

**Medicaid Report of Implementation of Rules and Regulations,  
State Plan Amendments, and Waivers  
January 1, 2009 through December 31, 2010**

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, 2009 through December 31, 2010.

**ELIGIBILITY**

**Children’s Health Insurance Program (CHIP) – September 1, 2009.** Pursuant to Neb. Rev. Stat. § 68-915 (amended by LB603 of the 2009 Nebraska Legislature), eligibility for CHIP was expanded to include children whose family income does not exceed 200% (up from 185%) of the Federal Poverty Level. Currently, more than 29,100 children are enrolled in the CHIP program in Nebraska.

Regulations were effective September 1, 2009.

The Centers for Medicare and Medicaid Services (CMS) approved the State Plan Amendments to Medicaid and CHIP on October 20, 2009 and October 21, 2009, respectively.

**Pregnant Woman – January 1, 2010.** CMS notified DHHS that the unborn were not a Medicaid eligibility group. Effective March 1, 2010 all unborn cases were closed and eligibility was re-determined through the pregnant woman.

Regulations are pending.

The Medicaid State Plan Amendment was approved by CMS on May 4, 2010.

**Medicaid and CHIP Coverage of “Lawfully Residing” Children and Pregnant Woman – July 1, 2010.** Neb. Rev. Stat. § 68-969, (added by LB 1106 of the 2010 Nebraska Legislature) provided authority to allow for Medicaid and CHIP eligibility for pregnant women and children who are lawfully residing in the United States and otherwise eligible for Medicaid, respectively.

The State Plan Amendment was approved by CMS on September 21, 2010.

The CHIP State Plan Amendment was submitted on September 30, 2010, and is pending before CMS.

Fiscal savings to the State are estimated around \$216,000 for the fiscal year 2011 since, previously, Medicaid equivalent benefits were being provided with state only funds.

**Medicare Savings Programs Resource Increase—January 1, 2010.** The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) mandated an increase in the

resource allowance for Medicare Savings Programs (MSPs) effective January 1, 2010. The resource allowance for a unit of one increased from \$4,000 to \$6,600 and for two from \$6,000 to \$9,910. These new resource allowance amounts will be subject to Federal annual increase adjustments.

This new MSP/QMB (Qualified Medicare Beneficiary) group will receive the required copayment, deductibles and Part B premiums.

Regulations were effective May 1, 2010.

A Medicaid State Plan Amendment regarding the MSPs was approved by CMS with an effective date of January 1, 2010.

## **REIMBURSEMENT**

**Hospital Inpatient Rates – October 1, 2009.** Established payment rates for inpatient hospital services for the period of October 1, 2009 through June 30, 2010. The legislatively appropriated increase of 1.5% was included for fiscal year 2010. Changes to the hospital inpatient methodology include:

- Implementation of a new Diagnosis Related Group (DRG) Classification system using All Patient Diagnosis Related Group (AP-DRGs);
- Adoption of Medicare cost-to-charges ratios (CCR) used to calculate outlier payments in Medicaid. CCRs will be updated each year to reflect changes in the Medicare Inpatient Prospective Payment System (IPPS);
- Adjustment of base payment amounts in a budget neutral fashion;
- Revision of Direct Medical Education (DME) payment amounts to reflect the current intern and resident full time equivalents (FTEs) based on the federal fiscal year (FFY) 2009 Medicare IPPS;
- Revision of the Indirect Medical Education (IME) factors based on the FFY Medicare IPPS. IME rates will be updated each year to reflect changes in hospital intern-to-bed ratios in the Medicare system. The multiplication factor will be increased from 72.45% to 80.00%;
- Based on the proposed provider-specific Medicare outlier CCRs, establishment of separate budget neutrality factors for Transplant DRGs and Unstable DRGs, and, as such, establishment of a separate set of CCRs to calculate payments for Transplant DRGs and for Unstable DRGs. CCRs will be updated each year to reflect changes in the Medicare IPPS.
- Adjustment of capital payment amounts in a budget neutral fashion;
- Publishing tiered rates for inpatient psychiatric services;
- Defining the budget neutrality process; and
- Revision of payment methodology for out-of-state hospitals, using the same methodology as proposed for in-state hospitals, but excluding payments for direct medical education cost or indirect medical education cost.

Regulations were effective October 1, 2009.

State Plan changes were approved on March 12, 2010 with an October 1, 2009 effective date.

**Prospective Payment System for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) - March 10, 2010.** This change aligned the regulations with the currently approved Medicaid State Plan requiring a prospective payment system (PPS), simplified the process of rate setting and established a uniform annual rate adjustment method.

The funds for payment of FQHCs/RHCs under a PPS methodology were included in the 2009/2010 budget.

Regulations were effective March 10, 2010.

**Nursing facility rates – July 6, 2008.** Established payment rates for July 1, 2008 through June 30, 2009 with rebasing to the June 30, 2007 cost reports and an inflation factor of 4.0%. The regulation changes also included: 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.

Regulations were effective July 6, 2008.

The State Plan Amendment was approved by CMS on February 26, 2009.

**Nursing facility rates – July 1, 2009.** Established rates for July 1, 2009 through June 30, 2010 with rebasing to the June 30, 2008 cost reports and a proposed inflation factor of 0.78%. The proposed regulation changes also include: an update of Medicare-related references from 2006 to 2007, an increase in the maximum compensation of administrators, an increase for the “per-day” maximum on the fixed cost component of nursing facility rates paid through casemix and an update of rate and cost periods for new providers.

Regulations were effective July 1, 2009.

The State Plan Amendment was approved by CMS on April 2, 2010.

**Nursing facility rates – July 1, 2010.** Established rates for July 1, 2010 through June 30, 2011 with rebasing to the June 30, 2009 cost reports and a proposed negative inflation factor of 1.54%. The regulation changes also included a new casemix reimbursement methodology, based on the Resource Utilization Group (RUG) III 5.20 grouper. Nebraska previously used the RUG III 5.01 grouper, which would not be supported by CMS after October 1, 2010. Other changes included: an added definition and payment methodology for Indian Health Services nursing facilities; updated rate period references and administrator maximums; corrections to the swing bed payment methodology description to comply with the method described in Nebraska’s approved Medicaid State Plan and the method currently and historically used; revisions to the fee charged for a copy of a cost report to comply with DHHS policy; and revisions to the inflation factor language to describe the methodology.

Regulations were effective July 1, 2010.

The State Plan Amendment is pending before CMS.

**Intermediate Care Facilities for Mentally Retarded (ICR/MR) rates – July 6, 2008.** Established 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 regulation changes also included: 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.

Regulations were effective July 6, 2008.

The State Plan Amendment was approved by CMS on February 26, 2009.

**Intermediate Care Facilities for Mentally Retarded (ICF/MR) rates – July 1, 2009.** Established payment rates for July 1, 2009 through June 30, 2010 with rebasing to the June 30, 2008 cost reports and an inflation factor of 5%. The regulation changes also included: a clarification that the cost reporting period ends June 30, an update of Medicare-related references from 2006 to 2007, an increase in the maximum compensation of administrators and an update of rate periods and cost periods for the ICF/MR revenue tax component.

Regulations were effective July 1, 2009.

The State Plan Amendment was approved by CMS on April 2, 2010.

**Intermediate Care Facilities for Mentally Retarded (ICF/MR) rates – July 1, 2010.** Established payment rates for July 1, 2010 through June 30, 2011 with rebasing to the June 30, 2009 cost reports and an inflation factor of 2%. The regulation changes also included: an update of rate period references and administrator maximums; revisions to the inflation factor language to describe the methodology; and revisions to the fee charged for a copy of a cost report, to comply with DHHS policy.

Regulations were effective July 1, 2010.

The State Plan Amendment is pending before CMS.

**Intermediate Care Facilities for Mentally Retarded (ICF/MR) with four to fifteen beds – July 1, 2009.** The changes removed a regulatory barrier to the development of smaller, community-based ICF/MRs for individuals with developmental disabilities, as an alternative to facilities with 16 or more beds increasing the opportunity for individuals to reside in more home-like and community-integrated settings.

Removed the requirement that ICF/MRs with 4-15 beds are only reimbursed under provisions of the Nebraska Home and Community-Based Waiver program, established rates for ICF/MRs with 4-15 beds and established separate methodologies for rate determinations for ICF/MRs with 16 beds or more and ICF/MRs with 4-15 beds.

Regulations were effective July 1, 2009.

The State Plan Amendment was approved by CMS on April 2, 2010.

**Indian Health Services (IHS) Nursing Facility – March 1, 2010.** Regulation changes allow for reimbursement of an IHS nursing facility that will serve only IHS-eligible individuals and allow Medicaid to claim 100 percent federal match for these expenditures.

Regulations were effective March 1, 2010.

The State Plan Amendment was approved by CMS on September 28, 2010.

**Payment of Medicare Part A Nursing Facility Crossover Claims – July 1, 2010.** Medicaid will only pay the co-insurance amount for Medicare Part A nursing facility crossover claims if the amount already paid by Medicare is less than the Medicaid allowable amount for the service. If the amount already paid by Medicare is more than the Medicaid allowable amount for the service, Medicaid would not pay.

Regulations were effective July 1, 2010.

The State Plan Amendment was approved by CMS on July 8, 2010.

**Fee Schedule Rates – July 1, 2009.** A State Plan Amendment was submitted on September 16, 2009 which updates the effective date of the fee schedule rate changes appropriated by the Legislature from July 1, 2008 through June 30, 2009.

The State Plan Amendment is pending before CMS.

**Fee Schedule Rates – July 1, 2010.** A State Plan Amendment was submitted to CMS on September 29, 2010 which updates the effective date of the fee schedule rate changes appropriated by the Legislature from July 1, 2009 through June 30, 2010.

The State Plan Amendment is pending before CMS.

**Physician Reimbursement – July 1, 2010.** The Medicaid program implemented the Medicare site of service differential reimbursement system for physician payments. For selected procedures, the Medicare Physician Fee Schedule has one rate when the procedure is performed in a facility setting (usually a hospital), and a higher rate when the procedure is performed in any other setting (usually the physician's office). This compensation scheme is more equitable with respect to costs than a single-rate scheme; the procedures selected for site of service differential rates are those that would require a physician performing them in an office setting to have purchased equipment that would normally be owned by a facility, thus the physician performing the procedure in a facility is able to do so at a lower cost.

The State Plan Amendment was approved by CMS on October 19, 2010.

**Supplemental Payments to UNMC Physicians and Nebraska Pediatric Practice, Inc. - April 6, 2010.** Current Medicaid reimbursement for physician services in Nebraska is based upon a set fee schedule. Similar to what has been done in other states, the University of Nebraska Medical Center (UNMC) Physicians worked with DHHS to develop a physician upper payment limit (UPL) program to provide higher reimbursement to designated physician groups. The development, implementation, and ongoing operation of the concept as well as the non-federal share of the enhanced payments will be funded by UNMC.

Regulations were effective April 6, 2010.

The State Plan Amendment was approved by CMS on August 26, 2010.

**Supplemental Payments to UNMC College of Dentistry - July 1, 2010.** Current Medicaid reimbursement for dental services in Nebraska is based upon a set fee schedule. Similar to what has been done in other states, the UNMC College of Dentistry worked with DHHS to develop a dental upper payment limit (UPL) program to provide higher reimbursement to designated dental groups.

Regulations were effective July 1, 2010.

The State Plan Amendment was approved by CMS on August 26, 2010.

**Inpatient Hospital Rate Change – July 1, 2010.** A State Plan Amendment was submitted to CMS on June 6, 2010 to implement the legislatively appropriated increase of provider rates of 0.5%.

The State Plan Amendment was approved by CMS on August 18, 2010.

**Outpatient Hospital Rate Reduction – July 1, 2010.** A State Plan Amendment was submitted to CMS on June 16, 2010 which would reduce the current payment rate of 82.45% of the cost-to-charge ratio to 75% of the cost-to-charge ratio.

Regulations are pending.

The State Plan Amendment was approved by CMS on December 8, 2010.

**Orthodontic Reimbursement.** Proposed regulations clarify that the date of payment for orthodontic treatment must occur after the orthodontist receives an approved prior authorization and after the initial appliances have been placed. The regulations further require that, if a Medicaid client who is receiving orthodontic treatment transfers to another dentist, the authorized dentist must refund the portion of the amount paid by Medicaid that applies to the treatment not completed to Medicaid.

Regulations are pending.

**Physician Assistants.** Proposed regulations provide for enrollment of physician assistants as

Medicaid providers under a group provider agreement for physical health services. In addition, the proposed regulations would repeal provisions for payment of physicians' mileage for home, nursing facility, and ICF/MR visits.

Regulations are pending.

**Community Support Services.** CMS informed DHHS that the monthly payment for Community Support Services must be changed to a service by service rate.

Regulations are pending.

The State Plan Amendment was approved by CMS on November 30, 2010.

## **BENEFITS**

**Partial Hospitalization-- pending.** On June 28, 2010, DHHS submitted a State Plan Amendment to add Partial Hospitalization services. Partial Hospitalization services were previously a waiver service only. This change will allow partial hospitalization services to any Medicaid eligible client who meets the medical need for the service.

Regulations are pending.

The State Plan Amendment is pending before CMS.

**Radiology Management – September 1, 2009.** Established prior authorization for all non-emergency Computerized Tomography (CT) scans, Magnetic Resonance Angiogram (MRA) scans, Magnetic Resonance Imaging (MRI) scans, Magnetic Resonance Spectroscopy (MRS) scans, Nuclear Medicine Cardiology scans, Positron Emission Tomography (PET) scans, and Single Photon Emission Computed Tomography (SPECT) scans. This applies only to services rendered in an outpatient setting and excludes both inpatient and emergency room services.

Regulations were effective September 1, 2009.

The State Plan Amendment was approved by CMS on June 30, 2009.

**Managed Care Expansion – November 1, 2009.** Expanded the designated coverage areas of mandatory enrollment for the basic benefits package (medical/surgical plans) to include Cass, Dodge, Gage, Otoe, Saunders, Seward, and Washington counties (continuing to include Douglas, Sarpy, and Lancaster).

Regulations were effective July 11, 2009.

The State Plan Amendment was approved by CMS on March 3, 2010.

**Managed Care Disenrollment - July 1, 2009.** Limits managed care client disenrollment to: with cause, at any time, and without cause once every 12 months thereafter and at specified times

related to changes in eligibility. Makes other technical editing revisions, such as the Department's name and references to Department staff.

Regulations were effective July 11, 2009.

The State Plan Amendment was approved by CMS on December 7, 2009.

**Pediatric Feeding Disorder Clinic (LB 342) – July 1, 2010.** A State Plan Amendment to provide for Medicaid payments for the comprehensive treatment of pediatric feeding disorders through interdisciplinary treatment was submitted to CMS on May 27, 2010.

Regulations are pending.

The State Plan Amendment is pending before CMS.

**Implementation of At-Risk Managed Care – August 1, 2010.** Effective November 1, 2009, managed care was expanded from Douglas, Sarpy and Lancaster counties to include the counties of Otoe, Cass, Washington, Saunders, Dodge, Gage, and Seward. DHHS selected two Managed Care Organizations (MCOs), United Health Care of the Midlands, Inc. (Share Advantage) and Coventry Health Care of Nebraska, Inc. for the ten county area. The two MCO contracts began August 1, 2010. The Primary Care Case Management (PCCM) program ended July 31, 2010. The MCOs will cover more than 95,000 clients.

Regulations were effective August 18, 2010.

The State Plan Amendment was approved by CMS on June 22, 2010.

**Medical Home Pilot Project (LB 342).** DHHS has developed a two-year medical home pilot program in consultation with the Medical Home Advisory Council. Through a Request for Interest process, two practices were selected for this pilot: Kearney Clinic and Plum Creek Medical Group, Lexington. The purpose of the pilot is to improve health care access and health outcomes for patient and to contain costs of the medical assistance program. The payment methodology includes a per-member-per-month (PMPM) with an option to meet advanced medical home to receive an additional reimbursement incentives. To support the practices in transforming into a patient-centered medical home, they will receive comprehensive technical assistance, a patient registry, and funding for care coordination staff. The pilot, expected to be implemented in early 2011, will be evaluated for improved health care access and improved health outcomes for patients, Medicaid cost containment, patient satisfaction, and provider satisfaction.

Regulations are pending.

The State Plan Amendment is pending before CMS.

**Early Intervention for Infants and Toddlers with Disabilities Medicaid Waiver – January 31, 2009.** This waiver was terminated and the few children served under it were transferred to the Aged and Disabled Medicaid Waiver with no loss of services to the affected children.

The regulations governing the Early Intervention Waiver were repealed on February 25, 2009.

**Home Again Service, Aged and Disabled Medicaid Waiver – November 9, 2009.** Adopted regulations to implement the Home Again Service in the home and community-based Aged and Disabled Waiver. This service supports Medicaid-eligible nursing facility residents who are transitioning to a more independent living situation of their choice by authorizing payment for items and services that are essential to a successful move from the nursing facility, and which cannot be obtained through any other source.

Regulations were effective November 9, 2009.

**Tobacco cessation services and products – December 1, 2008.** Added coverage of tobacco cessation products and services.

Regulations were effective December 1, 2008.

The State Plan Amendment was approved by CMS on March 10, 2009.

**Preferred Drug List (PDL) – October 14, 2009.** The Medicaid Prescription Drug Act, Neb. Rev. Stat. § 68-950, provided appropriate pharmaceutical care to Medicaid recipients in a cost-effective manner through the development of a PDL. Regulations were revised to allow for the collection of supplemental rebates, the implementation and maintenance of the PDL and the formation of an advisory board, the Pharmaceutical and Therapeutics Committee.

Regulations were effective September 5, 2009.

A State Plan Amendment was approved by CMS on July 28, 2009 authorizing the State of Nebraska to enter into The Optimal PDL Solution (TOP\$) multi-state purchasing pooling agreement to collect supplemental rebates. On July 26, 2010 a State Plan Amendment approved minor changes in the Supplemental Rebate Agreement.

**Subacute Psychiatric Inpatient Services – April 12, 2008.** A State Plan Amendment for Adult Subacute Psychiatric Inpatient Services was submitted to CMS to provide coverage for subacute psychiatric inpatient hospital services for adult clients who are in need of additional days of treatment at an inpatient level of care but are not acute enough for inpatient psychiatric treatment.

Regulations were effective April 12, 2008.

The State Plan Amendment was approved by CMS on May 18, 2010.

**Licensed Independent Mental Health Practitioners (LIMHPs) – October 1, 2008.** A State Plan Amendment to add LIMHPs to the State Plan was approved by CMS. This change allowed

the LIMHP to practice independently and to supervise the treatment of other licensed practitioners who require clinical supervision of their services.

Regulations were effective October 1, 2008.

The State Plan Amendment was approved by CMS on June 3, 2010.

**Secure Psychiatric Residential Rehabilitation Services – April 1, 2010.** This amendment to the State Plan provides intensive community based treatment and rehabilitation service for individuals with severe and persistent mental illness in a secure and safe environment.

Regulations were effective June 15, 2010.

The State Plan Amendment was approved by CMS on March 19, 2010.

### **Amendments to the Approved Waiver Applications**

Amendments to Children’s Developmental Disabilities (DD) waiver, Comprehensive Adult DD waiver, Residential Adult DD waiver, and Day Services Adult DD waiver, approved April 1, 2010, established reimbursement for specialized assisted services on a daily rate basis. No fiscal impact.

Amendments to Community Supports Adult waiver and Comprehensive Adult DD waiver, approved April 1, 2010, increased the number of slots on each waiver to allow individuals with existing funding authorization to participate. No fiscal impact.

Amendments to Comprehensive Adult DD waiver, Residential Adult DD waiver, and Day Services Adult DD waiver, approved May 1, 2010, expanded the definition of Vocational Planning services and Integrated Community Employment service options for individuals with existing funding authorization. No fiscal impact.

Amendments to Children’s DD waiver, Community Supports Adult waiver, Comprehensive Adult DD waiver, Residential Adult DD waiver, and Day Services Adult DD waiver, approved October 1, 2010, updated Division roles and responsibilities related to specialized provider certification activities and investigation of complaints. No fiscal impact.

Amendment to Nebraska Health Connections Combined Waiver was approved August 1, 2010. An amendment to the 1915(b) waiver was approved August 1, 2010, discontinues the Primary Care Case Management program for physical health managed care and implements 2 full-risk, capitated Managed Care Organizations (MCO) health plans in 10 counties. The amendment also allows the mandatory enrollment of special needs children and American Indians in the expansion counties.

**Autism Waiver State Plan Amendment – No Implementation.** The autism waiver was approved by CMS with an effective date of April 8, 2010. Autism waiver regulations went into effect October 6, 2010. The State Plan Amendment related to parental premiums as required by

Neb. Rev. Stat. § 68-966 was approved by CMS with an effective date of March 18, 2010. The legislation regarding the waiver required the receipt of matching funds from private donations to finance the program. DHHS was notified in July 2010 that the primary donor has decided not to proceed with the planned financial donation. So that DHHS would be ready to implement the waiver upon receipt of the private funds required in the statute, the regulations continued through the promulgation process.

**The Community Supports Program Medicaid Waiver for Adults with Intellectual or Development Disabilities - August 1, 2009.** CMS approved the Home and Community Based Services (HCBS) waiver renewal for a five year period. Services provided by this waiver consist of community living and day supports (CLDS), respite services, personal emergency response system, assistive technology and supports, home modifications, and vehicle modifications.

## **ADMINISTRATION**

**Tribal Consultation – pending.** A State Plan Amendment incorporating the tribal consultation process was submitted to CMS on December 6, 2010 setting forth the consultation process between the State and various tribal entities, as required by Federal law. This process applies to proposed State Plan Amendments as well as 1915(b) waiver renewals, managed care waiver amendments and initial waivers. Tribal entities have an opportunity to comment and respond to the proposed State Plan Amendment prior to submission to CMS.