DD Briefing Testimony
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Good morning, Senator Coash and members of the Health and Human Services and Developmental Disabilities Special Joint Committees. My name is Courtney Miller (C-O-U-R-T-N-E-Y M-I-L-L-E-R), Director of the Division of Developmental Disabilities (DD) with the Nebraska Department of Health and Human Services.

I appreciate the opportunity to come before you today and provide a brief update regarding our Home and Community-Based Services (HCBS) waivers through the Centers for Medicare and Medicaid Services (CMS) and our Rate Methodology. A lot of good work has been happening since I appeared before you in December of 2015.

Medicaid Waiver Approval

As noted within the DHHS Business Plan that was released in June 2016, the Developmental Disabilities Division began our process on consolidating and renewing our Medicaid Waiver services. Currently the Division has 3 approved Waivers (Adult Day, Adult Comprehensive & Children's) providing services to individuals with intellectual/developmental disabilities. Two of the waivers (Adult Day & Adult Comprehensive) expired in December 2015 and are currently on approved temporary extensions from CMS. We have been working diligently over the last year to renew these three waivers into two: Adult Day Services & Comprehensive. This change was made based on town hall input; the strategy streamlines the process of service delivery throughout an affected individual's life.

The Division has been collaborating with CMS through bi-monthly conference calls as well as additional technical assistance calls as needed. Drafts of the two waivers have been regularly shared with CMS for input and feedback prior to our public comment period. In addition, the Division has been building relationships with stakeholders through 7 workgroups comprised of 420 members, 18 town hall meetings across the state and a monthly stakeholder meeting with 154 participants to gather input.

The Division is anticipating that these two new streamlined waivers will be in effect in early 2017. Once the draft application has been fully vetted and the public comment process has been completed, the DD Division will submit to CMS for final approval. Our goal is to have full implementation of the two HCBS Waivers completed by March 31, 2017.

Rate Methodology

Part of the waiver renewal process also required the Division to unbundle the existing services and rate methodologies, developed in 2010-2011 and implemented in July 2014. Many of our current services include multiple billable services within one billing service code. Navigant Consulting Inc., was retained by the Division to begin assisting us with

this process. As part of this process, it was determined that an existing billing practice implemented in July 2014 was in conflict with federal reimbursement requirements. CMS subsequently informed the Division that the billing document did not match the approved rate methodology if in fact residential providers were billing for day habilitation services that were already factored into the residential rates and said that a reimbursement for claims submitted must occur.

All residential rates assume a participant's sick leave and holidays at 15 days per year. In addition, all daily residential rates assume that a participant is outside the home in a day habilitation program 35 hours per week.

All claims involving residential rates must be reviewed. I am currently negotiating with CMS on a claim review methodology. I anticipate that this process and all claims would be concluded by the end of the first quarter of calendar year 2017 in March. At this time, there is no clear way to quantify the total number of claims that CMS will characterize as overpayments that have been made to providers.

I revised the agency's billing guidelines for all providers effective October 1, 2016. These new billing guidelines will continue to reimburse providers at the State General Fund portion of their payment (48.15%), for any excess hours of day habilitation that are not allowable for federal reimbursement through Medicaid.

Upon approval from CMS of the Medicaid Waiver renewals with new rate methodologies, we will be able to return to full federal claiming at that time, and reimburse providers both the full General Fund and the full Federal Fund dollars.

To obtain CMS approval for waiver renewals with a new rate methodology, a corrective action plan is also required to rebase our existing payment structures. The Request for Proposal (RFP) for this process is in development.

Again, I appreciate the opportunity to come before you today and provide an update, and I would be happy to answer any questions you may have.