
Nebraska Medicaid Reform Biennial Report

2006

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Prepared in Accordance with Neb. Rev. Stat. § 68-908(4)

**Prepared by
Richard P. Nelson, Director
Department of Health and Human Services
Finance and Support**

Nebraska Medicaid Reform Biennial Report
§ 68-908(4)

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Nebraska Medicaid Reform Biennial Report

Neb. Rev. Stat. § 68-908(4)

I. Introduction

Medicaid reform was mandated by the Nebraska Legislature in LB 709 (2005), the Medicaid Reform Act (Neb. Rev. Stat. §§ 68-1087 to 68-1094; LB 709, §§ 1-8). The act mandated "fundamental reform" of the state's Medicaid program and a significant rewriting of Medicaid-related statutes. It required the preparation of a Medicaid reform plan to make specific recommendations for reform. The Nebraska Medicaid Reform Plan was submitted to the Governor and Legislature on December 1, 2005.

Following submission of the Nebraska Medicaid Reform Plan, the Legislature adopted the Medical Assistance Act (Neb. Rev. Stat. §§ 68-901 to 68-949; LB 1248 (2006)). The Medical Assistance Act substantially recodified statutes relating to the medical assistance program with an emphasis on continuing the reform efforts initiated with LB 709 (2005). To meet the reporting requirements of the Medical Assistance Act § 68-908(4), the Director of the Department of Health and Human Services Finance and Support (the Department) has prepared this 2006 Medicaid Reform Biennial Report. It is the first installment in a series of status reports to be published in even-numbered years.

The motivation for Medicaid reform has not changed in the last year. The findings the Legislature documented in Neb. Rev. Stat. § 68-904 persist: many Nebraskans find it impossible to access necessary health care services without publicly-funded assistance; because publicly-funded assistance, alone, is insufficient for meeting all the needs of eligible clients, including low-income children, families, and aged persons and persons with disabilities, other public and private sources of funding are necessary to meet Nebraskans' health care needs. Perhaps most importantly, the state must continue to address the rate of growth in expenditures of the medical assistance program. The program is unsustainable if expenditures regularly grow at a rate faster than General Fund revenues.

The process for adopting a Medicaid reform plan is described in the Medicaid Reform Plan. Internal work groups had approximately three months to generate ideas, perform research, and prepare draft recommendations. The succeeding months were spent conducting public meetings, Medicaid Reform Advisory Council hearings, and preparing the final report. Since then, each strategy identified in the report was assigned to a chairperson and small committee within HHSS. Some strategies are slated for implementation in the coming fiscal year, some are further off and some have timelines yet to be determined. The goal of this report is to provide an update to the Governor, the Legislature, the Medicaid Reform Council, and the public on the status of reform activities in progress.

There is another recent law that is important to Nebraska's Medicaid reform. The federal Deficit Reduction Act of 2005 (Pub. L. No. 109-171) made a number of changes to the federal law governing Medicaid eligibility and benefits. The law includes some new requirements that states must implement. Examples are citizenship documentation, treatment of income and assets, and asset transfers for Medicaid eligibles. The law also allows states increased flexibility in administration of the program, such as options for cost sharing and long-term care insurance partnerships. The Deficit Reduction Act also provides several competitive opportunities for grant funding. All of these grants are time-limited, some have state matching funds requirements, and some have limited and limiting objectives.

II. Discussion

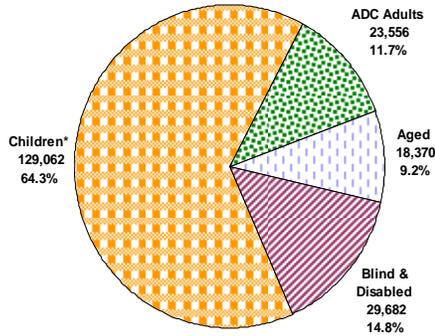
A. Eligible Recipients

The figure below (Figure 1) displays the makeup of the Medicaid eligible population in 2006 by eligibility category. It then shows the percentage of expenditures by those same eligibility categories. The graphic does not account for all Medicaid expenditures, in part because some payments and refunds are not specific to a recipient or eligibility category. Examples of transactions not shown are drug rebates, payments made outside the claims processing systems, and premium payments paid on behalf of persons eligible for Medicare.

Figure 1

**NEBRASKA MEDICAID
AVERAGE MONTHLY
ELIGIBLE PERSONS BY CATEGORY**

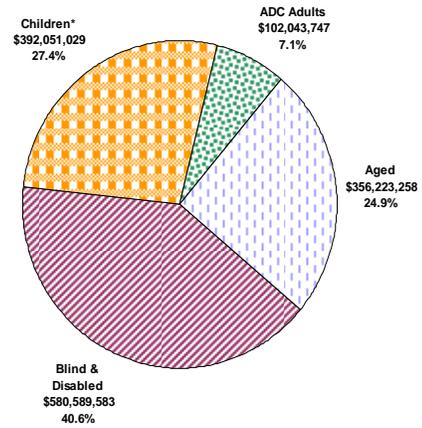
Fiscal Year 2006
Total: 200,670



*Includes certain pregnant women not otherwise eligible

**NEBRASKA MEDICAID VENDOR
EXPENDITURES BY ELIGIBILITY**

Fiscal Year 2006
Total: \$1,430,907,617



1,430,907,617	Vendor Payments
25,609,456	DSH/Rate Adjustments
25,890,391	Medicare Premiums
28,637,845	Intergovernmental Transfer (IGT)
35,373,472	Other Payments (MC, Transport, FICA)
(75,015,099)	Rebates/Refunds
(70,437,636)	GF Paid in Other Budget Programs
12,102,822	Medicare Part D Clawback
1,413,068,868	Net Program 344/348 Expenditures

The total increase in average monthly eligibles from FY 2005 to FY 2006 was less than 1 percent. The largest single increase was in the Blind & Disabled category which grew at 3.3 percent. Average monthly eligibles in the Children category grew by 0.75 percent and in the Aged category by 0.4 percent. ADC Adults decreased from FY 2005 to FY 2006 by 0.4 percent.

B. Covered Services

Federal Medicaid statutes mandate states to provide certain services and allow a choice of others. The Nebraska Medical Assistance Act delineates the mandatory and optional services offered in this state.

Federal Medicaid Mandatory and Optional Services Covered in Nebraska (Neb. Rev. Stat. § 68-911)

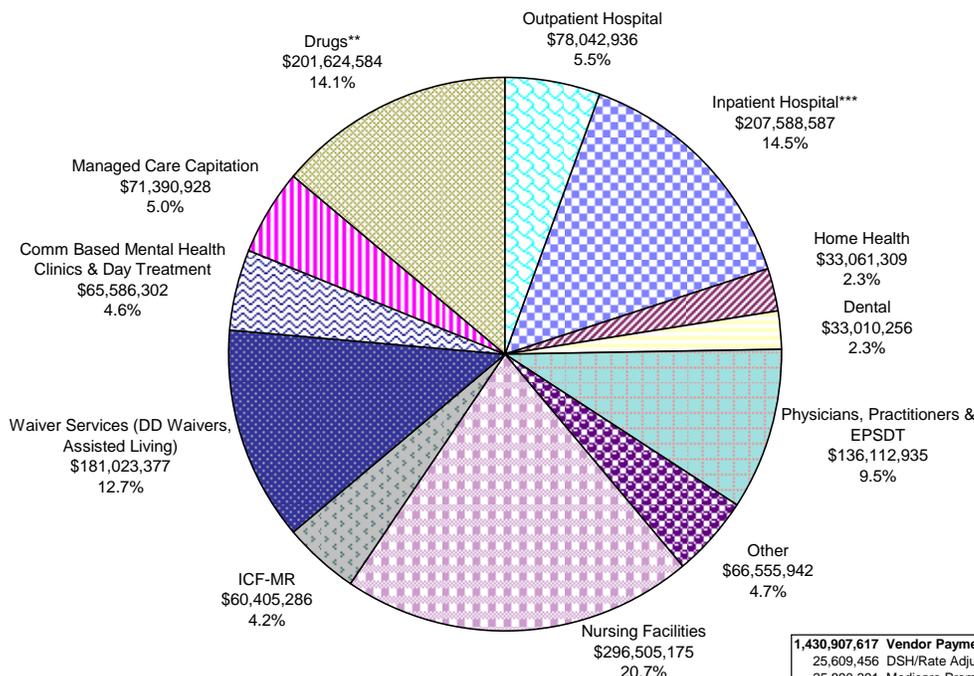
Mandatory Services	Nebraska Optional Services
<ul style="list-style-type: none">• Inpatient and outpatient hospital services• Laboratory and X-ray services• Nursing facility services• Home health services• Nursing services• Clinic services• Physician services• Medical and surgical services of a dentist• Nurse practitioner services• Nurse midwife services• Pregnancy-related services• Medical supplies• Early and periodic screening and diagnosis treatment services for children	<ul style="list-style-type: none">• Prescribed drugs• Intermediate care facilities for the mentally retarded• Home and community-based services for aged persons and persons with disabilities• Dental services• Rehabilitation services• Personal care services• Durable medical equipment• Medical transportation services• Vision-related services• Speech therapy services• Physical therapy services• Chiropractic services• Occupational therapy services• Optometric services• Podiatric services• Hospice services• Mental health and substance abuse services• Hearing screening services for newborn and infant children

Expenditures

Medicaid expenditures to vendors in FY 2006 were \$1,430,907,617. Figure 2 shows the consumption of services by vendor type. It does not include drug rebates, payments made outside the claims processing systems, or premium payments made on behalf of Medicare eligibles.

Figure 2

**NEBRASKA MEDICAID VENDOR EXPENDITURES BY SERVICE
FISCAL YEAR 2006***
(Includes CHIP/Title XXI and NFOCUS Payments for HCBS Waiver Services)
Total Vendor Payments \$1,430,907,617



* Includes payments to vendors only, not adjustments, refunds or certain payments for premiums nor services paid outside the Medicaid Payment System (MMIS) or NFOCUS. (Payments for certain Waiver services are made through NFOCUS)
 ** \$72.2 million in offsetting drug rebates received from manufacturers is not reflected in the Drug expenditures of \$201,624,584
 *** DSH payments of \$22.2 million are not reflected in the Inpatient Hospital Expenditures of \$207,588,587

Expenditures may not sum due to rounding.

1,430,907,617 Vendor Payments	
25,609,456	DSH/Rate Adjustments
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(75,015,099)	Rebates/Refunds
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12,102,822	Medicare Part D Clawback
1,413,068,868	Net Program 344/348 Expenditures

Total vendor payments increased from \$1,396,568,237 in FY 2005. The amount paid to each vendor group increased slightly with the exception of Drugs, which decreased by \$40 million. Under the new Medicare Prescription Drug Benefit, Drug-related vendor payments in the last six months of FY 2006 were paid by Medicare instead of Medicaid for all Medicaid-eligible persons who also were eligible for Medicare (dual eligibles). Expenditures for Drugs actually increased by more than \$11 million in the first six months of the fiscal year compared to the same time period in the previous year.

Prescription Drugs and Medicare Part D

The passage of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, Pub. L. 108-173) created a new Medicare Part D Prescription Drug Benefit. When the program became effective on January 1, 2006, the federally-funded Medicare program became the primary payer of drug benefits for dual eligible persons. This could have resulted in significant savings for states in general fund costs for Medicaid prescription drugs, but MMA section 103(b) included a provision requiring states to pay the federal government a portion of their savings in support of the Part D program. This payment has become popularly known as “clawback.”

The MMA statute explicitly established the phased-down state contribution, or clawback, formula. The required contribution for CY 2006 is calculated according to a federal formula that is supposed to determine a state payment equal to 90 percent of what the state's share of costs would have been for Medicaid drug coverage for dual eligible beneficiaries. The formula declines from 90 percent in 2006 to 75 percent over 10 years. The basis of the calculation was the 2003 per capita Medicaid drug costs increased by an update factor, specified in the statute. States owe

clawback amounts monthly based on the number of dual eligibles in that month. In State Fiscal Year 2006, there were six months of accrued payments. Only four months of payments were actually posted by June 30, 2006 due to the lag between billing month and payment month. Only the state clawback payment is posted to the accounting system. Total Medicaid expenditures drop because the state no longer pays the federal share it once did when payments were made directly to pharmacies. It will be necessary to continue to track clawback payments as the formula will continue to be tied to the escalating price of drugs and the number of dual eligible Nebraska recipients.

Figure 3

**Nebraska Medicaid Prescription Drug and Clawback Payments
SFY 2005 and SFY 2006**

	State Fiscal Year 2005			State Fiscal Year 2006		
	GF	FF	Total	GF	FF	Total
Vendor Payments*						
July - December	\$47,352,856	\$70,325,622	\$117,678,487	\$52,021,897	\$76,939,101	\$128,960,998
January - June	\$49,916,384	\$73,761,476	\$123,677,860	\$29,297,958	\$43,365,628	\$72,663,586
Clawback Payments**						
Clawback Paid***	\$0	\$0	\$0	\$12,102,822	\$0	\$12,102,822
Clawback Accrued****	\$0	\$0	\$0	\$6,051,411	\$0	\$6,051,411
Total	\$97,269,240	\$144,087,098	\$241,356,347	\$99,474,088	\$120,304,729	\$219,778,817

* Vendor payments are made shortly after date of sale, usually within 7 days.

** Clawback payments are made to CMS approximating the state-funded share of payments by Medicare Part D for dual eligibles.

*** Clawback payments are made two months after the month billed. Four months were paid in SFY 2006.

**** Two months of clawback payments accrued in SFY 2006 and will be paid in SFY 2007.

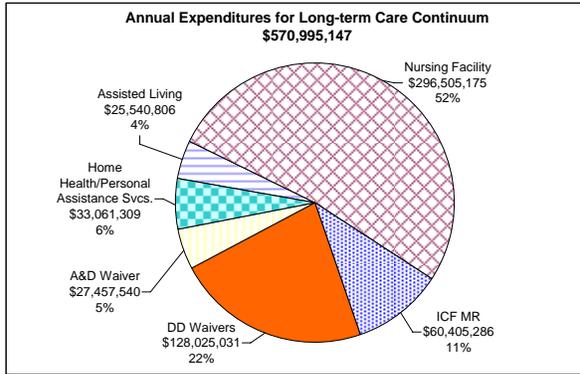
Long-Term Care Service Continuum

Long-Term Care is a single phrase used to represent multiple levels of care provided in multiple settings beginning with community-based services and moving continuously in the direction of institutional care. This is known as the Long-Term Care Service Continuum. Many clients receive a mix of community-based and institutional services and, although there are variations among the populations served, the overall costs of caring for clients increases as clients receive more institutional and fewer community-based services. Serving the Physically Disabled and Blind population in the community is more expensive than serving the Aged population in the community. There is an even greater disparity in the cost of community-based services for the Developmentally Disabled compared to the Aged. On average, however, all community-based services are less expensive than the institutional alternative.

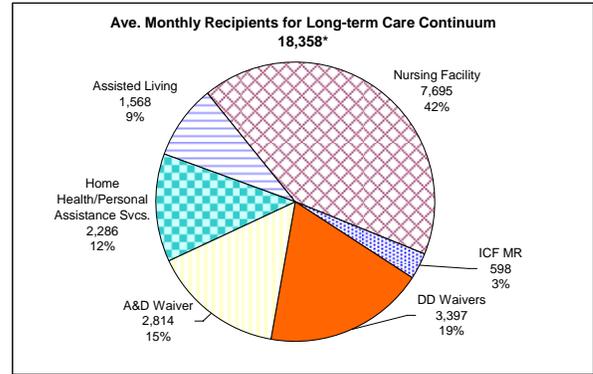
As Figure 4 shows, the costs for providing institutional care at Nursing Facility and ICF-MR levels in FY 2006 represents almost two-thirds of the total annual expenditure for Long-Term Care, whereas the recipients of those services represent less than half of the average monthly recipients of Long-Term Care Services. When comparing expenditures and recipients by eligibility group, the Aged account for 47 percent of spending, but represent 54 percent of the average monthly recipients; the Physically Disabled and Blind account for 20 percent of spending and 24 percent of average monthly recipients. The Developmentally Disabled account for 33 percent of spending and 22 percent of average monthly recipients.

Figure 4

SFY2006 Medicaid Recipients -- Annual Expenditures for Long-Term Care Service Continuum

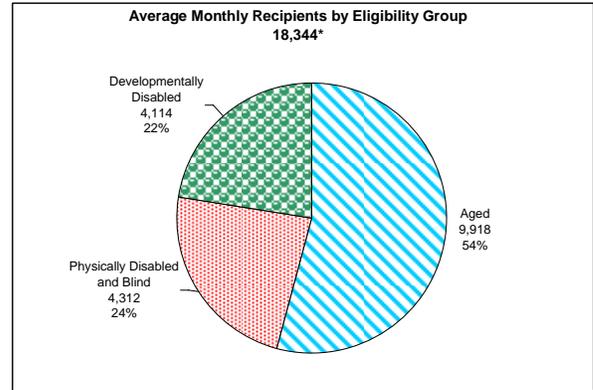
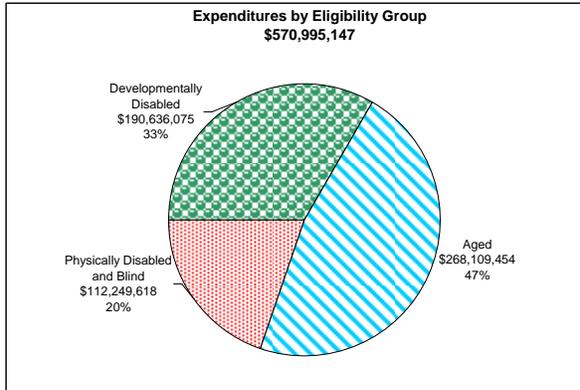


NF includes NF, NF-Hospice, Skilled NF/ICF Swing beds, SNF Special Services
AL includes Aged & Disabled Waiver and TBI Waiver



* Duplicated Count

SFY2006 Medicaid Expenditures and Recipients for Long-Term Care Service Continuum



* Unduplicated Count

The table below compares the average cost per day of the Aged, Physically Disabled, and Developmentally Disabled populations in the Home and Community-Based Services Waiver program for the seven lowest levels of care. Persons in lower levels of care are most likely to be able to transition into community-based services. Persons in higher levels of care will most likely continue to need Nursing Facility services. Costs are arrayed by service setting and geographic region. Services in the rural regions are consistently less expensive to provide than the same services in an urban setting.

Nebraska Medicaid HCBS Cost Effectiveness (Aged)

Average Cost per Day

	Rural	Urban	Statewide
Nursing Facility **	\$75	\$84	\$78
Assisted Living	\$42	\$46	\$44
Waiver In-Home	\$28	\$38	\$31
Waiver Average	\$34	\$44	\$37

** Seven lower care levels only

Payments through September 2006 for Dates of Service January - June 2006

HCBS Cost Effectiveness (Physically Disabled)

Average Cost per Day

	Rural	Urban	Statewide
Nursing Facility **	\$80	\$98	\$88
Assisted Living	\$45	\$51	\$49
Waiver In-Home	\$55	\$76	\$62
Waiver Average	\$54	\$69	\$59

** Seven lower care levels only

Payments through September 2006 for Dates of Service January - June 2006

HCBS Cost Effectiveness (Developmentally Disabled)

Average Cost per Day

	Rural	Urban	Statewide
ICF-MR	\$251	** All are rural	\$251
Waiver Average	\$104	\$119	\$111

Payments through September 2006 for Dates of Service January - June 2006

C. Provider Reimbursement

The state uses different methodologies to reimburse different Medicaid services. Practitioner, laboratory, and radiology services are reimbursed according to a fee schedule. Prescription drugs are reimbursed according to a discounted product cost calculation plus a pharmacy dispensing fee. Inpatient hospital services are reimbursed on a prospective rate using either a diagnosis related group or per diem. Critical Access Hospitals, federally qualified health centers, and rural health clinics receive a per diem based on the reasonable cost of providing services. Outpatient hospital reimbursement is a percent of the submitted charges. Nursing facilities are reimbursed on a daily rate by level of care. Rates are prospective, facility-specific, based on reported costs, and subject to limitations. ICF-MRs are reimbursed on a per diem based on a cost model. Home and community-based waiver services, including Assisted Living, are reimbursed at reasonable fees as determined by the Nebraska Department of Health and Human Services Finance and Support.

The table below shows a recent history of provider rate changes by provider type.

Biennial Budget Rate Increases Funded Program 344 and Program 348	SFY 2002 Percent	SFY 2003 Percent	SFY 2004 Percent	SFY 2005 Percent	SFY 2006 Percent	SFY 2007 Percent
Hospitals	3.00%	3.17%	-3.13%	3.20%	3.40%	3.70%
Practitioners	4.00%	0.00%	2.00%	2.00%	2.00%	2.00%
Nursing Facilities	6.00%	5.42%	2.00%	2.00%	6.00%	3.50%
Assisted Living	2.73%	3.28%	-2.00%	3.00%	2.00%	2.00%
ICF-MRs	4.02%	5.42%	-2.00%	3.00%	2.00%	2.00%

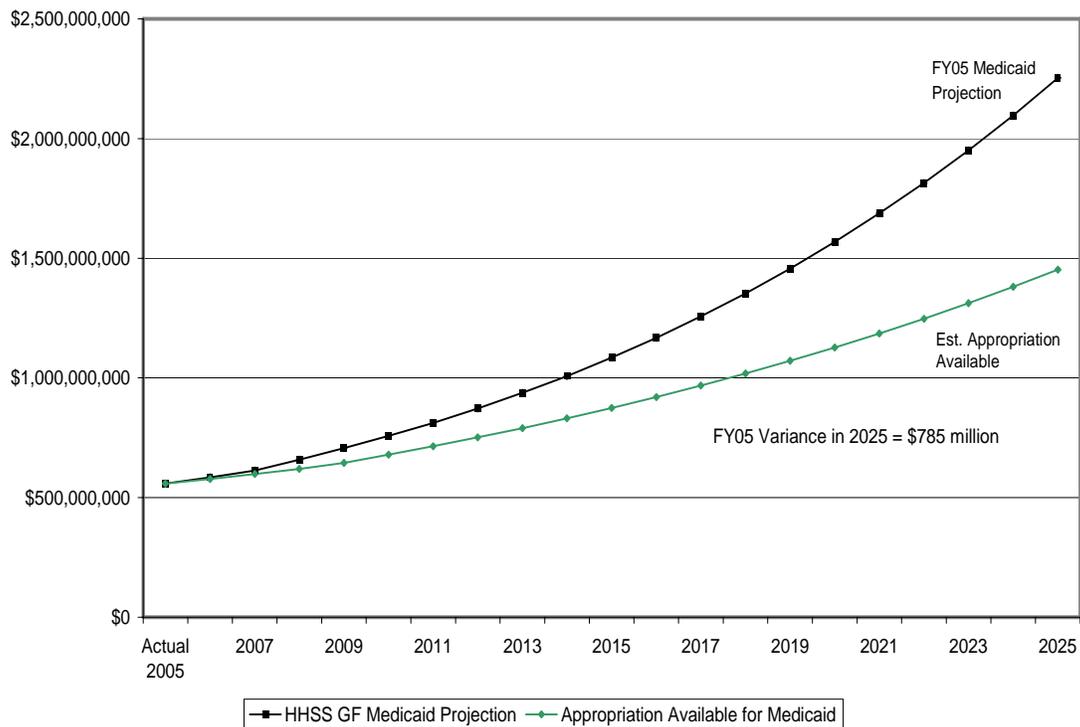
For Medicaid recipients participating in the 1915(b) capitated managed care waiver, a monthly payment is made to the Managed Care Organization (MCO) based on an actuarially-determined cost of services and administration per enrolled person. Medicaid providers are reimbursed by the MCO for services delivered to MCO clients. The MCO independently determines reimbursement methodology and rates for participating providers. As shown in Figure 2, page 6, capitated managed care constitutes about \$71 million or 5% of vendor expenditures.

D. Program Trends and Projections

In the Nebraska Medicaid Reform Plan of 2005, the Department estimated total federal and state Medicaid spending through 2025 after adjusting for demographic changes in the population and projected medical inflation over the next 20 years. At that time, the benchmark for funds available to Medicaid was maintained at the 2005 proportion of General Fund revenues. It was projected that by 2025 there would be a \$785 million gap between projected Medicaid General Fund expenditures and appropriations available for Medicaid. (Figure 5)

Figure 5

Projected Increase in Medicaid State General Fund Expenditures and Appropriations Available for Medicaid in Nebraska SFY2005 - SFY2025



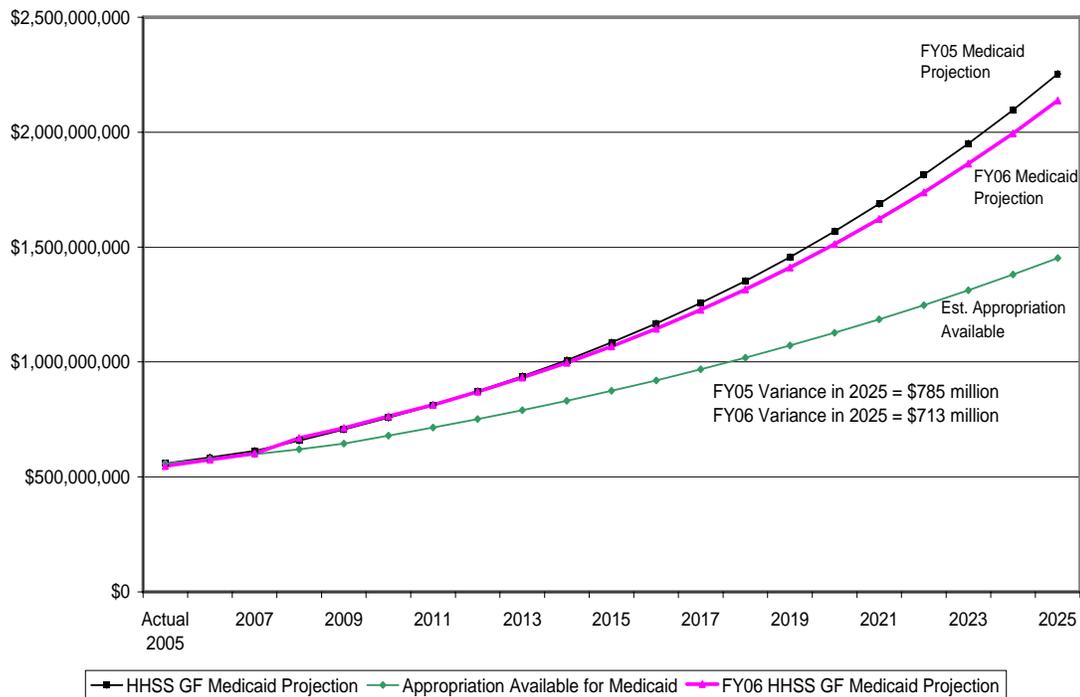
For the Nebraska Medicaid Reform Biennial Report 2006, the Department has revised forecasts of Medicaid eligible persons and costs as follows:

- The projected increase in average monthly eligible persons by age category within the total population is applied to the number eligible by category for the forecast period. The average monthly eligible persons by category was updated using final FY 2006 data.
- Average Monthly Cost per Eligible is the base for forecasting monthly Medicaid costs by eligibility category. Final FY 2006 averages were used in the calculation. The cost adjustment factor will continue to be calculated by blending historical Nebraska Medicaid average cost change rates for the last five years with the national annual medical expenditure per capita projections provided by the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary.

Population forecasts did not change. The 2005 base projections previously used were provided by the Center for Public Affairs Research at the University of Nebraska at Omaha. A new Nebraska population forecast will not be available until at least 2007. Based on the above revisions, the projected gap between estimated Medicaid General Fund expenditures and available appropriations in 2025 decreased by \$72 million to \$713 million. (Figure 6)

Figure 6

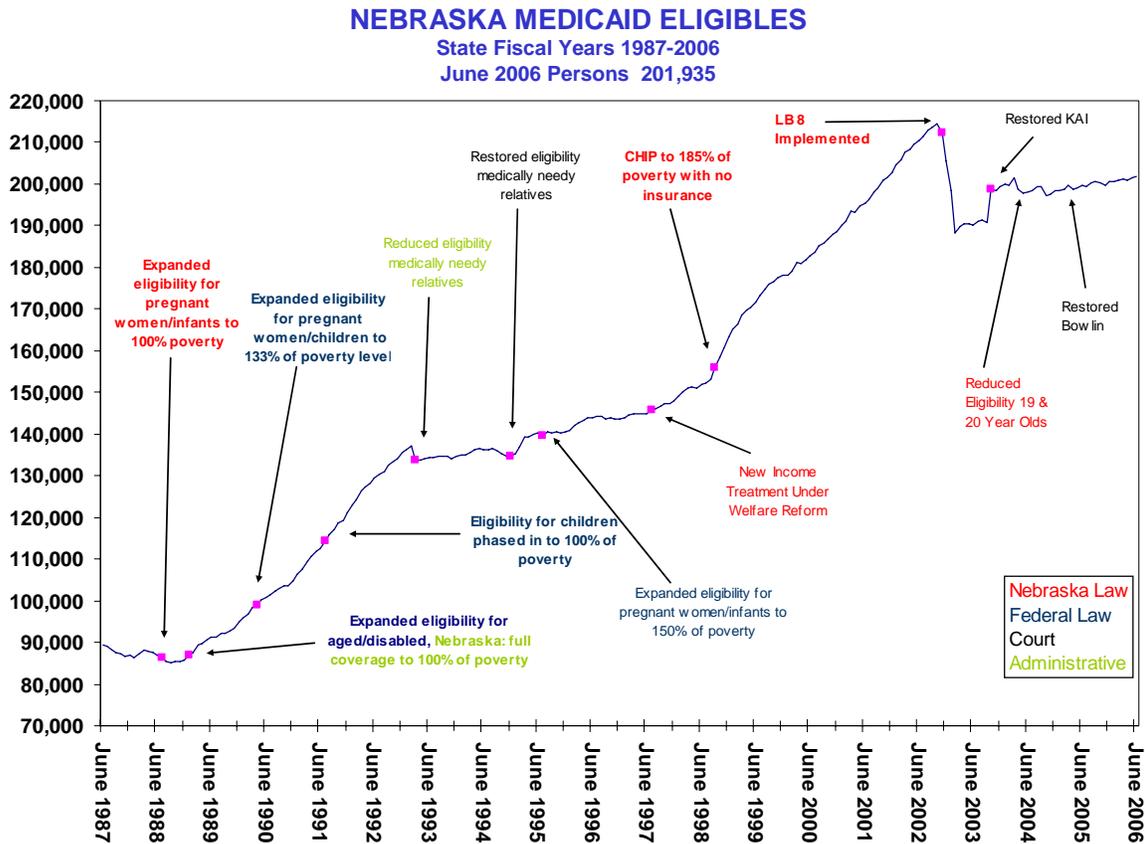
**Projected Increase in Medicaid State General Fund Expenditures
and Appropriations Available for Medicaid in Nebraska
SFY2005 - SFY2025**



Until late in 2002, the state experienced substantial growth in eligible populations primarily driven by program expansions. Many of the expansions were prompted by new federal legislation, some by new state statute, and some by legal action. Since 2004, the growth in Medicaid eligibility has moderated to an average annual rate of about 1 percent.

As shown in Figure 1 on page 4, the average monthly number of eligibles in FY 2006 was 200,670. Figure 7 tracks the monthly growth of eligibles. In June 2006, there were 201,935 persons eligible for Medicaid; and increase of 2,303 persons over June 2005.

Figure 7

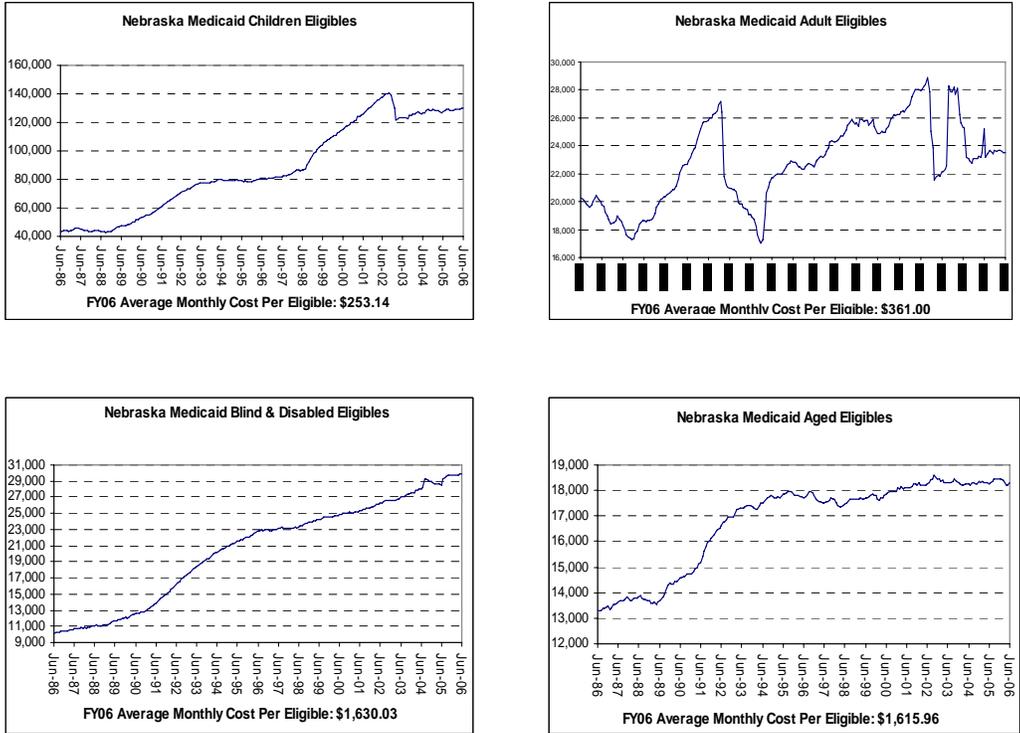


Those in bold had significant impact on the number of persons eligible for Medicaid.

The trends in the number of Medicaid eligibles by category are shown in Figure 8. The largest growth in eligibility continues to be in the Blind & Disabled category.

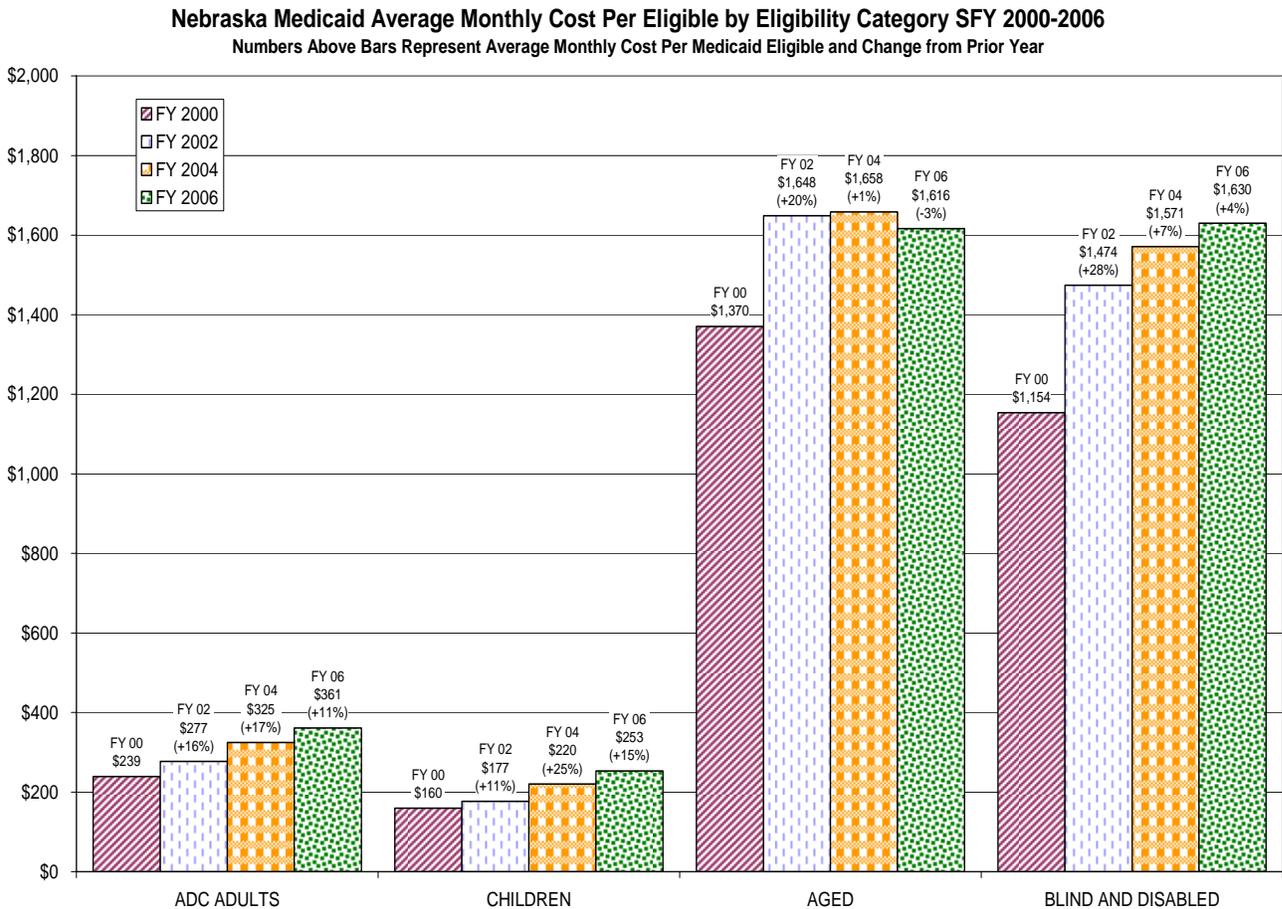
Figure 8

Trend in Nebraska Eligibles Through SFY 2006



Equally important to the fiscal sustainability of Medicaid is the trend in cost per Medicaid eligible person. The trends in average cost per category are shown in Figure 9.

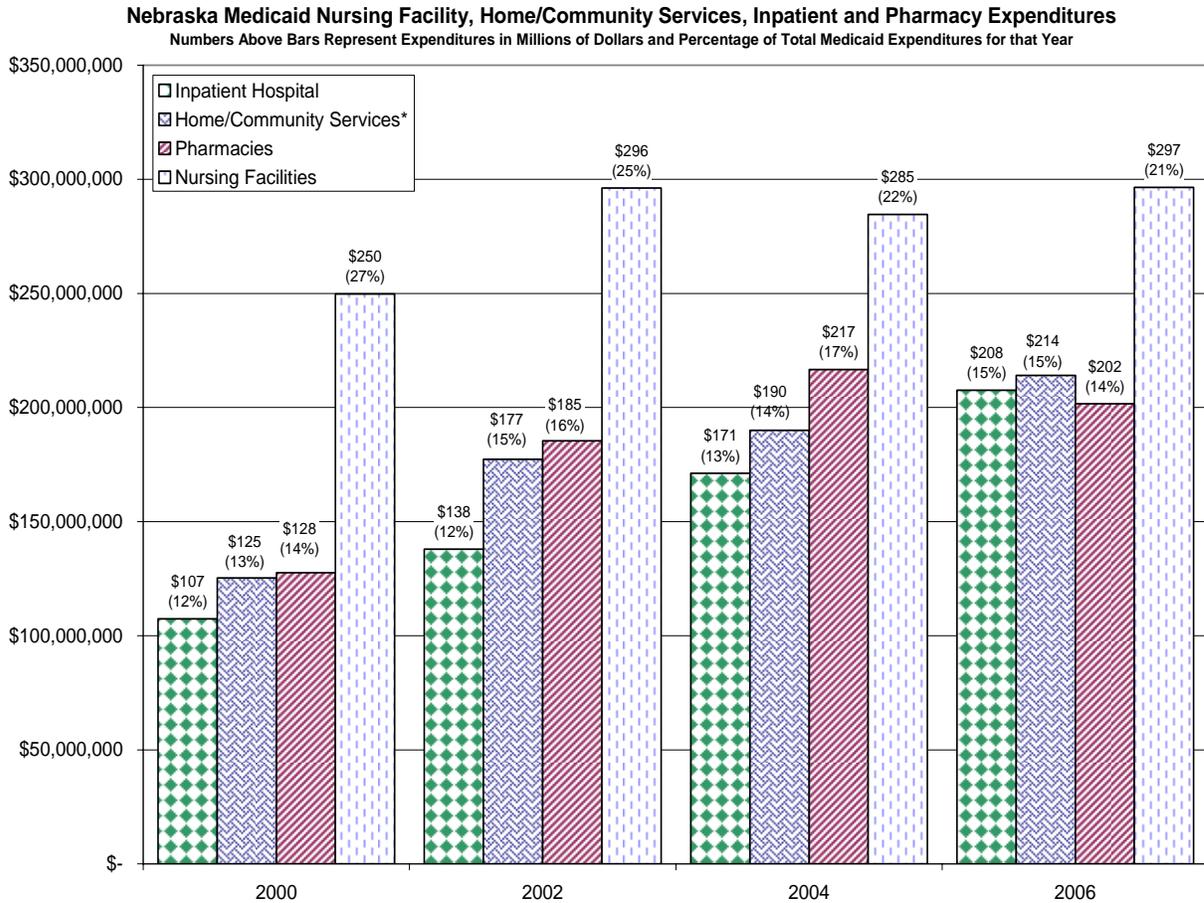
Figure 9



These trends are based on vendor payments. As such, they reflect the decrease in drug costs as a result of the Medicare Part D Prescription Drug Benefit and do not include the Clawback payment. The two eligibility categories that would reflect that decrease in drug costs are the Aged and Blind/Disabled. The vast majority of persons in the Aged category will have their drug costs paid by Medicare. A majority, but not all, of the Blind and Disabled category will have the drug costs paid by Medicare. The ADC Adult and Children's categories are unaffected by Part D. They continue to show in excess of 10% increases in average cost per eligible from SFY 2004.

The top four vendor expenditure categories in Medicaid are nursing facilities, pharmacies, home and community services, and inpatient hospitals. The home and community service category consists of assisted living facilities, home health and personal assistant services, and waiver services. The trends are shown in Figure 10.

Figure 10



*Includes HCBS Waiver Services, Home Health Services, and Personal Care Aide Services

The impact of the Medicare Part D Prescription Drug Benefit is clearly shown, with pharmacy expenditures declining from \$217 million in SFY 2004 to \$202 million in SFY 2006. A slight four-year decline in nursing facility expenses was reversed in 2006, although nursing facilities as a percentage of the overall Medicaid program continued a slight decline. Home and community services continues to grow both in dollar terms and as a percentage of the Medicaid program as more care and services are delivered outside of traditional institutional settings.

E. Program Budget and Expenditures

On September 15, 2006, HHSS submitted the biennial budget request to the Governor, including a request for Medicaid funding. This request was based on projected spending for FY 2008 and FY 2009. Utilization projections were a 1.5% increase for the Aged, a 3.5% increase for Blind and Disabled, a 1% increase in Children and no increase in ADC Adults. The budget projection takes into account the changes related to the new Medicare prescription drug benefit (Part D) and the required state contribution to the federal government (clawback). Also included were projected savings from Medicaid Reform strategies and associated costs to implement them.

The Medicaid request for Budget Program 348 is \$1,463,075,338 for FY 2008 and \$1,516,620,380 for FY 2009. The SCHIP request for Budget Program 344 is \$46,780,848 for FY 2008 and \$48,912,914 for FY 2009. The FY 2008 request includes an increase related to price and utilization projections consistent with state and federal requirements and the entitlement nature of the program.

Medicaid Reform savings are expected to span both years of the coming biennium. Estimates included in the budget projection totaled \$71.5 million in FY 2008 and an additional \$85.6 million in FY 2009. Savings for the following strategies were included: requiring prior authorization for new brand name drugs, an education program for prescribers of behavioral health drugs, expanding the capacity of the Aged and Disabled Waiver, developing rate setting methodology for long-term care services, setting limitations on optional services, implementing enhanced care coordination for high cost recipients and implementing a nurse home visitation program for high risk pregnant teens.

F. Status of Reform Implementation

The Medicaid program in Nebraska, as it is currently structured, is not fiscally sustainable

- Enforcement of residency standards has been reviewed

In addition to the federal regulations on residency, Nebraska statute specifies that an individual can not gain residency for Medicaid purposes if the individual enters directly into a medical institution upon entry into the state. The review determined that the state's residency regulations are as protective of Nebraska Medicaid interests as federal and state laws will allow.

- New federal citizenship and identification documentation is being collected from Medicaid applicants

HHSS implemented Section 6030 of the federal Deficit Reduction Act of 2005 on July 1, 2006. This federal legislation requires that agencies obtain specific documents establishing citizenship and identity for all clients claiming to be U.S. citizens. HHSS expects to have obtained all documentation on current clients by January 1, 2007. In the future, all applicants applying as U.S. citizens will be required to provide citizenship and identity documentation before benefits begin.

- Limits on Covered Services

A workgroup has begun to explore changing service limits to make them comparable to those found in private health insurance coverage. Study includes evaluating the appropriateness of a limit and how the limit could be defined and implemented.

At the same time, there are immediate utilization issues that can be addressed. HHSS would not implement coverage changes, but take opportunities to assure medical necessity through prior authorization of procedures or tests. Work will begin on regulations and instructions to providers for prior authorization of CT and PET scans. HHSS believes this can be done on a limited basis within the current Medicaid Management Information System (MMIS.)

The fastest growing expenditure category in the Medicaid program is prescribed drugs

- HHSS now requires prior authorization for all new brand name drugs where determined appropriate by Drug Utilization Review (DUR) Board

So far in calendar year 2006, the DUR Board has reviewed 25 new drug products recommending prior authorization on ten, quantity restrictions on two, age restrictions on two and further follow-up on four. Drugs recommended for prior authorization are tracked and algorithms to calculate or estimate cost savings are in development.

- HHSS partners are corresponding with prescribers of behavioral health drugs regarding best practices

An HHSS workgroup is partnering with Magellan Behavioral Health Services and the Nebraska Foundation for Medical Care (NFMC) to provide education and outreach to the prescribers of behavioral health drugs. Outreach includes educational resources, best practices information, feedback forms, and opportunities for consultations with HHSS, Magellan, and NFMC clinicians.

The workgroup has been meeting since January 2006. It has two ongoing projects and several more planned. Among the projects underway are analyses of patients taking three or more atypical antipsychotic medications in a 60-day time frame and children under the age of 5 taking behavioral health drugs. It is the goal of the workgroup that many of the initiatives undertaken as part of this collaboration will become a regular part of the business of the Medicaid behavioral health and pharmacy teams.

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- A Request for Proposals (RFP) has been written to obtain a consultant to study the use of preferred drug lists and purchasing pools. The RFP was released October 3, 2006 and six bids were received. Reviews are underway and the project is on schedule for a February 1, 2007 start date.

The RFP provided potential bidders with detailed background about current drug program management policies, the impact of Medicare Part D and an appendix with numerous charts and graphs. The RFP specified that the contractor will have three distinct responsibilities.

The first responsibility will be to conduct a baseline study of current policies and an analysis of data and to provide recommendations for improving the current drug coverage policy framework.

The second responsibility will be to conduct a feasibility study of issues related to implementing a Preferred Drug List and Pooled Purchasing. The study must address potential savings, start-up costs, and regulatory issues and must provide preliminary recommendations.

The third responsibility will be to prepare a project report that synthesizes the findings of the baseline study and the feasibility study and creates comprehensive recommendations for improving and updating the Department's Medicaid Drug program strategies.

Long-term care services for the elderly and disabled are the largest expenditure categories in the Medicaid program

- Home and Community Based Waiver has been renewed by CMS and approved for additional slots

The most recent Aged & Disabled Waiver renewal increased by 213 slots over the previous renewal. Waiver slots are projected to expand incrementally to meet the projected growth in the segments of the population expected to need long-term care services. The current renewal runs through July 31, 2011, but may be amended if warranted.

- HHSS has appointed a Rural Long-Term Care Reform Advisory Committee

The Rural Long-Term Care Reform Advisory Committee began work in 2006. Its goal is to recommend strategies to change Nebraska's rural long-term care system from one that relies on institutional care to one that serves consumers in non-institutional settings

The committee met August 30, 2006 to review pertinent data. The committee met again November 14, 2006 to discuss barriers to serving persons in the community. The committee plans to continue its work in 2007.

- A Long-Term Care Partnership program is being implemented

HHSS and the Nebraska Department of Insurance are collaborating on establishment of a long-term care partnership program in which persons who use benefits from qualified insurance policies to cover their long-term care expenses are allowed to protect an equivalent amount of assets for Medicaid eligibility and estate recovery purposes. The program's intent is to create incentives for private financing of long-term care and to provide an appropriate mechanism for sheltering assets. The Nebraska Long-Term Care Partnership was authorized in the LB 965 (2006). Federal authority was contained in the Deficit Reduction Act of 2005.

A Medicaid state plan amendment to obtain federal approval of this program was submitted to CMS September 25, 2006. The Department of Insurance, through the National Association of Insurance Commissioners (NAIC), is working to establish procedures to identify insurance policies that meet partnership requirements, to create reciprocity for these policies among states, to develop LTC policy exchange provisions, and to ensure that insurance sales agents receive appropriate training.

Medicaid policy emphasizes personal responsibility and accountability for the payment of health care and related expenses and the appropriate utilization of health care and related services

- CMS has approved a home and community-based waiver for persons with developmental disabilities that includes a "cash and counseling" model

The Community Supports program is consumer-directed and allows eligible individuals to direct authorized funding for services and supports that were not previously funded by the HHS Developmental Disabilities System (DDS). The program began as a pilot program effective August 1, 2006 with an annual per person \$18,000 cap and includes participation from a limited number of individuals in specific geographic areas of the state. In 2007, the Community Supports program is expected to become available statewide as a choice to individuals who have funding authorized by HHS-DDS.

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- HHSS has studied the feasibility of implementing a premium buy-in program for children with disabilities

Combining a Medicaid Reform Plan strategy with increased state flexibility granted under the federal Deficit Reduction Act of 2005, HHSS is recommending a program change that will implement a Medicaid buy-in program for families of children with disabilities. Further information on the recommendation is found in Recommended Program Changes on page 18.

Nebraska should encourage alternatives to Medicaid

- The Nebraska Health Insurance Policy Coalition is in the process of developing recommendations to encourage more small employers to offer health insurance coverage to their employees

The Policy Coalition has reviewed the results of surveys that were sent to small employers and employees who work for small employers to identify what types of insurance policies would be attractive to them both in terms of price and benefit package. The Coalition will make recommendations aiming to encourage small employers to offer or continue to offer health insurance to their employees.

- U.S. Department of Health and Human Services “Own Your Future” Grant has been approved

The grant emphasizes personal responsibility and focuses on utilizing a variety of strategies to help individuals to meet long-term care needs. Strategies include initiating family conversations about who will provide care, beginning financial and legal planning, exploring community resources for increasing home accessibility, engaging in preventive health activities and provision of nursing and personal care.

Nebraska is one of six states that have been selected to participate in the program in this federal fiscal year. An on-site Readiness Review by federal representatives took place October 12, 2006. The program was launched on November 20, 2006. An estimated 180,000 Nebraska households with occupants between the ages of 45 and 65 received a letter from Governor Heineman encouraging them to begin planning now for their long-term care needs.

G. Recommended Program Changes

Premium Payments for Specialized Children's Medicaid Coverage

The Nebraska Medical Assistance Act § 905(4), establishes as state public policy the importance of persons who receive Medicaid benefits assuming responsibility for the costs of services to the extent they are able. The Nebraska Medicaid Reform Plan (2005) recommended implementation of a premium payment for families with incomes above 150% of the federal poverty limit (FPL) whose children were receiving specialized Medicaid coverage (Strategy 1.5b1, page 27).

The Medicaid Program proposes to amend the Nebraska State Plan to impose a premium payment requirement on a sliding fee schedule for families of children in specialized programs whose income exceeds 185% FPL. Because this proposal contains a new premium requirement, Section 68-912(4) of the state Medical Assistance Act requires that the change not be implemented until there has been a reasonable opportunity for legislative consideration.

The federal Deficit Reduction Act of 2005, Section 6041, authorizes states to implement cost-sharing for Medicaid eligibles as a state plan amendment and no longer requires the use of a federal waiver process.

The Medical Assistance Act contains a provision for a study of the state Children's Health Insurance Program (SCHIP) that will delay any possible imposition of cost-sharing on that eligible population until after the 2008 legislative session. Neb. Rev. Stat. § 68-949(2) The SCHIP program covers children, without cost-sharing, whose family income is 185% FPL or less. To avoid any inequitable treatment of children, the current proposal would begin the premium requirement with children whose family income exceeds 185% FPL.

This proposal affects children in the following specialized programs: Katie Beckett and Home and Community-Based Children's Waivers. Neither of these programs, according to federal regulations, considers the family's income in determining Medicaid eligibility. Eligibility is determined based on the child's disabilities and medical needs. Only the income of the child is considered; parental income is disregarded. As a result, children can be eligible for the program even though family income may far exceed the federal poverty limit. The proposed change does not change the eligibility requirements. It only requires cost sharing through payment of a premium.

Details of a proposed sliding fee schedule are attached in Addendum A. The DRA requires the premium amount to be related to monthly income and family size and does not allow the premium to exceed 5% of income. Premiums will be imposed on a monthly basis, with the provision for families to prepay up to 6 months of premiums if they

choose to do so. Premiums will be due and payable on the 21st day of the month preceding the month of eligible services. A child's service will not be discontinued until the premium is 60 days past due, as allowed under the DRA.

III. Conclusion

In the year since the publication of the Medicaid Reform Plan, the Department has undertaken significant steps to implement the recommendations it contains. The medical assistance program in Nebraska is undergoing a transformation that will continue over the next biennium and beyond.

While the Department continues to implement changes, it remains cognizant of its reporting responsibilities to the Governor, the Legislature, and the Medicaid Reform Council. Under the Medical Assistance Act (Neb. Rev. Stat. §§ 68-901 to 68-949 LB 1248 (2006)), the Department must "develop recommendations relating to the provision of health care and related services for medicaid-eligible children under the state children's health insurance program" (SCHIP). The study must evaluate the organization and administration of the program, the possibility of expanded cost-sharing arrangements, and the limitations of services offered to program participants. The report is due December 1, 2007. Neb. Rev. Stat. § 68-949(2)

Additionally, the Department must provide recommendations for "further modification or replacement of the defined benefit structure of the medical assistance program." A study will take into account the needs of low-income Nebraska residents and the experience of other states that have attempted similar organizational and structural changes. These recommendations are due December 1, 2008. Neb. Rev. Stat. § 68-949(3)

The Nebraska Medicaid Reform Plan (2005) is intended to be a dynamic document that changes with changing circumstances, additional data, and experience. It is embraced as a dynamic document in the Medical Assistance Act which provides for the establishment of the Medicaid Reform Council to oversee and support the implementation of Medicaid reforms, such as those contained in the Medicaid Reform Plan.

The Department of Health and Human Services Finance and Support looks forward to continuing to work with the Governor, the Legislature, and the Medicaid Reform Council to improve Medicaid for the current and future generations.

Addendum A

Premium Payments for Specialized Children's Medicaid Coverage

For children eligible for Medicaid in the Home and Community-Based Services (HCBS) Waivers and Katie Beckett program a premium would be charged for children in families with income in excess of SCHIP income standards. The premiums would be small at the lower income levels and would not be assessed for families with income below 185% of the Federal Poverty Level (FPL) in recognition of the additional basic living expenses incurred by families with disabled children. Assessment of premiums would begin for families at 185% FPL in an amount equal to 1 percent of gross income. For a family of three, this is approximately \$26 per month. Monthly premiums would increase as income increases. At 500% FPL, the premium would be equal to 5 percent of gross income. HHSS estimates more than \$83,000 per month in premiums under this proposal. Annually, the program would generate almost \$1 million in premiums. The majority of affected families with Medicaid-eligible children in these eligibility groups have income in the 185% - 300% FPL range.

Proposed Premium for Specialized Children's Medicaid Coverage Monthly Premium Amounts - Family of Three

<u>%FPL</u>	<u>Annual Gross Income</u>	<u>Monthly Premium Due</u>	<u>% of Gross</u>
185%	\$30,710 - \$34,029	\$25.59	1.00%
205%	\$34,030 - \$37,349	\$35.45	1.25%
225%	\$37,350 - \$40,669	\$46.69	1.50%
245%	\$40,670 - \$43,989	\$59.31	1.75%
265%	\$43,990 - \$47,309	\$73.32	2.00%
285%	\$47,310 - \$50,629	\$88.71	2.25%
305%	\$50,630 - \$53,949	\$105.48	2.50%
325%	\$53,950 - \$57,269	\$123.64	2.75%
345%	\$57,270 - \$60,589	\$143.18	3.00%
365%	\$60,590 - \$63,909	\$164.10	3.25%
385%	\$63,910 - \$67,229	\$186.40	3.50%
405%	\$67,230 - \$70,549	\$210.09	3.75%
425%	\$70,550 - \$73,869	\$235.17	4.00%
445%	\$73,870 - \$77,189	\$261.62	4.25%
465%	\$77,190 - \$80,509	\$289.46	4.50%
485%	\$80,510 - \$83,829	\$318.69	4.75%
505%	\$83,830 - \$87,149	\$349.29	5.00%
525%	\$87,150 - \$90,469	\$363.13	5.00%
545%	\$90,470 - \$93,789	\$376.96	5.00%
565%	\$93,790 - \$97,109	\$390.79	5.00%
585%	\$97,110 - \$100,429	\$404.63	5.00%
605%	\$100,430 - \$103,749	\$418.46	5.00%
625%	\$103,750 - \$107,069	\$432.29	5.00%
645%	\$107,070 - \$110,389	\$446.13	5.00%
665%	\$110,390 - \$113,709	\$459.96	5.00%
685%	\$113,710 - \$117,029	\$473.79	5.00%
705%	\$117,030 - \$120,349	\$487.63	5.00%
725%	\$120,350 - \$123,669	\$501.46	5.00%
745%	\$123,670 - \$126,989	\$515.29	5.00%

Estimated Impact

As of June 2006, there were 800 children eligible for Medicaid in the HCBS Waivers and Katie Beckett program. Under the recommended program change, almost half would continue to be eligible without a premium required. Full assessment of income would be required to determine actual premiums, the number of children affected, and fiscal impact; this information is currently unavailable since no assessment of parental income is made at this time.
