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State/Territory Name: Nebraska

State Plan Amendment (SPA) #: 24-0002

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

March 13, 2024

Matthew Ahern
Interim Director
Division of Medicaid & Long-Term Care
Nebraska Department of Health & Human Services
301 Centennial Mall South
Lincoln, NE 68509

Re: Nebraska State Plan Amendment (SPA) 24-0002

Dear Director Ahern:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) NE-24-0002. This Alternative Benefit Plan (ABP) was submitted to align with dental plan changes made to the state plan, NE-24-0001. NE-24-0001 proposed to eliminate the $750-per-year adult dental benefit limit, to allow public health licensed dental hygienists to provide certain dental services, and to better align language in the State Plan with state regulations in 471 NAC 6.

We conducted our review of your submittal according to statutory requirements 42 CFR 440. This letter is to inform you that Nebraska Medicaid SPA 24-0002 was approved on March 13, 2024, with an effective date of January 1, 2024.

If you have any questions, please contact Tyson Christensen at 816-426-6440 or via email at tyson.christensen@cms.hhs.gov.

Sincerely,

[redacted]

Digitally signed by James G. Scott -S
Date: 2024.03.13 16:28:01 -05'00'

James G. Scott, Director
Division of Program Operations

cc: Dawn Kastens
Catherine Gekas-Steeby

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: Nebraska

Transmittal Number:

Enter the Transmittal Number (TN), including dashes, in the format SS-YY-NNNN or SS-YY-NNNN-xxxx (with xxxx being optional to specific SPA types), where SS = 2-character state abbreviation, YY = last 2 digits of submission year, NNNN = 4-digit number with leading zeros, and xxxx = OPTIONAL, 1- to 4-character alpha/numeric suffix.

NE-24-0002

Proposed Effective Date

01/01/2024 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR 440

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2024	$ 705398.00
Second Year	2025	$ 947342.00

Subject of Amendment

Dental coverage

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**

  Describe:

- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**

  Describe:

  Not required under 42 CFR 430 12(b)(2)(i)

Signature of State Agency Official

Submitted By:	**Crystal Georgiana**
Last Revision Date:	**Mar 1, 2024**
Submit Date:	**Dec 19, 2023**

Alternative Benefit Plan

State Name: Nebraska

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: NE - 24 - 0002

Alternative Benefit Plan Populations ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Nebraska Alternative Benefit Plan

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

Add	Eligibility Group:	Enrollment is mandatory or voluntary?	Remove
Add	Adult Group	Mandatory	Remove

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

The Nebraska ABP will include individuals who become pregnant in the adult group prior to their next annual eligibility renewal.

V.20181119

Alternative Benefit Plan

State Name: Nebraska Attachment 3.1-L- OMB Control Number: 09381148

Transmittal Number: NE - 24 - 0002

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	**ABP2a**
The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.	Yes

Explain how the state has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements.

Nebraska has fully aligned the benefits in its Nebraska ABP with the approved Medicaid State Plan by using duplication and adding the remaining Medicaid covered services by including additional Section 1937 covered benefits. Benefits provided by the base benchmark plan that are not included in the Medicaid State Plan were substituted for State Plan benefits not provided in the base benchmark plan. The EHB category where substitution occurred meets the standard of actuarial equivalence.

V.20160722

Alternative Benefit Plan

State Name: Nebraska Attachment 3.1-L- [ ] OMB Control Number: 0938-1148

Transmittal Number: NE - 24 - 0002

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package ABP3.1

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: Nebraska Alternative Benefit Plan

Selection of EHB-Benchmark Plan

The state/territory must select an EHB-benchmark plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

EHB-benchmark plan name: BCBS of Nebraska: Blue Pride Plus Option 102 Gold

The EHB-benchmark plan is the same as the Section 1937 Coverage option: No

Indicate the EHB-benchmark option as described at 45 CFR 156.111(b)(2)(B) the state/territory will use as its EHB-benchmark plan:

State/Territory is selecting one of the below options to design an EHB package that complies with the requirements for the individual insurance market under 45 CFR 156.100 through 156.125.

- ◉ State/Territory is selecting the EHB-benchmark plan used by the state/territory for the 2017 plan year.
- ○ State/Territory is selecting one of the EHB-benchmark plans used for the 2017 plan year by another state/territory.
- ○ State/ Territory selects the following EHB-benchmark plan used for the 2017 plan year but will replace coverage of one or more of the categories of EHB with coverage of the same category from the 2017 EHB-benchmark plan of one or more other states
- ○ Select a set of benefits consistent with the 10 EHB categories to become the new EHB-benchmark plan. (Complete and submit the ABP5: Benefits Description form to describe the set of benefits.)

Type of EHB-benchmark plan:

- ◉ Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ○ Any of the largest three state employee health benefit plans by enrollment.
- ○ Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ○ Largest insured commercial non-Medicaid HMO.

Alternative Benefit Plan

Assurances

☑ The state/territory assures the EHB plan meets the scope of benefits standards at 45 CFR 156.111(b), does not exceed generosity of most generous among a set of comparison plans, provides appropriate balance of coverage among 10 EHB categories, and the scope of benefits is equal to, or greater than, the scope of benefits provided under a typical employer plan as defined at 45 CFR 156.111(b)(2).

☑ The state/territory assures that all services in the EHB-benchmark plan have been accounted for throughout the benefit chart found in ABP 5.

☑ The state/territory assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid State Plan.

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

◉ Benchmark Benefit Package.

○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).

○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):

○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):

◉ Secretary-Approved Coverage.

◉ The state/territory offers benefits based on the approved state plan.

○ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

◉ The state/territory offers the benefits provided in the approved state plan.

○ Benefits include all those provided in the approved state plan plus additional benefits.

○ Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.

○ The state/territory offers only a partial list of benefits provided in the approved state plan.

○ The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

Please briefly identify the benefits, the source of benefits and any limitations:

(1) The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5; and (2) The state assures the accuracy of all information in ABP5 depicting amount, duration, and scope parameters of services authorized in the currently approved Medicaid State Plan.

Other Information Related to Selection of the Section 1937 Coverage Option and the EHB-Benchmark Plan (optional):

See Nebraska Alternative Benefit Plan ABP5.

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20190813

Alternative Benefit Plan

State Name: Nebraska | Attachment 3.1-L- | OMB Control Number: 09381148

Transmittal Number: NE - 24 - 0002

Alternative Benefit Plan Cost-Sharing — ABP4

☑ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. No

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Alternative Benefit Plan

State Name: Nebraska

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: NE - 24 - 0002

Benefits Description ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Blue Cross Blue Shield of Nebraska: BluePride Plus Option 102 Gold
Aligned Medicaid ABP

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary- Approved

Alternative Benefit Plan

☑ 1. Essential Health Benefit: Ambulatory patient services — Collapse All ☐

Benefit Provided: Outpatient Hospital Services
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
All psychiatric testing and evaluations must be performed by a licensed psychologist or under the supervision of a licensed psychologist.

Benefit Provided: Physician's Services
Source: State Plan 1905(a)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Prior authorization required for cosmetic and reconstruction surgical procedures, except for the following, cleft lip and cleft palate, post-mastectomy breast reconstruction, congenital hemangioma's of the face, and nevus (mole) removals.

Benefit Provided: Clinic Services
Source: State Plan 1905(a)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Alternative Benefit Plan

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.

The "facility fee" includes payment for services and items provided by an ASC in connection with a covered surgical procedure.

Prior authorization is required for the 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 by hospital affiliated clinics or free-standing clinics.

Remove

Benefit Provided: Hospice Care

Source: State Plan 1905(a)

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: Other

Scope Limit:

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 periods.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

A client may elect to receive hospice care during one or more of the following election periods: an initial 90-day period, a subsequent 90-day period, an initial 60-day period, a subsequent 60-day period, and a third 60-day period.

Additional 60-day benefit periods must be approved as an exception under the prior authorization provision.

Remove

Benefit Provided: Home Health Services

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: Other

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage for all home health agency services is based on medical necessity, and must be necessary to continuing a medical treatment plan, prescribed by a licensed physician, nurse practitioner, physician

assistant, or clinical nurse specialist, and re-certified at least every 60 days.

Remove

Benefit Provided: Other Practitioner Services

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: Chiropractic Services

Source: State Plan 1905(a)

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: Other

Duration Limit: Other

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

No limits, all treatments based on medical necessity.

Remove

Benefit Provided:

Source:

Authorization: Yes

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 2. Essential Health Benefit: Emergency services Collapse All ☐

Remove

Benefit Provided: Emergency Hospital Services

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: Transportation Services: Emergency

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Covers medically necessary ambulance services required to transport a client during an emergency or required to obtain medical care.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 3. Essential Health Benefit: Hospitalization Collapse All ☐

Remove

Benefit Provided:
Inpatient Hospital Services

Source:
State Plan 1905(a)

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

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, it is covered if the transplant is medically necessary and non-experimental. Prior Authorization is required.

Prior authorization is required for cosmetic and reconstructive surgical procedures except for the following conditions: cleft lip and cleft palate, post-mastectomy breast reconstruction, congenital hemangioma's of the face, and nevus (mole) removals.

Add

Alternative Benefit Plan

☑ 4. Essential Health Benefit: Maternity and newborn care — Collapse All ☐

Benefit Provided: Nurse-Midwife Services
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: Other
Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Nurse-Midwife services are covered 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 to the terms of the practice agreement between the nurse-midwife and the physician.

Benefit Provided: Inpatient Hospital Services-Maternity
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Outpatient Hospital Services-Maternity
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Freestanding Birth Center Services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services are limited to facility services provided during the labor, delivery and postpartum periods.

Cesarean 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.

Benefit Provided: Other Practitioners Services-Maternity

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Physician's services-Maternity

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Does not cover routine office visits to a physician when a nurse-midwife is providing complete obstetrical care, unless documentation of medical necessity for the physician's office visit is submitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Extended Services for Pregnant Women

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: Other

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: 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.

Benefit Provided: Tobacco Cessation-Maternity

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Home Health Services-Maternity

Source: State Plan 1905(a)

Remove

Alternative Benefit Plan

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
Other

Scope Limit:
Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Coverage for all home health agency services is based on medical necessity, and must be necessary to continuing a medical treatment plan, prescribed by a licensed physician, nurse practitioner, physician assistant, or clinical nurse specialist, and re-certified at least every 60 days.

Add

Alternative Benefit Plan

Collapse All ☐

■ 5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

☑ The state/territory assures that it does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Remove

Benefit Provided: Outpatient Hospital Services: MH/SUD

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: Other

Duration Limit: Other

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Intensive outpatient mental health services include psychotherapy by professionals 2-4 times a week 3-6 hours per day.

Partial hospitalization includes up to 7 days a week 3-6 hours per day. Recipients must be seen by a physician 3 times a week. The provider must have access to pharmacy, dietary, nursing, psychology and psychotherapy.

Remove

Benefit Provided: Inpatient Hospital Services: MH/SUD

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: Physician's Services: MH/SUD

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: Other

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Treatment crisis intervention must be clinically necessary to relieve a crisis prior to comprehensive psychiatric assessment.

Adult crisis stabilization provides continuous 24-hour observation and supervision up to 72 hours for individuals who do not require assessment and treatment in an acute inpatient hospital setting.

Benefit Provided: Rehabilitative Services: MH/SUD

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Clinic Services: MH/SUD

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Alternative Benefit Plan

Benefit Provided:
Other Practitioner's Services: MH/SUD

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
Other

Scope Limit:
Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Treatment crisis intervention must be clinically necessary to relieve a crisis prior to comprehensive psychiatric assessment.

Adult crisis stabilization provides continuous 24-hour observation and supervision up to 72 hours for individuals who do not require assessment and treatment in an acute inpatient hospital setting.

Benefit Provided:
Home Health Services: MH/SUD

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

Psychiatric Nursing Services are mental health home health services that are provided to eligible clients who are unable to access office based services.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage for all home health agency services is based on medical necessity, and must be necessary to continuing a medical treatment plan, prescribed by a licensed physician, nurse practitioner, physician assistant, or clinical nurse specialist, and re-certified at least every 60 days.

Add

Alternative Benefit Plan

■ 6. Essential Health Benefit: Prescription drugs

☑ The state/territory assures that the ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☐ Limit on number of prescriptions		
☐ Limit on brand drugs		
☒ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

Alternative Benefit Plan

☑ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices — Collapse All ☐

☑ The state/territory assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (45 CFR 156.115(a)(5)(ii)). Further, the state/territory understands that separate coverage limits must also be established for rehabilitative and habilitative services and devices. Combined rehabilitative and habilitative limits are allowed, if these limits can be exceeded based on medical necessity.

Benefit Provided: Home Health Services: PT, OT, ST, & Audiology
Source: State Plan 1905(a)
Remove

Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

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.

Coverage for all home health agency services is based on medical necessity, and must be necessary to continuing a medical treatment plan, prescribed by a licensed physician, nurse practitioner, physician assistant, or clinical nurse specialist, and re-certified at least every 60 days.

Benefit Provided: Physical Therapy and related services: PT
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: Other
Duration Limit: Per fiscal year
Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

A combined total of 60 therapy sessions which include rehabilitative and habilitative services (physical therapy, occupational therapy, and speech therapy) are covered for individuals age 21 and older. May be exceeded based on medical necessity.

Benefit Provided: Physical Therapy and related services: OT
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan

Amount Limit: Other

Duration Limit: Per fiscal year

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

A combined total of 60 therapy sessions which include rehabilitative and habilitative services (physical therapy, occupational therapy, and speech therapy) are covered for individuals age 21 and older. May be exceeded based on medical necessity.

Remove

Benefit Provided: Short-Term Nursing Facility Services

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

As approved in section 3.1-A of the Medicaid state plan.

Remove

Benefit Provided: Home Health Services: Medical Supplies, Equipment,

Source: State Plan 1905(a)

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Other

Duration Limit: Other

Scope Limit:

Does not cover items which primarily serve personal comfort, convenience, education, hygiene, safety, cosmetic, and new equipment of unproven value, external powered prosthetics and equipment of questionable current usefulness or therapeutic value.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Orthotic devices when medically necessary and prescribed. One pair of orthopedic shoes at the time of purchase. One pair of shoes in a one-year period.

Prior authorization is required for some rental and purchase of items.

Coverage for all home health agency services is based on medical necessity, and must be necessary to

continuing a medical treatment plan, prescribed by a licensed physician, nurse practitioner, physician assistant, or clinical nurse specialist, and re-certified at least every 60 days.

Remove

Benefit Provided: Svs. for ind. with speech, hearing, & language

Source: State Plan 1905(a)

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Other

Duration Limit: Other

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Complete title: Services for individuals with speech, hearing, & language disorders

A combined total of 60 therapy sessions which include rehabilitative and habilitative services (physical therapy, occupational therapy, and speech therapy) are covered for individuals age 21 and older. May be exceeded based on medical necessity.

For clients age 21 and older, covers hearing aids limited to not more than one aid per ear every four years and then only when required by medical necessity.

Does not cover hearing aid batteries for residents of a nursing facility except with the initial fitting. Does not cover accessories which are for convenience and not medically necessary.

Remove

Benefit Provided: Physical therapy and related services: ST

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: Other

Duration Limit: Per fiscal year

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

A combined total of 60 therapy sessions which include rehabilitative and habilitative services (physical therapy, occupational therapy, and speech therapy) are covered for individuals age 21 and older. May be exceeded based on medical necessity.

Remove

Benefit Provided: Prosthetic Devices

Source: State Plan 1905(a)

Alternative Benefit Plan

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Other

Duration Limit:

Other

Scope Limit:

Does not cover items which primarily serve personal comfort, convenience, education, hygiene, safety, cosmetic, and new equipment of unproven value, external powered prosthetics and equipment of questionable current usefulness or therapeutic value.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Orthotic devices when medically necessary and prescribed. One pair of orthopedic shoes at the time of purchase. One pair of shoes in a one-year period.

Prior authorization is required for some rental and purchase of the items.

Add

Alternative Benefit Plan

☑ 8. Essential Health Benefit: Laboratory services

Collapse All ☐

Benefit Provided:
Other Laboratory and X-ray Services

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided: Family Planning Services & Supplies

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

No authorization required.

Benefit Provided: Other Diagnostic, Screening, Preventative,

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Covers diagnostic and screening mammograms. Covers immunizations for adults (age 21 & older) when medically necessary.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

*Complete title: Other Diagnostic, Screening, Preventative, and Rehabilitative Services

Benefit Provided: Nutrition Services

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medical Nutritional Therapy is only available to select individuals with medical needs that require nutritional assessment, intervention, and continued monitoring.

Available only by physician or nurse practitioner referral.

Add

Alternative Benefit Plan

☑ 10. Essential Health Benefit: Pediatric services including oral and vision care

Collapse All ☐

Remove

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
Up to age 21

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services described in section 1905(a) of the Social Security Act that are not covered under the 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 require prior authorization.

Add

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

Alternative Benefit Plan

☒ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Base Benchmark Benefit that was Substituted: Primary Care Visit to Treat an Injury or Illness

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Physician's Services and Other Practitioner Services in EHB 1: Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted: Specialist Visit

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Physician's Services and Other Practitioner Services in EHB 1: Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted: Outpatient Surgery Physician/Surgical Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Physician's Services and Other Practitioner Services in EHB 1: Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted: Hospice Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Hospice Care in EHB 1: Ambulatory Patient Services.

Base Benchmark Plan: The covered person must have a life expectancy of six months or less as documented in writing by the attending physician. The hospice services must be ordered by a physician. Services provided must be appropriate for palliative support or management of a covered persons with terminal medical illness.

Base Benchmark Benefit that was Substituted: Urgent Care Center or Facilities

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Outpatient Hospital Services and Clinic Services in EHB 1: Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted: Emergency Room Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Emergency Hospital Services in EHB 2: Emergency Services.

Base Benchmark Benefit that was Substituted: Emergency Transportation/Ambulance
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Transportation Services: Emergency in EHB 2: Emergency Services.

Base Benchmark Benefit that was Substituted: Home Health Care Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Home Health Services EHB 1: Ambulatory Patient Services.

Base Benchmark Plan: Limited to 60 days.

Base Benchmark Benefit that was Substituted: Inpatient Hospital Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Inpatient Hospital Services EHB 3: Hospitalization.

Base Benchmark Benefit that was Substituted: Inpatient Physician and Surgical Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Inpatient Hospital Services: EHB3: Hospitalization.

Base Benchmark Benefit that was Substituted: Skilled Nursing Facility
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Short-Term Nursing Facility Services in EHB 7: Rehabilitative and Rehabilitative Services and Devices.

Base Benchmark Plan: 60 day(s) per year
Exclusions: Skilled nursing facility care does not include:
a) supportive services for a stabilized condition;
b) care which can be learned and given by unlicensed or uncertified medical personnel;
c) routine health care services;
d) general maintenance or supervision of routine daily activities; or
e) routine administration of oral or nonprescription drugs.

Base Benchmark Benefit that was Substituted: Prenatal and Postnatal Care

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Outpatient Hospital Services-Maternity, Physician Services-Maternity, Other Practitioner's Services-Maternity, Nurse-midwife Services, Free Standing Birth Center Services, Inpatient Hospital Services-Maternity, Tobacco Cessation-Maternity, Home Health Services-Maternity, Extended Services for Pregnant Women in EHB 4: Maternity and Newborn Care.

Base Benchmark Benefit that was Substituted: Delivery and All Inpatient Services for Maternity

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Inpatient Hospital Services-Maternity, Nurse-midwife Services, Free Standing Birth Center Services in EHB 4: Maternity and Newborn Care.

Base Benchmark Benefit that was Substituted: Basic Dental Care - Child

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Medicaid State Plan EPSDT Benefits in EHB 10: Pediatric Services - including oral and vision. Base Benchmark Plan: Limit: 2 exam(s) per year.

Base Benchmark Benefit that was Substituted: Well Baby Visits and Care

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Medicaid State Plan EPSDT Benefits in EHB 10: Pediatric Services - including oral and vision.

Base Benchmark Benefit that was Substituted: Dental Check-up for Children
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplication: Covered under Nebraska Medicaid State Plan as Medicaid State Plan EPSDT Benefits in EHB 10: Pediatric Services - including oral and vision.

Base Benchmark Benefit that was Substituted: Eye Glasses for Children
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplication: Covered under Nebraska Medicaid State Plan as Medicaid State Plan EPSDT Benefits in EHB 10: Pediatric Services - including oral and vision.

Base Benchmark Benefit that was Substituted: Routine Eye Exam for Children
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplication: Covered under Nebraska Medicaid State Plan as Medicaid State Plan EPSDT Benefits in EHB 10: Pediatric Services - including oral and vision.

Base Benchmark Benefit that was Substituted: Laboratory Outpatient and Professional Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplication: Covered under Nebraska Medicaid State Plan as Other Laboratory and X-ray Services in EHB 8: Laboratory Services.

Base Benchmark Benefit that was Substituted: X-rays and Diagnostic Imaging
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplication: Covered under Nebraska Medicaid State Plan as Other Laboratory and X-ray Services in EHB 8: Laboratory Services.

Base Benchmark Benefit that was Substituted: Imaging (CT/PET Scans, MRIs)
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Other Laboratory and X-ray Services in EHB 8: Laboratory Services.

Base Benchmark Benefit that was Substituted: Mental/Behavioral Health Outpatient Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Outpatient Hospital Services: MH/SUD, Physician's Services: MH/SUD, Clinic Services: MH/SUD, Other Practitioner's Services: MH/SUD, Rehabilitative Services: MH/SUD and Home Health Services: MH/SUD in EHB 5: Mental Health and Substance Use Disorder Services.

Base Benchmark Benefit that was Substituted: Mental/Behavioral Health Inpatient Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Inpatient Hospital Services: MH/SUD, Physician's Services: MH/SUD, Clinic Services: MH/SUD, Other Practitioner's Services: MH/SUD, Rehabilitative Services: MH/SUD in EHB 5: Mental Health and Substance Use Disorder Services.

Base Benchmark Plan: Excludes programs that treat obesity or gambling addiction and residential treatment programs.

Exclusions include: programs for co-dependency; employee assistance; probation; prevention; educational or self-help; programs which treat obesity, gambling, or nicotine addiction; Custodial Care for Mental Illness and/or Substance Dependence and Abuse; halfway house or Substance Dependence and Abuse maintenance programs; programs ordered by the Court determined to be not Medically Necessary.

Base Benchmark Benefit that was Substituted: Substance Abuse Disorder Outpatient Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska's 1915(b)(3) waiver services as Outpatient Hospital Services: MH/SUD, Physician's Services: MH/SUD, Clinic Services: MH/SUD, Other Practitioner's Services: MH/SUD, Home Health Services: MH/SUD in EHB 5: Mental Health and Substance Use Disorder Services.

Base Benchmark Benefit that was Substituted: Substance Abuse Disorder Inpatient Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska's 1915(b)(3) waiver services as Inpatient Hospital Services: MH/SUD, Physician's Services: MH/SUD, Clinic Services: MH/SUD, Other Practitioner's Services:

MH/SUD in EHB 5: Mental Health and Substance Use Disorder Services.

Base Benchmark Benefit that was Substituted: Durable Medical Equipment
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Home Health Services: Medical Supplies, Equipment, and Appliances in EHB 7: Rehabilitative and Habilitative Services.

Base Benchmark Benefit that was Substituted: Chemotherapy
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Physician's Services in EHB 1: Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted: Prosthetic Devices
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Home Health Services: Prosthetic Devices and Home Health Services:Medical Supplies, Equipment, and Appliances in EHB 7: Rehabilitative and Habilitative Services.

Base Benchmark Benefit that was Substituted: Transplant
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Inpatient Hospital Services in EHB 3: Hospitalization.

Base Benchmark Benefit that was Substituted: Other Practitioner Office Visit (RN, PA)
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Physician's Services and Other Practitioner Services in EHB 1: Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted: Nutritional Counseling
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Nutrition Services in EHB 9: Preventative and Wellness Services and Chronic Disease Management.

Base Benchmark Plan: Only for diabetes management.

Base Benchmark Benefit that was Substituted: Rehabilitative OT and Rehabilitative PT

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Home Health Services: PT, OT, ST, & Audiology, Physical Therapy and related services: PT, and Physical Therapy and related services: OT, and Services for Individuals with speech, hearing, and language disorders in EHB 7: Rehabilitative and Habilitative Services.

Base Benchmark Plan: Limit: 45 visit(s) per year

Explanation: Limits to rehab and hab combined: Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (combined limit to 45 sessions per calendar year).

Base Benchmark Benefit that was Substituted: Rehabilitative Speech Therapy

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Home Health Services: PT, OT, ST, & Audiology, Physical Therapy and related services: ST, services for individuals with speech, hearing, and language disorders in EHB 7: Rehabilitative and Habilitative Services.

Base Benchmark Plan: Limit: 45 visit(s) per year

Explanation: Limits to rehab and hab combined: Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (combined limit to 45 sessions per calendar year).

Base Benchmark Benefit that was Substituted: Outpatient Rehabilitation Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Home Health Services: PT, OT, ST, & Audiology, Physical Therapy and related services: PT, Physical Therapy and related services: OT, Physical Therapy and related services: ST, and in EHB 7: Rehabilitative and Habilitative Services.

Base Benchmark Plan: 45 treatment(s) per year
Limits apply to rehab and hab combined: physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (combined limit to 45 sessions per calendar year).

Base Benchmark Benefit that was Substituted: Habilitation Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Home Health Services: PT, OT, ST, & Audiology, Physical Therapy and related services: PT, Physical Therapy and related services: ST, Physical Therapy and related services:OT in EHB 7: Rehabilitative and Habilitative Services.

Base Benchmark Plan: Limit: 45 treatment(s) per year

Autism exclusions: Services for treatment of austism spectrum disorders, including, but not limited to applied behavioral anaylsis and early intensive behavioral intervention.

Services for autism spectrm disorders or pervasive developmental conditions, developmental delays or sensory integration disorders...unless otherwise required by law or specifically covered elsewhere in this contract.

Explanations: Nebraska supplemented this EHB category for Habilitative Services: "Health care services that help a person keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings." Quantitative limits on services apply to outpatient, only.

Base Benchmark Benefit that was Substituted: Chiropractic Care

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Chiropractic Services in EHB1: Ambulatory Patient Services.

Base Benchmark Plan: Limit: 20 visit(s) per year. Chiropractic physiotherapy has a combined limit with PT, OT and speech therapies of 45 sessions per calendar year. Chiropractic manipulative adjustments have a combined limit with osteopathic physiotherapy of 20 sessions per calendar year.

Base Benchmark Benefit that was Substituted: Dialysis

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Clinic Services, Outpatient Hospital Services, and Physician Services in EHB1: Ambulatory Patient Services and Inpatient Hospital Services in EHB3: Hospitalization.

Base Benchmark Benefit that was Substituted: Accidental Dental

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Clinic Services, Outpatient Hospital Services, and Physician Services in EHB1: Ambulatory Patient Services and Inpatient Hospital Services in EHB3: Hospitalization.

Base Benchmark Plan: Benefits are limited to treatment provided within 12 months of the injury. Benefits are not available for orthodontics or dental implants. Benefits shall not be provided for such services when the injury occurs as the result of eating, biting, or chewing.

Base Benchmark Benefit that was Substituted: Radiation

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Physician Services in EHB1: Ambulatory Patient Services and Inpatient Hospital Services in EHB3: Hospitalization.

Base Benchmark Benefit that was Substituted: Infusion Therapy

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Physician Services in EHB1: Ambulatory Patient Services and Inpatient Hospital Services in EHB3: Hospitalization.

Base Benchmark Benefit that was Substituted: Reconstructive Surgery

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Physician Services in EHB1: Ambulatory Patient Services and Inpatient Hospital Services in EHB3: Hospitalization.

Base Benchmark Plan: Available only post-mastectomy or when required to restore, reconstruct or correct any bodily function that was lost, impaired or damaged as a result of injury or illness.

Base Benchmark Benefit that was Substituted: Diabetes Education

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substitution: Diabetes Education was removed and replaced in EHB9: Preventative and Wellness Services and Chronic Disease Management by substitution with the actuarial value of Family Planning Services & Supplies, which are not covered in the base benchmark plan. Coverage for Family Planning Services & Supplies comes from the preventative coverage provided in the State Plan.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:
Preventative Care/Screening/Immunization

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Other Diagnostic, Screening, Preventative, and Rehabilitative Services in EHB 9: Preventative and Wellness Services and Chronic Disease Management.

Base Benchmark Benefit that was Substituted:
Outpatient Facility Fee (e.g. ambulatory surgery)

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Nebraska Medicaid State Plan as Clinic Services in EHB 1: Ambulatory Patient Services and Freestanding Birth Center Services in EHB 4: Maternity and Newborn Care.

Add

☐ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

Alternative Benefit Plan

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All ☐

Other 1937 Benefit Provided: Personal Assistance Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: 40 hours per week

Duration Limit: 7 day period

Scope Limit: Other

Other: Personal assistance services are authorized by the state or designee, provided by qualified providers who are not legally responsible relatives, and are furnished inside the home, and outside the home with limitations. Provided at a client's worksite to the extent the authorized task might otherwise be needed in the home and community. Not provided to individuals residing in residential facilities where personal assistance services are required under the licensing requirements.

Other 1937 Benefit Provided: Rural Health Clinic Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Yes

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other: No prior authorization.

Other 1937 Benefit Provided: FQHC

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other:
No prior authorization.

Other 1937 Benefit Provided:
Certified Pediatric & Family Nurse Practitioner

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
No prior authorization.

Other 1937 Benefit Provided:
Podiatrists' Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Other

Duration Limit:
Other

Scope Limit:
Covers medically necessary podiatry services within the scope of the podiatrists' licensure and within program guidelines.

Other:
Orthotic devices and orthotic footwear: Covers orthotic devices, orthopedic footwear, shoe corrections, and other items for the feet if medically necessary for the client's condition.

Pallatative 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.

Other 1937 Benefit Provided:
Dental Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Other

Duration Limit:
Other

Scope Limit:
Other

Other:
Diagnostic services and preventive dental care, do not require prior authorization.

Periodic oral evaluation is covered once every 180 days or more often if medically necessary.

Oral Surgery: Oral surgery, as defined by HCPCS, is covered as a physician service.

Cosmetic Services: Cosmetic dental services are not covered.

Radiology: Nebraska covers the following radiographs: Intraoral complete series, intraoral periapical films, extraoral films, bitewings, panoramic films, and cephalometric film. Coverage of these procedures is specified in state regulations.

Endodontics: Nebraska Medicaid covers endodontics for anterior and posterior teeth when the prior authorization request, which includes submitted x-rays with clinical documentation, substantiates medical necessity.

Periodontics: Nebraska Medicaid covers periodontics for anterior and posterior teeth when prior authorized.

Remove

Other 1937 Benefit Provided:
Dentures

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Other

Duration Limit:
Other

Scope Limit:
Other

Other:
The following prosthetic appliances are covered 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;
2. The client does not have a history of lost prosthetic appliances;
3. A repair will not make the existing denture or partial functional;

4. A reline will not make the existing denture or partial functional; or
5. A rebase will not make the existing denture or partial functional.

Partial dentures for clients are covered that do not have adequate occlusion.

Prior authorization is required for replacement/complete dentures, maxillary resin base partials, and flipper partials.

Other 1937 Benefit Provided:
Eyeglasses

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
1

Duration Limit:
Every 24 months

Scope Limit:

Other:

Exams: Eye examinations are covered for clients age 21 and older once every 24 months. More frequent eye examinations will also be covered when reasonable and appropriate.

Eyeglass frames: Eyeglass frames are covered 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.

Eyeglass lenses: Eyeglass lenses under the following conditions:
1. The client's first pair of prescription eyeglasses; or
2. Change in size due to growth; or
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, a pair of lenses is covered within a 24 month period when anyone of the above medical reasons exist. Lenses must meet the specifications for eyeglass lenses and coverage criteria.

Contact lens services are covered only when prescribed for correction of keratoconus, monocular aphakia, or other pathological conditions of the eye when useful vision cannot be obtained with eyeglasses. Contact lenses are not covered when prescribed for routine correction of vision.

Services not covered: Sunglasses, multiple pairs of eyeglasses for the same individual, non-spectacle

mounted aids, hand-held or single lens spectacle mounted low vision aids, and telescopic and other compound lens systems, and replacement insurance.

Remove

Other 1937 Benefit Provided:
Private Duty Nursing Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Other

Duration Limit:
Other

Scope Limit:
None

Other:
The following limitations are applied 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.)

Remove

Other 1937 Benefit Provided:
Case Management

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
For aged, blind, and disabled individuals, AFDC-related individuals, and individuals with developmental disabilities.

Other:
No prior authorization.

Other 1937 Benefit Provided: Intermediate Care Facility Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Other

Other: No prior authorization required. For individuals with intellectual disabilities. The individual must have a diagnosis of an intellectual disability as the primary diagnosis and can benefit from active treatment.

Other 1937 Benefit Provided: Inpatient Psychiatric Services Under Age 21

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other: Prior authorization and certification of need required.

Other 1937 Benefit Provided: Telehealth

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other: Services are covered when provided via telehealth technologies subject to the limitations as set forth in 3.1-A and 3.1-B of the approved Medicaid state plan. Services requiring “hands on" professional care are excluded.

Alternative Benefit Plan

Remove

Other 1937 Benefit Provided:
Non-Emergency Medical Transportation

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

Other:
Authorization for NEMT services shall be requested for a scheduled trip at least three business days in advance, with the exception of an unscheduled trip for urgent medical care. The authorization shall be requested and the trip(s) shall be arranged according to the most appropriate mode of transportation for the service provided to the client.

Remove

Other 1937 Benefit Provided:
Respiratory Care Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Must be reasonable and necessary for the diagnosis or treatment of an illness or injury.

Other:
No prior authorization required.

Remove

Other 1937 Benefit Provided:
Abortion Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Only as required under 42 CFR 457.475.

Other:

Other 1937 Benefit Provided: Critical Care Hospital

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: As defined in 42 CFR 440.170(g).

Other: No prior authorization is required.

Other 1937 Benefit Provided: 1915(c) HCBS Waivers

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Other

Duration Limit: Other

Scope Limit: Other

Other: Services as outlined in Nebraska's approved 1915(c) HCBS Waivers.

Other 1937 Benefit Provided: Long-Term Nursing Facility Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:
Other

Other:
As approved in section 3.1-A of the Medicaid state plan.

Other 1937 Benefit Provided:
PACE

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Other

Duration Limit:
Other

Scope Limit:
Other

Other:
As approved in section 3.1-A in Nebraska's Medicaid State Plan.

Other 1937 Benefit Provided:
Optometrists' Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
All surgical procedures provided by an optometrist or ophthalmologist require approval from the Primary Care Case Management plan.

Other 1937 Benefit Provided:
Medically-monitored Inpatient Withdrawal Managemen

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Other

Duration Limit:
Other

Scope Limit:
Other

Other:
Medically-monitored Inpatient Withdrawal Management (ASAM Level 3.7-WM) is an organized service delivered by medical and nursing professionals, which provide for 24-hour medically supervised evaluation under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. This level provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour residential care.

Other 1937 Benefit Provided:
Opioid Treatment Program (OTP)

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Other

Duration Limit:
Other

Scope Limit:
Other

Other:
The OTP service offers community-based, non-residential rehabilitative services for individuals diagnosed with an opioid use disorder, as defined in the Diagnostic Statistical Manual. OTP services include rehabilitative services to administer opioid treatment medication and to alleviate the adverse medical, psychological, or physical effects to opioid addiction.

Other 1937 Benefit Provided:
Medication-Assisted Treatment (MAT)

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Other

Duration Limit:
Other

Scope Limit:
Other

Other:
MAT is provided as defined in the approved state plan 3.1A and if applicable, 3.1B pages.

MAT is provided in accordance with 1905(a)(29) for the period beginning October 1, 2020, and ending September 30, 2025.

Alternative Benefit Plan

Other 1937 Benefit Provided:
Routine Patient Cost in Qualifying Clinical Trials

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Varies

Duration Limit:
Varies

Scope Limit:
Varies

Other:
See Supplement to Attachment 3.1-A, Item 30 and 3.1-B, Item 30. Coverage of Routine Patient Cost in Qualifying Clinical Trials.

Other 1937 Benefit Provided:

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other:

Add

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20190808

Alternative Benefit Plan

State Name: Nebraska

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: NE - 24 - 0002

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

◉ Through an Alternative Benefit Plan.

○ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

- ☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
- ☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- ☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- ☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- ☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- ☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

V.20160722

Alternative Benefit Plan

State Name: Nebraska | Attachment 3.1-L- | OMB Control Number: 09381148

Transmittal Number: NE - 24 - 0002

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- ☒ Managed care.
  - ☒ Managed Care Organizations (MCO).
  - ☐ Prepaid Inpatient Health Plans (PIHP).
  - ☐ Prepaid Ambulatory Health Plans (PAHP).
  - ☐ Primary Care Case Management (PCCM).
- ☒ Fee-for-service.
- ☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

☑ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

New members are auto-enrolled in one of the three MCOs after eligibility determination based on a pre-determined algorithm. All members will have 90 days from initial MCO assignment to select a different MCO, and choice counseling in selecting the Plan that best fits the member's needs is available through the Enrollment Broker and website www.neheritagehealth.com.

Members who are being transitioned from Medically Needy with a Share of Cost into Heritage Health Adult will be auto-assigned to an MCO by the State's conflict-free Enrollment Broker if not already enrolled in an MCO. Members will have 90 days from initial MCO assignment to select a different MCO, and choice counseling in selecting the Plan that best fits the member's needs is available through the Enrollment Broker and website www neheritagehealth.com.

Parent caretakers with a 5% disregard and members who are being transitioned into Heritage Health Adult will maintain enrollment in their current MCO.

Nebraska currently has a robust population of providers who participate in Medicaid and are contracted with Heritage Health plans. All Nebraska Managed Care Organizations have provided the State with detailed plans on ensuring adequate access to services for the Adult Group. All MCOs will also have to attest to network adequacy prior to the addition of the Medicaid Adult Group population.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. Yes

Alternative Benefit Plan

The managed care program is operating under (select one):

- ○ Section 1915(a) voluntary managed care program.
- ◉ Section 1915(b) managed care waiver.
- ○ Section 1932(a) mandatory managed care state plan amendment.
- ○ Section 1115 demonstration.
- ○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: Jun 23, 2017

Describe program below:

Nebraska Medicaid's managed care program, called Heritage Health, is comprised of three managed care organizations who are responsible for overseeing the delivery of comprehensive, integrated physical, pharmacy, behavioral health, and dental services statewide for Medicaid enrollees utilizing a risk bearing model.

Additional Information: #type# (Optional)

Provide any additional details regarding this service delivery system (optional):

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

- ◉ Traditional state-managed fee-for-service
- ○ Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

Nebraska Medicaid State Plan Services that are excluded from MCO benefits will continue to be delivered as traditional state managed fee-for-service, which includes Long-term custodial care services, personal assistance services, and HCBS 1915(c) services. When a client becomes eligible during an inpatient hospital stay, the services will be delivered as traditional state managed fee-for-services.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

Alternative Benefit Plan

State Name: Nebraska

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: NE - 24 - 0002

Employer Sponsored Insurance and Payment of Premiums — ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.

No

The state/territory otherwise provides for payment of premiums.

Yes

Provide a description including the population covered, the amount of premium assistance by population, required contributions, cost-effectiveness test requirements, and benefits information.

Participation in Nebraska's Health Insurance Premium Payment (HIPP) Program is voluntary. 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 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. Nebraska will be following the cost-effectiveness methodology as found in the approved State Plan, Attachment 4.22-C, pages 1-3.

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

V.20160722

Alternative Benefit Plan

State Name: Nebraska | Attachment 3.1-L- | OMB Control Number: 09381148

Transmittal Number: NE - 24 - 0002

General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

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V.20160722

Alternative Benefit Plan

State Name: Nebraska Attachment 3.1-L- [ ] OMB Control Number: 09381148

Transmittal Number: NE - 24 - 0002

Payment Methodology ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

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V.20160722