

**Health and Human Services and Appropriations Committees Briefing
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Good afternoon, Chairman Stinner and Chairwoman Howard and members of the Appropriations and Health and Human Services Committees, I appreciate the opportunity to respond to the budget and cost questions on behalf of the Division of Medicaid and Long-Term Care (MLTC).

For ease of presentation and transparency in responding to your questions, I am going to respond to them separately as the questions were presented from a different perspective. I would like to begin by addressing the questions we've received related to costs from Senator Howard and the HHS Committee. These topics are on slide 9, for your reference.

To answer the first question received from Chairwoman Howard, the objective of the 1115 Waiver is not cost savings. The primary objective is intended to meet people where they are to provide pathways for wellness and life success. It is important to note that part of the 1115 Waiver Demonstration is a financial demonstration that requires that the Waiver pass a budget neutrality test. While there may potential savings in aid costs as a result of administering the Heritage Health Adult benefit package, any potential savings or cost differentials have not been determined, as key components of the benefit plan need to be reviewed and approved by CMS as part of the 1115 Demonstration Waiver process.

Regarding question two, additional administrative costs will be expected to operate under the structure proposed for the 1115 Waiver. IT costs and staffing (such as for the 6-month eligibility determinations) are the primary drivers. While there is an investment on the front end for these administrative costs, this investment positions MLTC to mitigate long-term risk for program integrity issues identified from other states expansion experiences (where states have incurred large federal disallowances for federal share payments made to ineligible beneficiaries – which I would reference the articles included in Exhibit 5), the investment also allows us to ensure that we provide a high quality experience with the Heritage Health Adult program for beneficiaries and providers, and to maximize on the value of the buy we already make with the managed care organizations for our beneficiaries and taxpayers. To that end, we do not anticipate “increased capitation payments to the MCO’s to administer the program”. Currently the MCOs receive an “administrative load” of around 10% of the per-member per-month medical costs. This administrative load compensates the MCO for the value they bring as a managed care organization (care/case management, utilization management, claims processing, value adds, provider/community engagement, Program Integrity, and such). Furthermore, we have not

quantified any savings anticipated as a result of community engagement requirements as this is not the intent of the waiver.

In response to question three, currently Nebraska is one of 47 states covering adult dental services in some form; most of which offer the benefit in a limited capacity for adults. I would like to note that Nebraska Medicaid reduced the adult dental benefit limit from \$1000 to \$750 per person per state fiscal year (SFY) beginning in SFY18. Emerging data does not show any material increase in Emergency Department visits for dental issues from this change, despite an average reduction in utilization per 1000 beneficiaries, for adults, of around 15%. More detailed analysis will be part of the budget neutrality financial projections of the 1115 waiver demonstration. Furthermore we would not anticipate an impact to providers for the services not included in the basic coverage.

On question four, MLTC supports consumer choice as part of the Heritage Health managed care program. MLTC issued a press release regarding the news of Centene's potential acquisition of Wellcare and has communicated the department's expectation that the health plans honor the terms of the current contract period, which ends effective December 31, 2021. This press release is provided as exhibit 15.

Regarding question five, the MCOs have not expressed concerns about the Heritage Health Adult plan. MLTC has engaged them as stakeholders to date for feedback and will continue to engage them as work on the 1115 Waiver ramps up.

Finally – to respond to Chairwoman Howard's sixth question, MLTC will amend the contracts to include enrollment of the Medicaid Expansion population on or around April – June 2020 (as noted in our timeline, Exhibit 4 in your binder). MLTC does not negotiate terms and conditions or rates for MCO contracts.

At this point I would like to transition to slide ten and address the questions we've received related to budget from Senator Stinner and the Appropriations Committee.

MLTC continues to update the expansion cost estimates for each State Fiscal Year (SFY) of the upcoming biennium. MLTC does not agree that a prorated reduction of nine months (relative to the start date being 10.1.19 as opposed to 1.1.19) is appropriate.

MLTC is in agreement that there should be NO reductions, or offsets, to Aid for programs 348 for WWC, program 347 for state disability, and program 038 for behavioral health for SFY19-20 as offsets for Medicaid expansion. MLTC is providing updated offset amounts for these programs for anticipated program cost offsets for SFY 20-21. The program is anticipating a significantly higher "ramp-up" of members, due to the additional time in the implementation plan, heightened public awareness, and the early beneficiary application period. This assumes full ramp up as of 10/1/2020, and assumes 9 months of offsets versus 12 months in SFY 20-21.

Similarly for Medicaid Expansion Aid costs, the assumption of a prorated reduction is not appropriate, we have estimated full ramp-up on 10.1.2020 as noted above. MLTC is providing an updated aid estimate assuming full ramp in for 9 months of SFY 20-21. MLTC is not

estimating any aid expenditures for SFY 19-20. MLTC would also caution that while we have done significant research, there still remains some uncertainty as to what to expect for counts of individuals currently have insurance availability that may try to become eligible for Medicaid. Nearly every state that has implemented expansion has seen higher enrollment than what was initially estimated (as documented in articles in Exhibit 5, specifically the article titled, “Medicaid Expansion enrollment is on track to surpass projections”).

MLTC is also providing an updated estimate for the administrative costs for Medicaid Expansion implementation and operations. Most notably, MLTC anticipates increased IT related costs and additional staff to implement the Medicaid Expansion plan as submitted. MLTC is asking to move some preliminary aid appropriations to administrative appropriations to implement the program; this is thoughtful and purposeful plan to implement a program that is aimed at providing a high quality experience for beneficiaries and providers, as well as to increase our Program Integrity and Data & Analytics infrastructure to mitigate significant financial risks that have been experienced by other states that have implemented without the proper infrastructure in place.

While MLTC has researched and planned extensively for this implementation, we continue to assess and learn as we work with internal and external partners. As such we respectfully ask that the Appropriations committee support the total amount the Governor has recommended to implement Medicaid expansion for the two-year biennium. This will allow the department to have the resources necessary to implement successfully, without delay. Any unexpended appropriations that may accrue during the upcoming biennium should be preserved to address the remaining and any new uncertainties related to Medicaid expansion and the potential growth of enrollment for the following 2021 – 2023 biennium. MLTC would like to reiterate that while we have worked hard to prepare a sound plan, there are several items that have surfaced as new learnings that are not fully incorporated as documented expenses in our estimates as we do not have sufficient information and data to document the request, to include items such as:

1. Nearly every expansion state experienced more eligible persons in the expansion population than original state or national estimates projected,
2. Program Integrity issues including significant audit findings carrying millions of dollars in disallowances for benefits paid to persons that should not have been eligible under expansion,
3. Increased infrastructure to support data and analytics platforms and processes to improve outcomes and experiences for members and providers, and
4. Increased infrastructure for formal processes and resources to perform provider rate studies to ensure proper payment and access.

Thank you again for the opportunity to speak to the questions provided on cost and budget from both committees. I would now like to invite the Medicaid Director, Dr. Matthew Van Patton, to return for final remarks before taking questions.