DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTHCARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

1. TRANSMITTAL NUMBER: 04-002

2. STATE: Nebraska

FOR: HEALTHCARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

4. TO: REGIONAL ADMINISTRATOR
HEALTHCARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. PROPOSED EFFECTIVE DATE
March 1, 2004

6. TYPE OF PLAN MATERIAL (Check One)

☐ NEW STATE PLAN ☐ AMENDMENT TO A CONSIDERED AS NEW PLAN ☐ AMENDMENT

(COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT) (Section numbers refer to the Act)

7. FEDERAL STATUTE/REGULATION CITATION
1905(a)(4)(B) of the Act; 42 CFR 435.831; SSAM, Ch. 4, Sec. 4300 & 4320; P.L. 108-33

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 2.2-A, Page 7
Attachment 2.2-A, Item B, Pages 1-3
Attachment 2.5-A, Page 6
Attachment 4.19-B, Item 18, Page 1 of 2
Attachment 4.19-B, Item 18, Page 2 of 2
Supplement to Attachment 4.19-B, Page 2

9. EFFECTIVE DATE OF PLAN MATERIAL
a. FFY 2004 b. QTR 3
b. FFY 2005 b. QTR 1

10. PAGE NUMBERS OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable)
Attachment 3.1-A, Page 7
Attachment 2.5-B, Page 6
Supplement 2 to Attachment 4.19-B, Page 2

11. SUBJECT OF AMENDMENT
Administration of Optional Services

12. GOVERNOR'S REVIEW (Check One)
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO COMMENT RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER AS SPECIFIED:
Governor Dave Heineman

13. SIGNATURE OF STATE AGENCY OFFICIAL
Robert Wise

14. TITLE
Administrator

15. DATE SUBMITTED
March 2, 2004

16. RETURN TO:
Margaret Bowie
HHS-FAS
301 Centennial Mall South
Lincoln, Nebraska 68509

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
March 2, 2004

18. DATE APPROVED
May 3, 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
March 1, 2004

20. SIGNATURE OF REGIONAL OFFICIAL
Thomas W. Lenz (signature)

21. TYPED NAME
Thomas W. Lenz

22. TITLE
Associate Regional Administrator, Div. of Medicaid

23. REMARKS

Nebraska (04-002)
approved: 05/03/04
effective: 03/01/04

FORM HCFA-179 (7-78)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE OF NEBRASKA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

CITATION	Medical and Remedial Care and Services Item 18	**Hospice Care**
42 CFR Part 418 Subpart G		**Method of Payment**
State Medicaid Manual, Chapter 4, Section 4306 and 4307		Hospice care is reimbursed utilizing the principles of reimbursement as detailed in the State Medicaid Manual, Chapter 4, Sections 4306 and 4307 as amended by Public Law 105-33, "Balanced Budget Act of 1997". Note: Medicaid pays all costs for hospital services provided when a client receiving the Medicaid Hospice benefit is hospitalized for an acute medical condition that is not related to the terminal diagnosis. For dual-eligible, residing in IMD/NF settings, hospice bills Medicare for hospice services and bills Medicaid for room and board. Medicaid will pay 95% of the NF rate to the hospice and the hospice is responsible to reimburse the facility. However, in the case of the IMD, room and board may not be billed.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE OF NEBRASKA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

P.L. 105-33

Payment Rates

Only one rate is applicable for each day of routine home care, continuous home care, inpatient respite care and general inpatient care.
For continuous home care, the amount of payment is determined based on the number of hours of continuous care furnished to the client on that day.
Payment rates are adjusted for regional differences in wages. The Bureau will compute the adjusted rate based on the geographic location at which the service was furnished to allow for the differences in area wage levels, using the same method used under Part A of Title XVIII.
The hospice will be paid an additional amount on routine home care and continuous home care days to take into account the room and board furnished by the facility for Medicaid clients residing in a Nursing Facility or Intermediate Care Facility for the Mentally Retarded (ICF/MR). When a client resides in a Center for Developmental Disabilities (CDD) or Assisted Living Facility (ALF), room and board is not reimbursed.

Refer to the Annual Medicaid Bulletins for the most current rates.
[illegible]

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEBRASKA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMB	Part A SP Deductibles	SP Coinsurance
	Part B SP Deductibles	SP Coinsurance
Other Medicaid Beneficiaries	Part A SP Deductibles	SP Coinsurance
	Part B SP Deductibles	SP Coinsurance
Dual Eligible (QMB Plus)	Part A SP Deductibles	SP Coinsurance
	Part B SP Deductibles	SP Coinsurance
QMB	Part A MR Deductibles	MR Coinsurance-Title XVIII only services Inpatient Hospital Services Provided in Small Rural Hospitals and Skilled Nursing Units in Small Rural Hospitals Hospice Care
	Part B MR Deductibles	MR Coinsurance-Prescription Drugs
Other Medicaid Beneficiaries	Part A MR Deductibles	MR Coinsurance-Inpatient Hospital Services provided in Small Rural Hospitals and Skilled Nursing Units in Small Rural Hospitals Hospice Care
	Part B MR Deductibles	MR Coinsurance-Prescription Drugs
Dual Eligible (QMB Plus)	Part A MR Deductibles	MR Coinsurance-Title XVIII only services Inpatient Hospital Services provided in Small Rural Hospitals and Skilled Nursing Units in Small Rural Hospitals Hospice Care
	Part B MR Deductibles	MR Coinsurance-Prescription Drugs

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE OF NEBRASKA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

LIMITATION ON THE AMOUNT, DURATION AND SCOPE OF CERTAIN ITEMS OF PROVIDED MEDICAL AND REMEDIAL CARE AND SERVICES ARE DESCRIBED AS FOLLOWS

Medical and Remedial Care and Services-Item 18

CITATION
1905 (o) of the Social Security Act

Hospice Care

42 CFR Part 418

The Nebraska Medical Assistance Program will provide reimbursement for hospice care for Medicaid clients that are terminally ill. Terminally ill means that the client is diagnosed with a medical prognosis that his/her life expectancy is six months or less if the illness runs its normal course.

Election Statement

An election statement must be filed with a specific hospice for the client who meets the requirements. An election to receive hospice care will be considered to continue through the initial certification period and the subsequent election periods without a break in care as long as the client remains in the care of the hospice and does not revoke the election.

Dually eligible (Medicare and Medicaid) clients must elect hospice care in the Medicare program.

Election Period

A client may elect to receive hospice care during one or more of the following election periods:

1. an initial 90-day period;
2. a subsequent 90-day period;
3. an initial 60-day period,
4. a subsequent 60-day period,
5. a third 60-day period.

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

Transmittal # MS-04-02 Approval Date May 3, 2004 Effective Date March 1, 2004

Supersedes # New Page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE OF NEBRASKA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

LIMITATION ON THE AMOUNT, DURATION AND SCOPE OF CERTAIN ITEMS OF PROVIDED MEDICAL AND REMEDIAL CARE AND SERVICES ARE DESCRIBED AS FOLLOWS

Certification of Terminal Illness

The client must be certified as terminally ill with a six-month life expectancy by the Hospice medical director and the attending physician at the beginning of the first benefit period and by the Hospice medical director for all subsequent benefit periods. The hospice provider must obtain written certification of the terminal illness for each certification period even when a single election continues in effect for two or more periods.

Plan of Care

A written plan of care must be established and maintained for each client admitted to a hospice program. The care provided to a client must be consistent with the plan and be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions. The plan of care must be established before services are provided.

Waiver of Payment for Other Services

A client waives all rights to Medicaid payments for the duration of the election of hospice care for the following services:

Hospice care provided by a hospice other than the hospice designated by the client; and

Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except for services provided:

by the designated hospice, or

the client's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE OF NEBRASKA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S)*

The following ambulatory services are provided: *

Item No

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

2. a. Outpatient hospital services.
b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.
c. Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the Plan and furnished in a FQHC.

3. Other laboratory and x-ray services.

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.
c. Family Planning services and supplies for individuals of child-bearing age.

5. a. Physician services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.
b. Medical and surgical services furnished by dentists (in accordance with section 1905 (a)(5)(B) of the Act)

6. a. Podiatrists' services.
b. Optometrists'
c. Anesthetists'
(CRNAs & Anesthesiologists)
d. Podiatrists' services

7. Home Health Services:
a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.
b. Home health aide services provided by a home health agency.
c. Medical supplies, equipment and appliances suitable for use in the home.

9. Clinic services.

12. Prescribed drugs, dentures, and prosthetic devices.
a. Prescribed drugs.
c. Prosthetic devices

13.d. Rehabilitative services.

15. Intermediate Care Facility for the Mentally Retarded (ICF/MR) services

17. Nurse-midwife services.

18. Hospice Care

19. Optional targeted case management services.

20. Extended services for pregnant women

21. Certified pediatric or family nurse practitioners' services.

24. a. Transportation
d. Nursing facility services provided for patients under 21 years of age.

*Description provided on Attachment 3.1-A

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All covered groups

9. Intermediate care facility services.
X Provided: ____ No limitations ___X___ With limitations

10. Intermediate care facility services for persons determined, in accordance with section 1902(a)(31) of the Act, to be in need of such care, including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

___X___ Provided: ____ No limitations ___X___ With limitations

10C. Inpatient psychiatric facility services for individuals under 22 years of age

___X___ Provided: ____ No limitations ___X___ With limitations

11. Nurse-midwife services.

___X___ Provided: ____ No limitations ___X___ With limitations

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

X Provided: ____ No limitations ___X___ With limitations

Description provided on attachment.

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

15. Intermediate care facility services for persons determined, in accordance with section 1902(a)(31) of the Act, to be in need of such care, including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions:

_X_ Provided ___ No limitations _X_ With limitations
___ Not provided.

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

_X_ Provided ___ No limitations _X_ With limitations
___ Not provided

17. Nurse-midwife services:

_X_ Provided ___ No limitations _X_ With limitations
___ Not provided.

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

_X_ Provided ___ No limitations _X_ With limitations
___ Not provided.