Nebraska Department of Health and Human Services

Division of Medicaid and Long-Term Care

Nebraska Medicaid Reform Annual Report

September 15, 2009

Draft prepared for the Medicaid Reform Council in Accordance with Neb. Rev. Stat. § 68-908(4)

Prepared by
Vivianne M. Chaumont, Director
Division of Medicaid and Long-Term Care
Department of Health and Human Services

Nebraska Medicaid Reform Annual Report
Neb. Rev. Stat. § 68-908(4)

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. 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 Medicaid Program with an emphasis on continuing the reform efforts initiated with LB 709 (2005).

The motivation for Medicaid reform remains the same. The findings the Legislature documented in Neb. Rev. Stat. § 68-904 have not changed: many low-income Nebraskans have health care needs and are unable, without assistance, to meet those needs; Medicaid provides essential coverage for necessary health care for eligible low-income Nebraska children, pregnant women and families, aged persons and persons with disabilities; and Medicaid alone cannot meet all the health care needs of all low-income Nebraskans. Nebraska must continue to address the rate of growth in expenditures of the Medicaid program. The program is unsustainable if expenditures regularly grow at a rate faster than General Fund revenues.

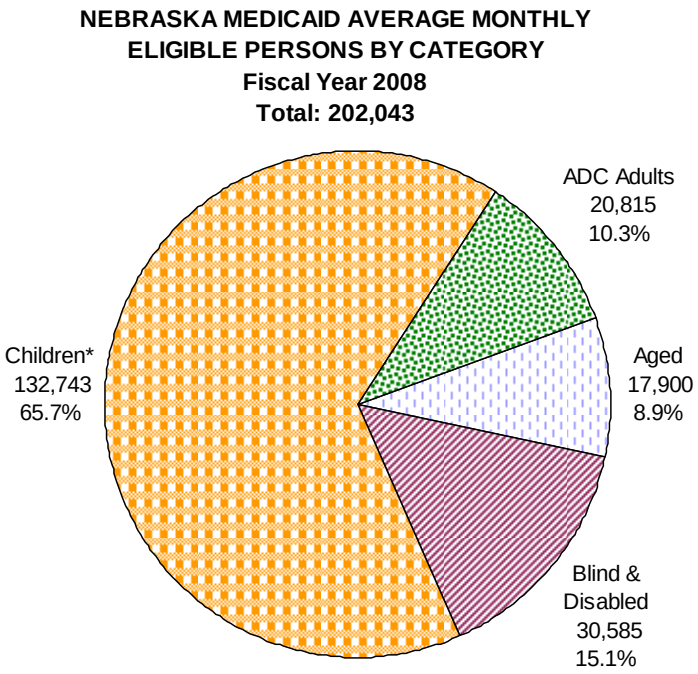
This report meets the reporting requirements of Section 68-908(4) which states that the Department of Health and Human Services (DHHS) shall prepare an annual summary and analysis of the Medicaid Program for legislative and public review, including, but not limited to, a description of eligible recipients, covered services, provider reimbursement, program trends and projections, program budget and expenditures, the status of implementation of the Medicaid Reform Plan, and recommendations for program changes.

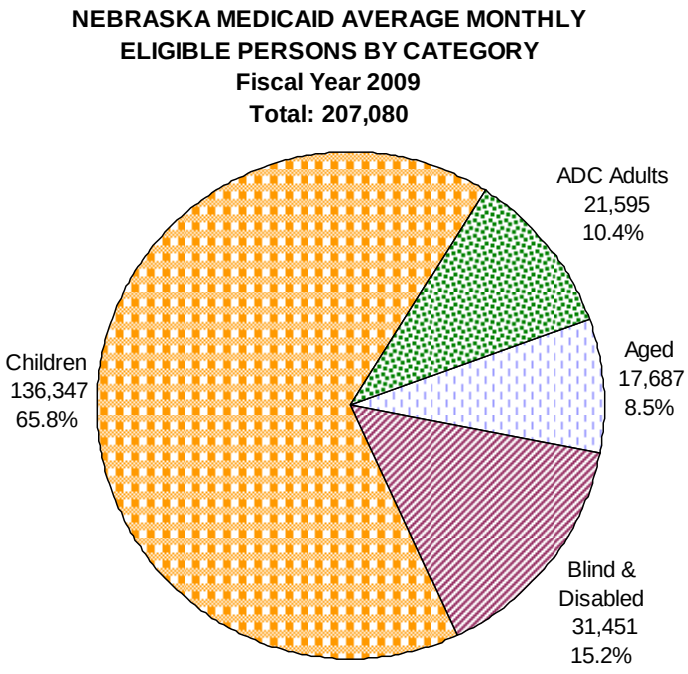
II. Discussion

A. Eligible Recipients

Nebraska Medicaid provides coverage for the following eligibility categories: Children, ADC Adults, Aged, and Blind and Disabled. Figure 1 compares client eligibility by category for State Fiscal Years (SFY) 2008 and 2009.

Figure 1





The total increase in average monthly eligibles from SFY 2008 to SFY 2009 was less than 2.5%. The largest percentage increase was in the Aid to Dependent Children (ADC) Adults category which grew 3.7%. Average monthly eligibles in the Blind and Disabled category grew by 2.8%, while the Children increased by 2.7%, and eligibles in the Aged category decreased by 1.2%. (Figure 1)

Growth in Medicaid eligibility, which had been moderate from SFY 2006 through SFY 2008, experienced a significant increase in the latter half of SFY 2009. This is likely the result of the economic downturn. Historically, Nebraska has been affected late by such downturns and has then lagged in its recovery. Assuming continued pressure on Medicaid caseloads due to weak economic conditions and factoring in the statutory expansion of Children's Health Insurance Program (CHIP) eligibility to 200% FPL in LB 603, eligibility is projected to increase 9.3% in SFY 2010 and 5.1% in SFY 2011.

Figure 2

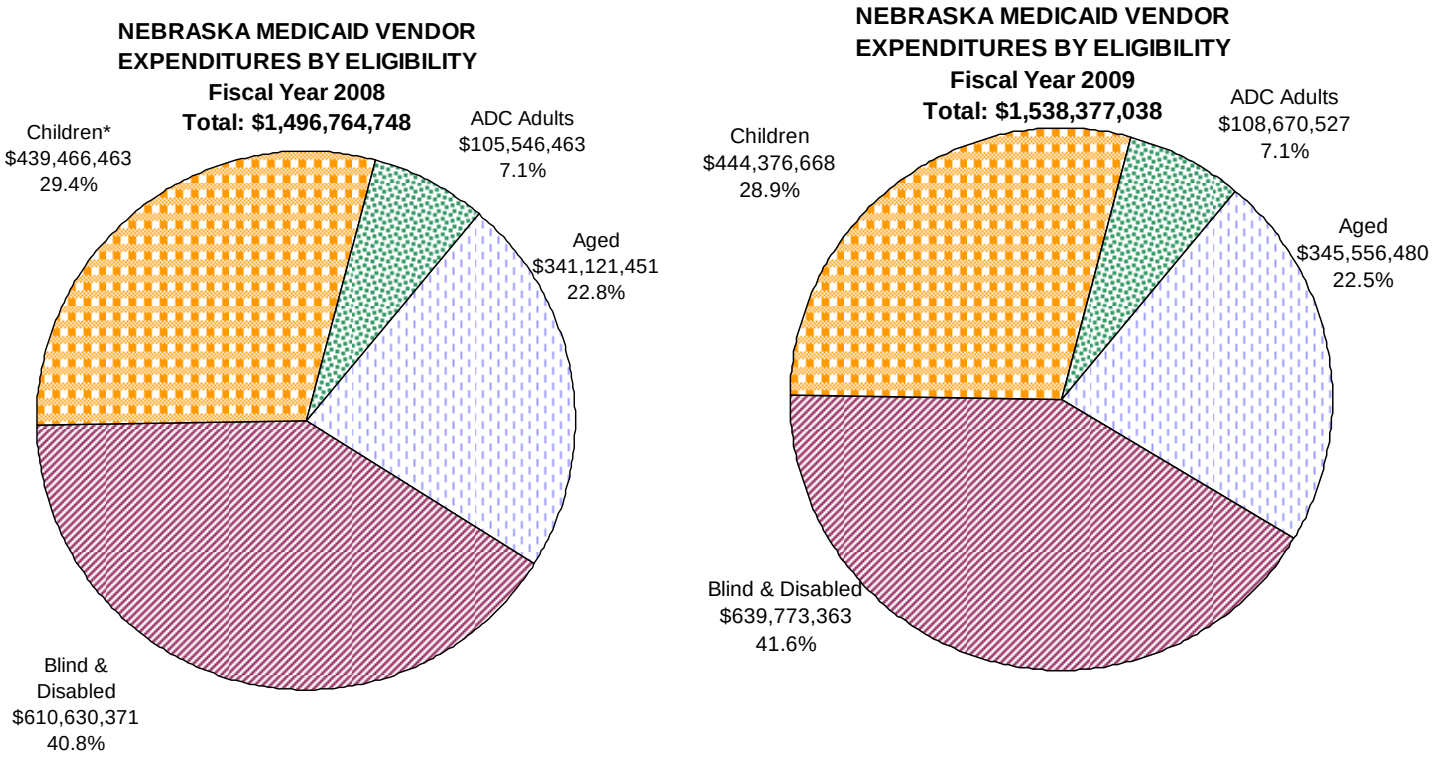


Figure 2 compares vendor expenditures by eligibility category for SFYs 2008 and 2009. The graphic does not account for all Medicaid expenditures, in part because some payments and refunds are not specific to a recipient or eligibility category. Examples of transactions not shown are drug rebates, payments made outside the claims processing systems, and premium payments paid on behalf of persons eligible for Medicare.

Total Medicaid vendor expenditures experienced an increase of 2.8% from SFY 2008 to SFY 2009. The largest increase in expenditures was in the Blind & Disabled category, which increased by 4.8% from SFY 2008 to SFY 2009. Aid to Dependent Children (ADC) Adult expenditures were the second fastest growing category, increasing by 3% from SFY 2008 to SFY 2009, followed by Aged, which increased at 1.3%. Expenditures for Children grew by 1.1%.

The average monthly cost per eligible increased .3% from SFY 2008 to SFY 2009. The largest cost per eligible increase was in the Aged category, which increased by 2.5%, followed by Blind and Disabled at 1.9%. Medicaid expenditures per eligible decreased by .9% for ADC Adults and by 1.4% for Children.

B. Covered Services

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

Federal Medicaid Mandatory and Optional Services Covered in Nebraska

(Neb. Rev. Stat. § 68-911)

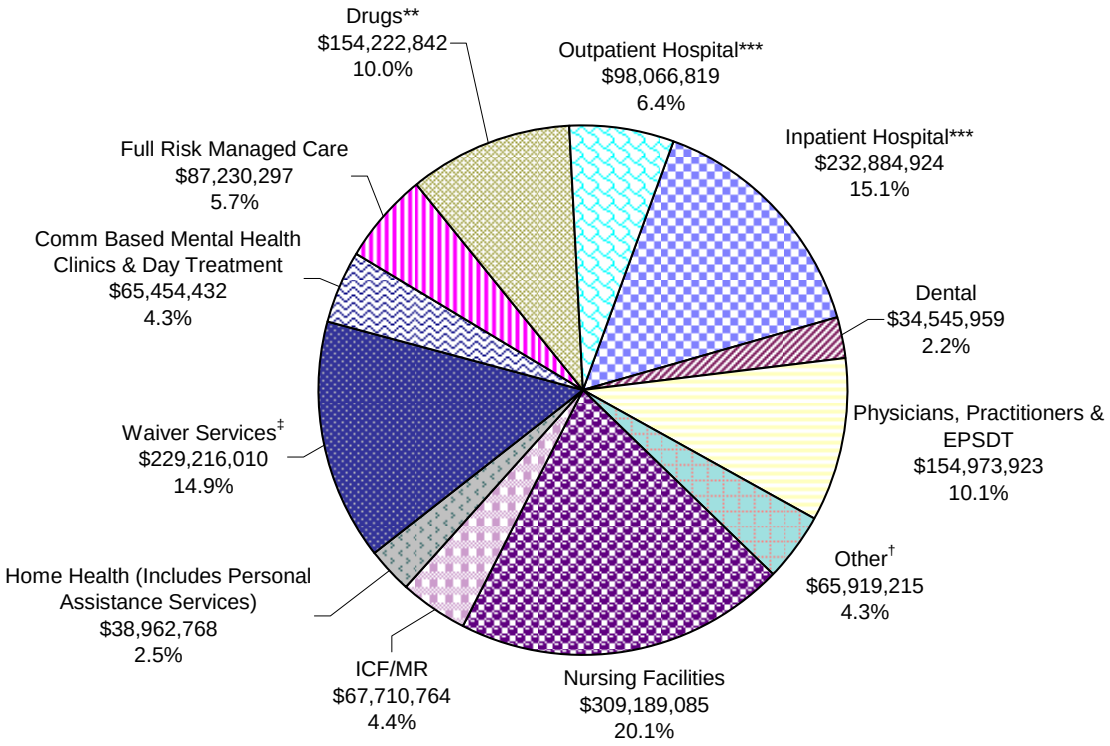
Mandatory Services	Nebraska Optional Services
• Inpatient and outpatient hospital services • Laboratory and x-ray services • Nursing facility services • Home health services • Nursing services • Clinic services • Physician services • Medical and surgical services of a dentist • Nurse practitioner services • Nurse midwife services • Pregnancy-related services • Medical supplies • Early and periodic screening and diagnosis treatment (EPSDT) services for children	• Prescribed drugs • Intermediate care facilities for the mentally retarded (ICF/MR) • 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 • School-based administrative services

Expenditures

Medicaid expenditures to vendors in SFY 2009 totaled $1,538,377,038. Figure 3 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 3

NEBRASKA MEDICAID VENDOR EXPENDITURES* BY SERVICE
FISCAL YEAR 2009
Total Vendor Payments $1,538,377,038



* Includes payments to vendors only, not adjustments, refunds or certain payments for premiums or services paid outside the Medicaid Payment System (MMIS) or N-FOCUS

** $48.5 million in offsetting drug rebates is not reflected in the drug expenditures of $154,222,842

*** DSH payments of $33.9 million are not reflected in Inpatient or Outpatient Hospital Expenditures

† Includes Speech/ Physical Therapy, Medical and Optical Supplies, Ambulance, and Lab/Radiology

‡ Developmental Disabilities, Aged and Disabled, Traumatic Brain Injury, Early Intervention

Expenditures may not sum due to rounding.

$1,538,377,038	**Vendor Payments**
$50,054,906	Disproportionate Share Hospital Payments
$33,363,755	Medicare Premiums
$5,377,654	Intergovernmental Transfer (IGT)
$52,324,255	Other Payments (Managed Care, Transportation, Federal Insurance Contributions Act taxes)
($50,235,380)	Rebates/Refunds
($96,504,504)	General Funds Paid in Other Budget Programs
$38,138,789	Medicare Part D Clawback
$1,570,896,513	**Net Medicaid Expenditures**

Total vendor payments increased $41,612,290, or 2.8%, from SFY 2008 to SFY 2009. From SFY 2008 to 2009 vendor expenditures for Inpatient and Outpatient Hospital Services and Waiver Services showed significant increases. (Table 1)

Table 1

Nebraska Medicaid Vendor Expenditures

	FY 2008		FY 2009		FY 2008 to FY 2009	
	Expenditures	% of Total	Expenditures	% of Total	Change	% Change
Nursing Facilities	$306,404,724	20.5%	$309,189,085	20.1%	$2,784,361	0.9%
Inpatient Hospital	$222,717,632	14.9%	$232,884,924	15.1%	$10,167,292	4.6%
Waiver Services (DD Waivers, Assisted Living)	$208,260,116	13.9%	$229,216,010	14.9%	$20,955,894	10.1%
Physicians, Practitioners & EPSDT	$154,068,520	10.3%	$154,973,923	10.1%	$905,403	0.6%
Drugs	$151,919,025	10.1%	$154,222,842	10.0%	$2,303,817	1.5%
Outpatient Hospital	$88,274,074	5.9%	$98,066,819	6.4%	$9,792,745	11.1%
Managed Care Capitation	$87,710,321	5.9%	$87,230,297	5.7%	-$480,024	-0.5%
Other	$68,470,842	4.6%	$65,919,215	4.3%	-$2,551,627	-3.7%
Comm Based Mental Health Clinics & Day Treatment	$67,888,158	4.5%	$65,454,432	4.3%	-$2,433,726	-3.6%
ICF-MR	$67,763,037	4.5%	$67,710,764	4.4%	-$52,273	-0.1%
Home Health	$38,227,383	2.6%	$38,962,768	2.5%	$735,385	1.9%
Dental	$35,060,916	2.3%	$34,545,959	2.2%	-$514,957	-1.5%
Total	$1,496,764,748	100%	$1,538,377,038	100.0%	$41,612,290	2.8%

Long-Term Care Services

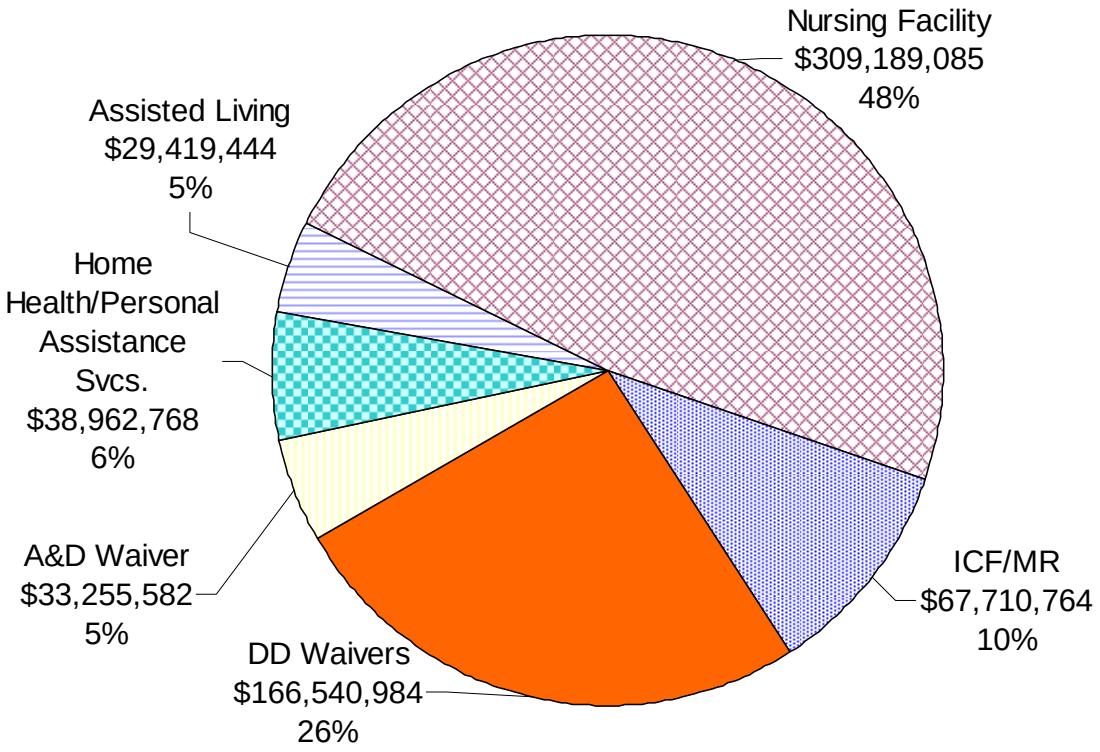
Long-Term Care services support individuals with chronic or ongoing health needs related to age or disability. Services are geared to multiple levels of client need ranging from limited assistance with activities of daily living to complex nursing interventions. Assistance can be offered in a variety of settings from care in an individual's home, to care in small group settings with community supports, to care in a nursing facility or intermediate care facility for persons with mental retardation. In general, home and community-based care is less expensive and offers greater independence for the consumer than facility-based care. For these reasons, state and federal initiatives encourage the development of care options in the community as an alternative to institutional care, as long as a safe plan of care can be established.

Efforts to encourage home and community-based alternatives to facility-based care are resulting in a gradual rebalancing of long-term care expenditures. Comparison of Fiscal Year 2009 spending with Fiscal Year 2008 spending shows a slight decline in the percentage of dollars directed to institutional providers (nursing facilities and ICF/MR) and a corresponding increase in the proportion of spending for services in less restrictive settings. (Figure 4) Institutional payments declined from 60% of total long-term care expenditures in 2008 to 58% in 2009. Home and Community payments increased from 40% of total long-term care expenditures in 2008 to 42% in 2009.

Figure 4

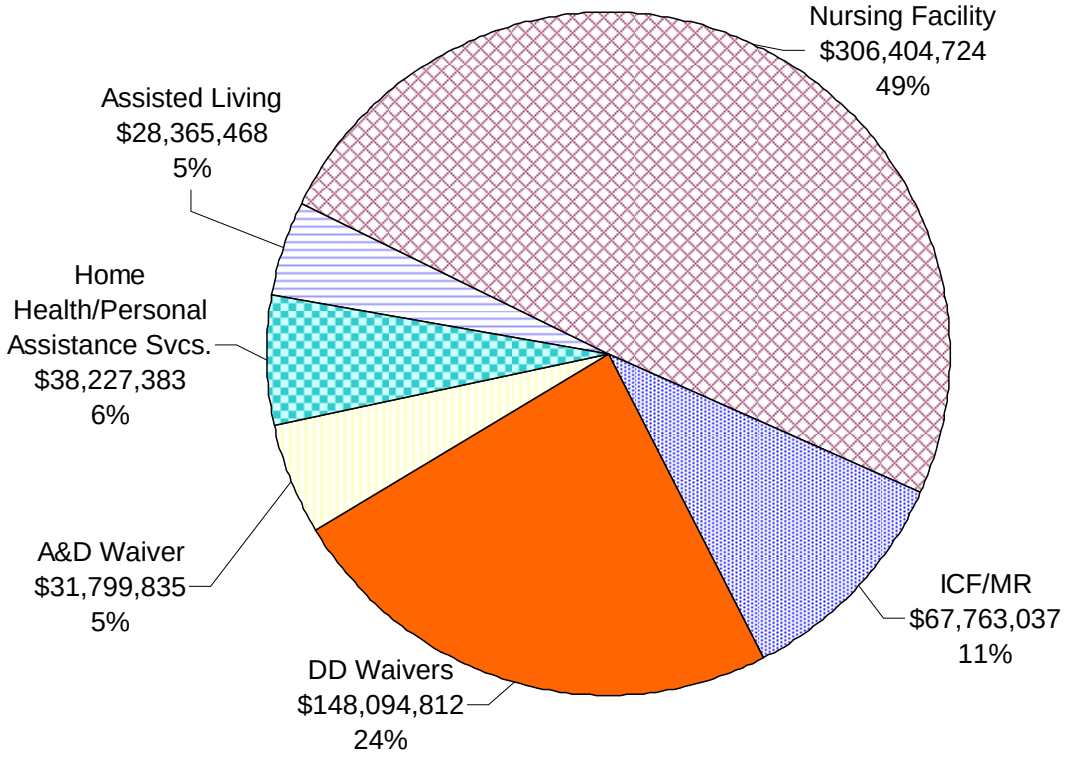
SFY 2009 Medicaid Expenditures for Long-Term Care Services

Total: $645,078,627



SFY 2008 Medicaid Expenditures for Long Term-Care Services

Total: $620,655,260



C. Provider Reimbursement

DHHS uses different methodologies to reimburse 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 based on a prospective system using either a diagnosis related group or per diem rate. Critical Access Hospitals are reimbursed a per diem based on reasonable cost of providing the service. Federally Qualified Health Centers are reimbursed on a prospective payment system. Rural Health Clinics are reimbursed cost or a prospective rate depending on whether they are independent or provider based. Outpatient Hospital reimbursement is based on a percentage of the submitted charges. Nursing Facilities are reimbursed a daily rate based on facility cost and client level of care. Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) are reimbursed a per diem rate based on a cost model. Home and Community-Based Waiver Services, including Assisted Living, are reimbursed at reasonable fees as determined by DHHS.

Table 2 below shows a recent history of provider rate changes by provider type.

Table 2

Annual Budget Rate Increases Funded	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007	SFY 2008	SFY 2009
Hospitals	3.17%	-3.13%	3.20%	3.40%	3.70%	1.95%	1.90%
Practitioners	0.00%	2.00%	2.00%	2.00%	2.00%	1.40%	1.40%
Nursing Facilities	5.42%	2.00%	2.00%	6.00%	3.50%	2.50%	2.50%
Assisted Living	3.28%	-2.00%	3.00%	2.00%	2.00%	2.00%	2.00%
Non-public ICF-MRs	5.42%	-2.00%	3.00%	2.00%	2.00%	2.50%	2.50%

For Medicaid recipients participating in at-risk managed care, Medicaid pays a monthly capitation payment to the Managed Care Organization (MCO) based on actuarially determined cost of services and administration per enrollee. 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 3, at-risk managed care constitutes over $87 million or 5.7% of vendor expenditures.

For Medicaid recipients participating in the Primary Care Case Management (PCCM) managed care program, Medicaid pays a monthly payment to the Primary Care Physician (PCP) for care management. Medicaid also pays the PCCM Administrator for administration of the PCCM program. Claims for services provided to recipients are paid directly to providers by the Medicaid program. Nebraska Medicaid paid approximately $120 million, or approximately 8% of vendor expenditures, for PCCM clients for services similar to those covered under the MCO plan.

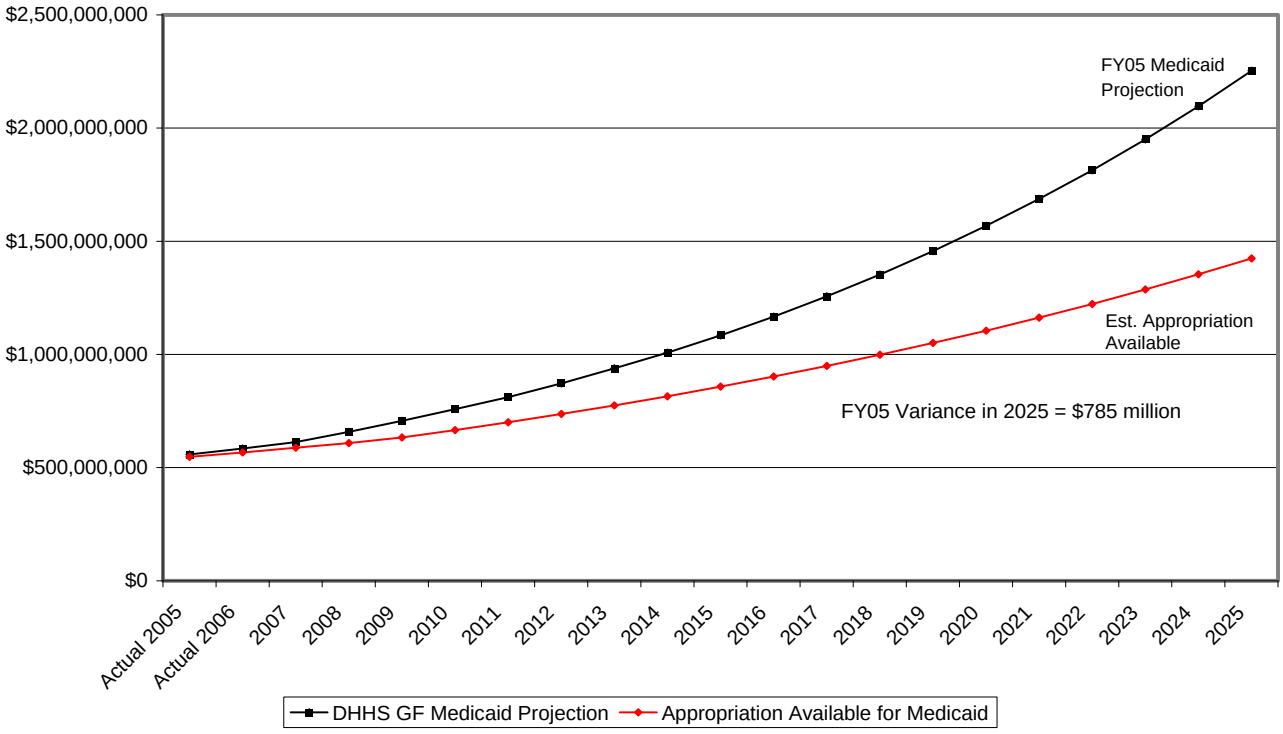
D. Program Trends and Projections

In the Nebraska Medicaid Reform Plan of 2005, DHHS estimated total federal and state Medicaid spending through 2025 by adjusting for demographic changes in the population and projected medical inflation over the next 20 years. Holding the proportion of General Fund revenues allocated to Medicaid constant, 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

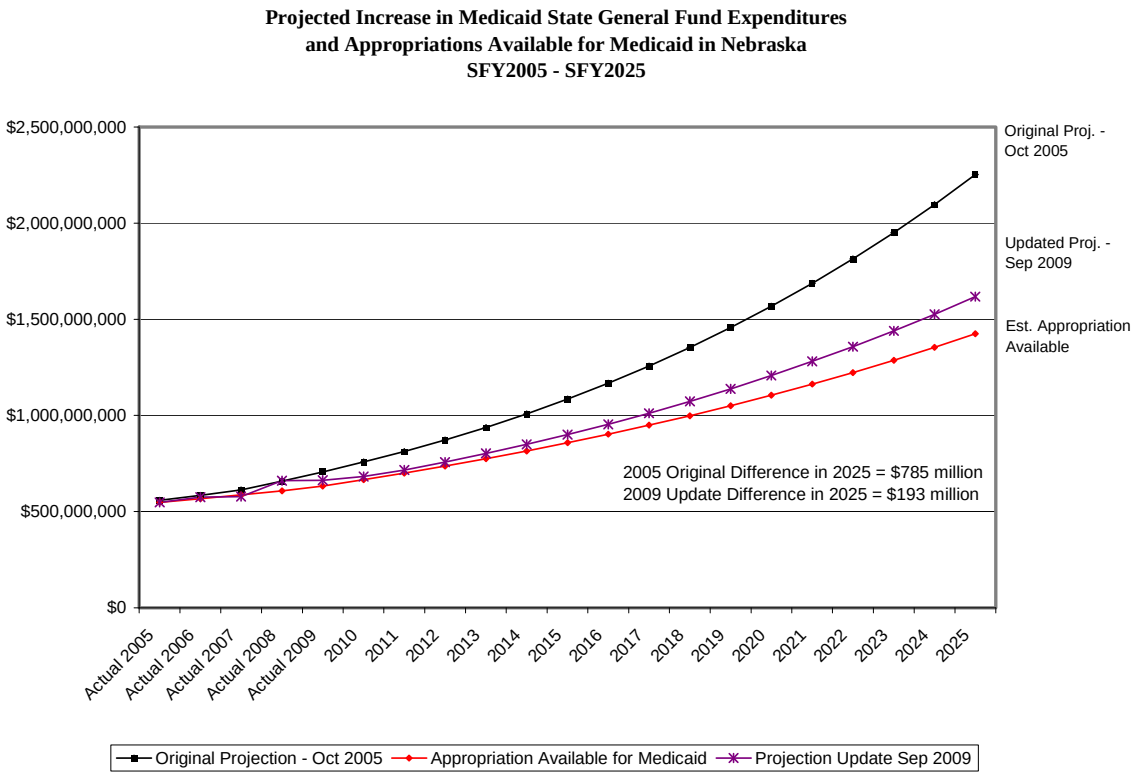


For the 2009 Nebraska Medicaid Reform Annual Report, DHHS forecasts Medicaid eligible persons and costs as follows:

- The average monthly eligible persons by category are updated using final SFY 2009 data. Actual Medicaid caseload for 2008 and 2009 was lower than projected.
- Average monthly cost per eligible is the base for forecasting monthly Medicaid costs by eligibility category. Final SFY 2008 averages were used in the calculation. The cost adjustment factor continues 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.

The 2005 base projections previously used were provided by the Center for Public Affairs Research at the University of Nebraska at Omaha. Based on the above revisions, the projected gap between estimated Medicaid General Fund expenditures and available appropriations in 2025 decreased to $193 million. (Figure 6)

Figure 6



The estimate was developed as a product of two projections for each fiscal year: average monthly Medicaid eligibles and average monthly Medicaid expenditures per eligible. The resulting average monthly total Medicaid expenditure projection was multiplied by 12 to reach an annual figure. It was then multiplied by 0.4 to estimate the General Fund portion of the projected total Medicaid expenditures.

The projection of average monthly Medicaid eligibles was also based on two sources: average monthly Medicaid eligibles in SFY 2005 and a projection of Nebraska population growth. The Nebraska population forecast was developed by the Center of Public Affairs Research at the University of Nebraska at Omaha. The report projected future Nebraska population by age. The assumption underlying the eligibility projection was that the ratio of average monthly eligibles in each eligibility category to the total population in the age group corresponding to that category would remain constant. For example, in SFY 2007, there were 128,107 average monthly eligibles in the Children category. This represented 24.3% of children less than 21 years of age in Nebraska. It was, therefore, projected that the average monthly children eligible for Medicaid would be 24.3% of whatever the number of children under 21 was for that year in the population forecast. The same projection was done, through 2025, for average monthly Medicaid eligibles in each category: Aged, Blind and Disabled, Adults, and Children.

The other factor in the projection of Medicaid expenditures was a projected average monthly cost per eligible in each of the five categories. This was developed from two factors: actual growth of average monthly cost per eligible in Nebraska Medicaid from SFY 2000 - SFY 2005, and projections available at the time from the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) on increases in the cost of health care from 2006 to 2014. In particular, the percentage increase applied to the average monthly cost per eligible for each year in the projection was the average of the average growth in actual Medicaid expenditures per eligible in that category SFY 2000 – 2005 and the projected growth in health care costs from the

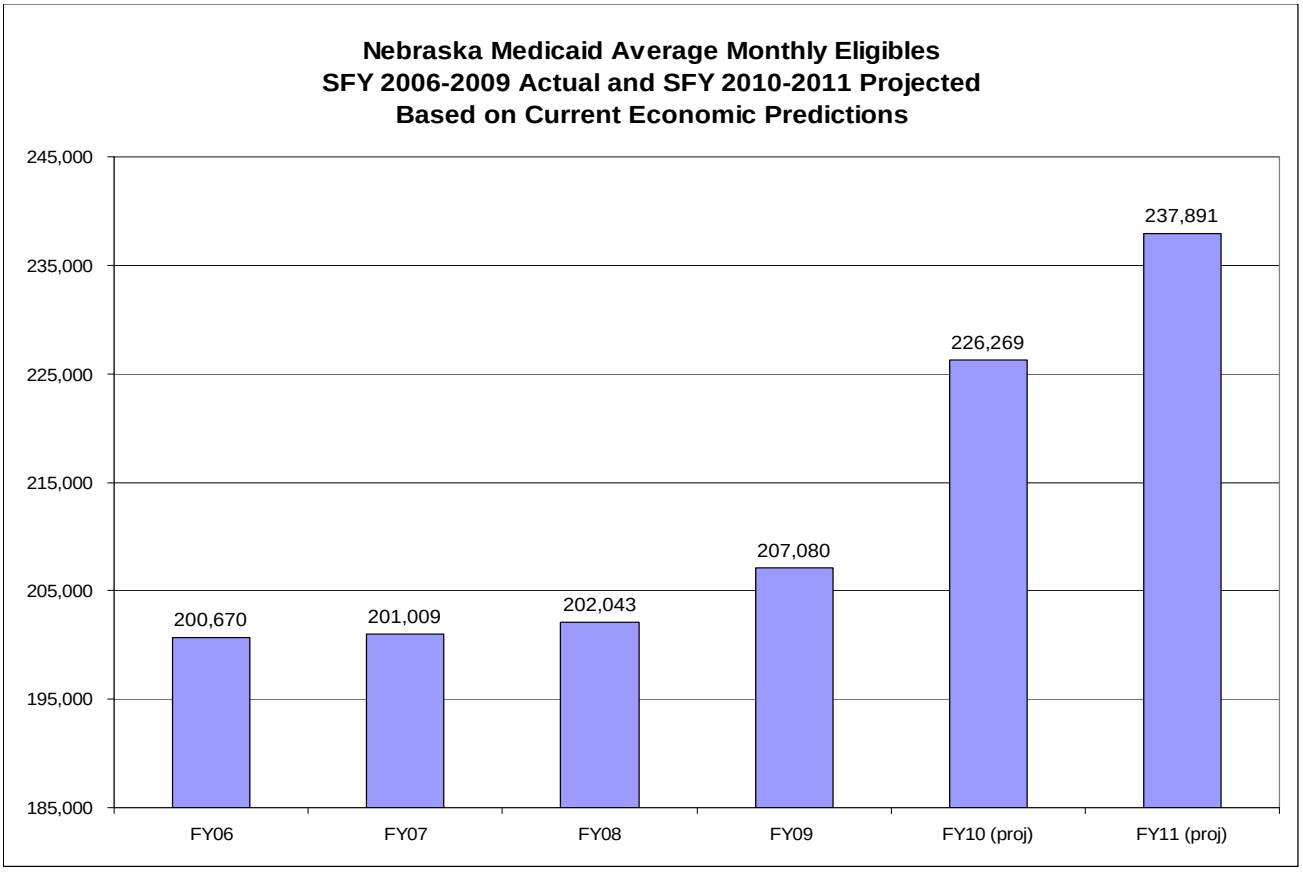
CMS Office of the Actuary for that time. These average monthly costs per eligible projections were multiplied by the average monthly eligibles projections described above to arrive at the projected Medicaid expenditures used in the charts in question.

While actual Medicaid eligibles grew faster than projected using the population forecast, the distribution of eligibles was different than projected. In particular, the Medicaid Children category has grown at a faster rate than the general population of children in Nebraska. The Aged and Adult categories have grown at a much slower rate than their corresponding age groups in the general population. This is significant because the Aged group tends to have higher costs, on average, and Children tend to have the lowest costs of any Medicaid eligibility group. While there are slightly more people eligible for Medicaid than anticipated, it has also been a significantly less costly mix of eligibles than anticipated.

Growth in Medicaid eligibility, which had been moderate from SFY 2006 through SFY 2008, experienced a significant increase in the latter half of SFY 2009. Assuming continued pressure on Medicaid caseloads due to weak economic conditions and factoring in the statutory expansion of Children's Health Insurance Program (CHIP) eligibility to 200% FPL in LB 603, eligibility is projected to increase 9.3% in SFY 2010 and 5.1% in SFY 2011.

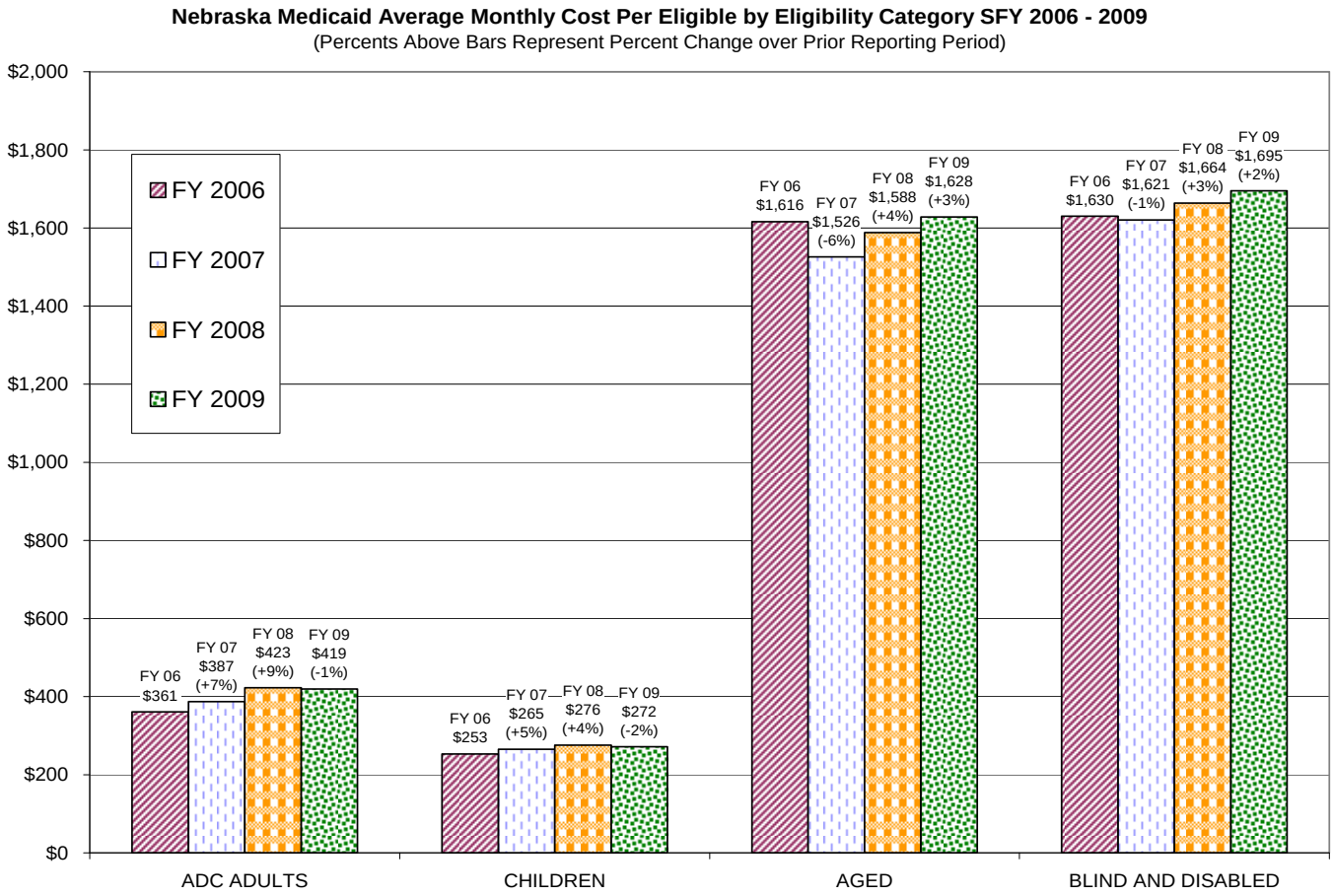
As shown in Figure 1, the average monthly number of eligibles in SFY 2009 was 207,080. Figure 7 tracks the annual growth of eligibles. In June 2009, there were 213,745 persons eligible for Medicaid, an increase of 11,071 persons over the same month in 2008.

FIGURE 7



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 8.

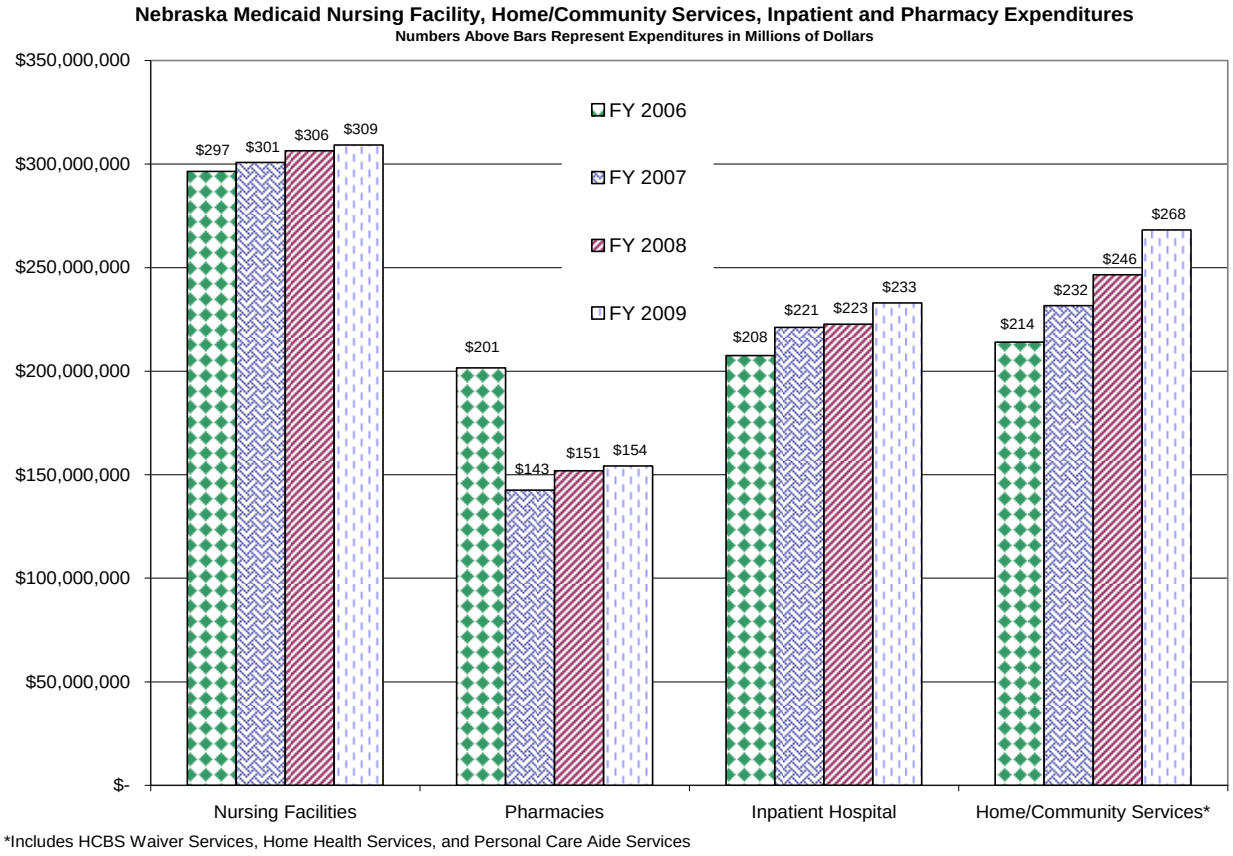
Figure 8



These trends are based on vendor payments. The majority of persons in the Aged and the Blind and Disabled categories now have their drug costs paid by Medicare. (Medicare Part D took effect in January 2006, thus Medicare Part D affected only the second half of SFY 2006). The ADC Adult and Children's categories are unaffected by Part D.

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 home health, personal assistance services and waiver services, including assisted living. The trends are shown in Figure 9.

Figure 9



The impact of the Medicare Part D Drug Benefit is clearly shown, with pharmacy expenditures declining from $201 million in SFY 2006 to $154 million in SFY 2009. Spending for nursing facility services is increasing although declining as a percentage of the overall Medicaid program. Home and community services continue to grow both in terms of dollars and as a percentage of the Medicaid program as more care and services are delivered outside of traditional institutional settings. Expenditures for inpatient hospital services continue to increase.

E. Program Budget and Expenditures

Continuation funding for Medicaid for SFY 2010 and 2011 was enacted in LB 315, the mainline appropriations bill of the 2009 legislative session. The Medicaid appropriation included a rate increase of 1.5% per year for most provider categories as well as an adjustment in the state and federal funding split to reflect enhanced Federal Medical Assistance Percentage (FMAP) funding available to DHHS as a result of the federal American Recovery and Reinvestment Act (ARRA). Enhanced federal funding is anticipated through December 31, 2010.

Additionally, the Medicaid appropriation for SFY 2011 was reduced to recognize anticipated savings from the following policy changes:

Change	General Fund Impact
1. Reduction in Indirect Medical Education factor reimbursement for hospitals from 72.64% to 70%	($50,775)
2. Reduction in outpatient hospital reimbursement from 82.45% of cost to 75% of cost	($899,826)
3. Coverage of disability childcare limited to the cost exceeding traditional childcare	($725,380)
4. Premium payment for families whose income exceeds 185% of the Federal Poverty Level and whose children are served through home and community-based waivers or Katie Beckett eligibility	($213,215)
5. Implementation of two-tiered payment rates for office and facility-based care provided by physicians	($700,000)

F. Medicaid Reform Activities

1. DHHS will implement a premium buy-in program for children with disabilities

For children with special health care needs who access Medicaid through home and community-based waivers and through Katie Beckett provisions, parental income is disregarded when determining the child's eligibility for services. DHHS recommended the application of premium payments for families with incomes exceeding 185% FPL. In order to comply with the American Recovery and Reinvestment Act of 2009, which increased Nebraska's Federal Medical Assistance Percentage (FMAP) formula, the premium buy-in program will not be operational until January 2011.

2. DHHS is implementing the Preferred Drug List

In 2008, the Nebraska Legislature passed the Medicaid Prescription Drug Act, which will provide appropriate pharmaceutical care to Medicaid recipients in a cost-effective manner through the development of a Preferred Drug List (PDL). A committee consisting of physicians, pharmacists and public members have been appointed and are determining which medications will be included on the PDL and which drugs are the most efficacious and safe within therapeutic classes. Medication costs for the State will be reduced by 1) a partnership with other states in a multi state purchasing pool to enhance Nebraska's supplemental rebates and 2) increased utilization of less costly medications. The PDL will be developed by the end of calendar year 2009.

3. DHHS implemented Money Follows the Person Grant

Nebraska was one of 31 states selected by the Centers for Medicare and Medicaid Services to host a five-year demonstration project called Money Follows the Person. The goal is to help rebalance Medicaid's long-term care spending by decreasing the percentage of funds spent for facility-based care and increasing the percentage spent on home and community-based services. Eligible participants who currently reside in nursing homes or intermediate care facilities for persons with developmental disabilities and who wish to relocate are assisted with their transition from facilities back to their own home or to other suitable community residences, such as houses, apartments, or small group living arrangements. Nebraska's Operational Protocol for Money Follows the Person was approved June 20, 2008. As of June 30, 2009, thirty-nine individuals have been transitioned into the community.

4. DHHS has developed and will implement a Long-Term Care Needs Assessment Tool

DHHS will implement the Nebraska Home Care Tool for assessing whether clients meet the functional criteria to be eligible for services of the Aged and Disabled Medicaid Waiver or a nursing facility. Programming of the electronic tool and validity is complete. In conjunction, the regulations which address level of care criteria have been revised. Proposed implementation is January 1, 2011.

5. DHHS conducted a study for rate setting methodology for Long-Term Care Services

DHHS contracted with Myers & Stauffer for a study to review and provide recommendations for nursing facility reimbursement structure. The contractor submitted its final report to DHHS

in April 2009. The report and its recommendations were presented by the contractors to Nebraska's nursing facility providers in May 2009. A provider workgroup was established for the purpose of discussing potential improvements to Nebraska's nursing facility reimbursement methodology.

6. **DHHS will evaluate emerging technologies and identify available, cost effective technology for distance care**

Nebraska Medical Technology Solutions, Inc. submitted a report June 22, 2009 reviewing current telemonitoring equipment and service options along with methodologies for reimbursing providers. NMTS conducted a literature search and surveyed Medicaid programs, private insurers, and health care companies. DHHS is reviewing the report and will evaluate the efficacy of utilizing telemonitoring equipment and automated medication dispensing devices to reduce the need for nursing and physician intervention.

7. **DHHS implemented enhanced care coordination for high-cost recipient with multiple medical conditions**

DHHS contracted with US Care Management to provide a voluntary Enhanced Care Coordination for high-cost Medicaid recipients who have multiple medical conditions. The program has been underway since July 1, 2008 and is to continue to June 30, 2011 with the option to renew for three additional years. There were 425 active members as of July 31, 2009. Of the 425 members there are 27% (116) diagnosed with asthma; 18% (75) with diabetes; 8% (35) schizophrenia; 8% (35) hypertension and 11% (46) with depression. Most of the high- risk members have at least one additional co-morbid condition that requires increased coordination and education. There is a positive trend in the utilization activity among the cohort enrolled from initial period and again after five months of claims data. Although too early to determine true impact, these early metrics show promise that the program interventions may have impacted inpatient hospital admissions, although there is evidence of increased use of ER visits during this period. The staff continues to educate on the appropriate use of ER to reverse this trend.

8. **DHHS conducted a hospital methodology study**

DHHS contracted with Navigant Consulting to conduct a hospital inpatient rate study. The study rebased the hospital inpatient rates and evaluated the Disproportionate Share Hospital (DSH) methodology. New rates will be implemented October 1, 2009.

9. **DHHS expanded managed care**

DHHS initiated a procurement process for the purpose of selecting two Managed Care Organizations (MCOs) in a ten county area. All bids were rejected. A reprocurement process is underway with an intended implementation date of July 1, 2010. Managed care has been expanded from Douglas, Sarpy and Lancaster counties to include the counties of Otoe, Cass, Washington, Saunders, Dodge, Gage, and Seward. Effective November 1, 2009, clients in these counties will be required to select a primary care physician and will be enrolled in the Primary Care Case Management (PCCM) plan.

10. **DHHS implemented policies to avoid payment of 'Never Events'**

"Never Events" are errors in medical care that are of concern to both the public and healthcare professionals and providers, and are clearly identifiable and measurable. CMS has announced that Medicare will no longer pay the extra cost of treating certain categories of conditions that occur while the patient is in the hospital. DHHS amended the Medicaid State Plan to be consistent with Medicare Policy. This provision applies only to those claims in which Medicaid is a secondary payer to Medicare.

11. **DHHS implemented changes to the PCCM Program**

Effective July 1, 2009, requirements for physician-to-physician referrals for clients enrolled in the PCCM Program were eliminated. Disenrollment regulations were implemented which limit disenrollment from one plan to another, without cause, to once every 12 months.

12. **DHHS implemented Electronic Fund Transfer (EFT) for payments to Medicaid providers**

Effective January 1, 2009, regulations were implemented to require that all Medicaid providers accept payment electronically. All newly enrolled Medicaid Providers are required to complete the necessary Automated Clearing House form to allow for electronic funds transfer. Effective September 9, 2009, payment to any Medicaid Provider who has not completed the necessary paperwork to accept payment by EFT will be held until such paperwork is properly completed and submitted to DHHS so that payments can be released electronically.

13. **DHHS is implementing electronic billing by providers**

Electronic claim submission assists DHHS to operate a more efficient payment system. DHHS currently receives over 90% of claims electronically. DHHS' current MMIS is able to accept and process all incoming claim types for services provided to eligible clients. Providers benefit when they submit electronic claims with shorter turnaround time for payments resulting in improved cash flow, improved tracking and monitoring capabilities, and reduced postage and paper handling costs. DHHS has begun an awareness campaign to remind providers of the benefits of electronic claim submission.

14. **DHHS implemented a new Medicaid card**

In August 2009, DHHS discontinued the monthly mailing to clients of the 8 ½" x 11" document containing person-specific Medicaid eligibility information. All clients now have a permanent wallet-sized plastic identification card issued once, similar to private health insurance. Providers can easily verify eligibility through two telephone and two electronic systems. This new card will be easier for the client to carry as well as reduce significantly printing and mailing costs.

15. **DHHS will procure a transportation broker for non-emergency medical transportation**

DHHS has determined that centralized management of transportation services would result in program efficiencies. DHHS is in the process of developing a request for proposal for a transportation broker.

16. **DHHS implemented radiology management services**

DHHS contracted with MedSolutions to provide radiology management services which require prior authorization of high tech outpatient radiology procedures, such as Computerized Tomography (CT) scans, Magnetic Resonance Angiogram (MRA) scans, Magnetic Resonance Imaging (MRI) scans, Magnetic Resonance Spectroscopy (MRS) scans, Nuclear Medicine Cardiology scans, Positron Emission Tomography (PET) scans, Single Photon Emission Computed Tomography (SPECT) scans. A State Plan Amendment was submitted to and approved by CMS. The Program was implemented on September 1, 2009. Radiology procedures when performed during an inpatient hospitalization or for treatment of an emergency medical condition through the hospital's emergency room are not affected.

17. **DHHS has begun development of a Program of All-Inclusive Care for the Elderly (PACE)**

The PACE Program provides comprehensive health care services within a defined geographic area for voluntarily enrolled individuals age fifty-five and older. DHHS will make capitated payments to a PACE organization which will utilize Medicare, Medicaid, and private pay revenues to provide coordinated care. The organization will be at-risk for all covered services offered by Medicare and Medicaid.

A minimum period of 18-24 months is required to launch an operational PACE Program. DHHS is establishing procedures to identify organizations qualified to serve one or more target areas in Omaha or Lincoln. Interested providers must first pass a state readiness review to demonstrate their capabilities to deliver PACE services and are then invited to submit an application to CMS. The final step is execution of a program agreement between CMS, DHHS, and the PACE entity.

G. Program Changes

1. **DHHS expanded eligibility for Children's Health Insurance Program (LB 603)**

Eligibility for the Children's Health Insurance Program was expanded to cover children whose family income does not exceed 200 percent (formerly 185 percent) of the federal poverty level. This will add approximately 5,400 children to the program in fiscal year 2010. DHHS is engaged in an outreach effort to provide information related to this change to the public, providers, advocacy groups, as well as DHHS staff.

2. **DHHS will implement a new service for children with Autism (LB 27)**

DHHS plans to implement an intensive early intervention service based on behavioral principles for children with Autism Spectrum Disorder who receive such services prior to the age of 9. This service will be provided statewide under a Medicaid Home and Community Based Waiver and serve approximately 85 children annually. The waiver application was submitted to CMS August 31, 2009.

3. **DHHS will implement a Medical Home Project (LB 396)**

No later than January 1, 2012, DHHS will design and implement a medical home pilot program, in consultation with the Medical Home Advisory Council, in one or more geographic regions of the state to provide access to medical homes for patients. The purposes of the project are to improve health care access and health outcomes for patients and to contain costs of the medical assistance program. DHHS will establish necessary and appropriate reimbursement policies and incentives under such a program to accomplish the purposes of the Medical Home Pilot Program Act. DHHS was recently awarded a grant by The National Academy for State Health Policy to provide participating states with technical assistance.

4. **DHHS allowed for Medicaid reimbursement for ICF/MR services with 4-15 beds**

Effective August 2009, DHHS amended its regulations to allow for Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) with 4-15 beds to be reimbursed under Medicaid provisions. This change facilitates the establishment of facilities of this size and provides an alternative to Nebraska's larger ICF/MR facilities. The establishment of ICF/MRs with 4-15 beds in Nebraska increases opportunities for individuals with developmental disabilities and concurrent medical needs to live in more home-like, community-integrated settings.

5. **DHHS will maximize federal funding with University of Nebraska Medical Center Physicians**

Current Medicaid reimbursement for physician services in Nebraska is based upon a set fee schedule. Similar to what has been done in other states, the University of Nebraska Medical Center (UNMC) will work with DHHS to develop a physician upper payment limit (UPL) program to provide higher reimbursement to designated physician groups. The development, implementation, and ongoing operation of the concept as well as the non-federal share of the enhanced payments will be funded by UNMC.

6. **DHHS will establish reimbursement for Pediatric Feeding Disorder services (LB 342)**

No later than July 1, 2010, DHHS will submit a State Plan Amendment to provide for Medicaid payments for the comprehensive treatment of pediatric feeding disorders through interdisciplinary treatment.

7. **DHHS will add Secure Residential services (LB 603)**

DHHS submitted a State Plan Amendment to provide Medicaid payments for Secure Residential Services. Secure Residential is a 24-hour residential program that provides intensive mental health services for adults as an alternative to long-term psychiatric hospitalization or upon discharge from the Regional Center. DHHS is awaiting federal approval.

8. **DHHS will evaluate implementation of Health Information Technology provisions of the federal law**

The American Recovery and Reinvestment Act (ARRA) promotes the use of and incentive funding for Health Information Technology. Grants are available through the Centers for Medicare and Medicaid Services to assist states and Medicaid providers in adopting electronic health records systems. DHHS is taking steps to utilize these funding streams.

9. **DHHS will evaluate use of a data matching contractor for Coordination of Benefits and Health Insurance Premium Payment (HIPP) programs**

DHHS is researching software and/or services to enhance the Department's current Third Party Liability (TPL) and Health Insurance Premium Payments (HIPP) programs. There are vendors who have large databases available that assist DHHS in increasing its ability to recover funds from TPL resources and identify other health insurance coverage that could lead to increased cost avoidance related to medical claims.

III. Conclusion

In the four years since the publication of the Medicaid Reform Plan, DHHS has undertaken significant steps to implement the recommendations it contains. Many of the recommendations have become a part of the Medicaid Program. To slow the growth of the Medicaid Program and ensure fiscal sustainability, thoughtful and dynamic strategies that go beyond those proposed in the Medicaid Reform Report of 2005 are discussed in this report. These strategies have been developed to make Medicaid more efficient and cost effective through better management of services, better delivery of care, more appropriate services, and improved administration of the program. Due to current economic conditions, Medicaid eligibility has been increasing steadily. This growth is anticipated to continue in the coming year. However, the Medicaid Reform initiatives that are being undertaken will help to mitigate this growth.

The Department of Health and Human Services, Division of Medicaid and Long-Term Care looks forward to continuing to work with the Governor, the Legislature, and the Medicaid Reform Council to improve Medicaid for current and future generations.