
NEBRASKA MEDICAID REFORM PLAN

December 1, 2005

Prepared Under the Authority of LB 709 (2005)

Submitted to

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LB 709 (2005)

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Nebraska Medicaid Reform Plan LB 709 (2005)

I. Executive Summary

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 motivation for Medicaid reform is both personal and financial. Many Nebraskans have health care and long-term care needs and are unable, without assistance, to meet those needs. More than 200,000 persons are currently eligible to receive Medicaid benefits in Nebraska each month.

Medicaid is a state program administered as a public assistance entitlement program under broad federal guidelines applicable to all state Medicaid programs. The cost of the Medicaid program is shared by the state and federal government. Medicaid costs are affected by (1) caseload (determined by eligibility criteria), (2) utilization (determined by services covered and service limits), and (3) unit price (determined by provider reimbursement rates).

Total Nebraska Medicaid expenditures now exceed \$1.4 billion annually. The rate of growth in Medicaid expenditures continues to exceed the growth in General Fund revenues, and is not sustainable, raising serious concerns about the availability of Medicaid for future generations of Nebraskans. The growth in Medicaid expenditures can be attributed to many causes, including demographic and economic factors, personal lifestyle choices, health care system factors, and the structure of Medicaid as a public assistance entitlement.

Medicaid reform is difficult because the Medicaid program is extremely complex, and changes to the program are dependent on state and federal administrative and legislative actions for their enactment and implementation. But substantial reform is needed.

The reform recommendations in this plan are based on a significant amount of research and public input. The reform approach taken in the plan is both short-term and long-term. In the short term, the plan suggests immediate changes to moderate the growth of Medicaid spending without significantly impacting current eligibility, provider reimbursement, or covered services. In the long term, the plan emphasizes the necessity of addressing the underlying structure and public policy of the Medicaid program, and incrementally identifying and implementing other necessary and appropriate reforms.

The plan concludes that the Medicaid Program in Nebraska, as it is currently structured, is not fiscally sustainable. The plan recommends the adoption of a public policy statement that recognizes the appropriate role of the state in assisting low-income persons to access necessary medical services, but does so in a manner that allows the state to maintain control over its Medicaid budget.

The plan recommends, as a short-term strategy, that Nebraska retain the existing Medicaid defined benefit program and promptly implement changes within the current structure, including the use of additional waivers. The plan offers 28 recommendations with related strategies, which can be implemented over the next few years. These recommendations are

estimated to reduce projected state fund expenditures by more than \$30 million a year by State Fiscal Year 2008 and more than \$74 million a year by State Fiscal Year 2015.

The plan recommends, as a long-term strategy, that the reform experience of other states implementing defined contribution programs and other reform models be closely monitored with a view toward adopting an improved structure when it is proven effective.

The Medicaid Reform Plan is presented to Governor Heineman, the Legislature, and the public as the starting point for the reform. The recommendations propose essential decisions that need to be made now. The strategies propose actions to be taken in the next few years. Both are necessary to moderate the unsustainable growth of Medicaid. The Medicaid Reform Plan, however, is not the end. It is the beginning of an ongoing process.

II. Introduction

A. Motivation for Medicaid Reform

The motivation for Medicaid reform is both personal and financial. In LB 709 (2005), the Legislature underscored the importance of Medicaid for Nebraskans, and expressed concern about its future financial sustainability.

In Neb. Rev. Stat. §68-1089 (LB709, §3), the Legislature found that “(1) The Medicaid program under Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq. provides essential health care and long-term care coverage to low-income children, pregnant women, and families, individuals with disabilities, and senior citizens serving over one in ten Nebraskans; (2) The Medicaid program covers one in four children in rural areas; (3) The Medicaid program is the largest single purchaser of maternity care and pays for over one-third of the births in the United States each year; (4) Medicaid is America’s single largest purchaser of nursing home services and other long-term care, covering the majority of nursing home residents; (5) In Nebraska, the elderly and individuals with disabilities comprise twenty-three and three-tenths percent of the Medicaid population and represent sixty-seven and two-tenths percent of Medicaid expenditures; (6) In Nebraska, low-income children and their parents comprise seventy-six and seven-tenths percent of the Medicaid population and represent thirty-two and eight-tenths percent of Medicaid expenditures; (7) Medicaid pays for personal care and other supportive services necessary to enable individuals with disabilities to remain in the community, to work, and to maintain independence; and (8) Medicaid is the single largest source of revenue for the nation’s safety net hospitals and health centers and is critical to the ability of these providers to continue to serve Medicaid enrollees and uninsured Americans.”

In Neb. Rev. Stat. §68-1088 (LB709, §2), the Legislature found that “(1) The medical assistance program has resulted in significantly increased expenditures by the State of Nebraska; (2) In response to such increased expenditures, the Legislature has taken various actions affecting the availability and adequacy of medical assistance benefits to Nebraska residents under the program; (3) As a result of such increased expenditures, the medical assistance program may become fiscally unsustainable; and (4) Fundamental reform of the medical assistance program is necessary in order to ensure future sustainability of the program for the benefit of Nebraska residents.”

Many Nebraskans have health care, long-term care, and related needs, and are unable, without assistance, to meet those needs. In the future, as the population of Nebraska changes and the number of elderly Nebraskans increases, more Nebraska residents will require more health

care, long-term care, and related services. As more Nebraskans require more services, total Medicaid General Fund appropriations will continue to grow at a rate faster than the growth in state General Fund revenues.

Total Medicaid appropriations grew from \$201 million in SFY 1987 to \$1.4 billion in SFY 2005 and from 8.8% of state General Fund appropriations to 17.2%. The average annual growth in Medicaid appropriations during the period was 10.8%. Average annual growth in state General Fund revenues during the period was 6.9%.

If Medicaid expenditures remain at their current percentage of General Fund appropriations, the Nebraska Health and Human Services System (HHSS) has estimated that, at the present rate of growth, total Medicaid expenditures will increase to almost \$5.6 billion in 2025. The state General Fund portion of Medicaid expenditures will increase to approximately \$2.2 billion. Compared with the projected growth in General Fund Revenues over the period, the result will be a \$785 million gap in 2025 between projected Medicaid expenditures and projected appropriations available for Medicaid in Nebraska.¹

The number of persons eligible for Medicaid benefits in the most recent twenty-year period (1985 – 2005) grew from a monthly average of 88,000 eligible persons to almost 200,000, almost 11.5% of the state’s population, or one in every nine Nebraskans.

The Nebraska Medicaid program is not currently in a fiscal crisis. The Nebraska Legislature in recent years has acted to moderate the growth of Medicaid to a limited extent, which has now permitted the opportunity for thoughtful and informed decisions about Medicaid reform, before a crisis occurs.

The Medicaid program as currently structured and operated, however, will not effectively moderate the growth of Medicaid spending and cannot be fiscally sustained. While a program as large and complex as Medicaid cannot be rebuilt in an instant, the time for reform-minded decisions is now.

B. Medicaid Reform Issues and Considerations

With the passage of LB 709 (2005), the Governor and the Nebraska Legislature have made Medicaid reform a high priority.

Neb. Rev. Stat. §68-1090 (LB709, §4) calls for reform of the Medicaid program and a substantive recodification of Medicaid statutes, “including, but not limited to, the enactment of policies to (1) moderate the growth of Medicaid spending; (2) ensure future sustainability of the medical assistance program for Nebraska residents; (3) establish priorities and ensure flexibility in the allocation of medical assistance benefits; and (4) provide alternatives to Medicaid eligibility for Nebraska residents.”

Neb. Rev. Stat. §68-1091(2) (LB709, §5) requires the Medicaid reform plan to “consider and address (a) the needs of low-income, disabled, and aged persons currently receiving Medicaid services; (b) avoiding the shifting of the primary costs of health care services to providers of care; (c) the appropriate role of county government in providing health care services; (d) the availability and affordability of private health care insurance and long-term care insurance; (e) the personal responsibility of persons, who are able, to select and provide for all or a portion of the payment for their health care services; (f) the fiscal sustainability of such plan; and (g) alternatives to increase federal funding for services in order to reduce dependence on General Funds and maintain or increase the total amount of funding for such services, and the possible utilization of national consultants to assist in the consideration of such alternatives.”

C. The Medicaid Reform Process

LB 709 (2005) requires development of a Medicaid reform plan by two persons, one appointed by Governor Dave Heineman and one appointed by Senator Jim Jensen as chair of the Legislature's Health and Human Services Committee. (Neb. Rev. Stat. §68-1092; LB 709, §6). The designees are Richard Nelson, Director of HHS Finance and Support, appointed by Governor Heineman; and Jeff Santema, legal counsel to the Health and Human Services Committee of the Nebraska Legislature, appointed by Senator Jensen.

The designees are required to: (1) consult with the Governor, the Health and Human Services Committee, the HHSS Policy Cabinet, and the federal Centers for Medicare and Medicaid Services (CMS); (2) solicit public input; (3) conduct at least one public meeting in each congressional district; (4) provide monthly reports to the Governor and the committee; (5) meet monthly with the Medicaid Reform Advisory Council and (6) develop and submit a Medicaid reform plan to the Governor and the Legislature by December 1, 2005.

The Health and Human Services Committee of the Legislature is required to conduct a public hearing on the plan by December 15, 2005 (Neb. Rev. Stat. §68-1092; LB 709, §6). The chair of the Health and Human Services Committee, in consultation with the committee, may introduce legislation in 2006 to implement the plan (Neb. Rev. Stat. §68-1094; LB 709, §8).

LB 709 establishes a Medicaid Reform Advisory Council consisting of ten persons, five appointed by the Governor and five appointed by Senator Jensen as chair of the Legislature's Health and Human Services Committee, and representing health care providers, health care consumers/advocates, business, insurers, and elected officials (Neb. Rev. Stat. §68-1093; LB 709, §7).

Members of the Medicaid Reform Advisory Council are Senator Don Pederson, chair (Appropriations chair, Nebraska Legislature); Kathy Campbell, vice chair (Executive Vice President, CEDARS Home for Children Foundation); Gayle-ann Douglas (Executive Vice President, Douglas Manufacturing Corp.); Mary Lee Fitzsimmons (Iowa/Nebraska Primary Care Association); Steve Martin (President/CEO, Blue Cross/Blue Shield of Nebraska); Ron Ross (Nebraska State Treasurer); Wayne Sensor (CEO, Alegent Health); Cory Shaw (CAO, University Medical Associates); Pat Snyder (Executive Director, Nebraska Health Care Association); and Tony Sorrentino (Executive Vice President, Silverstone Group).

The Medicaid Reform Advisory Council is required to (1) meet monthly with the Medicaid reform designees; (2) review monthly reports submitted to the Governor and committee by the designees; and (3) review the Medicaid reform plan and provide recommendations relating to the plan to the Governor and the committee by December 14, 2005. The council is not required to develop the plan, and is only one source of input to the designees during development of the plan.

During development of the plan, the Medicaid reform designees met with CMS representatives from Kansas City; met both formally and informally with members of the Health and Human Services Committee of the Legislature, participated in regular meetings with the HHSS Policy Cabinet and HHSS staff, and provided regular briefings to Governor Heineman. Designee monthly reports may be accessed at www.hhss.ne.gov/med/reform (Nebraska Health and Human Services System), or www.unicam.state.ne.us/committees/hhs.htm (Nebraska Legislature).

Medicaid reform public input meetings were conducted by the designees in Omaha (10-25-05), Lincoln (10-26-05), Grand Island (10-27-05), Scottsbluff (11-1-05), and North Platte

(11-2-05). Medicaid legislative public forums were conducted in Broken Bow (11-3-05), O’Neill (11-3-05), and Columbus (11-4-05). Preliminary findings and recommendations were provided in advance of the meetings and forums and presented for public input. Eight members of the Nebraska Legislature and three members of the Medicaid Reform Advisory Council attended one or more of the meetings or forums.²

In addition, the Medicaid reform designees have received significant feedback regarding Medicaid reform in the form of (1) written reports, recommendations and other feedback,³ (2) meetings with various individuals and groups,⁴ and (3) HHSS internal work groups.⁵

The Medicaid reform designees have also reviewed Nebraska Medicaid and related statutes⁶ and Medicaid reform proposals from other states, and conducted other research on the topic of Medicaid reform.

The implementation of LB709 and preparation of this plan have been both deliberate and deliberative. Considerable effort has been made to ensure that recommendations and other information in the plan are based on accurate and objective data, rather than subjective perception or emotion. Great care has also been taken to ensure that the Medicaid reform process has been open, and carefully attentive to a wide variety of opinions and perspectives.

III. Discussion

A. Nebraska's Medicaid Program

General:

On July 30, 1965, President Lyndon B. Johnson signed H.R. 6675⁷ which created Title XVIII (Medicare)⁸ and Title XIX (Medicaid)⁹ of the federal Social Security Act. Legislation to establish a medical assistance (Medicaid) program in Nebraska was enacted in 1965¹⁰ and became effective on July 1, 1966.¹¹

Since their original adoption, Nebraska Medicaid statutes¹² have been amended at least forty-six times in twenty-six different legislative sessions.¹³ Other Medicaid-related provisions include Aid to Dependent Children (ADC) statutes,¹⁴ the Early Intervention Act for children and toddlers with disabilities,¹⁵ the Nebraska Telehealth Act,¹⁶ and the Welfare Reform Act,¹⁷ among others.¹⁸

Medicaid is a public assistance entitlement program administered by the state within broadly established federal guidelines. The cost of the program is shared by the state and federal government. Medicaid federal financial participation (FFP) applies to program services and to Medicaid-related administrative expenses. The FFP, calculated as a Federal Medical Assistance Percentage (FMAP), for Medicaid program services in Nebraska is approximately 60%. Approximately 40% of Medicaid costs are paid with state General Funds.¹⁹ The FMAP for Medicaid administration expenses is 50%, with some exceptions.²⁰

The federal Balanced Budget Act of 1997 (BBA)²¹ created a new Title XXI of the federal Social Security Act (SSA) to establish a state children’s health insurance program (SCHIP)²², and applied a higher FMAP to such programs.²³ Under the BBA, states had the option to formulate their SCHIP programs as a Medicaid expansion, a separate children’s health insurance plan, or a combination of the two. The Title XXI SCHIP program in Nebraska was established as a Medicaid expansion.²⁴ The combined Title XIX and Title XXI children’s health insurance program in Nebraska is called Kid’s Connection.

Titles XIX and XXI of the federal Social Security Act and related rules and regulations establish certain minimum mandatory standards for state Medicaid programs. Elements of the state Medicaid program must be approved by the federal Centers for Medicare and Medicaid Services (CMS). The Medicaid “state plan” is a comprehensive written document, developed and amended collaboratively with CMS, that describes the nature and scope of the state’s Medicaid program, and gives assurances that the state will administer the program in compliance with federal requirements.²⁵

The state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets payment rates for services; and administers the program on a day-to-day basis. Core federal requirements applicable to all state Medicaid programs include statewideness,²⁶ comparability,²⁷ freedom of choice,²⁸ and sufficiency in amount, duration, and scope of Medicaid services.²⁹ Portions of federal Medicaid authorizing legislation may be “waived” to provide states with greater Medicaid flexibility.³⁰

Medicaid is (1) a chronic and long-term care program for low income seniors and persons with disabilities; (2) a supplement to Medicare for this same population; (3) an insurance-like program for low income pregnant women, children and some parents; and (4) a funding source for safety net hospitals and community health centers that serve a disproportionately high share of uninsured persons.

Medicaid in Nebraska is shaped by public policy established by the United States Congress and the Nebraska Legislature and the complex interaction of four interrelated elements: (1) eligibility, (2) benefits, (3) reimbursement, and (4) administration. Medicaid coverage includes both federally mandated and state optional services and eligible persons.

Medicaid program costs are affected by (1) caseload (determined by eligibility criteria), (2) utilization (determined by services covered and service limits), and (3) unit price (determined by provider reimbursement rates).

Total state and Federal expenditures for the Medicaid program in Nebraska approached \$1.4 billion in state fiscal year 2005 (SFY05), an increase of 41.9 percent in the last five years, for an average increase of 7.2% per year. General fund expenditures for the Medicaid program increased almost 48.1% from SFY00 to SFY05, for an average increase of 8.2% each year. During the same time period, state revenues increased only about 3.5% per year.

The majority of Medicaid beneficiaries in SFY 2005 were children and pregnant women (66.0%), but the majority of Medicaid expenditures (62.4%) were made on behalf of the elderly and persons with disabilities (Figure 1). The highest Medicaid expenditures in SFY 2005 were for nursing home care, inpatient hospital services, and prescription drugs. Total Medicaid long-term care expenditures were approximately 36.3% of the Medicaid budget in SFY 2005.

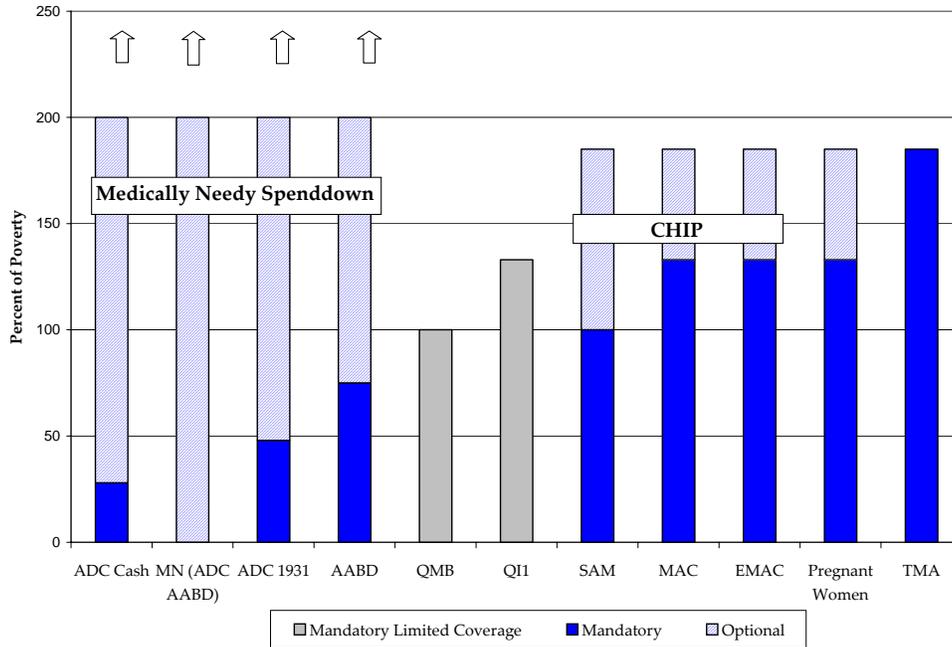
Figure 1
Percent of Monthly Eligibles and Expenditures by Population Group
State Fiscal Year 2005



Eligibility

The following persons are eligible for medical assistance in Nebraska:³¹ (1) dependent children under age 19;³² (2) aged, blind and disabled persons,³³ (3) persons under age 19 who are eligible under §1905(a)(i) of the federal Social Security Act (SSA),³⁴ (4) children and pregnant women with family incomes up to 185% of the federal Office of Management and Budget income poverty guideline (federal poverty level, or FPL),³⁵ (5) medically needy caretaker relatives,³⁶ (6) employed persons with disabilities with incomes up to 250% FPL,³⁷ and (7) women under age 65 needing breast or cervical cancer treatment who are not otherwise Medicaid eligible.³⁸ Medicaid coverage is also provided for disabled children,³⁹ and ADC families.⁴⁰ Figure 2 shows federal poverty level (FPL) guidelines applied to current Nebraska Medicaid mandatory and optional eligibility categories.⁴¹

Figure 2
Medicaid Eligibility Categories in Nebraska by Percent of Federal Poverty Level (FPL)



Families cannot be “subdivided,” or “stacked,” for purposes of determining Medicaid eligibility,⁴² and special “spousal impoverishment” provisions apply to allow higher income and asset deductions for “community spouses” of Medicaid-eligible long-term care facility residents.⁴³ An “earned income disregard” of \$100 per month, along with other allowable “disregards,” are also deducted from an applicant’s gross income before application of the appropriate federal poverty standard to determine his or her Medicaid eligibility.⁴⁴

Services

Medicaid-covered services are addressed in Neb. Rev. Stat. §§ 68-1019 to 68-1019.09. Medical assistance payments are made directly to vendors, and the following services must be covered: (1) care in an institution for mental diseases for persons over 65; (2) inpatient and outpatient hospital care; (3) laboratory and X-ray services; (4) nursing home services; (5) care home services; (6) home health care services; (7) nursing services; (8) clinic services; (9) services by state-licensed practitioners; and (10) drugs, appliances, and health aides prescribed by state-licensed practitioners.⁴⁵

In 1993,⁴⁶ the Legislature provided for the establishment of premiums, copayments and deductibles, and limitations on the amount, scope and duration of Medicaid services.⁴⁷ Medicaid payments for hearing screening for infants and newborns,⁴⁸ telehealth consultations,⁴⁹ and school Medicaid administrative activities⁵⁰ are also covered.

Services covered by Medicaid in Nebraska include both federally mandated services and state optional services. Federally mandated services include inpatient hospital, outpatient hospital, rural health clinics, laboratory and X-ray, nursing facility for persons age 21 and older, early and periodic screening for children (EPSDT), family planning services and supplies,

physician services, dental medical and surgical, home health, medical supplies, nurse-midwife, and nurse practitioner services.

State optional services include intermediate care facilities for the mentally retarded (ICF-MR/MR), case management for persons with mental retardation/developmental disabilities (MR/DD), MR/DD waiver services, rehabilitation services, medical transportation, prescription drugs, personal care aides, aged and disabled waiver services, chiropractic, dental, durable medical equipment, occupational therapy, optometry, physical therapy, podiatry, speech therapy, vision related services, and home and community-based waiver services.

Table 1
Federal Medicaid Mandatory and Optional Services Covered in Nebraska

| Mandatory Services | Nebraska Optional Services |
|---|--|
| <ul style="list-style-type: none"> • Nursing facility services for individuals aged 21 or older • Inpatient hospital services (other than Institutions for Mental Diseases) • Physician’s services • Outpatient hospital services and rural health clinic services • Home health services • Laboratory and X-ray services • Early and periodic screening and diagnosis and treatment (EPSDT) • Medical supplies • Family planning services and supplies • Nurse practitioner services • Medical and surgical services of a dentist • Nurse-midwife services | <ul style="list-style-type: none"> • Prescribed drugs • Home and community-based services (HCBS) for persons with mental retardation/developmental disabilities (MR/DD) • Intermediate care facilities for persons with mental retardation (ICF-MR) • HCBS for older adults and persons with disabilities • Dental services • Rehabilitation services • Case management for persons with mental retardation/developmental disabilities • Personal care services • Durable medical equipment • Medical transportation • Vision related services • Speech therapy • Physical and occupational therapy • Chiropractic services • Podiatric services • Optometric services • Hospice services |

Reimbursement

The Nebraska Medicaid program provides reimbursement for medically necessary covered services, generally without the imposition of premiums, copayments, or deductibles. It includes no lifetime maximum, no calendar year deductible, no calendar year coinsurance maximum, no maximum/total out of pocket per calendar year, and no overall contract maximum.

The state applies different levels of reimbursement to various Medicaid services. Practitioner services are reimbursed according to a fee schedule based on “relative value data” for the particular services provided. Prescription drugs are reimbursed according to product cost, expressed as a discounted “average wholesale price” (AWP), plus a pharmacy dispensing fee. Urban inpatient hospital services are reimbursed on a “per discharge” basis (based on “diagnostic

related group”⁵¹ classifications). Rural “critical access” hospitals are reimbursed according to a per diem rate based on actual cost and special federal rules applicable to such hospitals. Outpatient services are reimbursed at 82.45 percent of cost as indicated on the provider’s Medicare cost report. Nursing facility services are reimbursed according to a “prospective payment system,” at reasonable cost as determined from cost reports filed by the provider and using 19 different levels of payment rates based on acuity. ICF-MR facilities are reimbursed prospectively based on their cost reports but subject to a cost model. Laboratory and radiology services are reimbursed according to a federally established fee schedule. Federally qualified health centers (FQHCs) and rural health clinics (RHCs) are reimbursed according to actual cost per service provided (encounters), at a rate determined from provider Medicare cost reports and adjusted annually. Home and community-based waiver services are reimbursed at “reasonable fees” determined by the Nebraska Department of Health and Human Services Finance and Support. Federal law prohibits waiver payments to exceed a public provider cost.

Administration

Medicaid in Nebraska is administered by the state Medicaid Division within the Department of Health and Human Services Finance and Support. Medicaid eligibility determinations are processed through the Department of Health and Human Services under a Memorandum of Understanding with the Department of Health and Human Services Finance and Support. The Nebraska Department of Justice maintains a separate unit under the False Medicaid Claims Act to identify and investigate cases of alleged Medicaid fraud.

The Nebraska Health and Human Services System (HHSS) currently (1) establishes policy and procedures for the Medicaid program through the adoption and promulgation of rules and regulations; (2) determines Medicaid eligibility; (3) determines the amount, scope, and duration of Medicaid-covered services; (4) receives, processes, and pays Medicaid claims; and (5) oversees the day-to-day management and operation of the program.

Various administrative issues have been addressed in Nebraska law since 1965 to control Medicaid costs, including assignment of rights provisions,⁵² contracting and purchasing guidelines,⁵³ nursing facility screening requirements,⁵⁴ transfer of assets provisions,⁵⁵ estate recovery requirements,⁵⁶ the Managed Care Plan Act,⁵⁷ garnishment provisions,⁵⁸ and the False Medicaid Claims Act.⁵⁹ Various cost-saving administrative procedures have also been established and implemented by the department under its broad state and federal statutory authority.

The Medicaid Division has recently enhanced its management capabilities through the installation of a new decision support software program. The software enables management to improve its monitoring and analysis of claims by population and service, surveillance and utilization review, and federal reporting. Drawing on a complete data base of claims starting with SFY 2000, it also allows the Division to trend data.

The management capabilities of the state Medicaid Division will also be improved with the creation of a new Medicaid Management Information System (MMIS). The new system will replace the decades-old system currently being used to process most Medicaid claims. The new system is expected to be operational in SFY 2009, and will allow providers web based access to recipient eligibility status, and claims status. It also will improve the submission and processing of electronic claims.

The decision support software and MMIS, together, will enable Medicaid to more efficiently oversee the entire Medicaid reform process.

Expenditures

Total Federal and State expenditures to Medicaid vendors in Nebraska increased from \$943.2 million in SFY00 to almost \$1.4 billion in SFY 2005. This increase may be attributed, in part, to: (1) increases in the number of Medicaid eligibles; (2) changes in the type or amount of services used; and (3) increases in the cost of services. Table 2 shows the changes in the number of Medicaid eligibles and expenditures between SFY 2000 and SFY 2005 for each eligibility category. The number of eligibles increased in all five population categories, except the Adults population, which decreased 16.7%. Adults with Disabilities is the fastest growing category of Medicaid-eligible persons. The number of Medicaid-eligible adults with disabilities increased 16.8% from SFY 2000 to SFY 2005, compared to a 9.8% increase overall. Expenditures increased from SFY 2000 to SFY 2005 for all five categories, ranging from an increase of 23.9% for the Aged to an increase of 69.5% for the Children & Pregnant Women.

Table 2
Change in Average Monthly Eligibles and Expenditures
By Population Group
State Fiscal Years 2000 and 2005

| Population Group | SFY00 | | SFY05 | | % Change from SFY00 | |
|----------------------------|----------------|-----------------------|----------------|------------------------|---------------------|---------------|
| | Eligs. | Exps. | Eligs. | Exps. | Eligs. | Exps. |
| Children & Pregnant Women | 114,502 | \$208,845,485 | 132,547 | \$354,041,638 | +15.8% | +69.5% |
| Children with Disabilities | 4,075 | \$46,588,277* | 4,330 | \$69,712,266 | +6.3% | +49.6% |
| Adults | 25,205 | \$70,429,802 | 20,984 | \$101,121,518 | -16.7% | +43.6% |
| Adults with Disabilities | 20,896 | \$318,845,366* | 24,405 | \$501,951,861 | +16.8% | +57.4% |
| Aged | 18,203 | \$298,523,461 | 18,522 | \$369,853,967 | +1.8% | +23.9% |
| Total | 182,881 | \$943,232,391* | 200,788 | \$1,396,681,250 | +9.8% | +48.1% |

* These numbers have been adjusted to include DD waivers paid manually.

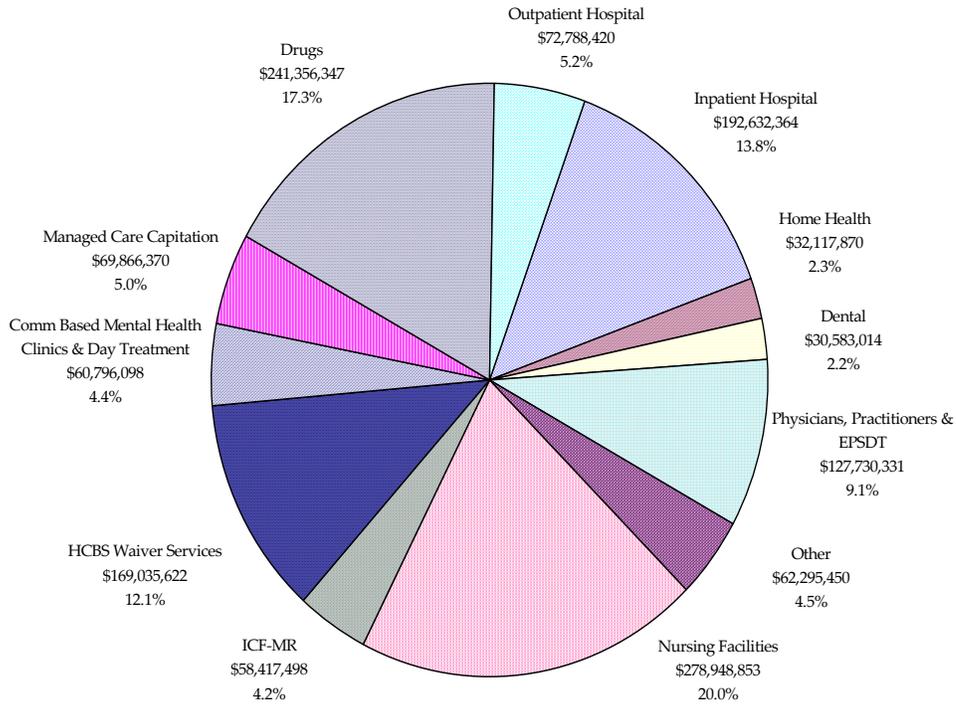
In SFY 2005, the adults with disabilities had the highest average cost per person (\$20,568), followed by the aged (\$19,968). Children & pregnant women and adults had the lowest average cost per person (Table 3).

Table 4
Average Medicaid Expenditures (Cost) per Eligible
By Population Group
State Fiscal Years 2000 and 2005

| Population Group | Average Cost per Eligible | | Change from SFY00 to SFY05 |
|----------------------------|---------------------------|----------------|----------------------------|
| | SFY00 | SFY05 | |
| Children & Pregnant Women | \$1,824 | \$2,671 | +46.4% |
| Children with Disabilities | \$11,433 | \$16,100 | +40.8% |
| Adults | \$2,794 | \$4,819 | +72.5% |
| Adults with Disabilities | \$15,259 | \$20,568 | +34.8% |
| Aged | \$16,400 | \$19,968 | +21.8% |
| Total | \$5,158 | \$6,956 | +34.9% |

Figure 3 shows the breakout of total Medicaid expenditures in SFY 2005 by type of service. The largest share of expenditures in SFY05 was for nursing facility services, followed by prescribed drugs, inpatient general hospital services, and HCBS waiver services.

Figure 3
Nebraska Medicaid Vendor Expenditures by Service
State Fiscal Year 2005



Medicaid has grown, in part, because of the increase in overall health care costs and deliberate choices to expand Medicaid, both nationally and in Nebraska. Many factors contribute to the increase in health care costs generally, and to increased Medicaid costs specifically, including, but not limited to, (1) demographic factors, (2) economic factors, (3) lifestyle factors, (4) health condition factors, (5) health care system factors, and (6) other demand factors.

Demographic factors include population increases generally; increases in the over age 65 and over age 85 populations; and an increasing proportion of immigrants to Nebraska from other countries (language barriers and unfamiliarity with the U.S. healthcare system sometimes result in greater use of higher intensity, higher cost, but more visible and accessible services such as emergency rooms).

Economic factors include the rising cost of health insurance that causes some employers and employees to drop coverage; and weakened economies which result in people losing their jobs and their employer-provided health insurance.

Behavioral/lifestyle factors that contribute to poorer health, include smoking; overweight or obesity; sedentary lifestyles; and poor or unhealthy diets.

Health condition factors include an increased prevalence of certain diseases, including diabetes, asthma, and hypertension; increased diagnosis of mental disorders, particularly depression; and increased survival rates for infants with complex medical conditions.

Health care system factors include the increased cost of prescription drugs, including new generation medications; spending on new health care technology; malpractice costs, including the cost of malpractice insurance; the increased number of diagnostic tests performed; and the lack of availability and accessibility of lower-intensity or lower cost services (e.g., assisted living, home health care, nurse practitioners).

Other demand factors include inappropriate use of higher intensity services; response to direct-to-consumer advertising of prescription drugs (television advertisements that encourage the viewer to “talk to your doctor about...”); and decline in the effectiveness of older antibiotics.

Many of the factors contributing to the increase in Medicaid costs are external to, and beyond the control, of the state Medicaid program. The greatest potential long-term impact on Medicaid expenditures also requires profound changes in, among other things, personal behaviors, prescribing practices, or the availability of, and access to, lower-intensity health care services.

Medicaid Cost Drivers

The greatest increases in Medicaid expenditures are in the categories of prescribed drugs and long-term care. Prescribed drugs, including over-the-counter medications increased almost \$114 million from SFY00 to SFY05, or 89.1%. Expenditures for nursing facility services increased \$29.2 million, or 11.6%. Expenditures for home and community-based waiver services (HCBS) increased 120.8% from SFY00 to SFY05, reflecting the expanded availability of HCBS, which has resulted in less expensive, less restrictive community services for many elderly and persons with disabilities.

Despite cost containment efforts in Nebraska that have slowed the growth of prescribed drug expenditures, Medicaid prescribed drug expenditures nearly doubled in the past five years, from \$127.6 million in SFY00 to \$241.4 million in SFY05. Prescribed drugs now represent more

than 17% of all Medicaid expenditures. By population group, more than 44% of all prescribed drug expenditures were for adults with disabilities.

Expenditures for prescribed drugs for children and pregnant women increased 142.6%, from \$19.3 million in SFY00 to \$46.7million in SFY05. Prescription drug expenditures for children with disabilities and adults with disabilities increased 111.3% and 100.5%, respectively.

In SFY 2005, more than 3.9 million prescriptions, including refills and new prescriptions, were filled for Medicaid-eligible persons, for an annual average of 19.6 prescriptions per person. A person receiving a 30-day supply and five refills of a single drug would have six prescriptions for the year. The average number of prescriptions filled per person in SFY05 ranged from 6.4 prescriptions for children and pregnant women to 70.4 prescriptions for persons aged 65 and older.

In terms of total expenditures, the top two therapeutic classes of prescribed drugs in SFY05 were mental health drugs: ataractics (tranquilizers) and psychostimulants (antidepressants). These two therapeutic classes accounted for 26.6% of all prescribed drug expenditures in SFY05, and over 30% of the prescribed drug cost increase from SFY00 to SFY05. This situation may change when Medicare Prescription Drug Coverage (Part D) becomes available for dual-eligible (Medicare and Medicaid) persons on January 1, 2006.⁶⁰

Long-term care services, including home and community based services (HCBS), nursing facility services, and intermediate care facilities for the mentally retarded (ICF/MRs), accounted for more than one-third of Medicaid expenditures in SFY05. Between SFY00 and SFY05 there was a shift in the locus of long-term care services, from more intensive nursing facility services to less expensive, generally less intensive, assisted living or home and community-based services. Expenditures on nursing facilities increased 11.6% from SFY00 to SFY05, for an average increase of only 2.2% a year.⁶¹ At the same time, expenditures for assisted living services increased from \$4.8 million to \$23.9 million, an average annual increase of 37.6%. Expenditures for other home and community-based waiver services increased from \$71.3 million in SFY00 to \$145.1 million in SFY05. Nursing facility services continue to account for a large share of Medicaid long-term care costs, but nursing facility share of long-term care costs continues to decrease.

B. Medicaid Public Policy and the Role of Government

The State of Nebraska currently provides a program of medical assistance for its residents, but the underlying public policy of the program is unclear.

Medicaid was established forty years ago to provide publicly (i.e., taxpayer) funded medical assistance for needy individuals. What began as a relatively small program to provide access to medical and long-term care for a mandatory population of low income children, families, elderly and persons with disabilities, has become a rapidly growing program for mandatory and optional populations that consumes an ever-increasing portion of state and federal budgets. The program has become increasingly complex and difficult to administer.

The fundamental question of Medicaid reform still remains: What is the role and responsibility of government in helping to meet the health care and long-term care needs of its citizens? In an environment of unlimited needs and limited resources, government can only do so much, and others will be left to do the rest. It is not only a question of how much assistance, but of what kind of assistance should government provide, and to whom.

Medicaid is imposing unrealistic demands on state government and has created unrealistic expectations. It has undermined the willingness of those who are able to save for and provide for their own health care and long-term care needs. Unless realistic and appropriate limits can be placed on government's role in the provision of medical assistance, Medicaid will never be truly reformed.

Medicaid cannot meet all Nebraskans' health care and long-term care needs, just as state welfare assistance programs, by themselves, cannot eliminate poverty. Medicaid reform should not seek to expand the role of government to meet a goal that is ultimately unattainable.

Placing limits on the role of government is fundamentally a question of setting priorities. How can government best expend resources entrusted to it by Nebraska taxpayers to achieve the greatest good for the greatest number of people, with maximum flexibility and controlled expenditure growth?

Medicaid, as a matter of public policy, should emphasize core principles of access, prevention, shared participation and responsibility, and sustainability. State General Funds, cash funds, and federal funds under the federal Medicaid program should be used to provide a program of medical assistance for truly needy Nebraskans that: (1) will assist Nebraska residents to access appropriate health care services when needed; (2) encourage and enable Nebraska residents to live healthy lives and avoid the utilization of more intensive and more costly health care services; (3) encourage personal independence and freedom of choice and greater personal and private sector responsibility and accountability for the provision and prudent utilization of health care services; and (4) be appropriately managed and fiscally sustainable.

Medicaid must become more of a public-private partnership, in which government is not seen as the dominant partner. Government should function rather as a strong, but limited, partner in helping to facilitate the creation of an environment in which the health and welfare of its citizens is most effectively and efficiently promoted.

Medicaid plays a vitally important role, and therefore cannot be abandoned. The goal of fiscal sustainability is important so that Medicaid will be a strong and stable resource for future generations of Nebraskans.

C. The Direction of Reform

Public Assistance Entitlement

Medicaid's underlying foundation must be carefully examined in any serious consideration of Medicaid reform, and the potential benefits of a different model should be thoroughly explored.

Medicaid is fundamentally a public assistance entitlement, or "defined benefit" program, in which eligibility and benefits are essentially fixed, but costs are variable. In other words, a person determined to be Medicaid "eligible" is then "entitled" to all medically necessary Medicaid services, regardless of cost.

In a "defined contribution" model, eligibility and costs are fixed, but benefits are variable, and targeted to meet individual needs. It is essentially a model in which the medically necessary care of patients is managed within a "defined," or fixed, expenditure amount. This could theoretically be done in a variety of different ways.

In discussing the difference between a defined benefit and a defined contribution approach, one writer has noted that, in a defined benefit environment, cost containment becomes

a priority rather than quality and access to care. In a defined contribution model, more attention can be given to quality assurance and patient satisfaction.⁶²

Some states are beginning to explore ways of shifting their Medicaid programs from a defined benefit to a defined contribution model, in an effort to provide greater quality and access to care, within reasonable expenditure limits. In the long term, Medicaid reform in Nebraska must explore ways to make a similar paradigm shift. True reform cannot be achieved unless the underlying premise of Medicaid is reformed. The defined benefit nature of Medicaid is arguably the single greatest contributor to uncontrolled expenditure growth in the program.

Changing the public assistance entitlement structure of Medicaid is very complicated, however, and requires a great deal of intensive planning and extended negotiation with the federal Centers for Medicare and Medicaid Services (CMS), and should be approached with caution.

Short-Term Reform

In the short term, several things can be done to achieve necessary expenditure controls, without dramatically cutting eligibility, benefits, or provider reimbursements.

1. Focus on high-cost areas and populations.

The greatest Medicaid expenditures are for long-term care, inpatient hospital services, and prescribed drugs. The highest percentage of Medicaid expenditures are made on behalf of the elderly and disabled. Appropriate changes should be made to encourage the further development of lesser intensive home and community-based services, and greater attention should be given to managing the care and expenditures on behalf of the program's most costly recipients.

2. Focus on personal choice and responsibility.

The goal of Medicaid reform is the provision of necessary and appropriate health care and long-term care to needy Nebraskans. As much as possible, Medicaid should provide such care in an environment that discourages dependence on government public assistance and encourages the prudent exercise of personal decision-making and personal responsibility, to the extent able, for contributing to the cost of one's health care and long-term care needs, for making appropriate health care decisions, and for making healthy lifestyle choices.

3. Focus on access and the private sector.

Medicaid reform should explore and encourage the development of more federally qualified community health centers to meet the primary health care needs of low income Nebraskans. In addition, immediate reforms should focus on enhancing private sector participation in providing access to needed health care services for Nebraskans. This could take the form of encouraging the provision of more employer-sponsored health insurance, encouraging the purchase of long-term care insurance and the utilization of other personal long-term care financing strategies, and encouraging the passage of state mental health parity legislation.

4. No program expansions in eligibility, benefits, or provider reimbursements.

Great anxiety and concern has been expressed over the possibility of making drastic cuts in Medicaid eligibility, benefits, or provider reimbursements as part of Medicaid "reform." These concerns arise from the assumption that Medicaid reform is only about cutting the Medicaid

budget. While it is true that the budget is important and must be considered, the effect of any proposed fiscal constraints on current Medicaid eligibles must also be a top priority. Medicaid reform, therefore, should identify and implement appropriate expenditure controls, without imposing any contractions in current eligibility, benefits, or provider reimbursements, and without expansions that would result in increased costs to the Medicaid program. Medicaid reform must consider necessary and appropriate improvements, however, that should be made to methodologies and processes used in determining eligibility and provider reimbursements.

5. Focus on administration.

Short-term reforms should focus on strengthening and making administrative improvements to the program. Program administrators need access to adequate technology, expertise, and other supports to do their work effectively. Enhanced oversight and more effective management will require some additional resources in the short term, but will result in greater short-term and long-term savings to the program overall. Reform should also strive to achieve administrative simplification and the removal of any unnecessary and burdensome complexity and rigidity from the program.

6. Explore alternative funding mechanisms to offset increases in General Fund expenditures.

Alternative financing strategies should be explored to offset the growth in Medicaid General Fund expenditures, but appropriate caution must be exercised in their implementation.

Statutory Recodification

Medicaid statutes in Nebraska were first adopted in 1965, and became effective on July 1, 1966. Nebraska state law now contains several disparate provisions, in Chapter 68, and article 10, that have been added since the program's inception.

Medicaid reform legislation in 2006 should focus on both technical and substantive goals. Technical goals should include repealing obsolete and unnecessary provisions, reformatting existing provisions, and making clarifying changes to existing statutory language.

Substantive goals should include (1) an explicit statement of public policy for the Medicaid program, (2) changes to provide more flexibility and permit the implementation of administrative and other reforms to the program, (3) explicit directives for the exploration and implementation of long-term reforms, and (4) necessary and appropriate changes in Medicaid-related statutes to accomplish other reform objectives.

Medicaid reform legislation in 2006 must be clearly substantive in order to comply with legislative intent in LB 709 (2005).

IV. Findings, Recommendations and Strategies

Based upon: a) an analysis of the data by the Medicaid Reform Work Groups; b) input from the Medicaid Reform Advisory Council; c) input from the public meetings held in each Congressional District; d) input from various professional, provider and consumer organizations, advocacy groups and the general public; and e) independent research, the designees present the following findings and recommendations as the bases for the Medicaid Reform Plan, and an outline of the strategies to address them.

These recommendations and strategies reflect essential decisions that should be made and actions that should be taken now. They do not reflect all of the input received during the planning process. That input has been compiled and is a part of the public record. It is available to build upon in the future. This Medicaid Reform Plan is the beginning of the process, not the end.

A. FINDING 1:

The Medicaid Program in Nebraska, as it is currently structured, will not be fiscally sustainable in the future.

1.0 Fiscal Sustainability

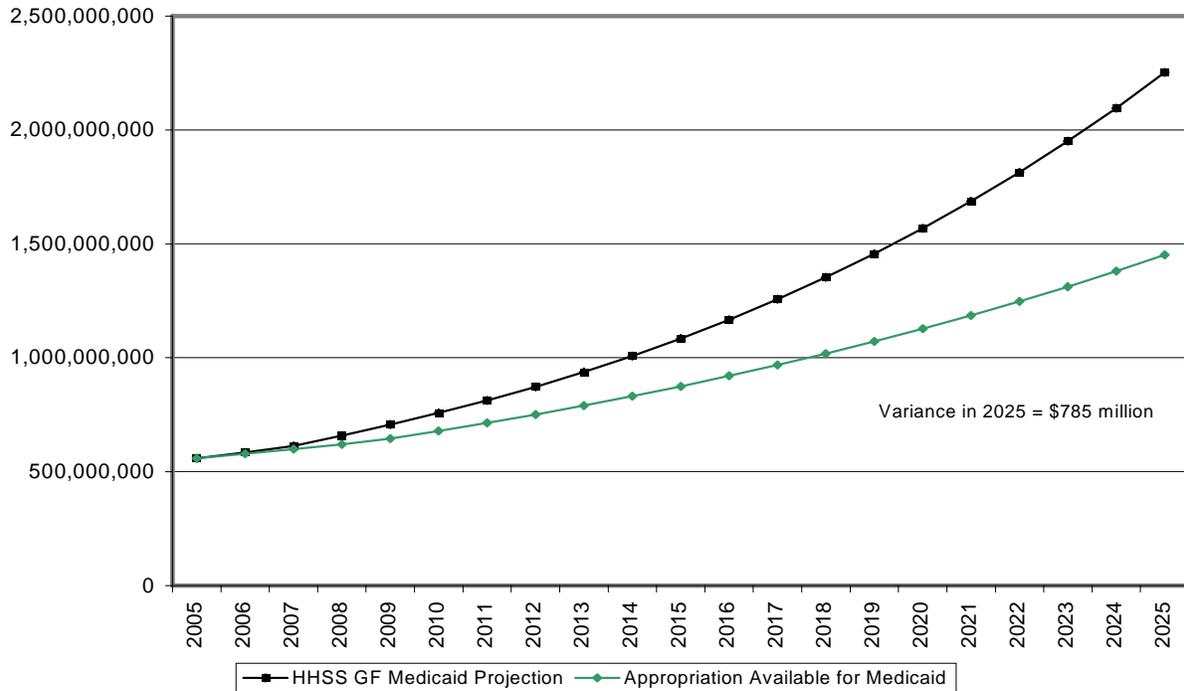
Background:

State and Federal expenditures for the Medicaid program in Nebraska approached \$1.4 billion in SFY 2005, an increase of 41.9% over the last five years, for an average annual increase of almost 7.2%. General fund expenditures increased 48.1%, for an average annual increase of almost 8.2%. During the same time period, state revenues increased only about 3.5% per year. Medicaid and the State Children’s Health Insurance Program (SCHIP) consumed 17.2% of state General Fund appropriations in state fiscal year 2004-05 (SFY 2005), more than twice the rate of twenty years ago (6.3% in SFY 1985). Other budget programs that provide state Medicaid match include: Program 38 – Behavioral Health Aid; Program 365 – Regional Centers ; Program 421 – Beatrice State Developmental Center; and Program 424 – Developmental Disabilities. When these programs are included, the Medicaid and State Children’s Health Insurance Programs consumed 20.1% of state General Fund appropriations in SFY05.

The Nebraska Health and Human Services System (HHSS) projects that, adjusting for demographic changes in the population and projected medical inflation over the next 20 years, total federal and state Medicaid expenditures in Nebraska would increase to nearly \$5.6 billion by 2025. The state's share of these expenditures would increase to about \$2.2 billion by 2025.

The General Fund appropriation available for the Medicaid program will increase to only \$1.4 billion by 2025, assuming Medicaid maintains its proportion of projected general fund revenues of 20.1%. The result is a \$785 million gap between projected Medicaid General Fund expenditures and the projected appropriations available for Medicaid in Nebraska in 2025 (Figure 4). At this rate, unless efforts are taken to curb the growth in Medicaid and CHIP expenditures, they will significantly outpace the projected growth in state revenues.⁶³

Figure 4
Projected Increase in Medicaid State General Fund Expenditures
and Appropriations Available for Medicaid in Nebraska
2005 – 2025



This report is recommending a number of short-term changes to the existing defined benefit program. These changes will moderate the growth of Medicaid, but they are inadequate to assure fiscal sustainability of the program in the long-term. Without any changes, the Medicaid program is projected to consume 25.0% of the general fund budget in 2015 and 31.2% in 2025. The estimate of cost-savings from the recommended changes is enormous in dollar terms but is still calculated to consume 23.2% of the general fund in 2015 and 28.1% in 2025. While it is imperative to take immediate, short-term steps to moderate the growth of the program, it is also necessary to pursue more aggressive changes in the long-term.

Nebraska’s response to the issue of fiscal sustainability should start with a statement of public policy that frees the state from uncontrollable cost increases that can wreak havoc on the state budget and priorities for other essential state services.

Recommendation 1.0a:

We recommend that a reasonable and well-articulated Medicaid public policy be developed and adopted for inclusion in the Nebraska Revised Statutes to guide future Medicaid program decisions. Such policy should assist needy Nebraskans to access necessary medical services in a manner that allows maximum flexibility and controlled expenditure growth and does not create any entitlement under state law.

Strategy 1.0a1:

In SFY2006, the designees will recommend that the state of Nebraska adopt in statute the following language:

The purpose of the Nebraska Medicaid Program is to assist low-income persons to obtain access to needed health care and related services. Funding for the program will be based on an assessment of state resources and the competing needs of other state-funded programs.

Strategy 1.0a2:

As part of each biennial budget preparation, HHSS will update demographic and health cost inflationary projections and prepare an analysis of the long-term cost impact of the Medicaid program. This information will be made publicly available as a part of the budgeting and appropriations process.

1.1 Medicaid Program Structure (Defined Benefit vs. Defined Contribution)

Background:

States have many options for reforming Medicaid. Some options call for major changes to existing Medicaid programs; other options call for changes within the current structure of existing Medicaid programs. Some states, like Florida and South Carolina, for example, have embarked on major reform efforts intended to substantively change their Medicaid programs. While their strategies vary, the intent is to transform their Medicaid programs from “defined benefit” to “defined contribution” plans.

The current Medicaid entitlement program in Nebraska is a “defined benefit” program. Under a “defined benefit” program, **eligibility** and **benefits** are fixed, but **costs** are variable. In other words, once an individual is determined to be eligible for Medicaid, he or she becomes entitled to receive all of the medically necessary services available through the state’s Medicaid program, regardless of cost. “Defined contribution” programs can be set up in a variety of ways; however, in general, under a defined contribution program, **eligibility** and **costs** are fixed, but **benefits** are variable and targeted to meet individual needs. Making this kind of substantive change to a state’s Medicaid program requires the submission and approval of a state waiver from the Centers for Medicare and Medicaid Services (CMS). To date, CMS has approved only one such waiver, for the state of Florida, but it has yet to be implemented.

One of the most attractive features of a defined contribution program is the predictability of the expenditures for the Medicaid program. In general, under a “defined contribution” program, the state allocates a risk-adjusted sum of money to each Medicaid recipient. This risk-adjusted sum is typically based upon the age, health status, and health care spending history of the individual. The Medicaid recipient can then use that money to purchase a health insurance policy. Typically, the recipient would have several health care plans from which to choose. Some plans may carry a high premium, but have low cost-sharing requirements; others plans may have a low premium, but higher cost-sharing requirements. Service coverage may vary from plan to plan. The individual, with the assistance of a benefits counselor, would select the plan most appropriate for his or her situation.

The defined benefit nature of Medicaid is a contributor to uncontrolled growth in the program. Changing to a defined contribution approach, however, is very complicated and requires a great deal of intensive planning and extended negotiation with the federal Centers for Medicare and Medicaid Services, and should only be done with great care. However, the potential exists for greater predictability of future Medicaid expenditures with a defined contribution program.

Recommendation 1.1a:

We recommend at this time that Nebraska retain the existing Medicaid defined benefit program and implement changes within the current structure, including the use of additional waivers.

Strategy 1.1a1:

A description of the proposed strategies follow in sections 1.2 through 7.1.

Recommendation 1.1b:

We recommend that over the next few years HHSS closely monitor the Medicaid reform experience of other states with defined contribution programs and other reform models to determine the effects on Medicaid recipients, their health outcomes, and the cost-effectiveness of the services, with a view toward adopting an improved structure when it is proven effective.

Strategy 1.1b1:

In SFY 2008, HHSS will retain the services of a consultant to evaluate the health outcomes and cost effectiveness of alternative Medicaid reform approaches in other states, including but not limited to, defined contribution programs. Depending upon the results of the evaluation, HHSS may make additional recommendations for legislative reform of Medicaid.

1.2 Medicaid Eligibility

Background:

Eligibility in the Nebraska Medicaid Program is already quite restrictive. Mandatory eligibility ranges from 37% to 70% of the Federal Poverty Level (FPL) for adults, and

from 100% to 133% of the FPL for children. With the exception of two small programs (the women's breast and cervical cancer program, and the working disabled buy-in program), and a small number of dual-eligible persons (i.e., persons eligible for both Medicaid and Medicare), optional eligibility in Nebraska falls into two areas: medically needy and the State Children's Health Insurance Program (SCHIP).

- **Medically Needy Program** – This option allows states to extend Medicaid eligibility to persons who have more income than allowed to qualify under the mandatory or optional categorical needy groups, but have medical expenses that exceed their income. In order to be covered under the medically needy program, persons with income above the mandatory level must: 1) meet the resource test (i.e., have resources below \$4,000 for an individual or below \$6,000 for a family); and 2) have medical expenses that exceed their excess income. Under the medically needy program, these persons are required to contribute their income above the Medicaid Medically Needy eligibility level⁶⁴ to their cost of care, and Medicaid pays the difference.
- **The State Children's Health Insurance Program (SCHIP)** covers children without creditable insurance coverage up to 185% of the FPL. In Nebraska, SCHIP is a Medicaid expansion program so, under federal Medicaid rules, there are no cost sharing requirements for children's programs. Children who qualify for SCHIP are entitled to all Medicaid services that are considered medically necessary.

Both of these populations are within the priority populations that should receive assistance in obtaining health care.

The designees have received no specific recommendations from the public to reduce eligibility for Medicaid services. We have received recommendations to expand eligibility for certain populations, e.g., an expanded Buy-in Program for persons with disabilities who are working. Because of the current projections of increased Medicaid expenditures for the existing eligible population, no expansions should be undertaken until other cost-saving recommendations in the Medicaid Reform Plan have been implemented and future cost savings initiatives have reduced the growth of expenditures to a fiscally sustainable level. Eligibility changes should only be considered when it can be established that the changes will not add to the demand on state general funds.

While we are not recommending changes in eligibility, we have become concerned that some people may be taking improper advantage of the federal Medicaid residency rules to qualify for Nebraska Medicaid to obtain medical services in Nebraska that should be paid for by the state of their actual residence.

Only U.S. citizens and legal aliens are entitled to Medicaid eligibility. Although HHSS currently requires proof of legal alien status before adding non-citizens to the eligibility roles, there also is concern that some illegal immigrants may be successfully using false documents to obtain Medicaid benefits.

Recommendation 1.2a:

We recommend that there be no immediate substantive change to current eligibility requirements, either by expanding or reducing eligibility standards. Residency standards, however, need further study to determine if they are being abused. Documentation of eligibility needs to be closely monitored to determine if false documents are being used.

Strategy 1.2a1:

In SFY2006, HHSS will conduct an investigation to determine whether persons from other states are abusing the residency rules that provide a person can not move to this state for the purpose of obtaining eligibility for Medicaid services. Based upon its findings, HHSS will seek the cooperation of Nebraska providers in obtaining reimbursement from the appropriate state of residency and will modify Nebraska regulations to strengthen the residency requirements to the extent allowed by federal law.

Strategy 1.2a2:

Beginning in SFY2006, HHSS will increase its monitoring of eligibility documents for the purpose of detecting false documentation. The existing rules denying eligibility will be applied where false documents are identified.

1.3 Partial-Month Eligibility

Background:

One administrative change to the eligibility rules that could be implemented is to convert from full-month to partial-month eligibility. Federal regulations require that Medicaid coverage be effective three months prior to the date of application (i.e., retroactive eligibility) and until the date an individual is no longer eligible. Nebraska has elected to follow a more generous federal option to provide eligibility for the full month if an individual is eligible at any time during the month. Therefore, during the first and last month of eligibility, Medicaid covers services for the entire month, rather than for the portion of the month when coverage is federally mandated. Some states have elected partial month coverage during the first and last months of eligibility, which is allowable under federal regulations.

Converting from full- to partial-month eligibility would save Medicaid dollars, but would require substantial expenditures up front to modify existing computer systems to support this change. However, over the long term, Medicaid should see savings by converting to partial-month eligibility.

Recommendation 1.3a:

We recommend that HHSS implement partial-month eligibility for the first month of eligibility. Implementing partial-month eligibility for the last month, however, would place an unreasonable administrative burden on providers to check continuing eligibility for each day of service.

Strategy 1.3a1:

In SFY 2006, HHSS will prepare and submit a State Plan amendment to CMS, and an amendment to state Medicaid regulations, implementing partial month eligibility for the first month of eligibility. HHSS will implement changes to the N-FOCUS system to identify partial-month eligibility and make that information available to providers through the current eligibility verification process.

1.4 Medicaid Covered Services

Background:

To examine the appropriateness of services covered under the current Medicaid program in Nebraska, HHSS completed a comparative analysis of the Medicaid program and the basic health, dental, and vision coverage available to Nebraska state employees. One area of difference is in the co-payment requirements. Under the Blue Cross/Blue Shield plans, many services require a co-pay (e.g., \$11 for generic drugs; \$15 for in-network office visits, \$27 for brand name drugs, \$50 for an outpatient surgery center). Federal law establishes Medicaid co-pay limits. For many services there is no Medicaid co-pay requirement in Nebraska. Other services, like physician office visits and prescribed drugs, require a \$2 co-pay.

The analysis revealed that, with the exception of long-term care services for the aged and persons with disabilities, which are not normally covered under commercial health insurance policies, the other health care services covered by the Nebraska Medicaid program are roughly equivalent to those available to State employees through employer-sponsored health plans, with the following exceptions:

- a) cost-sharing, through premiums, deductibles, and co-payments, are widely used in commercial employer-sponsored plans, but are allowed to be used only to a very limited extent in Medicaid;⁶⁵
- b) mental health services are more available in the Medicaid plan;
- c) some services are more limited as to total service, or total expenditures, in the employer-sponsored plan; and
- d) Medicaid covers more home and community-based services that are intended to be cost effective.

The Medicaid Program does require prior authorizations for specific services. To assist the Department in making coverage decisions for the Medicaid program, and individual authorization for specific medical procedures and tests, Nebraska will be partnering with other states and the Center for Evidence-Based Policy at the Oregon Health and Science University. This is a collaboration among state Medicaid programs for the purpose of making accessible high quality evidence to support benefit design and coverage decisions made by the Medicaid Program. The project includes high quality systematic reviews of existing evidence, technology assessments of existing and emerging health technologies, a web-based clearing house and communications tool to keep states informed of relevant developments, support in designing rapid evaluations of products where no evidence

exists, and the support of highly qualified research staff to assist states in applying the evidence to their own needs.

Recommendation 1.4a:

We recommend that there be no change to covered services for most Medicaid populations in Nebraska. Limitations similar to those found in commercial health, dental and vision insurance policies should be implemented for optional services. Children and recipients of mental health services should be exempt from these limitations.

Strategy 1.4a1:

In SFY 2006, the designees will recommend the State enact a bill authorizing additional limitations on covered services. The principle will be to align limitations on services in Medicaid with those customarily found in commercially available health, vision and dental insurance policies. HHSS will prepare and submit a State Plan Amendment to CMS, and amendments to the state Medicaid regulations, identifying and implementing limitations on selected optional services. HHSS will file reports with the Governor and the Legislature as required by Neb. Rev. Stat.; §68-1019.01 and §68-1019.03.

1.5 Cost-Sharing

Background:

Cost sharing, in the form of co-pays, premiums and deductibles, is customary in the private insurance market. In the traditional Medicaid program, however, cost sharing is very limited and, just as importantly, unenforceable. Medicaid recipients cannot be denied services because they do not pay the co-pay. Federal regulations allow only minimal cost sharing for Medicaid eligible persons. The federal rules can only be changed through a federal waiver or, in the case of SCHIP, by establishing a separate, state SCHIP program.⁶⁶

There are several specialized Medicaid programs for children that do not presently require parents or other responsible parties to contribute to the costs of Medicaid, regardless of their income; i.e., the eligibility rules for these programs disregard parental income in determining the child's eligibility. These programs include: the Katie Beckett program that pays for in-home acute (hospital) level of services; the Aged and Disabled Home and Community-Based Waiver (as applied to children); the Children's Developmental Disability Waiver; the Early Intervention Waiver; and the State Ward program.

Co-pays are controversial because of the argument that they not only limit utilization of services to what is appropriate, but also reduce access to necessary health care. Clearly, there is a level of income at which individuals can begin to pay premiums and make co-payments. In a separate state SCHIP program, for example, a co-pay of up to 5% of family income is allowable. In a waiver program, cost sharing can be imposed through co-pays and deductibles, or through a "premium buy-in" program. While cost sharing

strategies may be unpopular, they are an important option for state Medicaid programs to consider.

Recommendation 1.5a:

We recommend that a separate state SCHIP program be established for children in families between 150% and 185% of FPL. The separate state SCHIP program in Nebraska would allow coverage to be tailored to the needs of that population and would allow additional cost-sharing to be required.

Strategy 1.5a1:

In SFY 2006 the State will adopt a statute establishing a combination SCHIP program: children and pregnant women between 100% and 150% of FPL will remain in the SCHIP expansion program, and children and pregnant women between 150% and 185% of FPL will be placed in a separate state SCHIP program. In SFY2008, HHSS will submit a State Plan Amendment to CMS and revise state regulations. The separate state SCHIP program will include limitations on covered services similar to those customarily found in commercially available health, dental, and vision policies. Mental health services will be administered through the Medicaid Administrative Services Organization and will be managed by prior authorization and not by limitations. Sliding fee cost-sharing will be established within federal limits, up to 5% of family income. Cost-sharing will be managed through a monthly premium rather than co-payments and deductibles. Implementation of a new Medicaid Management Information System (MMIS) in SFY 2009 will enable Medicaid to efficiently manage covered services and premium payments.

Recommendation 1.5b:

We recommend that parents of children in the Katie Beckett program, the Aged and Disabled Waiver program, the Children's Developmental Disability Waiver, the Early Intervention Waiver, and the State Ward program, whose income exceeds 150% of the FPL, be required to contribute to the costs of Medicaid for their children, on a sliding scale basis.

Strategy 1.5b1:

In SFY 2007, HHSS will submit waiver amendments to CMS, and amend state regulations, to require families whose children receive specialized children's Medicaid services and whose income exceeds 150% of poverty to make premium payments to Medicaid to participate in the program. Premium payments will be established on the basis of a sliding income scale. In SFY 2006, the designees will recommend that the Legislature amend the state ward statutes to require imposition of the sliding income scale premium by courts of appropriate jurisdiction.

B. FINDING 2:

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

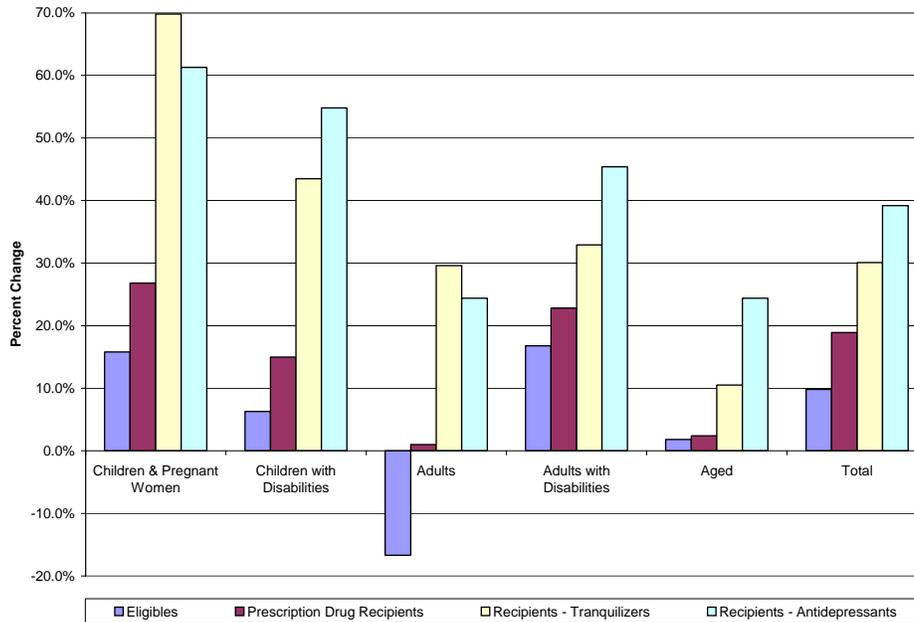
2.0 Prescribed Drugs

Background:

Medicaid expenditures on prescribed drugs in Nebraska increased from \$127.6 million in SFY00 to over \$241 million in SFY05, for an average annual increase of 13.6%. Cost containment strategies already implemented in the Nebraska Medicaid drug program, including mandatory generics and prior authorization for certain classes of drugs, have shown some success in controlling prescription drug costs.⁶⁷ Other strategies hold promise for further reduction in prescribed drug costs. For example, one strategy is to require prior authorization for all new brand name drugs until the efficacy and comparability with older drugs can be established. Other strategies for controlling prescribed drug costs, including preferred drug lists and use of purchasing pools, can be considered by the Medicaid program.

Prescribed drugs used to treat mental health disorders are among the highest cost, and fastest growing, classes of drugs in the Medicaid program. Medicaid expenditures on ataractics-tranquilizers, for example, grew an average of 16.1% per year over the past five years, from almost \$16.2 million in SFY00 to \$34.1 million in SFY05. Expenditures for antidepressants grew an average of 18.9% per year over the past five years. Figure 5 shows the percent increase, from SFY00 to SFY05, in the number of persons eligible for Medicaid for each of the five population groups, and the percent change in the number of Medicaid recipients receiving prescribed drugs, specifically tranquilizers and antidepressants. The number of persons eligible for Medicaid increased 9.8% from SFY00 to SFY05, but the number of persons eligible for Medicaid who received prescribed drugs through the Medicaid program increased 18.9%, and the number of Medicaid recipients receiving tranquilizers and antidepressants increased 30.1% and 39.7%, respectively. Even though the dual-eligible population will no longer be a part of the Medicaid prescribed drug program after January 1, 2006, this is clearly an area where opportunities for savings in the Medicaid program could be considered for the remaining populations.

Figure 5
Percent Change in Medicaid Eligibles and Prescription Drug Recipients
SFY00 to SFY05



One option for controlling expenditures on psychotropic medications is to replicate a program recently implemented in Missouri - the Mental Health Medicaid Pharmacy Partnership Program (MHMPPP). The MHMPPP has been successful in improving care for Medicaid recipients with severe mental illness while, at the same time, producing cost savings of \$7.7 million for the Missouri Medicaid program in state fiscal year 2004. The Program identifies inefficient and ineffective prescribing patterns for Medicaid recipients with mental illness, based on evidence-based “best practice” standards for mental health drug therapy. Some of the inefficient and ineffective prescribing patterns identified through this evaluation include: prescribing multiple medications from the same therapeutic class; duplicate prescribing of medication by different physicians for the same patient; children on three or more psychotropic medications; and premature, rapid switching from one medication to another. Under the Program, prescribers whose prescription practices vary from “best practices” are notified by letter and provided with information, in a non-threatening educational format, to help them make patient care decisions based on current medical evidence. The Program has resulted in changes in prescribing patterns to conform to standards of practice, and brought about improved quality of care and cost savings to the Missouri Medicaid program.

Recommendation 2.0a:

We recommend that Nebraska adopt a program, similar to the Missouri Mental Health Medicaid Pharmacy Partnership Program model, to improve the use of drugs used to treat mental health conditions and to control the growth in Medicaid spending. This approach does not rely on prior authorization, but uses monitoring and education of prescribers regarding best practices.

Strategy 2.0a1:

In SFY06, HHSS will review the research on best practices and work with professional organizations and health care providers to identify best practice standards for the prescribing of mental health drugs.

Strategy 2.0a2:

In SFY07, HHSS will analyze the data on current prescribing practices for mental health drugs in the Nebraska Medicaid Program and compare them to the best practice standards identified in Strategy 2.0a1. Based upon that analysis, and in consultation with professional associations, the behavioral health Administrative Services Organization and the Drug Utilization Review Board, HHSS will establish best practice and screening standards for the prescribing of mental health drugs in the Medicaid Program.

Strategy 2.0a3:

In SFY 2007, HHSS will make the determination whether to issue a contract for the management of the Medicaid Mental Health Drug Program or to manage the Program within the existing structure and processes of the Medicaid Program.

Recommendation 2.0b:

We recommend that the HHSS implement prior authorization for those new, brand name drugs, through the established Drug Utilization Review Board process, where it is deemed appropriate.

Strategy 2.0b1:

Beginning in SFY 2006, for all new drugs, HHSS will require drug manufacturers to provide standard written product information to the Drug Utilization Review (DUR) Director and the HHSS Pharmacy Consultant. The DUR Director and the HHSS Pharmacy Consultant will review each product and forward those products recommended for prior authorization review to the DUR Board. The DUR Board will review the product at their earliest meeting. The DUR Board will determine the products appropriate for prior authorization, develop criteria for prior authorization, and forward their recommendations to HHSS. HHSS will make the final decision on which drugs will require prior authorization, will finalize the criteria for prior authorization, and notify providers.

Recommendation 2.0c:

We recommend that HHSS contract with a consultant to: a) review the existing prior authorization and mandatory generics programs within the Nebraska Medicaid pharmacy program, and b) advise HHSS on whether the establishment of a preferred drug list (PDL) would be clinically appropriate and cost-effective for various drug classes and whether participation in a purchasing pool would result in additional savings to the Nebraska Medicaid Program.

Strategy 2.0c1:

In SFY2007, HHSS will contract with a consultant to study the existing Medicaid pharmacy cost containment strategies and determine whether establishment of a preferred drug list or purchasing pool would result in additional savings to the Nebraska Medicaid Program. If a preferred drug list appears to be cost-effective, HHSS will submit research regarding efficacy of drugs within appropriate classes to an independent board of physicians, pharmacists, and consumers for their recommendations. Their recommendations will be based on efficacy alone. HHSS will determine whether these recommendations can achieve cost-savings and, if so, add them to a preferred drug list and explore the cost-effectiveness of joining a purchasing pool.

C. FINDING 3:

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

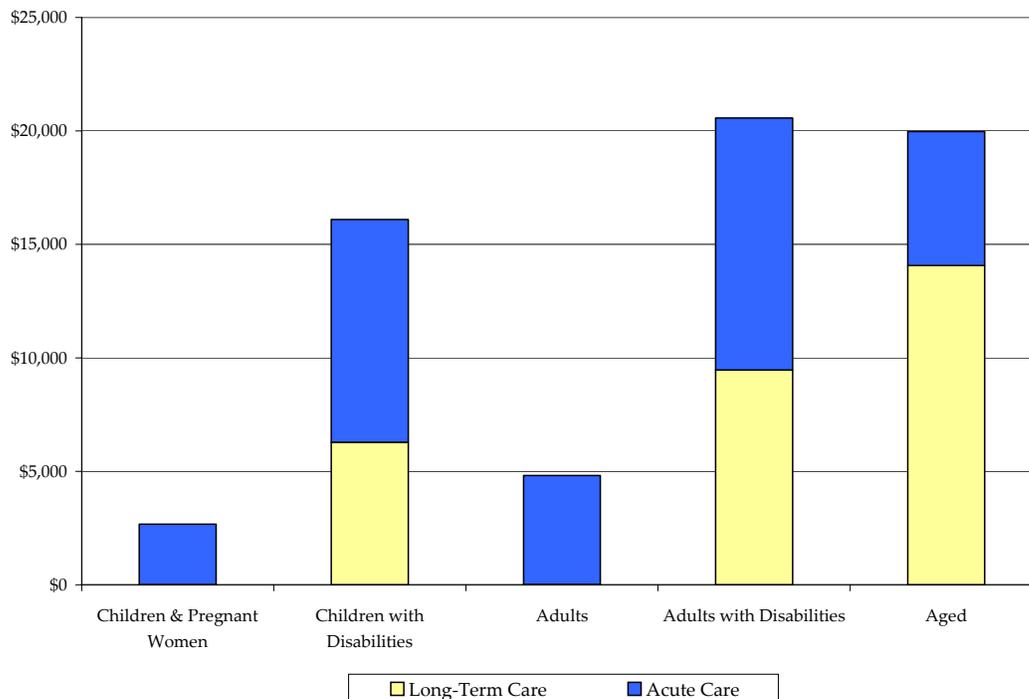
3.0 Long-Term Care

Background:

“Long-term care,” which includes nursing facility services, Intermediate Care Facilities for persons with Mental Retardation (ICF-MRs), home health services, and Home and Community Based Services (HCBS), including assisted living, is the largest cost category in the Nebraska Medicaid program.

The age 65+ population in Nebraska, the population with the highest utilization of long-term care services (Figure 6), is expected to grow 75% over the next 25 years, and the age 85+ population is expected to grow 53%.⁶⁸ Because of the projected increase in the age 65+ population in Nebraska, long-term care will continue to be a major cost center for Medicaid in the future. Although the number of adults with disabilities is not projected to increase significantly, many of those with disabilities will be aging into the age 65+ population. Current expenditures for persons with disabilities in a nursing facility average \$44,260 annually, compared to \$34,908 per year for the aged population. For these reasons, Medicaid reform must address long-term care services.

Figure 6
Average Medicaid Expenditures per Eligible
By Acute and Long-Term Care Services – SFY05



Nebraska has a proportionately high number of nursing facility beds and nursing facility residents. According to AARP data from 2003, Nebraska ranked sixth among the states in the number of nursing facility beds per 1,000 persons age 65 and over (71 beds per 1,000 elderly persons in Nebraska compared to 49 beds nationally). Nebraska also ranked sixth in the number of nursing facility residents as a percentage of the elderly population (5.9% in Nebraska versus 4.0% nationally). Nursing facilities still represent the majority of long-term care expenditures, but assisted living and in-home waiver services are receiving a growing share of dollars. While institutional care may be necessary and appropriate for some individuals, less restrictive environments should be preferred.

Nursing facility services represent the highest cost service category in the Medicaid program. Medicaid expenditures for nursing facility services in Nebraska exceeded \$278.9 million in SFY05. ICF-MR services cost the Medicaid program over \$58 million in SFY05.

Home and Community-Based Services (HCBS), including Assisted Living, are a lower-cost alternative to nursing facility or ICF-MR care for those persons who can be safely and appropriately served there. For example, during the last six months of 2004, the average cost per day for Aged individuals to the Medicaid program for the seven lowest

nursing facility care levels was \$74, compared to a statewide average of \$41 per day for assisted living, and \$30 per day for all other in-home HCBS waiver services⁶⁹. For persons with disabilities, the average cost per day for the seven lowest nursing facility care levels was \$83, compared to a statewide average of \$45 for assisted living, and \$63 for in-home services. In SFY 2005, the average cost for services in an ICF-MR was \$95,635 and in a Comprehensive Developmental Disability Waiver was \$54,461.

A comprehensive restructuring of the long-term care system is essential if the Medicaid program is to be fiscally sustainable in the future. The inherent bias in favor of institutionalization that currently exists needs to be replaced with a continuum of care that allows older adults and persons with disabilities to receive safe and appropriate services in the least restrictive and most cost-effective environment.

Recommendation 3.0a:

We recommend that HHSS seek approval from CMS to incrementally expand the capacity of the Aged and Disabled Home and Community-Based Services waivers in Nebraska as Nebraska's population ages.

Strategy 3.0a1:

In SFY2006, HHSS will submit a waiver to CMS to expand the Home and Community-Based Services waiver capacity. Based on current population projections, the Medicaid Program estimates that approximately 180 slots will be added each year from 2005 through 2015, and 360 slots will be added each year from 2016 through 2025.

Recommendation 3.0b:

We recommend that HHSS contract with a consultant to evaluate existing comprehensive assessment tools for determining the appropriateness of persons for nursing facility, assisted living, and home health care. The consultant will also assist the Medicaid program to identify quality based performance measures to adequately assess the quality and effectiveness of care in assisted living and in-home settings.

Strategy 3.0b1:

In SFY2007, HHSS will contract with a consultant to evaluate existing comprehensive assessment tools, or if necessary, to develop comprehensive assessment tools, for determining the appropriateness of persons for nursing facility, assisted living, and in-home services. The assessment tool will include social as well as medical components to identify safe and appropriate environments and necessary services. While a result of the assessment tool will be to eliminate the existing bias in favor of institutional care, the purpose of the contract will be to identify what is appropriate for the individual, based on his or her medical and social needs. This strategy continues to recognize that some individuals may be most appropriately served in an institutional setting.

Strategy 3.0b2:

HHSS will include in the consultant's contract provisions for evaluating existing quality-based performance measures, or if necessary, to develop such performance measures.

When implemented, the performance measures will be used to evaluate and improve the quality of care in each setting.

Recommendation 3.0c:

We recommend that HHSS contract with consultants to revise the current reimbursement methods for long-term care providers of nursing facility, ICF-MR, assisted living, and in-home services.

Strategy 3.0c1:

In SFY2007, HHSS will contract with a consultant to help update and revise the level of care system used in nursing facility reimbursement. Based on the revised levels of care, with the help of the consultant, the Medicaid program will develop reimbursement methodologies that are reasonable and appropriate for services provided in a nursing facility, assisted living facility, and in-home setting.

Strategy 3.0c2:

In SFY2008, HHSS will contract with a consultant to help update and revise the reimbursement methodology for both ICF-MRs and Community-Based Developmental Disability Services.

Recommendation 3.0d:

We recommend that HHSS establish an advisory committee to work with HHSS to encourage the development of Home and Community-Based Services under the Aged and Disabled Waiver, particularly in rural areas of the state.

Strategy 3.0d1:

In SFY2006, HHSS will establish an advisory committee that includes representatives of the Area Agencies on Aging, consumers, providers of long-term care services, and local public officials, to identify the need for and barriers to the provision of Home and Community-Based Services. HHSS, in conjunction with the advisory committee, will consider cost-effective ways to allow existing facility providers and their trained personnel in rural areas to provide in-home services, in addition to facility-based services.

Recommendation 3.0e:

We recommend that HHSS collaborate with the Area Agencies on Aging (AAAs) to better inform older adults of available, appropriate and cost-effective alternatives to nursing facility care.

Strategy 3.0e1:

Beginning in SFY2007, and building on the existing information program for aging persons, the new assessment tool, and increased availability of assisted living and in-home services, the AAAs will be better able to assist non-Medicaid eligible persons to make informed choices concerning the most appropriate and cost-effective services

available. In communities with stable or increasing real estate values, clients also can be educated on the availability of reverse mortgages to enable them to remain in their own homes and pay for in-home services, where appropriate.

3.1 Technological Innovations

Background:

Another possible strategy for controlling costs within the Medicaid program is to take greater advantage of recent innovations in technology as they relate to health care. One such innovation is telemonitoring that connects the individual with his or her health care provider. Via the telemonitoring device, the individual can transmit vital health information (e.g., blood glucose, heart rate, blood pressure) to their health care professional, who monitors the individual's condition. The goal of telemonitoring is to trigger interventions at the earliest possible stage, thereby reducing overall health care costs. A recent study found that home telemonitoring led to a 26% decrease in total hospital days per patient, and a 34% decrease in length of stay per hospitalization. The telemonitoring device would not replace routine visits to health care providers, but would provide valuable information to health care providers between visits, when interventions may be required.

Recommendation 3.1a:

We recommend that HHSS identify available, cost-effective technologies to improve distance delivery of health care services to Medicaid recipients, especially those in rural areas.

Strategy 3.1a1:

In SFY 2007, HHSS will contract with a consultant to evaluate emerging technologies, such as telemonitoring, which can increase the ability of persons to remain safely and appropriately in their own homes. These technologies are rapidly changing and becoming increasingly cost-effective. As they are identified, they can be included through State Plan Amendments or Waivers as covered expenditures.

Strategy 3.1a2:

Medicaid currently covers services provided by telehealth communications. HHSS will identify those facilities and providers that have telehealth capabilities and work with them to promote appropriate, cost-effective, and expanded use of telehealth services.

D. FINDING 4:

Consistent with the experience of commercial health insurance companies, a small percentage of Medicaid recipients account for the majority of Medicaid expenditures.

4.0 High-Cost Medicaid Recipients

Background:

High cost clients across eligibility categories spend a disproportionate share of the Medicaid dollars. The reasons for the high medical costs are often complex and involve many factors. A plan is needed to ensure that these clients have access to appropriate services and that these services are used in the most cost-effective way possible. One option would be to implement a Medicaid Enhanced Care Connection (ECC) model for high cost Medicaid clients. The ECC model builds on accepted standards of health care and disease management strategies as well as on the unique strengths in the state to lower the costs of medical care while maintaining and enhancing client's health. The focus of the ECC model is on persons with multiple medical conditions that can and do result in high costs.

Under the Medicaid ECC model, the primary physician authorizes specified Medicaid services as appropriate and medically necessary. An assigned public health nurse works closely with both the physician and the client to: a) establish and maintain a medical home; b) establish a medical plan of care; c) support compliance with the medical care plan; and d) connect clients with other needed local resources. Each plan of care is based on health assessments by the physician and by the public health nurse, joint planning with the client for appropriate cost-effective medical care, and enhanced support to the client to maintain health and reduce medical costs. Quality of care and utilization are systematically monitored on a regular basis to ensure appropriate use of Medicaid services.

Successful development and implementation of the Enhanced Care Connection model depends upon the expertise, cooperation, and collaboration of many persons in the health care and academic communities, including:

1. the medical community and their professional organizations to ensure that appropriate standards of medical care and disease management are used;
2. the public health nursing community and their professional organization to ensure that appropriate standards of public health nursing are used;
3. the local health departments and other local public health agencies to ensure that local management is provided and community resources are identified;
4. the university system in the state, including the medical schools to provide needed specialty support and updates on the current standards of care;
5. the state school of nursing to provide objective measurements of outcomes and quality of care; and
6. the hospitals and their professional association to ensure access to quality services as well as access to telehealth linkage with specialty services not available locally.

Under the Enhanced Care Connection model, primary physicians would be paid a monthly management fee for each Medicaid recipient enrolled in the plan. The primary physician most often will be a primary care physician. In some cases, the primary

physician may be a specialist. Primary care physicians will be enrolled in a Primary Care Case Management (PCCM) program and specialty physicians will be enrolled in a Specialty Care Case Management (SCCM) program.

The public health nurses in the client's local area would assist the client in identifying appropriate physician managers and communicating with both the client and the physician, as well as the local HHSS office and other local community resources as needed. Clients could receive small incentives to join the ECC plan and to adhere to their medical plans of care.

Some Medicaid recipients with multiple medical conditions are currently in managed care plans in Douglas, Sarpy and Lancaster counties. The strategies for coordinating their care will differ from the strategies for coordinating the care of non-managed care Medicaid recipients in other areas of the state.

Recommendation 4.0a:

We recommend that HHSS contract with a management entity to prepare, implement, and manage the Enhanced Care Connection model for high-cost Medicaid recipients with multiple medical conditions. HHSS will provide close medical and administrative oversight of the contracted management entity to ensure that the goals of the program are met and maintained.

Strategy 4.0a1:

In SFY 2006, HHSS will contract with a management entity to design, implement, and manage the Enhanced Care Connection model for high-cost Medicaid recipients with multiple medical conditions. The work of the management entity will include ensuring appropriate client and provider enrollment, public health nursing protocol development, articulation of current standards of care for disease management, training and ongoing oversight of daily operations. The management entity will consult with providers, public health organizations and consumers on the design of the program.

Strategy 4.0a1:

Beginning in SFY 2006, HHSS will identify Medicaid recipients with multiple medical conditions for enrollment in the Enhanced Care Connection model.

Recommendation 4.0b:

We recommend that enhanced care coordination services, for those Medicaid recipients with multiple medical conditions who are currently in managed care plans in Douglas, Sarpy and Lancaster counties, be provided by their current managed care providers.

Strategy 4.0b1:

Beginning in SFY 2007, HHSS will incorporate new expectations, requirements, and measurements for providing enhanced care coordination to Medicaid recipients with multiple medical conditions into the new managed care contracts. HHSS will also address the issue of high cost clients in the behavioral health managed care contract,

emphasizing better coordination between mental health and other medical service providers.

4.1 Enhanced Home Visitation Program for Pregnant Teens

Background:

Good prenatal care is essential in preventing adverse birth outcomes, such as low birthweight infants and developmental disabilities, that impair lives and result in large, long-term health care costs. Studies estimate that every dollar spent on prenatal care yields between \$1.70 and \$3.38 in savings by reducing neonatal complications. The savings increase dramatically when the long-term costs of caring for newborns with physical and developmental disabilities are considered, and are even greater when unforeseen maternal complications are avoided.⁷⁰ Prenatal care shows immediate cost benefits in caring for both the mother and the baby. Currently, a woman who receives Medicaid because of her pregnancy is eligible for prenatal care, and for 60 days of postnatal care. For some mothers, this may not be enough to ensure a healthy baby.

One program that has been effective in improving the outcomes of high-risk pregnancies is the enhanced home visitation program. It can be designed in a variety of ways, but it emphasizes nurse visits with the pregnant woman and then with the mother and child. Visits with the pregnant woman are more frequent during the early part of the pregnancy and with the mother and child in the period immediately following the birth. Visits become less frequent over time and can extend a year or more. During the visits, the nurse discusses the elements of a healthy pregnancy, general health issues, child development and parenting, safety and home environment, community resources and reaching personal goals. The purposes of the nurse home visitation program are to improve the outcomes of pregnancy, improve the child's health and development, and improve family self-sufficiency through goal setting. Short-term and long-term results of this type of program in other states have been positive.

Nurse home visitation programs are not new to Nebraska. Variations of this program have been established in Omaha, Lincoln, Hastings, Grand Island, and North Platte.

Recommendation 4.1a:

We recommend that HHSS include, as a covered service, a nurse home visitation program for high-risk pregnant teens and work with providers to help establish such programs in those parts of the state where those services do not currently exist.

Strategy 4.1a1:

In SFY2007, HHSS will file a waiver request with CMS to establish a home visitation program as a covered service for high-risk pregnant teens. HHSS will consult with existing home visitation programs regarding the parameters of the program.

Strategy 4.1a2:

In SFY2007, HHSS will work with community health centers, local health departments, or other public health entities to organize home visitation services in those areas of the state where they do not presently exist.

E. FINDING 5:

Persons receiving Medicaid have responsibility, to the extent able, to contribute to the cost of health care, to make informed decisions about the use of health care services, and to make healthy lifestyle choices.

5.9 Personal Responsibility

Background

Medicaid is a public assistance program. In Nebraska's case, the source of the general funds that pay the state's share of Medicaid comes from sales tax and income tax revenues paid by residents from every income level. Nebraska's taxpayers are prepared to assist low-income residents to obtain access to necessary healthcare, but they also reasonably expect Medicaid-eligible persons and families to assume personal responsibility, to the extent they are able.

Personal responsibility means a number of things. When people have an income that allows them to help pay for access to healthcare for themselves or their family, they should do so. People who are able to accumulate assets also have the responsibility to use those assets for their own healthcare and not transfer those assets to others in order to qualify for Medicaid.

Personal responsibility also means that people receiving Medicaid need to make responsible choices of effective services and products that are more cost-effective. Many eligible persons do so now. Others may not because they do not understand how to make appropriate choices or do not know that there is a legitimate expectation that they will do so.

Recommendation 5.0a:

We recommend that the cost-sharing recommendations found in section 1.6 be adopted and implemented according to the strategies proposed there as an appropriate part of personal responsibility.

Recommendation 5.0b:

We recommend that HHSS prepare and distribute educational materials that will assist Medicaid-eligible persons to better understand the healthcare system and how to make informed consumer choices.

Strategy 5.0b1:

In SFY2007, HHSS will prepare culturally competent video and written materials that describe the healthcare system and how it is accessed, the role of the primary care physician or clinic, how Medicaid determines what services will be paid for, and the role of personal responsibility in making good choices. These materials will be generally available through service area offices, public health departments, and consumer and provider organizations. The video and written materials will be available for downloading from the HHSS website. The materials will be prepared initially in English and Spanish and then prepared in other languages as appropriate.

Strategy 5.0b2:

In SFY2007, within HHSS, the Medicaid Program will collaborate with the Health Services Division to identify public health conditions particularly prevalent in the Medicaid population and to distribute culturally competent public health educational materials for consumers to address those issues. The materials will be distributed through the service area offices, public health departments, and consumer and provider organizations. Video and written materials will be available for downloading from the HHSS website. The materials will be prepared initially in English and Spanish and then prepared in other languages as appropriate.

Recommendation 5.0c:

We recommend that Nebraskans be encouraged to plan to provide for their own long-term care services as a part of their retirement planning

Strategy 5.0c1:

In SFY2007, HHSS will initiate a public service campaign to inform Nebraskans of the need to plan for long-term care services. The campaign will include an explanation that Medicare does not pay for most long-term care and that options are available to people in their planning.

Strategy 5.0c2:

On December 1, 2005, HHSS is issuing a separate report in cooperation with the Department of Insurance on the subject of Long-term Care Partnership Insurance. That report includes recommendations that are contingent on a change in federal law. If and when the federal law is changed, the state can implement those recommendations.

5.1 Cash and Counseling

Background:

Cash and Counseling places responsibility on the consumer to obtain appropriate services. Under the Cash and Counseling model, Medicaid beneficiaries are provided a flexible monthly allowance that allows them, or a designated personal representative, to directly purchase their personal care services and other needed support. They can draw on this account only to pay for Medicaid approved services. This is a client-directed service model where clients are trained to recruit and monitor providers. Average service

costs are calculated by the state and the state then determines the amount of funds that would be allocated to clients to purchase their own services. Extensive studies sponsored by the Robert Wood Johnson Foundation in New Jersey, Arkansas, and Florida have demonstrated that the Cash and Counseling model, where responsibility for the provider recruitment, approval and payment process was transferred to clients resulted in decreased Medicaid expenditures for the state in some cases. Studies also found that client demand for service quality increased and that providers were more responsive to client needs.

The experience of the states that have implemented these programs has been that the program is at least cost neutral considering both waiver and other Medicaid expenditures. Over time, any savings would be realized by encouraging and supporting home and community based-services to avoid institutional long-term care. It is also a positive move toward personal responsibility for the number and cost of services to consumers.

Recommendation 5.1a:

HHSS should develop a service delivery model of consumer directed home and community based care. This service delivery model would improve recipient satisfaction by giving them the opportunity to direct a cash allowance to purchase home and community based services as an alternative to nursing facility care.

Strategy 5.1.a1:

In SFY 2007, HHSS will develop a pilot program of cash and counseling that will identify specific services to be included. The targeted population would include selected recipients with physical disabilities and high cost service needs.

Strategy 5.1.a2:

HHSS will monitor the success of the pilot program, including consumer satisfaction and cost effectiveness. Successes and failures in other states will be studied. HHSS will continue to analyze the appropriateness of cash and counseling for additional services and populations in Nebraska and expand the program as its benefits are demonstrated.

F. FINDING 6:

Nebraska should encourage alternatives to Medicaid.

6.0 Alternatives to Medicaid

The Medicaid Reform Act also required the Medicaid designees to consider alternatives to Medicaid that should also be pursued. Some of those alternatives include the following.

6.1 Small Employer Insurance Coverage

In Nebraska, approximately 145,000 persons under the age of 65 are uninsured. The uninsured are more likely to have low incomes and to work for small employers. With the increasing costs of employer-sponsored health insurance coverage, small employers are having difficulty providing health insurance coverage to their employees.

In Nebraska, only 45% of private sector employers offer health insurance to their employees, significantly below the national average of 56%. This places Nebraska 47th among the 50 states and the District of Columbia in the percent of private sector employers that offer health insurance to their employees. In the private sector establishments that offer health insurance to their employees, only 71% of the employees are eligible for health insurance, significantly below the national average. By size of firm, employers with 100-999 employees have the lowest proportion of employees eligible for health insurance (62%), significantly below the national average for employers of that size (77%). The “take-up rate” for these employees is only 76%, also significantly below the national average. The “retail and other services” industry grouping in Nebraska has the lowest proportion of employees eligible for health insurance (55%), significantly below the national average of 64%.⁷¹ Where health insurance coverage is available, the employee’s contribution to employer health plans in Nebraska exceeds the national average.

Recommendation 6.1a:

We recommend that HHSS work with the State Department of Insurance to explore the possibility of creating a public/private partnership with small employers to offer insurance coverage to employees.

Strategy 6.1a1:

In SFY 2007, HHSS and the Department of Insurance will jointly create an advisory committee consisting of small employers, employees, and insurers to identify ways of improving the environment for affordable basic group health insurance plans. The agencies will consider the cost impact of various proposals on the general fund budget of the state.

6.2 Community Health Centers

Community Health Centers (CHCs) are an important part of the primary health care network. CHCs can provide improved access to primary and preventive care, discounted prescription drugs, behavioral health care, and usually dental care for low income, Medicaid-eligible and uninsured persons. They can be operated by local health departments and non-profit organizations.

Channeling persons without a medical home into community health centers has been demonstrated to result in fewer emergency room visits and less specialty and hospital care because these persons receive timely clinical and preventive services.

Currently, in Nebraska, five community health centers are designated as Federally Qualified Health Centers (FQHCs), including two in Omaha and one each in Columbus, Gering, and Lincoln. Since they receive federal funds, they are required to provide care to all persons, regardless of an individual's ability to pay or health insurance status. FQHCs receive cost-based reimbursement from Medicaid and collect some fees on a sliding fee scale.

The Iowa/Nebraska Primary Care Association has estimated that the community health centers in Nebraska have saved the state Medicaid program over \$1.5 million a year.

Recommendation 6.2a:

We recommend that HHSS establish a technical assistance committee to work with local health providers, elected officials, and other community leaders to establish community health centers, satellites of existing community centers and, where possible, to help them qualify as Federally Qualified Health Centers.

Strategy 6.2a1:

In SFY 2007, HHSS will establish a technical assistance committee to promote the establishment of community health centers and satellite operations. The committee will consist of persons with experience in public health, federal and state laws governing community health centers, financing, funding and grant writing, and administration of community health centers. The technical assistance committee will prepare materials to facilitate the understanding and establishment of community health centers and will work with appropriate delegations representing local communities interested in establishing such centers. Efforts will be made to encourage the establishment of comprehensive community health centers and to coordinate their efforts with those of other public and private health clinics, with licensed health professionals, and with health care facilities.

6.3 Federal Discount Prescription Program – “340B”

The 340B program is a federal program that requires manufacturers to sell covered outpatient drugs at a lower cost to certain “covered entities”. Covered entities include community health centers, Federally Qualified Health Centers (FQHCs) and FQHC look-alikes, migrant health centers, urban Indian clinics, and sexually transmitted disease clinics. Currently, the community health centers in Nebraska are taking advantage of the 340B program, but it is estimated four to six other eligible entities in Nebraska could be taking advantage of the program and reduce the cost of prescription drugs by 10 to 70 percent. As other community health centers are established, they can become eligible to participate in the program.

Recommendation 6.3a:

We recommend that HHSS encourage eligible providers to participate in the federal 340B program to reduce the cost of prescription drugs for low-income persons, including Medicaid recipients.

Strategy 6.3a1:

In SFY 2006, HHSS will identify entities potentially eligible for but not currently enrolled in the 340B program. HHSS will contact all such entities, provide them with any needed information on the 340B program, encourage them to apply for the program, and provide technical assistance in the preparation of the application and the establishment of an effective 340B program. As new entities are established, they also will be encouraged to apply for the program.

G. FINDING 7:

Alternative Medicaid funding strategies are possible sources of additional federal funds, but they must be employed carefully to avoid holding state appropriations hostage to future changes in federal policy.

7.0 Alternative Funding Strategies

Background

The Medicaid Reform Act required the Medicaid designees to consider alternatives to increase federal funding for services in order to reduce dependence on state General Funds. Funding strategies Nebraska has used in the past to maximize federal funds include: intergovernmental transfers (IGTs), provider taxes, certified public expenditures (CPEs), and certain disproportionate share hospital (DSH) payments. These strategies, which are regulated by the federal Centers for Medicare and Medicaid Services (CMS), rely on sources other than a direct state General Fund appropriation to the Medicaid program to satisfy the required non-federal share of the Medicaid match.

Establishing alternative funding programs can be complex. CMS examines all such proposals carefully, whether they are established under a state plan amendment or a waiver. There are stringent auditing requirements that must be met. Several organizations have indicated that they were researching the possibility of establishing a provider tax for nursing facilities and for hospitals or certified public expenditures. No formal proposals have been submitted to the designees for review at this time.

Any proposal involving Medicaid funding strategies must be reviewed prudently. First, we must determine whether the proposal will require an increase in general funds to support it. Next, we must consider the effect of a cutback in future federal funding as a result of a change in federal policy. The proposals need to be constructed in such a way that a change in federal policy will not require increased general fund expenditures to replace the federal funds.

Intergovernmental Transfers

Intergovernmental transfers (IGTs) involve the transfer of funds from one level of government to another to qualify for additional federal funds. CMS was originally a strong supporter of the IGT program, but has recently withdrawn its endorsement of these kinds of arrangements. Nebraska, along with many other states, is now phasing out its operation.

Provider Taxes

Provider taxes involve the levying of a state tax on an entire category of health care providers as a method to generate revenue. The tax must be applied uniformly to all providers in the category, but providers may be reimbursed for the portion of the tax allocated to Medicaid clients if their reimbursement is cost-based. Nebraska currently applies a 6% net revenue tax to ICF-MR providers, whose clients are largely Medicaid eligible. The Medicaid-related portion of the tax expense is paid back to the facilities as an allowable cost of doing business, and the reimbursement of this expense draws 60% federal funding. A portion of the tax proceeds is then freed up for other funding uses. Nebraska's provider tax generates \$3.5 million in tax revenue annually. The Legislature directed that the net proceeds of the tax, after the Medicaid share of the tax expense has been paid back to the providers, be used to support increased payments to non-state-operated ICF-MR providers and to community-based programs for persons with developmental disabilities. An additional \$1.4 million of the revenue earned is transferred to the state General Fund. The Legislature previously authorized a provider tax on managed care providers, but because Nebraska lacks a broad-based industry to tax, it has not been able to meet the requirements for implementation. CMS established a 6% maximum on provider tax arrangements, and a number of states have used this mechanism. As a part of federal Medicaid reform, the federal administration has proposed lowering this maximum to 3%. Therefore, the implementation of new provider taxes, in excess of 3%, runs the risk of disapproval or being short-lived.

Certified Public Expenditures (CPEs)

Certified public expenditures (CPEs) use public funds provided through a public entity other than the Medicaid agency to satisfy state (non-federal) matching requirements to leverage federal funds. Other state agencies or local public entities incur a Medicaid-eligible expense and provide the public funds for the required non-federal match. The Medicaid Agency then includes the expense on federal claims and passes the federal matching share through to the certifying entity. Nebraska has utilized this mechanism to provide federal fund support for Medicaid-related activities carried out at the local level (e.g., public health nurses in local health departments, Medicaid services provided in public schools, city- or county-owned nursing facilities serving Medicaid residents).

CPE also is used to pull in federal funding for state obligations that would otherwise be financed primarily with state dollars. The Behavioral Health Reform project has reduced the need for additional state funding by substituting use of Medicaid-covered community-based services for state regional center institutional care. State Regional Centers qualify for very

limited Medicaid funding. This strategy allows the state to provide a wider variety of less intensive and less expensive services without increasing the level of appropriated General Funds. Developmental Disability services that had been funded with only state General Funds have also been moved to Medicaid-covered community services for those persons eligible for Medicaid. Together with increased state General Fund appropriations over a period of years, the leveraging of federal Medicaid matching funds have enabled the state to serve a larger population of persons with developmental disabilities than would have been possible with state funding alone.

Recommendation 7.0a:

We recommend that HHSS carefully study possible ways to leverage federal funds without increasing the burden on the state general fund.

Strategy 7.0a1:

In SFY2006, HHSS will review any proposals for leveraging federal funds to determine their legality and feasibility. Any proposal that increases the expenditure of state general funds will be rejected. The proposal must also contain an exit strategy that will provide for the eventuality of a change in federal policy that limits or eliminates the strategy. Legislation and a state plan amendment would be required to implement any provider taxes.

Strategy 7.0a2:

In SFY2007 and future years, HHSS will review opportunities to leverage federal funds as they arise and may employ a consultant to assist.

V. Projected Cost Savings from Recommendations

The Medicaid Reform Plans recommendations are intended to moderate the growth of Medicaid in Nebraska and to reduce the amount of additional state dollars that are currently projected to be needed.

Each recommendation was analyzed to determine the effect the proposed reform would have on current eligible populations and current expenditures. Historical paid claims and eligibility data from Nebraska's MMIS were used whenever possible. The Internet was also used to research proposed reforms that have been patterned after existing programs in other states. Using this information, estimated savings were calculated based on the current Medicaid program. Estimated savings were estimated for future years using the same methodology used to project Medicaid expenditures over the next 20 years⁷² This methodology incorporates demographic changes in the population and projected medical inflation. In order to estimate the cost associated with the proposal, assumptions were made about how the reform would be implemented. These estimated costs were subtracted from the estimated savings to report net savings.

It is anticipated that the first full year of implementation for many of the recommended Medicaid reforms will be SFY 2008. Many of the recommended reforms will have up-front costs, particularly in the early years. Below (Table 4) are the estimated net savings to the Medicaid program for SFY 2008, SFY 2015 and SFY 2025.

Table 4
Estimated Net Savings for SFY 2008, SFY 2015 and SFY 2025

| Recommendation | Estimated Net Savings | | |
|---|-----------------------|----------------------|----------------------|
| | SFY 2008 | SFY 2015 | SFY 2025 |
| Partial-month eligibility for first month | \$797,000 | \$1,186,000 | \$2,606,000 |
| Cap on optional services | 1,742,000 | 2,914,000 | 5,856,000 |
| Separate state SCHIP program | 0 | 10,080,000 | 10,766,000 |
| Parents of children in special waiver programs be required to contribute to the costs of Medicaid | 5,159,000 | 6,182,000 | 7,803,000 |
| Mental health drug initiative | 1,360,000 | 2,929,000 | 8,395,000 |
| Prior authorization for new brand name drugs | 1,113,000 | 1,932,000 | 4,250,000 |
| Reduction of nursing facility utilization/ expansion of HCBS waiver slots | 41,066,000 | 121,641,000 | 437,972,000 |
| Savings from new rate structure for NF and ICF-MR | 3,256,000 | 4,582,000 | 7,563,000 |
| Enhanced Care Connection Plan | 12,900,000 | 20,714,000 | 40,747,000 |
| Enhanced Home Visitation Program | 4,333,000 | 7,498,000 | 16,414,000 |
| Expansion of CHCs/FQHCs | 1,111,000 | 1,830,000 | 3,801,000 |
| Total | \$72,837,000 | \$181,488,000 | \$546,173,000 |
| | | | |
| Estimated General Fund Reduction | \$30,781,000 | \$74,298,000 | \$219,902,000 |
| | | | |
| Benchmark General Fund Reduction | \$37,645,000 | \$205,745,000 | \$785,099,000 |

These projected expenditures provide a benchmark by which the State can monitor the progress of Medicaid reform.

IV. Appendices

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Appendix A
Written Recommendations Received from External Organizations as of November 15, 2005

| <u>Source</u> | <u>Subject</u> | <u>Recommendation</u> |
|---|-------------------------------------|--|
| Nebraska Medical Association (NMA) | Long Term Care | (1) Nursing Facilities/HCBS Waiver Services – support for community services, which allow the elderly to remain at home or in assisted living arrangements should help keep these costs down. Monitoring these programs for cost effectiveness will be important. |
| | | (2) Support for a long-term care insurance program which is simple and affordable could make a significant impact in these costs in the future. Coverage for even two years of care would have a significant impact if a large percentage of people were covered. |
| | Pharmacy | (3) A restricted formulary with generic drugs should be evaluated. Most of the time generic drugs are as effective and safe as branded products. |
| | | (4) A low-hassle way to obtain a branded drug when clearly needed should be part of this program. |
| | | (5) Many of the costly drugs are for psychiatric problems. A recent FDA advisory suggests that older antipsychotic drugs are safer than some of the new drugs being used. The NMA would assist HHSS in having psychiatrists review these drugs and developing a formulary. |
| | | (6) Consider restrictions on other drugs, e.g., antibiotics. |
| | | (7) Consider eliminating coverage for over-the-counter medications. |
| | Prevention/ Education | (8) Prevention and education programs to control inpatient hospital utilization. |
| | Chronic Illness Cost Containment | (9) Support of prevention and health education programs will help shift more responsibility to the consumer. Use Community Health Centers and public health agencies to work with clients on prevention and wellness. |
| | | (10) Provide follow-up to encourage clients to take |

Source

Subject

Recommendation

medications as prescribed and to make lifestyle changes, which would improve their health.

(11) Encourage more involvement by the public health system to provide follow-up and education to clients.

(12) Develop incentives for clients to keep their appointments and stay on recommended treatment programs. Develop disincentives for those that do not.

Personal
Responsibility

(13) For persons with chronic pain/addiction problems, require that they be seen at regular intervals at an approved pain clinic. Retaining Medicaid coverage should be conditioned on the client's follow-through with these treatment programs.

(14) Consumers need to have a financial stake in their insurance plan and health care expenses, but it needs to be at a level which is affordable.

(15) Incentives for responsible behaviors, and penalties for destructive behaviors, should be part of the Medicaid program.

Prenatal Care
Improvement

(16) Active interventions such as home visits and follow-up by a trained health professional are needed.

CHCs/Local
Health
Department's Role

(17) Community health clinics and regional/county health departments can reach out and help the uninsured before their problems become severe enough to require Medicaid assistance.

Inappropriate ED
Use

(18) Inappropriate use of ED services remains a problem. Tools to decrease this problem have been implemented elsewhere and need to be evaluated for use in Nebraska. Another problem is missed appointments. There needs to be a significant penalty in the system to deal with these problems. Access to an extended hours clinic might be helpful in more urban areas where it is feasible.

Promotion of
Health Insurance

(19) Work with the insurance industry to promote affordable health insurance coverage. Need better incentives for employers to offer health insurance to low and middle income employees.

| <u>Source</u> | <u>Subject</u> | <u>Recommendation</u> | |
|------------------------------------|---|---|---|
| | Under-Utilization of Services | (20) Transportation issues need to be addressed. Intervention programs for certain conditions (pregnancy) should be developed. | |
| Nebraska Dental Association | Sustain Provider Base | (21) Reduce administrative burdens so that provider enrollment and claims processing mirror commercial dental insurance practice. Consider commercial 3 rd party provider to administer claims/program. (22) Prevent erosion of current low reimbursement rates by tying reimbursement rates to a percentage of actual charges submitted. | |
| | Increase Provider Participation to Increase Access to Care | (23) Assure reasonable scope of basic dental care services for all eligible populations, consistent with contemporary dental practice, treatment, and prevention of dental disease. (24) Improve current Nebraska Medicaid rates to a market based system. (25) Tie reimbursement rates to a percentage of actual charges submitted, similar to Delaware or a 3 rd party provider. | |
| | Coalition of: <ul style="list-style-type: none"> • AARP • ARC of Nebraska • Association of Nebraska Community Action Agencies • Center for People in Need • Children & Family Coalition of Nebraska • March of Dimes- | Pharmacy | (26) Preferred Drug List (open formulary) (Strategy 1) (27) Drug purchasing pools (Strategy 2) (28) Counter detailing or academic detailing (entities other than drug companies, e.g., insurers or purchasers, can provide alternative messages to physicians – Massachusetts targets counter detailing to physicians who prescribe as many as six psychiatric drugs in the same therapeutic class.) The counter detailing could include providing physicians with studies showing, for example, that a much-advertised brand-name drug is no more effective than a less expensive, older alternative. (Strategy 3) |
| | | Home and Community Based Services | (29) Expand home and community based services (Strategy 4) |

| <u>Source</u> | <u>Subject</u> | <u>Recommendation</u> |
|--|---|--|
| <ul style="list-style-type: none"> Nebraska Chapter • National Association of Social Workers-NE • Nebraska Advocacy Services, Inc. • Nebraska Appleseed Center for Law in the Public Interest • Nebraska Association of Behavioral Health Organizations • Nebraska Catholic Conference • Nebraska Hospital Association • Nebraska Statewide Independent Living Council • Visiting Nurse Association of Omaha • Voices for Children in Nebraska | <p>Telemonitoring/ Home Med Units</p> <p>Smoking Cessation Programs</p> <p>Mental Health</p> <p>Home Visitation</p> | <p>(30) Explore use of a health monitoring system that a patient can use to take his or her own vital signs at home and then transmit the information to a central station for clinical evaluation. Such health monitoring systems may reduce inappropriate hospital/ED admissions. (Strategy 5)</p> <p>(31) Smoking cessation programs for pregnant women and post-partum mothers (Strategy 6)</p> <p>(32) Reconsider the requirement that Medicaid recipients receiving outpatient mental health services from a Licensed Mental Health Practitioner, who do not have a major mental illness and are not taking medications for their condition, receive an annual Mental Status Exam. Leave the decision to perform an annual MSE to the LMHP and supervising practitioner. Reconsider the requirement that the annual MSE be performed by the LMHP's supervisory practitioner. Allow for the MSE to be performed by any psychiatrist or psychologist chosen by the client, with the results forwarded to the LMHP. (Strategy 7)</p> <p>(33) Consider covering early childhood home visits to improve the health and well-being of pregnant and parenting women with infants and young children. (Strategy 8)</p> |

| <u>Source</u> | <u>Subject</u> | <u>Recommendation</u> |
|----------------------------------|----------------------|--|
| Nebraska Parity Coalition | Mental Health Parity | (34) Reconsider mental health parity as a way to reduce the costs of the State's Medicaid program. Current law allows the use of higher deductibles, copayments and coinsurance provisions for the treatment of mental health than for the treatment of physical illnesses. The unequal formula creates clear disincentives for people to seek early mental health treatment, resulting in greater costs down the road. |
| Area Agencies on Aging | Personal Assistance | <p>(35) Reconsider requirement for physician order for personal assistance (PA).</p> <p>(36) Reconsider the decision to allow HHSS workers outside of Douglas and Sarpy counties to conduct the client self-assessment interviews over the phone.</p> <p>(37) Reconsider authorizing hours for laundry, cleaning, etc. for PAs living with the client.</p> <p>(38) Could the state require PAs to pay for their own background checks?</p> <p>(39) Look into PAs billing while the client is in the hospital, nursing home, or jail. Look into PAs billing while they are in the hospital or jail. Look into PAs billing but not doing the work.</p> |
| | Fraud Issues | <p>(40) Establish a method for hospital/nursing home admitting clerks to notify HHSS when a person on Medicaid is admitted. This information could be forwarded to the HHSS worker and the person responsible for authorizing the billing sheets.</p> <p>(41) Establish a mechanism for identifying PAs under investigation or convicted of a crime that would prohibit him or her from being under contract with HHSS.</p> |
| | Disability Reviews | (42) Institute more rigorous annual reviews of disability. Some persons who are no longer disabled are still being considered disabled because of self-reporting which may not be accurate. |

| <u>Source</u> | <u>Subject</u> | <u>Recommendation</u> |
|---|---|---|
| | Premium Assistance | (43) Consider having Medicaid pay for employer-based health insurance for families when the parents' income is not sufficient to cover the insurance and is within Medicaid income guidelines. |
| | Cost of In-Home Care Versus Facility Care | (44) Examine the cost of in-home care versus the cost of care in a facility. |
| | Income Guidelines Senior Care Options | (45) Reexamine income guidelines (1619b). |
| | | (46) Expand the Senior Care Options program to include a contact by the AAA for everyone seeking nursing facility care. |
| | Medicaid Waiver | (47) Expand the Medicaid Waiver program to encourage home and community-based services as the first option. |
| | Care Management | (48) Expand the Care Management program. |
| Paula Foster – ENOA Medicaid Case Manager | Medicaid Buy-In | (49) Allow working and non-working Medicaid recipients to buy into Medicaid. This would require Medicaid recipients to pay the State of Nebraska Medicaid Program directly, rather than purchasing insurance or having a spend down. Also, persons who are not able to work, but have resources above the FPL, should be able to buy into the Medicaid program. |
| Steve Hess, Midwest Geriatrics (Florence Home) | Financial Abuse of Older Family Members | (50) Make it more difficult for families to financially abuse their older family members. |
| | Estate Planning to Qualify for Medicaid | (51) Place limits on estate planning to qualify for Medicaid. |
| | Statewide Purchasing Group | (52) Consider a statewide purchasing group for products and supplies |
| Roger Keetle – AARP, MAHSA, MAHCHA, | Long-Term Care | (53) Long-Term care savings plan (modeled after the College Savings Plan). |

| <u>Source</u> | <u>Subject</u> | <u>Recommendation</u> |
|--|---|---|
| NHCA, and NHA | | (54) Long-Term Care Insurance Partnership. |
| | Estate Recovery | (55) Medicaid Estate Recoveries. |
| Mark Intermill - AARP | Long-Term Care | (56) New classification of residential long-term care which would provide for some nursing case management, but not on-site 24-hour RN coverage |
| Nebraska Health Care Association - Pat Snyder | Long-Term Care | (57) Long-Term Care Savings Account. |
| | | (58) Long-Term Care Partnership Program. |
| | | (59) Tax Incentives for purchasing LTC insurance. |
| | | (60) Mandatory payroll withholding for long term care. |
| | | (61) Support expanded authorized pre-tax contributions to 125 savings accounts for long-term care insurance premiums. |
| | | (62) Reduce the frequency which service coordinators visit assisted living facilities. |
| | Subsidized Premiums | (63) State Payment/subsidization of Private Health Insurance Premiums. |
| | Estate and Asset Policy | (64) Estate and Asset Policy Reform. |
| | Pharmacy | (65) Preferred Drug List (for non-psychiatric patients). |
| | Purchasing Pools – Drugs | (66) Purchasing Pools. |
| Pay for Quality | (67) Pay for Quality/Efficiency. | |
| Prevention | (68) Preventative checkups and testing. | |
| Cash and Counseling | (69) “Money Follows the Person”. | |
| Case Management | (70) Improved Case Management. | |

| <u>Source</u> | <u>Subject</u> | <u>Recommendation</u> |
|---|--|--|
| | Incentivize NF or ALF to expand services Access | (71) Economic Development Incentives. (72) Improved access to Medicaid Home & Community Based Services. |
| Mark Intermill, AARP | Prescription Drug Cost Containment | (73) Look into Maine Rx Plus and Ohio's Best Rx drug discount program. (74) Consider older, less expensive, drugs for the treatment of schizophrenia. |
| Nebraska's Traumatic Brain Injury Advisory Council | Traumatic Brain Injury | (75) Expand the existing TBI waiver to include community-based service options and not be limited to only assisted living. (76) Increase the skills, knowledge and awareness of service providers within existing service delivery systems; training is needed to ensure statewide availability of service providers who are knowledgeable about brain injury. (77) Establish a state-funded Interim Crisis Fund to provide time-limited, flexible assistance in time of need to individuals with disabilities who do not currently qualify for Medicaid or Medicaid waiver services; reduce the number of individuals with disabilities that are forced to go on Medicaid by promoting and funding programs that lead to self-sufficiency through temporary time-limited support. |
| Vetter Health Services, Inc. | Long-Term Care | (78) Where population trends do not indicate an opportunity for future growth, the State of Nebraska would purchase and close small, inefficient long-term care facilities. (79) Create financial incentives for the merger/consolidation of facilities. (80) Allow owners of a facility to transfer their bed license to other locations where population trends dictate a future need so new facilities could be built. (81) Allow the sale of licensed beds to providers who would build new facilities in growth areas, or areas in |

Source

Subject

Recommendation

which population trends would indicate a future need for long-term beds.

Long-Term Care Insurance

(82) Work with the Nebraska legislature to pass a law implementing a state tax deduction or credit as an incentive to purchase long-term care insurance.

(83) Provide tax incentives to businesses that offer long-term care insurance as part of their employee benefit package.

Prescription Drug Cost Controls

(84) Customize a preferred drug list for the state's Medicaid program, including drugs that are most useful in patient care, taking into consideration clinical effectiveness and cost.

(85) The state should partner with other organizations and states to form purchasing pools to increase purchasing power and reduce costs.

Estate and Asset Policies

(86) Change the asset look-back period from three years to five years.

(87) Require individuals who transfer their assets into a trust for estate planning to purchase a long-term care insurance policy to cover their long-term care needs for a minimum of five years. If individuals elect not to purchase a long-term care insurance policy, the trust would be responsible for paying for any long-term care.

(88) Make provision for providers to file liens where they are owed monies to prevent assets from being sold before a lawsuit can be filed and a judgment obtained.

(89) Eliminate or reduce the exemption in state law that prevents recovery of the first \$5,000 of an estate if children survive the Medicaid beneficiary.

(90) Expand the definition of estate to include assets held in joint tenancy with rights of survivorship, life estates, living trusts, etc.

(91) Require automatic recoveries of small amounts held by Medicaid recipients in long-term care facilities.

| <u>Source</u> | <u>Subject</u> | <u>Recommendation</u> |
|---------------|--|---|
| | Elder Financial Abuse | (92) Pursue cases of suspected elderly financial abuse by families and responsible parties. |
| | Long-Term Care Savings Accounts | (93) Long-term care savings accounts could be offered as a tax-free savings plan for long-term care, allowing those individuals to deposit a portion of their income each year into their account. Amounts would be withdrawn, tax-free to reimburse long-term care expenses. |
| | Expanded Pre-Tax Contribution Accounts | (94) Allow for long-term care insurance premiums to be deducted pre-tax, and exempt from federal income and Social Security taxes as allowed under the Internal Revenue Code – Section 125. |
| | Eliminate Work Disincentives | (95) Eliminate the disincentive for Medicaid beneficiaries to work full-time or additional hours, making them exceed the income eligibility levels and losing health insurance coverage. |
| | Payments for Services Provided in an Alternative Setting | (96) Payments made by the State for services provided to an individual residing outside of a long-term care facility should not exceed the average payment that the State would have paid if the individual resided in a long-term care facility. |
| | Work Comp Laws | (97) Pass work comp laws that would penalize a person and/or doctor for falsifying an injury for the purpose of extending benefits. |
| | Tort Reform | (98) Pass stricter tort reform laws to prevent excessive settlements that, in turn, would reduce liability insurance premiums. |
| | Create Incentives for People to Enter the Health Care Profession | (99) The State of Nebraska and providers should work together to create incentives and scholarships for students attending LPN and RN programs. (100) Provide grants for students who wish to become CNAs and CMAs. (101) To control agency labor usage, there needs to be more professionals in the health care field. |

| <u>Source</u> | <u>Subject</u> | <u>Recommendation</u> |
|--|---|--|
| Nebraska Foundation for Medical Care (NFMC) | Review of Eligibility | <p>(102) Unless there is an internal department review, no one does a review of eligibility in the payment process for accuracy. When NFMC did a Payment Accuracy Methodology (PAM) review, we found a significant number of errors regarding payment issues, including:</p> <p>Out-of-state payments – we have seen several patients with out-of-state addresses who receive benefits from Nebraska Medicaid. We are unsure if they are ever corrected by Nebraska Medicaid.</p> <p>Worker’s Compensation – Medicaid has been billed for services provided which were direct results of a work-related injury. This could be screened more effectively if patient records associated with trauma or injury were screened from time to time.</p> |
| | Care Management | <p>(103) Persons with high Medicaid expenditures need someone to coordinate their care. We have reviewed charts where the care is being provided in a fragmented fashion which puts the patient at risk of needing further very expensive care. The Department needs to hire and train a small group of case managers for these patients (and not add them into an already busy caseworkers’ caseload).</p> |
| | One Day Stays | <p>(104) The current language in the Regulations regarding inpatient care, outpatient care, and the “24 hour rule” is outdated and causes problems including payment issues because of the rigidity of the rules. A change would allow more consistency and probably save money.</p> |
| | Pre-Authorizations | <p>(105) The Rules and Regulations pertaining to coverage of certain high-cost procedures are somewhat vague and no follow up is done to determine if the procedure performed actually improved the patient’s condition.</p> |
| | Multiple vs. Repetitive Single Procedures | <p>(106) There is no consistent review of procedures where multiple procedures are being performed which could have been done at the same time but which are being done separately. The Coding System allows billing for separate procedures done at separate times, when if performed at the same session they would be billed as the initial procedure and multiple subsequent procedures (billed at 50% or less of the initial procedure). This adds to HHSS expense.</p> |

Source**Subject****Recommendation**

Newborn Care

(107) The Diagnosis Related Groups (DRG) system was originally developed for Medicare and subsequently expanded to include other conditions. Newborn Care is an area which creates significant problems. Anything about a child that is even mildly abnormal can change the DRG, resulting in a dramatic shift in reimbursement. We encourage HHSS to consider requesting a re-evaluation of these DRGs, or the addition of a DRG to more accurately reflect children who may have a minor congenital condition, without jumping to a much higher paying DRG. If unable to change this, HHSS may wish to consider changing it's Rules and Regulations to control billing in this area.

Rehab Transfers

(108) Since hospitals are reimbursed on a DRG basis for inpatient care, it is to their advantage to move a patient as soon as stabilized to a Rehab situation. This becomes more problematic if there is also a rehab unit as a part of the hospital. NFMC has seen cases where a patient was transferred to a rehab unit (generally it is expected that the rehab stay would be several weeks in duration) only to be discharged within a few days. NFMC is concerned that had the patient stayed in the acute care setting a day or two more, the rehab stay would not have been necessary. Since NFMC does pre-authorizations for rehab stays, this can sometimes be caught before the patient goes to the rehab unit. However, with retrospective reviews, where the patient becomes eligible retrospectively, NFMC has no way to control this and is frequently asked to reconsider these areas.

**Nebraska
Pharmacists
Association**Expand Prior
Authorizations

(109) Consider putting all new drugs on prior authorization until the Drug Use Review (DUR) Board can review them.

Appropriate
Prescribing/Use

(110) Establish prescriber education program for proper prescribing, therapy and utilization of atypical antipsychotics (mental health medications) and for anti-infectives.

| <u>Source</u> | <u>Subject</u> | <u>Recommendation</u> |
|--|--|---|
| | Pharmacist-Based Medication Therapy Management | (111) Implement pharmacist-based medication therapy management services. |
| | Protect Access to Pharmacists in Rural Areas | (112) Protect access to pharmacists in rural areas. Consider providing incentives to pharmacists to provide medication therapy management services, dispense generics, and continued drug utilization reviews. |
| | Co-Payments and Eligibility Determination | (113) Review the residency requirements for Nebraska Medicaid eligibility. Individuals should be residents of NE for a set amount of time (at least 6 months) before becoming eligible for Medicaid. (114) Co-payments for prescription drugs should be mandated to curb abuse of the Medicaid system. |
| | Medicare Modernization Act (MMA) | (115) Insist that CMS provide oversight and management of the Medicare/Medicaid eligible (dual-eligible) population to ensure proper therapies and utilization, as well as patient adherence, to control costs. |
| | Provider Services | (116) Improve provider services by creating a more efficient system of submitting claims for durable medical equipment, supplies, and nutritional supplements. |
| Planned Parenthood of Nebraska & Council Bluffs Nebraska Parity Coalition | Family Planning Waivers | (117) Investigate Medical family planning eligibility expansions (i.e., family planning waivers). (Twenty-two states currently have obtained family planning waivers.) |
| Nebraska Dental Hygienists Association | Mental Health Parity | 118) Consider mental health parity as one way to control the growth of Medicaid while at the same time improving mental health care in Nebraska. 119) Revise the supervisory requirement of a dental hygienist by a dentist in public health settings in Nebraska; would improve access to care, utilization of care, and dental outcomes. |
| Region V Services Dave Merrill Nebraska Hospital Association | | 120) Recommend an independent analysis of the economic impact of Medicaid on Nebraska's economy. 121) The preliminary recommendation that Medicaid expenditures must not increase runs counter to overwhelming demographic reality. The Legislature |

Source

Subject

Recommendation

**Rural Health
Advisory
Commission**

must face the demographic reality that more citizens of the state may need the state's assistance in providing essential medical and long-term care services. The state must have a flexible public policy and be prepared to meet the needs of persons who cannot provide for themselves.

121) Based on our research, premiums, enrollment fees and cost sharing or co-payments which provide some personal responsibility for care must be very limited and used with extreme caution. NHA recommends that a cap on the maximum annual co-payment amounts be implemented under the current Medicaid cost-sharing program for persons with the highest medical needs.

123) NHA recommends that cost sharing be collected directly by the Medicaid agency through an offsetting of payment or the unpaid obligation will be shifted to providers in the form of uncollectible accounts.

124) The members of the Rural Health Advisory Commission support a restructuring of the whole system to improve accountability and quality of care.

Accountability of consumers and providers

125) Create a model that builds personal and business responsibility into the system. Take out the perverse incentives and the penalties that often keep people in the present system. Build on the use of best practices and the proper use of services.

Appropriate use of services

126) Rewards and penalties may need to be tied to a complete review process. Education of both providers and patients need to be part of any change model.

Home and Community-Based Services

127) The restructuring focus should begin where support systems are found – close to home, in the community. Have communities ask for a bid from integrated systems to provide a full array of needed services to serve local people.

Counseling for all enrollees

128) Social worker and/or team members should meet with every Medicaid eligible patient to help identify all issues that are involved in an enrollee's life and to help patients find the needed help. More mental health and

Source

Subject

Recommendation

Chronic care model

substance abuse providers are needed.
129) Need to reinforce provider best practices, link and integrate provider systems, and develop models that can work best with our state's demographics. Need a system that works to prevent chronic conditions and, when discovered, find the best solutions that are sustainable.

Integrated care with a right-sized services model

130) Integrated care can happen with the right set of incentives and education. The use of area bidding for complete sets of services and the focus of consumers now wanting the best care for the best price should create the arena for integrated care. Medicaid can help create this new model and help identify pieces of the health care puzzle that communities will want to take into consideration. Cost sharing, deductibles and accountability should create an atmosphere for integrated care that is truly quality oriented and supported. Move to an integrated care model that uses case management to help people better utilize the services available in the community

Wellness Promotion/ Education

131) Wellness promotion/education should be a key component of any proposed plan. This service will help prevent the need for many future services.

132) Nebraska needs to work with all border states to maintain equivalent services from state to state.

133) Medicaid costs [reimbursements] should not be reduced by paying providers less than their cost to care for these patients.

134) Move to a tiered delivery model of care/services which is based on income level and resources. This system would include a base service level with additional services being available upon review by the health care team. (The tiered income level would be used for the payment model and a tiered care model for services needed, delivered by appropriate providers for an appropriate time span.)

Appendix B
Medicaid Reform Meetings/Presentations
2005

February

Health and Human Services Committee, Nebraska Legislature

March

Children and Family Coalition of Nebraska

April

Nebraska Association of Private Residential Resources
Nebraska Hospital Association
Nebraska Association of Homes and Services for the Aging
Nebraska Health Care Association

May

Nebraska Consortium of Citizens with Disabilities
Nebraska Medical Association
Heartland Health Alliance

June

Health and Human Services staff
ARC of Nebraska

July

Nebraska Pharmacists Association
AARP Nebraska

August

Nebraska Area Agencies on Aging

September

Nebraska Medical Association
Rural Health Advisory Commission
Nebraska Dental Association
Catholic Charities of Nebraska
Multi-Agency Medicaid coalition¹
Children and Families Coalition of Nebraska
Traumatic Brain Injury Advisory Council

¹ Including representatives from AARP Nebraska, ARC of Nebraska, Association of Nebraska Community Action Agencies, Center for People in Need, Children and Families Coalition of Nebraska, March of Dimes - Nebraska Chapter, National Association of Social Workers - Nebraska Chapter, Nebraska Advocacy Services, Nebraska Appleseed Center for Law in the Public Interest, Nebraska Association of Behavioral Health Organizations, Nebraska Catholic Conference, Nebraska Hospital Association, Nebraska Psychological Association, Nebraska Statewide Independent Living Council, Visiting Nurses Association of Omaha, and Voices for Children of Nebraska.

Nebraska Consortium for Citizens with Disabilities
Mental Health Association of Nebraska Consumer Work Group

October

Nebraska Nurses Association
Rural Health Stakeholders Legislative Coalition
Mental Retardation Association of Nebraska
Nebraska Minority Health Association

Appendix C

HHSS Medicaid Reform Work Group Recommendations

Medicaid Alternatives

1. Create a Safety Net Commission to develop a plan for expanding and supporting the number of community health centers, satellites of existing centers, and look-alikes.
2. Expand the use of drug discount programs (e.g., the federal 340B Program) so that all eligible organizations can purchase prescription drugs at lower costs.
3. Create public-private partnerships between small employers and Medicaid through Premium Assistance Programs
4. Conduct a study to determine the feasibility of implementing a publicly-financed reinsurance program
5. Use tax subsidies to encourage the purchase of health insurance
6. Encourage more employers to offer and employees to purchase Health Savings Accounts
7. Explore the development of a large purchasing pool for health insurance

Children with Disabilities

1. Require parents to pay a premium for the medical care of minor children living in the home covered by a Home and Community Based waiver (Section 1915(c) or a Katie Beckett waiver (Section 1902(e)(3))
2. Implement a Developmental Disabilities (DD) quality management system
3. Combine existing waivers into a Medically Fragile Children's Waiver
4. Public information campaign to encourage parents to insure their children

Adults

1. Find solutions for the uninsured
2. Wellness/prevention initiatives/individual responsibility
3. Address large-scale cost of health care issues
4. Disease Management
5. Assess feasibility of enrolling pregnant women instead of unborn children
6. Administrative cost containment initiatives

Adults with Disabilities

1. Disease Management and health maintenance
2. Implement mandatory screening for nursing facility and ICF-MR admissions
3. Eliminate the institutional bias in funding and social policy decisions
4. Maximize federal Medicaid funding for community services with HCBS waivers while reducing the number of Nebraskans receiving institutional care
5. Remove exemptions of trusts for determining Medicaid eligibility
6. Eliminate Public Service Commission control over HHSS transportation options and expenditures
7. Implement HHSS staff as specialized case managers for high cost populations
8. Reduce durable medical equipment costs by use of the Assistive Technology Partnership

-
9. Reduce Medicaid costs resulting from motor vehicle injury
 10. Provide vouchers to clients to purchase services directly (Cash and Counseling)
 11. Support federal policy changes which would eliminate the two year wait for Medicare upon determination of disability

Aged

1. Encourage individuals to take responsibility for their own long-term care planning
2. Reverse Mortgages
3. Facilitate/foster personal responsibility for long-term care needs through promotion of, and education about, the benefits of advance planning and through positive incentives
4. Promote preventative health and education
5. Support the legislative initiative of NGA and the Medicaid Commission to close loopholes in asset transfers (Medicaid Estate Planning)
6. Mandate expansion of screening process used for Medicaid recipients to all newly admitted nursing facility residents
7. Vouchers or cash allowances/consumer-directed services
8. Educate hospital discharge planners about HCBS options
9. Require nursing facilities to disseminate Home and Community Based service information and use community based organizations to conduct information sessions at such facilities
10. Establish local long-term care coalitions
11. Reduce barriers to aging in place
12. Petition federal government to have Medicare assume full responsibility for the health care needs of their beneficiaries
13. Encourage the development, training and retention of a qualified long-term care work force in Nebraska
14. Expand waiver slots/services to accommodate population growth
15. Establish an additional level of assisted living care to recognize differences in resident care needs
16. Explore possibility of implementing a Medicaid waiver program for persons with mental illness who meet nursing home level of care criteria but whose needs could be safely met in an assisted living facility or at home
17. Encourage CMS to require that the new Medicare Drug Plan providers share information on Medicaid consumers' drug utilization with state Medicaid agencies
18. Develop a process that would provide for professional review of the prescribing of psychotropic medications
19. Move Medicaid nursing facility payments away from cost-based reimbursement to incentivize higher occupancy and greater efficiency
20. Remove the \$5,000 exempt property deduction for adult children in estate recovery collection process, and expand estate recovery efforts
21. Evaluate the feasibility of Medicaid coverage of emerging alternatives to traditional nursing facility care, such as the Green House Project
22. Convert from full-month to partial-month coverage at the beginning and end of a person's Medicaid eligibility

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23. Allow individuals who are paying insurance premiums for the purpose of becoming eligible to pay the State Medicaid program directly
 24. Explore possibility of sending Explanation of Benefits (EOBs) to Medicaid consumers each month.
 25. Use Adult Day Care services as a possibly cheaper way to help people recover from health problems or surgery outside of the hospital

Healthy Children and Pregnant Women

1. Make the pregnant woman the covered person for Medicaid rather than the unborn child
2. Improve access to and utilization of quality preventive health through EPSDT, including dental services and prenatal care
3. Develop best practice guidelines for prescribing psychotropic drugs to children
4. Enroll only fully licensed MH/SA providers
5. Cost containment through program management
6. Require that State Wards with private insurance utilize services in the network
7. Collect a case management fee or premium for MH/SA services for State Wards
8. Review and management of services to State Wards
9. Implement a separate SCHIP program
10. Require parents of State Wards to assign medical benefits to the state

Appendix D
Medicaid Public Input Meetings and Legislative Public Forums

Medicaid Public Input Meetings

Omaha

Date: 10-25-05 (Tuesday)

Location: TAC Building

Attendance: 100

Testifiers: 22

Additional Written Comments: 16

Lincoln

Date: 10-26-05 (Wednesday)

Location: State Capitol

Attendance: 80

Testifiers: 17

Additional Written Comments: 3

Grand Island

Date: 10-27-05 (Thursday)

Location: City Hall

Attendance: 50

Testifiers: 16

Additional Written Comments: 8

Scottsbluff

Date: 11-1-05 (Tuesday)

Location: Western NE Community College

Attendance: 60

Testifiers: 19

Additional Written Comments: 12

North Platte

Date: 11-2-05 (Wednesday)

Location: Mid-Plains Community College

Attendance: 25

Testifiers: 11

Additional Written Comments: 1

Legislative Public Forums

Broken Bow

Date: 11-3-04 (Thursday)

Location: Jennie Melham Mem Med Ctr

Attendance: 7

Testifiers: 6

Additional Written Comments: 0

O'Neill

Date: 11-3-05 (Thursday)

Location: Golden Age Senior Center

Attendance: 25

Testifiers: 6

Additional Written Comments: 4

Columbus

Date: 11-4-05 (Friday)

Location: Central Community College

Attendance: 6

Testifiers: 6

Additional Written Comments: 1

Format

1. Presentation (30-40 minutes)
 - a. Overview of Medicaid
 - b. Motivation for Medicaid reform
 - c. Overview of Medicaid Reform: LB 709
 - d. Prelim Findings and Recommendations
2. Public Input (80-90 minutes)

Medicaid reform public input meetings were conducted in Omaha (10-25-05), Lincoln (10-26-05), Grand Island (10-27-05), Scottsbluff (11-1-05), and North Platte (11-2-05). Legislative Medicaid public forums were conducted in Broken Bow (11-3-05), O’Neill (11-3-05), and Columbus (11-4-05). Preliminary findings and recommendations were provided in advance of the meetings and forums and presented for public input. Eight members of the Nebraska Legislature and three members of the Medicaid Reform Advisory Council attended one or more of the meetings or forums.

Following is a brief summary of feedback received:

1. Medicaid Generally

Public input generally agreed with the conclusion that Medicaid reform was necessary. There was general agreement that the current program could not be fiscally sustained if Medicaid expenditure growth continued to exceed the growth in state General Fund revenues. There was some input that the Medicaid program was not currently in a fiscal “crisis” and therefore did not need to be substantively reformed.

Testimony highlighted the importance and cost-effectiveness of the Medicaid program for Nebraska residents. Many testifiers discussed their personal experiences with the Medicaid program. Input addressed inadequacies in the current program, and the need to address waste, fraud, and abuse in the program. Others emphasized that Medicaid recipients generally were only the truly needy, were not personally irresponsible, and did not seek to abuse the system. Some input addressed inequities in the nature and scope of benefits provided to Medicaid recipients as compared with benefits contained in health insurance plans generally available to Nebraskans.

Testifiers expressed concern about the effect of potential Medicaid cuts on current recipients and providers of care. Input generally cautioned that any proposed reforms must first consider the needs of persons receiving Medicaid benefits, or who may receive Medicaid benefits in the future, consider and address adequate provider reimbursement, and should avoid shifting the cost of health care to providers or political subdivisions.

2. Disability Issues and Concerns

Public input advocated for expansion of the Medicaid “buy-in” for workers with disabilities, the enactment of mental health parity legislation, and the expansion of home and community-based services (HCBS) options for persons with disabilities. Input emphasized the importance of personal choice and self-determination for persons with disabilities. Input also highlighted the need to “rebalance” funding and address the current “institutional bias” in the Medicaid program.

3. Defined Contribution

There was a significant consensus that the Medicaid program should continue to be administered as a welfare entitlement, or defined benefit, program, and should not be changed to a defined contribution structure. Other input expressed support for such a change as a long-term reform objective.

Input received expressed support for the achievement of necessary cost savings to the Medicaid program within the existing entitlement structure, in a manner that does not impose restrictions on current eligibility or provider reimbursement.

4. Community Health Centers and Public Health

Public input generally supported the statewide development of more community health centers (federally qualified health centers, or FQHCs) or FQHC “look-alikes,” to enhance access to care for Nebraskans.

Input also emphasized the importance of local public health departments, which are now serving all ninety-three Nebraska counties, in providing necessary and cost-effective preventive health services for Nebraska residents.

5. Long-Term Care Issues and Concerns

The public generally agreed with the need to address the cost of long-term care services in the Medicaid program. There was general agreement with the preliminary recommendation to increase the availability of Medicaid home and community-based services (HCBS) for the elderly. The overall cost-effectiveness of HCBS, as compared with nursing facility or other institutional care, was generally acknowledged. Caution was expressed, however, to ensure that HCBS are appropriate and that services are carefully monitored for quality. Input emphasized that HCBS may not be appropriate in all cases.

There was general support for encouraging the purchase of long-term care insurance, addressing the inappropriate transfer of assets in order to qualify for Medicaid, and the need to address the availability and utilization of alternatives to Medicaid eligibility for the elderly. Several long-term care reforms were proposed and discussed.

6. Pharmacy

Public input generally supported the need to address issues related to the cost of prescription drugs under the Medicaid program. There was general support for preliminary findings and recommendations relating to the use of formularies and/or preferred drug lists, prior authorization of all new brand-name drugs, mandated use of generic equivalents, and utilization of the federal 340B program to access low-cost prescription drugs for Medicaid recipients.

Concern was expressed regarding the availability and cost of prescription drugs for Medicaid recipients, particularly “central nervous system” drugs for persons with serious mental illness.

7. Other

Input was received supporting expansion of the current Medicaid “family planning waiver” and the utilization of preventive dental services for Medicaid recipients. Public input also generally supported preliminary findings and recommendations relating to the establishment of public-private health insurance partnerships and the utilization of more effective case management and disease management initiatives on behalf of higher cost Medicaid recipient populations.

Appendix E
Glossary of Medicaid Related Terms

| | |
|-----------|--|
| AABD | Aid to the Aged, Blind and Disabled |
| ADC | Aid to Dependent Children |
| CHIP | Children’s Health Insurance Program |
| DSH | Disproportionate Share Hospital |
| E-MAC | Enhanced Medical Assistance for Children |
| FICA | Federal Insurance Contribution Act |
| FY | Fiscal Year |
| GF | General Fund |
| HCBS | Home and Community Based Services |
| ICF-MR | Intermediate Care Facilities for the Mentally Retarded |
| IGT | Intergovernmental Transfer |
| MAC | Medical Assistance for Children |
| MC | Managed Care |
| MMIS | Medicaid Management Information System |
| MN | Medically Needy |
| N-FOCUS | Nebraska Family Online Client User System |
| QI1 | Qualified Individuals 1 |
| QMB | Qualified Medicare Beneficiary |
| SAM | School Age Medical |
| SE-MAC | Special Enhanced Medical Assistance for Children |
| SFY | State Fiscal Year |
| SLIMB | Special Low Income Medicare Beneficiary |
| Title XIX | Title XIX of the Social Security Act – Medicaid |
| Title XXI | Title XXI of the Social Security Act – State Children’s Health Insurance Program |
| TMA | Transitional Medical Assistance |
| WD | Working Disabled |

Endnotes

¹ This calculation assumes that Medicaid's proportion of general fund revenues is at the FY05 level.

² See Appendix D: Medicaid Public Input Meetings and Legislative Public Forums.

³ See Appendix A: Written Recommendations Received From External Organizations.

⁴ See Appendix B: Medicaid Reform Meetings/Presentations.

⁵ See Appendix C: HHSS Medicaid Reform Work Group Recommendations.

⁶ Neb. Rev. Stat. §§68-1001 to 68-1086.

⁷ The Social Security Amendments of 1965, Public Law 89-97.

⁸ 42 U.S.C. §§1395 – 1395ccc.

⁹ 42 U.S.C. §§1396 – 1396v.

¹⁰ Laws 1965, c. 397, §3, p. 1277 et seq. (LB 937).

¹¹ Laws 1965, c. 397, §11, p. 1279 (LB 937).

¹² Neb. Rev. Stat. §§68-1001 to 68-1086. See also Appendix 1: Nebraska Medicaid Related Statutes.

¹³ Laws 1967: LB 318, c. 413, §§1-2; LB 621, c. 410, §2; Laws 1969: LB 883, c. 542, § 1; Laws 1979: LB 138; Laws 1981: LB 39; Laws 1982: LB 522; 1983:, LB 604; Laws 1984: LB 723, LB 904, LB 1127; Laws 1986: LB 1253, LB 1254; Laws 1988: LB 229, LB 352, LB 419; Laws 1989: LB 362; Laws 1990: LB 1136; Laws 1991: LB 224, LB 830; Laws 1993: LB 798, LB 804, LB 808, LB 816; Laws 1994: LB 1224; Laws 1995: LB 455; Laws 1996: LB 1044, LB 1155; Laws 1997: LB 307; Laws 1998: LB 1063, LB 1073; Laws 1999: LB 548, LB 559, LB 594; Laws 2000: LB 819, LB 892, LB 950, LB 1115; Laws 2001: LB 257, LB 677; Laws 2002: LB 21, LB 1278; Laws 2002 (Second Special Session): LB 8; Laws 2003: LB 411; Laws 2004, LB 1084; Laws 2005: LB 301, LB 709.

¹⁴ Neb. Rev. Stat. §43-504 et seq.

¹⁵ Neb. Rev. Stat. §§43-2501 to 43-2516.

¹⁶ Neb. Rev. Stat. §§71-8501 to 71-8508.

¹⁷ Neb. Rev. Stat. §§68-1708 to 68-1734.

¹⁸ Approximately ninety sections of the Nebraska Revised Statutes currently reference “medical assistance” or “medicaid,” in addition to references in Chapter 68, Article 10.

¹⁹ For federal fiscal year (FFY) 04-05 (October 1, 2004 to September 30, 2005) the federal medical assistance percentage (FMAP) for Nebraska was 59.64%. Federal Register, December 3, 2003 (Volume 68, Number 232), pp. 67676 – 67678. For FFY 05-06 (October 1, 2005 to September 30, 2006) the FMAP for Nebraska is 59.68%. Federal Register, November 24, 2004 (Volume 69, Number 226), pp. 68370 – 68373. For FFY 06-07 (October 1, 2006 to September 30, 2007), however, the FMAP for Nebraska will be 57.93%. Federal Register, November 30, 2005 (Volume 70, Number 229), pp. 71856 – 71857.

²⁰ Some exceptions include design, development, or installation of a Medicaid Management Information System (90% FFP), and compensation and training of skilled professional medical personnel (75% FFP).

²¹ H.R. 2015, Public Law 105-33, signed by President Clinton in August 1997.

²² Balanced Budget Act of 1997, H.R. 2015, Public Law 105-33. See 42 U.S.C. §§1397aa – 1397jj.

²³ For federal fiscal year (FFY) 04-05 (October 1, 2004 to September 30, 2005) the enhanced federal medical assistance percentage (FMAP) for Nebraska was 71.75%. Federal Register, December 3, 2003 (Volume 68, Number 232), pp. 67676 – 67678. For FFY 05-06 (October 1, 2005 to September 30, 2006) the enhanced FMAP for Nebraska is 71.78%. Federal Register, November 24, 2004 (Volume 69, Number 226), pp. 68370 – 68373. For FFY 06-07 (October 1, 2006 to September 30, 2007), however, the enhanced FMAP for Nebraska will be 70.55%. Federal Register, November 30, 2005 (Volume 70, Number 229), pp. 71856–71857.

²⁴ Laws 1998, LB 1063, §§5-10; Neb. Rev. Stat. §§68-1019, 68-1020, 68-1021, 68-1025.01, 68-1037, 68-1037.06.

²⁵ Additional information regarding the Nebraska state Medicaid plan and approved amendments to the plan may be accessed on the World Wide Web at <http://www.cms.hhs.gov/medicaid/stateplans/toc.asp?state=NE>.

²⁶ “Statewide operation. (a) Statutory basis. Section 1902(a)(1) of the Act requires a State plan to be in effect throughout the State, and section 1915 permits certain exceptions. (b) State plan requirements. A State plan must provide that the following requirements are met: (1) The plan will be in operation statewide through a system of local offices, under equitable standards for assistance and administration that are mandatory throughout the State. (2) If administered by political subdivisions of the State, the plan will be mandatory on those subdivisions. (3) The agency will ensure that the plan is continuously in operation in all local offices or agencies through-- (i) Methods for

informing staff of State policies, standards, procedures, and instructions; (ii) Systematic planned examination and evaluation of operations in local offices by regularly assigned State staff who make regular visits; and (iii) Reports, controls, or other methods. . . .” 42 CFR 431.50.

²⁷ “Comparability of services for groups. Except as limited in Sec. 440.250-- (a) The plan must provide that the services available to any categorically needy recipient under the plan are not less in amount, duration, and scope than those services available to a medically needy recipient; and (b) The plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all recipients within the group: (1) The categorically needy. (2) A covered medically needy group.” 42 CFR 440.240.

²⁸ “Free choice of providers. (a) Statutory basis. This section is based on sections 1902(a)(23), 1902(e)(2), and 1915 (a) and (b) of the Act. (1) Section 1902(a)(23) of the Act provides that recipients may obtain services from any qualified Medicaid provider that undertakes to provide the services to them. . . . (b) State plan requirements. A State plan, except the plan for Puerto Rico, the Virgin Islands, or Guam, must provide as follows: (1) Except as provided under paragraph (c) of this section, a recipient may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is-- (i) Qualified to furnish the services; and (ii) Willing to furnish them to that particular recipient. This includes an organization that furnishes, or arranges for the furnishing of, Medicaid services on a prepayment basis. (2) A recipient enrolled in a primary care case-management system, an HMO, or other similar entity will not be restricted in freedom of choice of providers of family planning services. . . .” 42 CFR 431.51.

²⁹ “Sufficiency of amount, duration, and scope. (a) The plan must specify the amount, duration, and scope of each service that it provides for-- (1) The categorically needy; and (2) Each covered group of medically needy. (b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. (c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under Secs. 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition. (d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.” 42 CFR 440.230.

³⁰ Examples of federal “waivers” available to states include home and community based services waivers (SSA §1915(c)), managed care waivers (SSA §1915(b)), and research and demonstration waivers (SSA §1115), including Health Insurance Flexibility and Accountability (HIFA) waivers.

³¹ Neb. Rev. Stat. §68-1020.

³² Neb. Rev. Stat. 68-1020(1). For definition of “dependent child,” see Neb. Rev. Stat. §43-504.

³³ Neb. Rev. Stat. §68-1020(1), §68-1001 et seq.

³⁴ Neb. Rev. Stat. §68-1020(1); Laws 1984: LB 1127; Laws 2003: LB 411. “Ribicoff children,” named for the former U.S. Senator who sponsored legislation authorizing coverage for this group, are children who meet income and resource requirements for ADC but who otherwise are not eligible for ADC because they do not meet the definition of “dependent child.” Included in this category are often children who are in state-sponsored foster care, or who are institutionalized or inpatients in psychiatric facilities.

³⁵ Neb. Rev. Stat. §68-1020(2); Laws 1988: LB 229; Laws 1998: LB 1063.

³⁶ Neb. Rev. Stat. §68-1020(2), Laws 2002 (Second Special Session): LB 8. Medically needy standard is 133% of the state’s ADC standard, or approximately 32% FPL.

³⁷ Neb. Rev. Stat. §68-1020(3), Laws 1999: LB 594, §34.

³⁸ Neb. Rev. Stat. §68-1020(4), Laws 2001: LB 677.

³⁹ The Early Intervention Act, Neb. Rev. Stat. § 43-2501 et seq.

⁴⁰ Neb. Rev. Stat. §43-504; and the Welfare Reform Act, Neb. Rev. Stat. §§68-1708 to 68-1734.

⁴¹ See Appendix 14: Glossary of Medicaid Related Terms.

⁴² Neb. Rev. Stat. §68-1020(5), Laws 2002 (Second Special Session): LB 8.

⁴³ Neb. Rev. Stat. §68-1038 to 68-1043.

⁴⁴ Neb. Rev. Stat. §68-1713.

⁴⁵ Neb. Rev. Stat. §68-1019.

⁴⁶ Laws 1993: LB 804, LB 808.

⁴⁷ Neb. Rev. Stat. §68-1019 (4), (5); Neb. Rev. Stat. §§68-1019.01 to 68-1019.09. Premiums have been established for two groups: those receiving transitional medical assistance (TMA) and employed persons with disabilities. Total premiums collected in FY 2004 were \$51,702 (TMA) and \$535 (employed persons with disabilities). Copayments have been established for 12 Medicaid-covered services: chiropractic office visits (\$1 per visit), dental services (\$3 per specified service), prescriptions (\$2 per person), eyeglasses (\$2 per dispensing fee), hearing aids (\$3 per dispensing fee), occupational therapy (\$2 per specified service), optometric office visits (\$2 per visit), outpatient

hospital services (\$3 per visit), physical therapy (\$1 per specified visit), physician office visits (\$2 per visit excluding primary care physicians providing primary care services), podiatrist office visits (\$1 per visit), and speech therapy (\$2 per specified visit). Total “savings” to the Medicaid program for copayments collected in FY 2004: \$3,763,354 (total funds); \$1,401,849 (General Funds). Approximately 91% of copayments received were for prescribed drugs. Nebraska Health and Human Services System.

⁴⁸ Neb. Rev. Stat. §68-1019.06; Laws 2000: LB 950.

⁴⁹ Neb. Rev. Stat. §§71-8501 to 71-8508; Laws 1999: LB 559.

⁵⁰ Neb. Rev. Stat. §§1071 to 68-1072; Laws 1999: LB 548.

⁵¹ Diagnostic related group (DRG) is a medical-based classification, representing 23 major diagnostic categories that aggregates patients into case types based on diagnosis. A diagnosis related group is a subset of a major diagnostic category. See www.iversonsoftware.com/reference/psychology/d/diagnostic_related_group.htm.

⁵² Neb. Rev. Stat. §68-1026 to §68-1028; Laws 1984, LB 723.

⁵³ Neb. Rev. Stat. §68-1029 to §68-1037; Laws 1984, LB 904.

⁵⁴ Neb. Rev. Stat. §81-2269; Laws 1993, LB 801; Laws 1995, LB 406.

⁵⁵ Federal requirement (42 U.S.C. 1396p(c)), see Neb. Rev. Stat. §68-1036.01; Laws 1993, LB 798; repealed Laws 1996, LB 1155.

⁵⁶ Neb. Rev. Stat. §68-1036.02; Laws 1994, LB 1224.

⁵⁷ Neb. Rev. Stat. §68-1048 to §68-1064; Laws 1993, LB 816.

⁵⁸ Neb. Rev. Stat. §68-1036.03; Laws 1994, LB 1224.

⁵⁹ Neb. Rev. Stat. §68-1073 to §68-1086; Laws 2004, LB 1084.

⁶⁰ Under the Medicare Prescription Drug plan (Part D), Nebraska will be required to pay a monthly “clawback” amount to the federal government beginning in February 2006.

⁶¹ Nursing facility expenditures actually decreased in SFY04 and SFY05 from a high of \$296.2 million in SFY03.

⁶² Richard Teske, “Abolishing the Medicaid Ghetto: Putting ‘Patients First,’” American Legislative Exchange Council, 2002, <http://www.alec.org/meSWFiles/pdf/0206.pdf>

⁶³ See the Medicaid designees’ October Report to the Governor and Legislature for an explanation of the methodology used to project Medicaid costs. Two changes were made to the original estimate of projected available appropriation for Medicaid, previously reported in the October Report. The original projection was based on estimated SFY 2005 Medicaid General Fund expenditures compared to estimated General Fund revenues. The model was updated to include SFY 2005 actual Medicaid General Fund expenditures for all budget programs that provide state Medicaid match and SFY 2005 actual General Fund revenues. The model was further updated to include SFY 2006 and SFY 2007 appropriations for Medicaid and SFY 2006 and SFY 2007 estimated General Fund revenues. The remaining assumptions related to population changes in Nebraska and estimated cost adjustments were not changed.

⁶⁴ 37% FPL

⁶⁵ Cost sharing is discussed in section 1.5.

⁶⁶ Under a separate state SCHIP program, once the enhanced SCHIP match money has been expended each year, additional expenditures are not matched and therefore pay at 100% General Fund. Under the Medicaid expansion SCHIP program, when the enhanced SCHIP match money has been expended each year, additional expenditures by the SCHIP program are matched at the regular federal match rate.

⁶⁷ For an overview of the Medicaid Pharmacy Program in Nebraska, see the designees’ August Report.

⁶⁸ Nebraska’s percentage of age 65+ population and percentage of age 85+ population both exceed the national average.

⁶⁹ Waiver services are non-medical services that states may be permitted to provide in lieu of traditional medical care to recipients who would otherwise need nursing facility care. Examples are adult day care, chore services, home delivered meals, and care in assisted living facilities.

⁷⁰ National Conference of State Legislatures; “America’s Newcomers: Funding Prenatal Care for Unauthorized Immigrants: Challenges Lie Ahead for States”; 2005.

⁷¹ Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends; “2003 Medical Expenditure Panel Survey – Insurance Component.”

⁷² See Endnote #63.