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State/Territory Name: NE

State Plan Amendment (SPA) #: 18-0002

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106

Division of Medicaid and Children's Health Operations

June 19, 2018

Matthew A. Van Patton, DHA, Director
Division of Medicaid and Long-Term Care
Nebraska Department of Health & Human Services
301 Centennial Mall South, 5th Floor
P.O. Box 95026
Lincoln, NE 68509-5026

RE: TN 18-0002

Dear Dr. Van Patton:

On March 16, 2018, the Centers for Medicare & Medicaid Services (CMS) received Nebraska's State Plan Amendment (SPA) Transmittal #18-0002, to implement a change in the state's cost effectiveness formula for its premium assistance program.

SPA 18-0002 was approved on June 14, 2018, with an effective date of January 1, 2018, as requested. Enclosed is a copy of the CMS-179 summary form, as well as the approved Attachment 4.22-C, Pages 1-3, for incorporation into the Nebraska State Plan. We are sending a companion letter to this approval to address related issues to this approval.

If you have any questions regarding this amendment, please contact Barbara Cotterman at (816) 426-5925.

Sincerely, 6/19/2018

James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

Signed by: James G. Scott -A

Enclosure

cc:
Kris Azimi
Rosalind Sipe
Nancy Keller

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
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Matthew A. Van Patton, DHA, Director
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Nebraska Department of Health & Human Services
301 Centennial Mall South, 5th Floor
P.O. Box 95026
Lincoln, NE 68509-5026

RE: Companion letter to Approval of TN 18-0002

Dear Dr. Van Patton:

This letter is being sent regarding the implementation of Nebraska State Plan Amendment (SPA) #18-0002, which is also approved on June 14, 2018, to expand the state's premium assistance program to include individual health insurance (IHI) plans. As part of the review of the SPA, the Centers for Medicare & Medicaid Services (CMS) and the state discussed the statutory requirements to protect beneficiaries from incurring any out-of-pocket costs that exceed the cost sharing limits applicable in the Medicaid state plan.

Individuals enrolled in premium assistance programs must be afforded the same benefits and cost sharing limits provided to all other Medicaid enrollees. Nebraska indicated it will provide a wrap-around benefit for any Medicaid service not included in the employer-sponsored insurance (ESI) and IHI plans. To effectuate the cost sharing wrap, the state will implement a provider enrollment strategy to engage ESI and IHI providers to enroll as Medicaid participating providers. Upon enrollment, the state will pay the difference between the Medicaid cost-sharing amount and the private cost-sharing amount (the cost-sharing wrap) up to the Medicaid rate for the service. The state will also inform the beneficiary regarding options available when the beneficiary obtains care from a non-participating Medicaid provider that refuses to enroll as a Medicaid-participating provider.

To help evaluate the success of the provider enrollment strategy, the state agreed to work with CMS to identify metrics and collect data in order to evaluate the extent to which plan providers are enrolled in Medicaid. Some examples of data elements to consider are: number of beneficiaries who report to the state that they had to pay the plan cost sharing charges (because provider is not a Medicaid-enrolled provider); number of those providers whom the state successfully enrolls in Medicaid for purposes of the wrap; and number of beneficiaries for whom state pays provider the cost sharing wrap (i.e., provider enrolled in both plan and Medicaid). This data will help the state and CMS the effectiveness of the state's provider enrollment strategy.

CMS is available to provide ongoing technical assistance to the state on these issues as the state moves forward in implementing its premium assistance program. If you have any questions concerning this letter, please contact Barbara Cotterman at (816) 426-6426.

Sincerely, 6/19/2018

James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

Signed by: James G. Scott -A

Enclosure

cc:
Kris Azimi
Rosalind Sipe
Nancy Keller

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 18-0002

2. STATE: Nebraska

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

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1906 of the Social Security Act
Section 1902(a)(30) and 1905(a)(29) of the Act *

7. FEDERAL BUDGET IMPACT:
a. FFY 2018 $0
b. FFY 2019 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.22-C pgs. ~~1&2~~ 1-3 *

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Att. 4.22-C pgs. ~~1&2~~ 1-3 *

10. SUBJECT OF AMENDMENT:
Health Insurance Premium Payment (HIPP) Cost Effectiveness Methodology

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Governor has waived review

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Matthew A. Van Patton, DHA

14. TITLE:
Interim Director, Division of Medicaid and Long-Term Care

15. DATE SUBMITTED:
March 16, 2018 *

16. RETURN TO:

Nancy Keller
Division of Medicaid & Long-Term Care
Nebraska Department of Health & Human Services
301 Centennial Mall South
Lincoln, NE 68509

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
March 16, 2018

18. DATE APPROVED:
June 14, 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
James G. Scott

22. TITLE: Associate Regional Administrator
for Medicaid and Children's Health Operations

23. REMARKS:

* Per pen and ink changes request from State dated 6/4/18.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

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

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

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

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

   i. Determine:

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

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

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

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

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

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

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

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

II. The Nebraska Medicaid program will not make a determination of cost-effectiveness in the following circumstances:

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

III. Redeterminations

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