STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

COST-SHARING FOR THE CATEGORICALLY NEEDY

Effective October 24, 2011, the Nebraska Medical Assistance Program established the following schedule of copayments:

Service	Amount of copayment
Chiropractic Office Visits	$1 per visit
Dental Services	$3 per specified service
Durable Medical Equipment	$3 per specified service
Generic Drugs	$2 per prescription
Brand Name Drugs	$3 per prescription
Eyeglasses	$2 per eyeglasses
Hearing Aids	$3 per hearing aid
Inpatient Hospital Services	$15 per admission
Mental Health and Substance Abuse Services	$2 per specified service
Occupational Therapy (non-hospital based)	$1 per specified service
Optometric Office Visits	$2 per visit
Outpatient Hospital Services	$3 per visit
Physical Therapy (non-hospital based)	$1 per specified service
Physicians (M.D.'s and D,O's)	
Office Visits	$2 per visit
(Excluding Primary Care Physicians - Family Practice, General Practice, Pediatricians, Internists, and physician extenders {including physician assistants, nurse practitioners and nurse midwives) providing primary care services)	
Podiatrists Services	$1 per visit
Speech Therapy (non-hospital based)	$2 per specified service

As a basis for determining the copayment amount, the standard copayment amount is determined by applying up to the maximum copayment amounts specified in 42 CFR 447.54(a)(3) to the agency's average or typical payment for that service. For inpatient hospital services, the amount was calculated so as to not exceed one-half of the first day's per diem for each hospital admission.

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The copayment is collected by the provider at the time the service is provided. If the client is unable to pay the copayment when the service is provided, the provider may bill the client for the amount of the copayment.

An Individual who is unable to pay the copayment is identified by self-declaration to the provider.

Certain individuals and services are excluded from copayments in compliance with 42 CFR 447.53.

Indians are exempt from copayments based on race. Effective August 1, 2012, in compliance with 42 CFR 447.57(c), payment under Medicaid due to an Indian health care provider or a health care provider through referral under contract services for directly furnishing an item or service to an Indian will not be reduced by the amount of the enrollment fee, premium, or similar charge, or any deductible, copayment, cost sharing, or similar charge that otherwise would be due from the Indian.

The State will take the following action to meet the requirements of 42 CFR 447.57(c):

Through July 31, 2012, all individuals who have a verified American Indian or Alaska Native (AI/AN) status on their eligibility record will be exempted from cost sharing. Beginning August 1, 2012, for claims processed through the Medicaid Management Information System (MMIS) for those individuals who have a verified AI/AN status on their eligibility record and receive a service or item from an Indian health care provider or a health care provider through referral under contract services will be exempt from cost sharing.

Indian Health Care Providers will be paid in full.

There will not be a cumulative maximum that applies to all charges imposed on a specified time period.