

**Medicaid Report of Implementation of Rules and Regulations,
Plan Amendments, and Waivers
January 1, 2007 through December 31, 2008**

Neb. Rev. Stat. § 68-909(4) requires the Department to periodically, but no less than biennially, report to the Governor, the Legislature, and the Medicaid Reform Council on the implementation of rules and regulations, Medicaid State Plan Amendments, and waivers adopted under the Medical Assistance Act and the effect of such rules and regulations, amendments, or waivers on eligible recipients of medical assistance and medical assistance expenditures. This report summarizes the implementation of rules, regulations, and State Plan Amendments from January 1, 2007 through December 31, 2008.

ELIGIBILITY

Deficit Reduction Act (DRA) of 2005 Requirements – February 28, 2007

- **Burial Trusts.** Allows Medicaid clients to have an irrevocable burial trust of up to \$4,000, that is excluded from available resources and not counted for Medicaid eligibility determination and provides for an annual increase beginning on September 1, 2006.
- **Gratuitous Transfer of Assets.** Lengthens the look-back period from 36 months to 60 months for all gratuitous transfers or deprivations of assets that occur on or after February 8, 2006. Changes the “start date” of the penalty period for the gratuitous transfer of assets to the later of the month of transfer or the month that the person is Medicaid-eligible and receiving nursing home or home and community-based waiver services. Requires that funds left after determining the penalty period are counted as income in the next month. Requires the addition of multiple gratuitous transfers of assets occurring in more than one month after the look-back period and treats the total as one transfer. Provides for a hardship waiver to determine if an undue hardship exists when a penalty for transfer of assets is imposed. Allows the nursing home to file an undue hardship waiver application on behalf of the client, with the client’s or the client’s guardian’s consent. Provides payment to the nursing facility, up to 30 days, while the hardship waiver is pending, if the individual is cooperating to the fullest extent in attempting to recover transferred assets.
- **Insurance Annuities.** Requires that the value of an annuity purchased on or after February 8, 2006 will be treated as disposal of an asset for less than fair market value unless the State of Nebraska is named as the remainder beneficiary in the first position or, if there is a community spouse or minor/disabled child, in the second position after the spouse or child.
- **Home Equity.** Requires that, if an individual’s home equity interest exceeds \$500,000, the individual is not eligible for medical assistance with respect to nursing facility services or other long-term care services.

- **Life Estate.** Defines “assets” to include the purchase of a life estate interest in another individual’s home unless the purchaser resides in the home for a period of at least one year after the date of purchase.
- **Documentation of Citizenship.** Requires that anyone applying for Medicaid as a United States citizen must submit a birth certificate, passport, or other official document, must be computer matched with other programs that establish citizenship, or must produce other federally accepted documentation of United States citizenship.

As a result of the new regulations, some individuals may not become Medicaid eligible or may have their eligibility delayed. Total funds appropriated to implement the changes amounted to \$312,608. Estimated savings were \$217,393 in the first year, \$1,779,890 in the second year and \$2,700,390 in the third year.

Coordination of Benefits – September 3, 2007. Requires a licensed insurer or self-funded insurer to provide coverage information to the Department without the individual’s authorization to determine the individual’s eligibility for Medicaid or to coordinate benefits.

Identifies and maintains health insurance coverage for clients with third party insurance and to coordinate benefits for payment of claims. Cost savings estimated at \$2.5 million total funds in the first year of implementation and \$5 million total funds for the second year of implementation.

The State Plan Amendment was approved by the Centers for Medicare and Medicaid Services (CMS) on January 31, 2007.

Long-Term Care Partnership Program – January 19, 2008. Allows an individual to purchase qualified long-term care insurance and later protect assets for Medicaid eligibility determination in the amount spent by the insurance. Removed an obsolete reference to the “Qualified Individual 2” eligibility category which is no longer authorized by federal law.

Promotes purchase of long-term care insurance. No additional costs or savings associated with the establishment of this program. In the long term, there are potential Medicaid savings.

The State Plan Amendment was approved by CMS on December 18, 2006.

Electronic Application for Assistance –December 28, 2008. Allows submission of an electronic application for assistance, including Medicaid. Clarifies that an electronic signature is considered valid.

REIMBURSEMENT

Disproportionate Share Hospital (DSH) payments – April 29, 2007. Created two pools for the basic disproportionate share payments. Increased the allotment to the “Disproportionate Share Hospital that Primarily Serves Children” and “Non-Profit Acute Care Teaching Hospitals Affiliated with a State-Owned University Medical College.” Eliminated the reserve pool. Created a new Uncompensated Care Pool. Specified the

process for calculating a specific Medicaid shortfall for each DSH along with uninsured care costs and the Medicaid upper payment limit.

Maintains access to services in hospitals receiving DSH payments. There is no change in state General Funds. Additional Federal Funds of \$8,392,881 in FFY 2007 and \$10,163,525 in FFY 2008 are available as a result of this change. For FFY 2009 and following years, the DSH allotment from the previous year will be increased by the percentage change in the consumer price index (CPI) for all urban consumers.

A State Plan Amendment was approved by CMS on January 26, 2007.

Claim certification on UB04 claim form – June 13, 2007. Allows providers to submit the HCFA-1450 claim form, version UB-04, without a signature, as the required provider's certification.

Maintains access by continuing payments to providers. No impact on expenditures.

Nursing facility rates – July 29, 2007. Establishes payment rates for nursing facility services for the period of July 1, 2007 through June 30, 2008 with rebasing to the June 30, 2006 cost reports and an inflation factor of 4.9%. The rates also include: an increase on the fixed cost component, a maximum on fixed costs paid under special needs contracts, a change to the basis for payment to new providers, removal of the provision that requires a special needs contract to be signed before payment can be made and clarification of proration for therapeutic leave bed holding days.

Maintains access to services provided in nursing facilities. The fiscal impact is an estimated increase of \$7,740,000 total funds.

The State Plan Amendment was approved by CMS on March 12, 2008.

Nursing facilities rates – July 6, 2008. Establishes rates for July 1, 2008 through June 30, 2009 with rebasing to the June 30, 2007 cost reports and a proposed inflation factor of 4.0%. The regulations also include: a definition of "revisit fees" and specification of revisit fees as an unallowable cost for Medicaid rates, clarification of maximum compensation of administrators, an increase for the "per-day" maximum on the fixed cost component of nursing facility rates paid through case mix, revision and repeal of regulations allowing for a temporary adjustment to the interim rates for new providers to be consistent with the Medicaid State Plan and revision of the length of time allowed for extensions of filing cost reports.

Maintains access to services provided in nursing facilities. The fiscal impact is an estimated increase of \$7,040,000 total funds.

The State Plan Amendment is pending before CMS.

Intermediate Care Facilities for Mental Retardation (ICF/MR) rates – July 29, 2007. Establishes payment rates for ICF/MR facilities for the period of July 1, 2007 through June 30, 2008 with rebasing to the June 30, 2006 cost reports and an inflation factor of 4.9%. Included miscellaneous technical changes, such as updating the effective dates of the payment plan and defining the rate period.

Maintains access to services provided in ICF/MR facilities. The estimated fiscal impact is an increase of \$420,000 in total funds.

The State Plan Amendment was approved by CMS on March 12, 2008.

Intermediate Care Facilities for Mentally Retarded (ICR/MR) rates – July 6, 2008.

Establishes payment rates for July 1, 2008 through June 30, 2009 with rebasing to the June 30, 2007 cost reports and an inflation factor of 5.8%. The regulations also include: clarification of maximum compensation of administrators, revision of the length of time allowed for extensions of filing cost reports and technical revision such as updating dates throughout the regulations.

Maintains access to services provided in ICF/MR facilities. The estimated fiscal impact is an increase of \$441,000 in total funds.

The State Plan Amendment is pending before CMS.

Intermediate Care Facilities for Mental Retardation (ICF/MR) provider tax – July 29, 2007. Reduces the ICF/MR provider tax rate cap to 5.5%, effective January 1, 2008 through September 30, 2011 in order to comply with federal and state requirements.

Maintains access to services provided in ICF/MR facilities. Reduces General Fund by approximately \$175,000 annually.

Transportation mileage rates - August 20, 2007. Establishes standards for transportation services provided by individuals and reimbursement not to exceed that paid for reimbursement of state employees under Neb. Rev. Stat. § 81-1176.

Increases access to services provided by individual transportation service providers. LB 1069 of the 2006 Legislative Session authorized DHHS to reimburse individuals for transportation services. The Medicaid appropriation was reduced \$202,478 to reflect expected savings in FY 07. Administrative appropriation was increased \$236,174 total funds in FY 07 and \$215,426 total funds in FY 08.

Inpatient hospital services rates – September 1, 2007. Decreased by 1.7% the peer group payment amounts and the direct medical education payment amount, resulting in a net 1.95% increase for SFY 2008. Effective July 1, 2008, the peer group payment amounts and the direct medical education payment amount will be inflated by 1.90%.

Maintains access to inpatient hospital services. Estimated to prevent an additional expenditure of \$2.3 million in FY 2008 and additional expenditure of \$4.9 million in FY 2009.

The State Plan Amendment was approved by CMS on October 10, 2007.

Pediatric immunization program. State Plan Amendment submitted on September 8, 2008, to update the Medicaid rate for administration of vaccines under the pediatric immunization program (Vaccines for Children) to \$10.28.

The State Plan Amendment was approved by CMS on November 14, 2008.

Hospital-based physician clinic services – December 15, 2008. Clarifies that hospital-

based physician clinic services must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional Transaction (ASC X12N 837).

Maintains access to physician services provided in a hospital-based physician clinic while insuring that hospitals do not take advantage of any perceived reimbursement loopholes. The Department estimates a savings.

BENEFITS

Community Supports Program – September 19, 2007. Establishes a statewide Developmental Disabilities service option for individuals with an existing funding authorization.

Additional self-directed services for clients with a developmental disability. No fiscal impact.

Ambulatory Surgical Centers (ASCs) – January 29, 2008. Retains the nine groups of procedures for reimbursement and CMS approved codes for coverage CY 2007.

Maintains access to services provided in ASC facilities. No fiscal impact.

The State Plan Amendment was approved on February 5, 2008.

Services coordination for Katie Beckett clients – March 2, 2008. Services coordination to be provided by Department staff rather than contract.

Reduction of approximately \$105,000 total funds annually.

Weight Management Clinics: Repeals obsolete regulations which had never been implemented.

No impact on clients. No fiscal impact.

Acute Inpatient Rehabilitation Services – March 25, 2008. Establishes payment for acute inpatient rehabilitation services. Clarifies that prior authorization is required.

Maintains access to services provided in acute inpatient rehabilitation facilities and distinct part units of acute care hospital facilities. No fiscal impact.

Adult Subacute Psychiatric Services – April 12, 2008. Provides coverage of adult subacute level of care for psychiatric services. Increases options for adult psychiatric patients who no longer require acute inpatient hospital services but require further inpatient stabilization before moving to community-based services.

Adds new level of care for adult psychiatric services. It is estimated that there will be an increase in spending for community-based psychiatric treatment for adults with a corresponding decrease in expenditures for inpatient settings. Net savings estimated at \$973,817 in General Funds.

The State Plan Amendment is pending before CMS.

Chiropractic services – July 1, 2008. Establishes a limit on chiropractic services of 12 treatments per year for adults age 21 and older.

For CY 06, 80% of adult clients who used chiropractic services utilized less than 12 visits. Savings estimated at approximately \$69,000 per year General Funds.

The State Plan Amendment is pending before CMS.

Eyeglasses – July 1, 2008. Establishes a limit of one pair of eyeglass frames or lenses in a 24-month period for adults age 21 and older.

For FY 05 and 06, 93% of adult clients received less than one pair of frames in 24 months and 82% of adult clients received less than one pair of lenses in 24 months. Savings estimated at approximately \$120,000 per year General Funds.

The State Plan Amendment is pending before CMS.

Dental services – July 1, 2008. Establishes a limit of \$1,000 per year for adults age 21 and older.

For FY 07, 90% of adult clients received less than \$1,000 in dental benefits. Estimated savings is \$1,503,015 General Funds for the first year and \$525,000 General Funds annually thereafter.

The State Plan Amendment is pending before CMS.

Physical, occupational and speech therapies – July 1, 2008. Establishes a combined limit of 60 therapy visits per year for adults age 21 and older.

For CY 06, 91% of adult clients received less than 60 therapy visits for year. The estimated savings is \$807,000 General Funds annually.

The State Plan Amendment is pending before CMS.

Hearing aids – July 1, 2008. Establishes a limit of one hearing aid, monaural or binaural, every four years for each recipient age 21 and older and revises the prior authorization process for hearing aids to purchases that exceed \$500.

During CY 03-06, 95% of adult clients received less than one or a pair of hearing aids during four years. Estimated savings is \$90,000 General Funds annually.

The State Plan Amendment is pending before CMS.

Sterilizations and sexual impotence treatment – November 25, 2008. Repeals provision for Medicaid coverage of sterilization services not authorized by federal law and coverage of diagnosis and treatment of sexual dysfunction.

Brings program into compliance with federal requirements on sterilization thereby maintaining funding for covered services. Minimal fiscal impact due to the infrequent utilization of these services.

Tobacco cessation services and products – December 10, 2008. Add coverage of tobacco cessation products and services under the following terms: 1) a Medicaid client must enroll and actively participate in the Nebraska Tobacco Free Quit-Line; 2) drug products will be covered for a 90-day supply during a 12-month period, with two quit attempts allowed (two 90-day supplies of drug products could be covered during a single

12-month period); a total of four tobacco cessation counseling visits will be covered when provided by a medical care provider (physician or mid-level practitioner) or by a tobacco cessation counselor (a licensed pharmacist who has met specific requirements); and 3) coverage of services and drugs is limited to two quit attempts in a 12-month period. The regulations also remove “smoking cessation products” from the list of non-covered drug products and add “certain drugs or classes of drugs that are used for tobacco cessation” to the list of products requiring prior approval.

Provides access to smoking cessation services. This new service category will result in an increase in expenditures for the Medicaid program. A total of \$594,000 was appropriated for these services.

The State Plan Amendment is pending before CMS.

PROVIDER ISSUES

National Drug Codes (NDC) – May 6, 2008. Requires hospitals to report all physician-administered drugs used in the outpatient setting by the appropriate NDC number on claims.

Maintains access to physician-administered drugs used in the hospital outpatient setting. Cost savings are anticipated but not able to be quantified.

Licensed Independent Mental Health Practitioners (LIMHP) – September 28, 2008. Added LIMHPs to practitioners who can bill for Medicaid mental health services without need of supervision. Added LIMHPS to practitioners who can supervise Licensed Mental Health Practitioners who provide Medicaid mental health services.

Provides access to mental health services. Minimal fiscal impact.

The State Plan Amendment is pending before CMS.

National Drug Codes (NDC); Out-of-state physicians; Lab and radiology; Vaccines – November 3, 2008. Clarifies that physicians must use NDC number on claims for all physician-administered medications. Provides for the negotiation of rates that are an exception to the fee schedule for out-of-state physician services. Removes 40% limitation on payments for the professional component of lab and radiology services. Clarifies requirements for participation in the Vaccine for Children (VFC) program.

Maintains access to physician and hospital services. Estimated savings due to collection of drug rebates for physician-administered drugs.

State-operated Residential Treatment Centers (RTCs) – June 14, 2008. Removes the limit of two units of 20 beds for state-owned and operated residential treatment centers for youth needing mental health and/or substance abuse treatment services so long as each RTC unit does not exceed 20 beds and only if all other in-state RTC providers have declined to serve the child within a reasonable period of time. The regulations also clarify the requirement that clients must be treated by a psychiatrist or physician personally and face-to-face at least six out of seven days, or more often, if medically necessary.

Access to mental health and/or substance abuse services for children and adolescents in RTCs.

Tamper-Resistant Prescription Pads – June 16, 2008. Requires all Medicaid providers who prescribe medication by written prescription to meet the federal requirements for tamper-resistant prescription pads.

Maintains access to prescription medications. There is minimal administrative cost for implementation.

Hospital outpatient observation services – October 14, 2008. Defines “hospital outpatient services” and clarifies that Medical payment for outpatient stays up to 48 hours in length are made using the outpatient hospital payment methodology.

Maintains access to outpatient services provided in a hospital. No fiscal impact.

Assertive Community Treatment (ACT) – November 22, 2008. Allows an Advanced Practice Registered Nurse (APRN) to provide some hours for ACT services that were previously required to be delivered by a psychiatrist.

Provides better access to ACT services. Allowing Medicaid payment for some ACT services that are currently funded only by General Funds Division is estimated to result in an annual state General Fund savings of \$347,623 to \$708,740. The change may also result in cost savings due to the reduced Medicaid per diem rate for ACT services provided by an APRN.

Dental Hygienists – November 22, 2008. Allows dental hygienists to enroll as Medicaid providers of dental services and to be paid for those services provided within their scope of practice as allowed under state law. LB 247 (2007) § 24-25 allows dental hygienists to perform public health-related services in a public health setting or in a health care or related facility.

Expands access to dental services. Estimated increase of \$475,300 total funds per year based on an increase in utilization due to the availability of additional providers.

Electronic Funds Transfer – December 28, 2008. Requires that all payments made to providers for Medicaid approved medical services be made by electronic funds transfer (EFT). This increases Medicaid efficiencies, reduces the costs associated with distribution of paper warrants, and results in faster payments to the providers. The estimated savings is \$27,000 General Funds annually.

ADMINISTRATION

Managed Care – October 28, 2008. Revises enrollment broker services to allow greater flexibility in contracting for these services. A reference to contacting the State Ombudsman for information regarding appeals and grievances was eliminated.

Increases flexibility of administration of managed care. The fiscal impact of these regulations is an administrative cost savings to the Department.

The State Plan Amendment is pending before CMS.

Medicaid Integrity Program. State Plan Amendment to provide assurance that

Nebraska complies with the requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act. Plan was approved by CMS on June 2, 2008.

Early Intervention for Infants and Toddlers with Disabilities Medicaid Waiver – December 4, 2008. Notifies CMS of the Department’s election to terminate this waiver and transfer the six children served to the Aged and Disabled Medicaid Waiver. This is to reduce the administrative burden associated with operating two waivers which serve overlapping target populations. All clients on the waiver are eligible for the same services through the Aged and Disabled Waiver. The Early Intervention Waiver is planned to end by January 30, 2009.

TECHNICAL CLEAN-UP STATE PLAN AMENDMENTS

Nurse Aid/Nursing Facility Investigations; Surveys. Wording changes to bring Plan pages into line with the current organizational structure and operations. There is no fiscal impact. A State Plan Amendment was approved December 10, 2008.