STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

State Methodology for Determining Cost-Effectiveness of
Individual and Group Health Plans

I. The Nebraska Medicaid program determines the cost-effectiveness for payment of qualifying group or individual market health insurance premiums using the following methodology:

a. Any Medicaid-eligible client who has an existing, ongoing, and medically-confirmed medical condition determined by the Department to be considered a cost-effective condition is deemed to meet the cost-effective criteria.

b. When the criteria of *a.* are not met, cost-effectiveness will be calculated as follows:

   i. Determine:

      1. The annual anticipated cost for Medicaid services generally covered by the private health insurance based on the client's age, sex, and eligibility category.

   ii. Total the results of each of the following calculations:

      1. The portion of the group or individual market health insurance premium payable by the HIPP program.
      2. A predetermined annual administration cost per participant.
      3. The expected cost to Nebraska Medicaid for any deductibles, coinsurance and/or copayments.

   iii. Subtract the result of *ii.* from the result of *i*.

   iv. If the result is greater than or equal to $10, the policy would be determined cost-effective.

   v. If the result is less than $10, the policy would not be considered cost-effective.

c. When the criteria of *a*. and *b*. are not met, specific information relating to the individual circumstances of the Medicaid-eligible client may be provided. On a case-by-case basis and at the sole discretion of Nebraska Medicaid, a determination of cost-effectiveness can be made if sufficient evidence is provided to demonstrate savings to Nebraska Medicaid.

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Enrollment in the HIPP Program is voluntary. For Medicaid eligible clients, enrollment in the HIPP Program does not change the client's eligibility for benefits through the state plan or cost sharing obligations under the state plan.

Individuals enrolled in the HIPP program are afforded the same beneficiary protections provided to all other Medicaid enrollees. In addition to the benefits wrap, which is provided to ensure that individuals enrolled in the HIPP program receive all services and benefits available under the Medicaid State plan, the Nebraska Medicaid program also provides a wrap to any cost-sharing that exceeds the cost-sharing described in the State plan up to the Medicaid allowable taking into account the amount paid by the primary insurance. In order to effectuate this cost sharing wrap benefit:

a. The state has a provider enrollment process for non-participating providers to ensure that providers who provide services to Medicaid members can be enrolled and paid through the state Medicaid program.
b. To effectuate the cost sharing wrap, the state encourages non-participating providers to enroll by conducting targeted outreach to inform non-participating Medicaid providers on how to enroll in Medicaid for the purposes of receiving payment from the state.
c. Beneficiaries are informed by Nebraska Medicaid on how to submit receipts for direct reimbursement from the Medicaid agency in the event that a provider in the group or individual health plan does not elect to enroll as a Medicaid provider.

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II. The Nebraska Medicaid program will not make a determination of cost-effectiveness in the following circumstances:
   a. The client is eligible for or enrolled in Medicare.
   b. Payment of health insurance premiums have been fully reimbursed or offset by a third party, including, but not limited to:
      i. An employer.
      ii. An individual court-ordered to provide medical support.
   c. The recipient is only eligible for a medically needy (spend down) program.
   d. The group or individual market health insurance only provides catastrophic, limited benefit, limited duration, or indemnity coverage.

III. Redeterminations
   a. Nebraska Medicaid will complete a redetermination of eligibility annually for all clients enrolled in the HIPP Program. This redetermination must include:
      iii. Verification of eligibility for Nebraska Medicaid.
      iv. Completion of the cost-effective calculation as outlined in *I*.
   b. A redetermination of eligibility may be conducted at any point if:
      i. The monthly premium of the group or individual market health insurance increases by more than $50;
      ii. There is a change in eligibility category or status for Nebraska Medicaid;
      iii. The services offered by the group or individual market health insurance decrease;
      iv. There is a change in the deductible, co-insurance or any other cost-sharing provisions of the group or individual market health policy; or
      v. There is reason to believe a change has occurred which may affect eligibility for HIPP enrollment.
   c. Failure to provide requested documentation, or failure to meet HIPP enrollment eligibility as outlined in *I*. and *II*. May result in termination of eligibility for the HIPP Program.