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.  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.

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.)

This provision is not applicable to this 1932 State Plan Amendment.

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1932(a)(5) 42 CFR 438.50 42 CFR 438.10	<u> X </u> 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. <u>List all services that are excluded for each model (MCO &amp; PCCM)</u>  <u>For the MCO program:</u> 1. Pharmacy 2. Dental 3. HCBS Waiver services 4. Mental Health/Substance services 5. Hospice services 6. Nursing Facility services-custodial level of care 7. ICF/MR services 8. School-based services covered under Medicaid in Public Schools 9. Non-Home Health Agency Approved Personal Care Aide Services (PAS) 10. Optional targeted case management services  <u>For the Enhanced PCCM program:</u> No services are excluded for the Enhanced PCCM program.
1932 (a)(1)(A)(ii)	M. <u>Selective contracting under a 1932 state plan option</u>  To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.  1. The state will <u> X </u> /will not_____ intentionally limit the number of entities it contracts under a 1932 state plan option.  2. <u> X </u> The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

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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.)*

For the MCO program:

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.

For the Enhanced PCCM program:

There is no limit on enrollees. There is a limited number of providers in the geographic areas. Nebraska used a Request for Information competitive process soliciting applications from interested Family/General Practice, Internal Medicine, and Pediatric providers in non-managed care areas of the state.

4. \_\_\_\_ The selective contracting provision is not applicable to this state plan.