Division of Medicaid & Long-Term Care

Nebraska Medicaid Annual Report

December 1, 2012

Prepared in Accordance with Neb. Rev. Stat. § 68-908(4)

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Department of Health & Human Services
DHHS
NEBRASKA

Division of Medicaid and Long-Term Care

State of Nebraska
Dave Heineman, Governor

December 1, 2012

We are pleased to present the Medicaid Annual Report for State Fiscal Year 2012. The Children's Health Insurance Program, CHIP, which Nebraska administers as a Medicaid expansion, is included in the Report.

In SFY 2012, Nebraska Medicaid's expenditures of $1.6 billion accounted for 16.7% of total state budget. While the number of average monthly eligible persons under Medicaid rose modestly in SFY 2012, 0.9% to 237,543, a multi-year cycle of increased numbers of eligible persons and the national economic downturn have posed significant challenges for management of the Medicaid program. These pressures underline the importance of ongoing efforts to control Medicaid costs, and emphasize the importance of the Medicaid Reform efforts begun under the Legislature's mandate in 2006.

As outlined in this report, the Division of Medicaid and Long-Term Care has undertaken a number of projects and initiatives in the past year aimed at increasing efficiency and decreasing costs. Many of these efforts involve increasing the use of technology to support services provision, operations, and oversight. State legislation and new federal requirements have also resulted in numerous projects, most with the same target of better fiscal management and more efficient service provision. This report offers a window into the ongoing work of the Division, highlighting the year's major initiatives, describing the larger projects for the year ahead, and detailing the persons served and services provided through the program.

Sincerely,

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

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

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I. INTRODUCTION

Medicaid is a public health insurance program that provides coverage for low-income individuals. Originally enacted in 1965 under Title XIX of the Social Security Act, Medicaid is an entitlement program (a program which guarantees benefits to anyone who meets the qualifications) which covers a low-income population including seniors, children and individuals with disabilities.

State Medicaid programs are administered by the states with oversight from the Centers for Medicare and Medicaid Services (CMS) through the federal Department of Health and Human Services (HHS). Every state outlines the eligibility, benefits, provider payments, and service delivery systems of its specific Medicaid program within broad guidelines set by the federal government. Eligibility and benefit packages can vary widely from state to state.

The Children's Health Insurance Program (CHIP) was created in 1997 under Title XXI of the Social Security Act, and was designed to offer insurance coverage for low-income children whose family income is above Medicaid limits. States administer their CHIP programs in a variety of different ways. In Nebraska, CHIP has been operated as a "Medicaid expansion," meaning that CHIP, with a few exceptions, operates using the same delivery system, benefit package and regulations as Medicaid.

Medicaid and CHIP are financed jointly by the federal government and state governments, with the federal government matching state spending at a rate known as the Federal Match Assistance Percentage, or FMAP, which varies from state to state. FMAP is based on each state's per capita income relative to the national average and is highest in the poorest states, varying from 50% to 83%. Nebraska's FMAP in FFY 2012 was 56.64% for Medicaid and for CHIP, 69.56%.

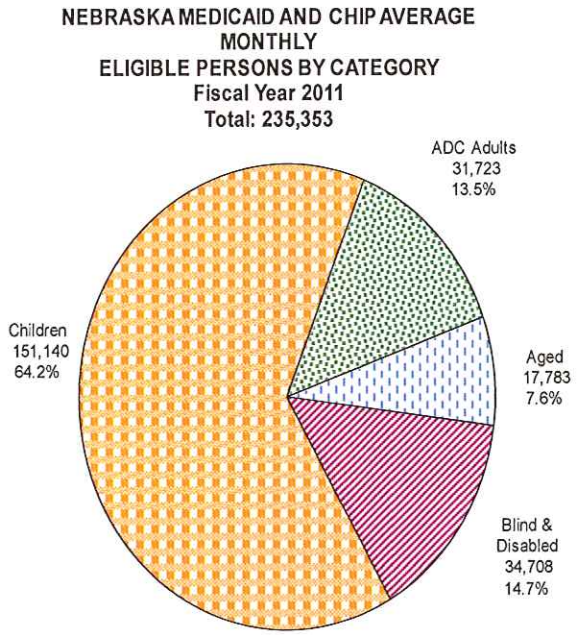
II. DISCUSSION

A. ELIGIBLE CLIENTS

Nebraska Medicaid provides coverage for individuals in the following eligibility categories: Children, Aged, Blind & Disabled and Aid to Dependent Children (ADC) Adults. Additional eligibility factors vary by group and include income, resources and employment status. Nebraska's CHIP, sometimes called Kids Connection, has operated as a Medicaid expansion program since May of 1998 and provides health coverage for eligible uninsured children if they have income at or below 200 percent of the federal poverty level (FPL) and are not eligible for Medicaid.

ELIGIBLE POPULATIONS

Figure 1



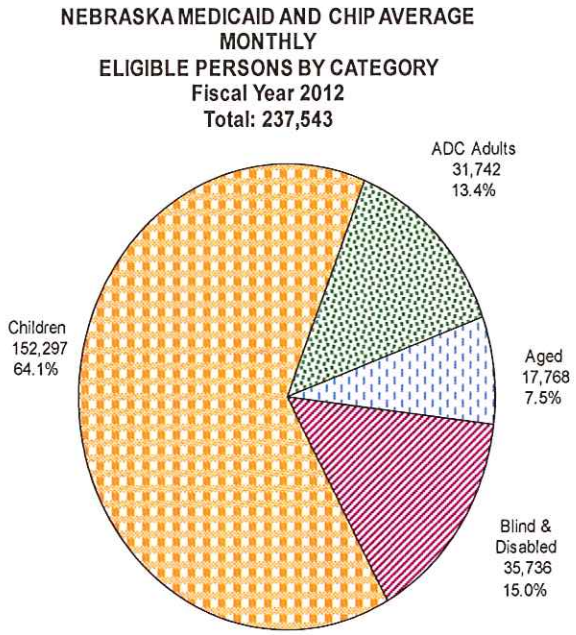
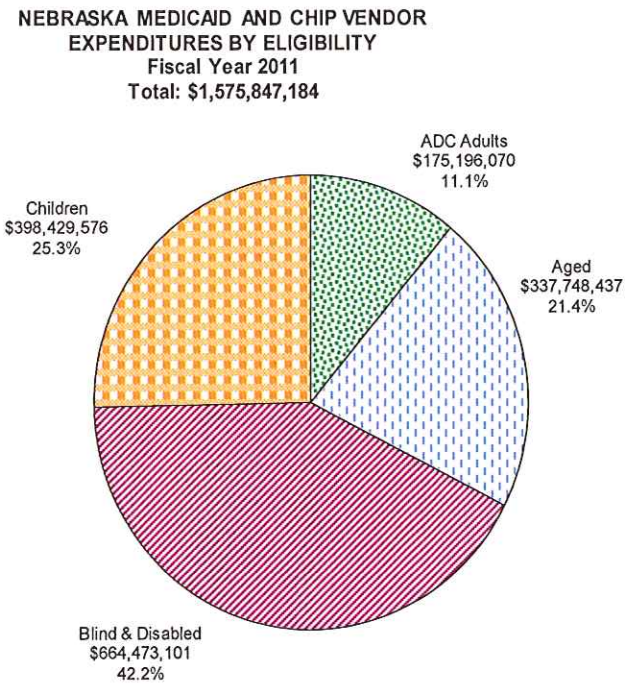


Figure 2



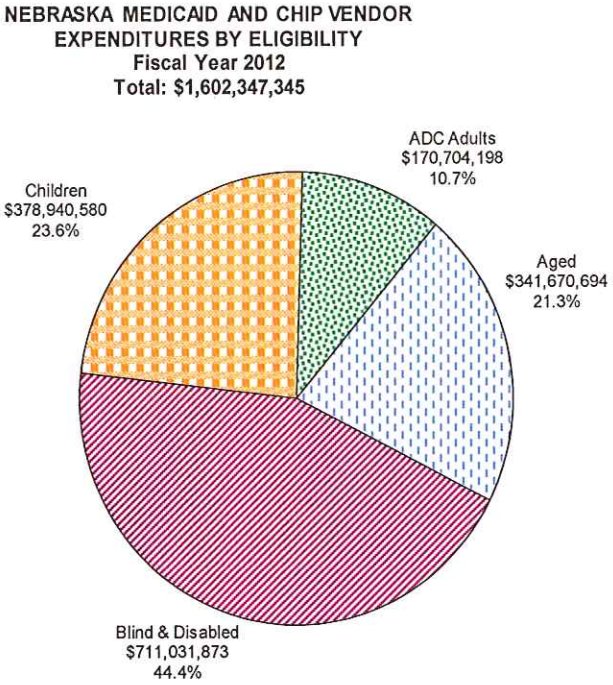


Figure 1 compares eligibility categories for State Fiscal Years (SFY) 2011 and 2012. The total increase in average monthly eligibles from SFY 2011 to SFY 2012 was 0.9%. The largest percentage increase was in the Blind & Disabled category, which grew 3.0%. Average monthly eligibles in the Children category grew by 0.8%. ADC Adults in the Aged category each decreased by 0.1%.

Figure 2 compares vendor expenditures by eligibility category for SFYs 2011 and 2012. Viewing Figures 1 and 2 together provides insight into the cost differences of different eligibility categories. While the Aged and Blind & Disabled represent 22.5% of clients, they account for 65.7% of expenditures. This is almost the exact opposite with children who account for 64.1% of clients but only 23.6% of expenditures.

Figure 2 does not account for all Medicaid/CHIP expenditures, in part because some payments and refunds are not specific to a recipient or eligibility category. Examples of transactions not shown are drug rebates, payments made outside the Medicaid Management Information Systems (MMIS), and premium payments paid on behalf of persons eligible for Medicare. Client demographic data are not available for these expenditures. This means that some expenditures, particularly in the Aged and Blind & Disabled categories, are understated. For example, Medicare Part B and Part D premium payments for clients who are eligible for both Medicaid and Medicare, i.e. duals. These premium payments totaled $90,050,152 in SFY12. Prorating these expenditures between the Blind & Disabled and the Aged increases total expenditures in SFY 2012 for Blind & Disabled to 44.8% and to 22.7% for the Aged.

The largest increase was 7% in the Blind & Disabled category. Over half of this increase can be explained by the recertification of the Beatrice State Developmental Center (BSDC) allowing it, once again, to bill as a Medicaid provider. The expenditures for Intermediate Care Facility for persons with Mental Retardation (ICF/MR) services, such as those offered by BSDC, increased $24,500,012 from SFY 2011 to SFY 2012.

Other service categories which contributed to the increase in Blind & Disabled expenditures are prescribed drugs and home-and community-based waiver services (HCBS). Prescribed drugs increased approximately 7% ($4,887,840) from $68,055,387 in SFY 2011 to $72,943,227 in SFY 2012. HCBS services increased approximately 6%, or $12,406,168 from $216,418,741 in SFY 2011 to $228,824,909 in SFY 2012. The majority of this increase was in the waivers which serve persons with developmental disabilities. The three service types, ICF/MR, prescribed drugs, and HCBS, account for approximately 90% of the increased expenditures in the Blind & Disabled category. The remaining 10% is spread over several service types with less than 3% in any given service.

The Aged category was the second largest growing eligibility category with expenditures increasing 1.2% ($3,922,257) from $337,748,437 in SFY 2011 to $341,670,694 in SFY 2012. The largest increase in expenditures for the Aged was Nursing Facilities at $4,208,930. Total Nursing Facility expenditures increased to $230,560,888 in SFY 2012 compared to $226,351,958 in SFY 2011. The increase in nursing facilities expenditures is the result of LB 600 passed in the 2011 Legislative Session. LB 600, also known as the Nursing Facility Quality Assurance Assessment Act, established a nursing facility provider tax. The majority of the tax is

used to enhance Medicaid rates paid for Nursing Facility services. As in the Blind & Disabled, ICF/MR services accounted for a significant portion, $2,882,627 of the increase in expenditures. HCBS had the next highest increase in expenditures at $513,918, a 1.8% increase from SFY 2011.

The final two eligibility groups, ADC Adults and Children, had a decline in expenditures from SFY 2011 to SFY 2012. The expenditures for Children had the largest decrease, 4.9%, $19,488,996. ADC Adult expenditures decreased 2.6%, $4,491,872. The reduction in expenditures is attributable to managed care.

The most significant decrease was $15,918,649 to Inpatient Mental Health services. This decrease was the direct result of policy changes, effective July 1, 2011, to come into compliance with CMS rules regarding behavioral health services provided in a residential setting. While capitation payments increased 16.5%, $13,783,183, there were corresponding decreases in services in Managed Care such as physician services, 19%, $7,070,983; Inpatient Hospital, 8%, $6,162,035 and Laboratory Services, Radiology, and Home Health.

ADC Adults experienced similar decreases in expenditures due to the expansion of Managed Care. Capitation payments increased at just under 16%, $9,642,414. There were corresponding decreases in Inpatient Hospital services 20%, $6,578,315; Physician services, 18%, $3,776,384; and Outpatient Hospital services, 10%, $1,799,021. The remaining reductions totaled $3,350,115 and were spread out between several services such as Laboratory & Radiology, Home Health, Family Planning and Other Care.

B. COVERED SERVICES

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

Figure 3

Federal Medicaid Mandatory and Optional Services Covered in Nebraska
Neb. Rev. Stat. 68-911

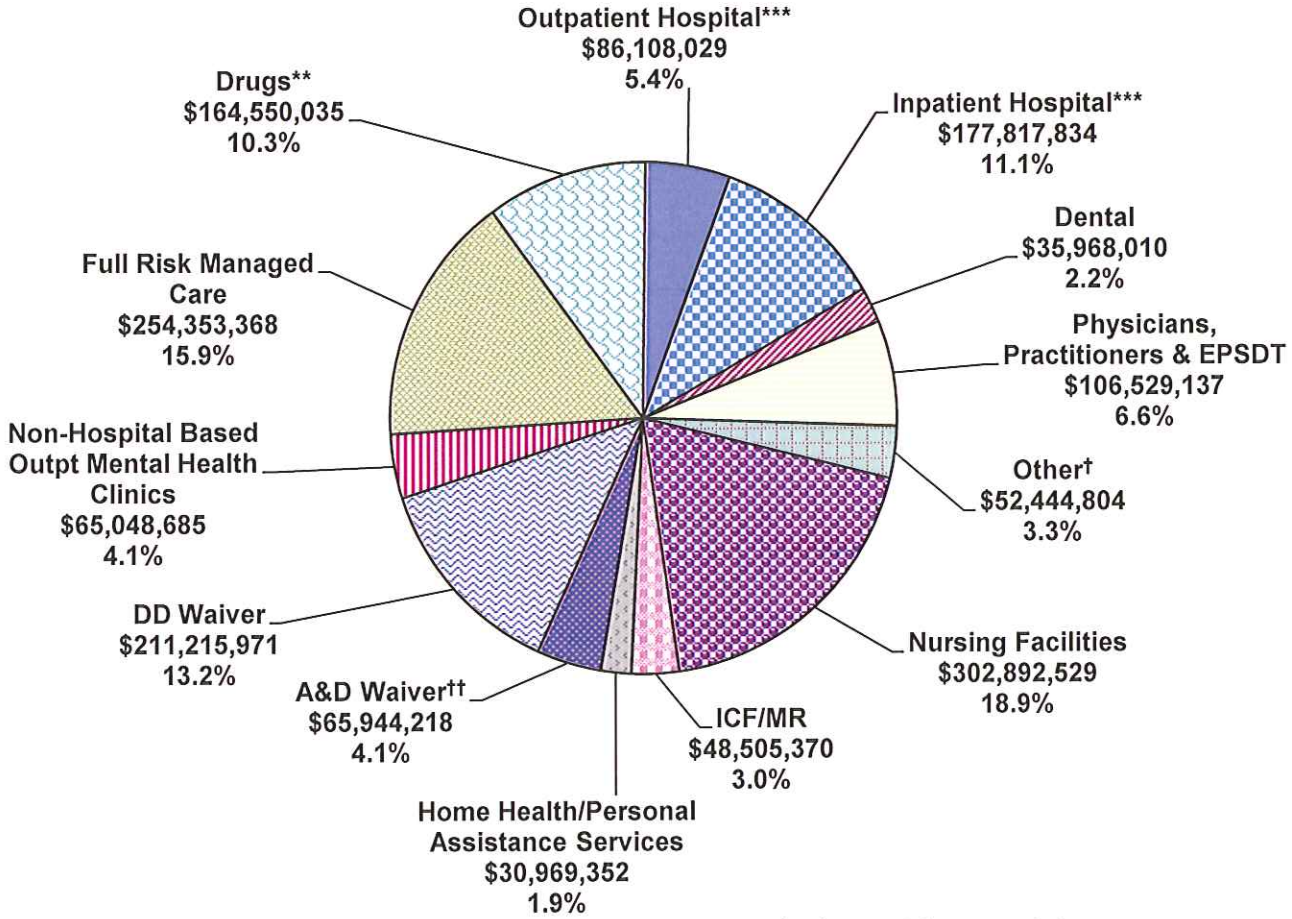
Mandatory Services	Nebraska Optional Services
• Inpatient and outpatient hospital services • Laboratory and x-ray services • Nursing facility services • Home health services • Nursing services • Clinic services • Physician services • Medical and surgical services of a dentist • Nurse practitioner services • Nurse midwife services • Pregnancy-related services • Medical supplies • Early and periodic screening and diagnosis treatment (EPSDT) services for children	• Prescribed drugs • Intermediate care facilities for the mentally retarded (ICF/MR) • Home and community-based services for aged persons and persons with disabilities • Dental services • Rehabilitation services • Personal care services • Durable medical equipment • Medical transportation services • Vision-related services • Speech therapy services • Physical therapy services • Chiropractic services • Occupational therapy services • Optometric services • Podiatric services • Hospice services • Mental health and substance abuse services • Hearing screening services for newborn and infant children • School-based administrative services

VENDOR EXPENDITURES

Figure 4 shows how the $1.6 billion in Medicaid/CHIP expenditures to vendors are distributed by vendor type. Total vendor payments increased $26,500,161 or 1.7% from SFY 2011 to SFY 2012. The modest nature of this increase can be partially explained by the transition to managed care. However, implementation of new billing processes related to federal HIPAA 5010 requirements resulted in delays in billing and payment which may cause expenditures to be understated. 2013 expenditures may reflect the resolution of the billings issues resulting from the 5010 implementation.

Figure 4

Nebraska Medicaid and CHIP Vendor Expenditures* by Service
Fiscal Year 2012
Total Vendor Payments $1,602,347,345



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

** $81.8 million in offsetting drug rebates is not reflected in the drug expenditures of $164,550,035

*** DSH payments of $50.2 million are not reflected in Inpatient or Outpatient Hospital Expenditures

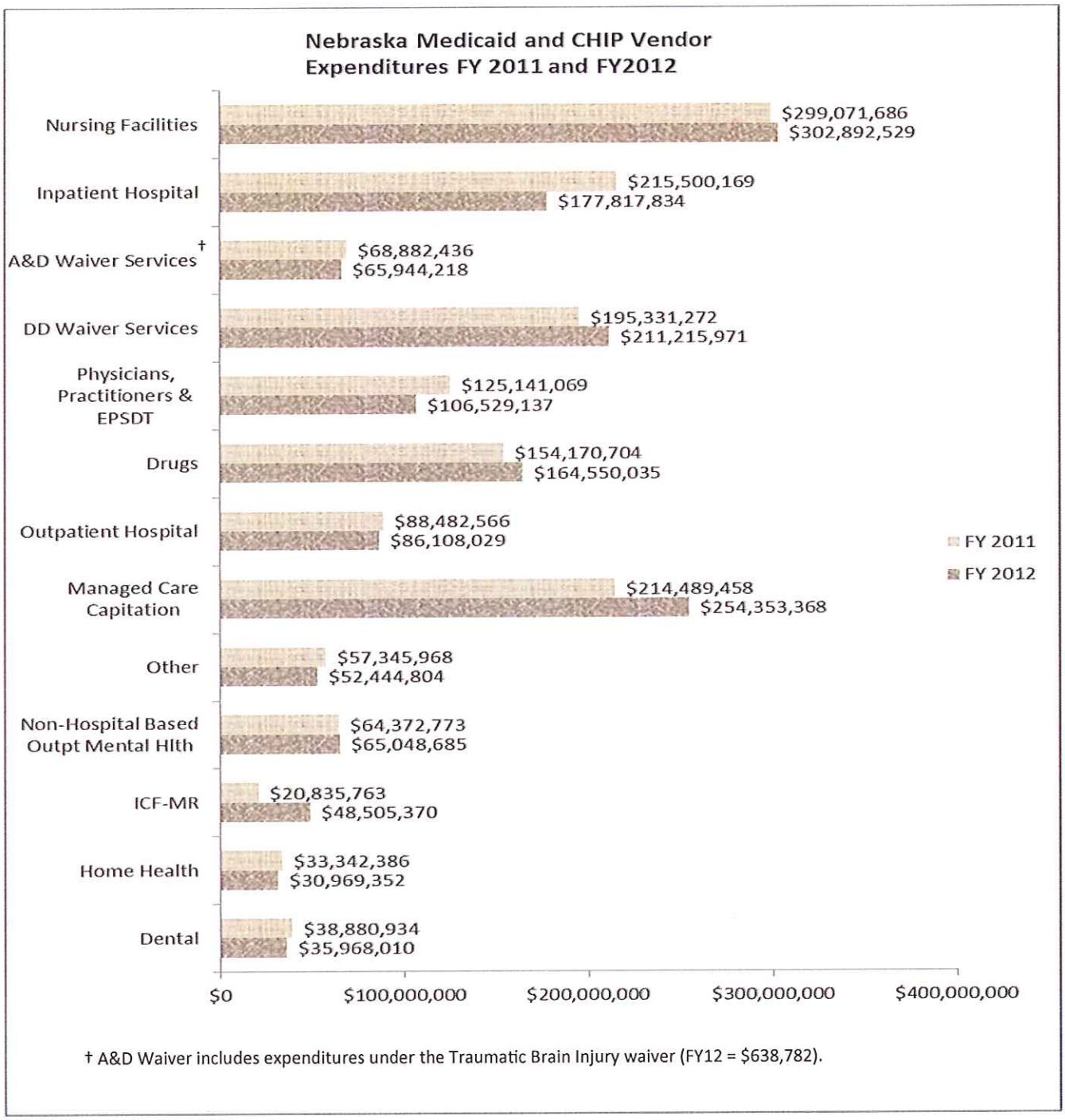
† Includes Speech/ Physical Therapy, Medical/Optical Supplies, Ambulance, and Lab/Radiology

†† A&D Waiver includes $638,782 of expenditures under the Traumatic Brain Injury waiver

A significant shift in the management and administration of Medicaid services has taken place over the past several years with the growth of managed care. Full risk managed care is a health care delivery system where Managed Care Organizations (MCOs) are contracted to operate a health plan that authorizes, arranges, provides, and pays for the delivery of services to enrolled clients. Managed care offers an opportunity to assure access to a primary care provider, emphasizes preventive care, and encourages the appropriate utilization of services in the most cost-effective setting. Nebraska Medicaid has utilized managed care in three urban counties since 1995, and added the seven surrounding counties in August 2010. As of July 1, 2012, Nebraska's managed care program was further expanded to statewide managed care for physical health services. This move is projected to result in additional savings in Medicaid and CHIP over time.

Figure 5 shows vendor expenditures from SFY 2011 and 2012 side by side. Expanding full-risk capitated physical health managed care to cover 10 counties explains the decrease in these services and the corresponding increase in the Managed Care Capitation service. Even after taking into account billing issues related to the implementation of HIPAA 5010 transactions and the full provider revalidation process, which may artificially lower SFY 2012 expenditures, these decreases show that the Managed Care program is controlling the costs of Medicaid and CHIP.

Figure 5



† A&D Waiver includes expenditures under the Traumatic Brain Injury waiver (FY12 = $638,782).

Figure 6

$1,602,347,345	**Vendor Payments**
$50,240,317	Disproportionate Share Hospital/Rate Adjustments
$43,376,690	Medicare Premiums
$ 4,363,355	Intergovernmental Transfer (IGT)
$42,987,099	Other Payments (Managed Care, Transportation, Federal Insurance Contributions Act taxes, AssistTech, Upper Limit Pmts)
($88,984,249)	Rebates/Refunds
($112,510,238)	General Funds Paid in Other Budget Programs
$46,673,462	Phased Down Contribution
$1,588,493,780	**Net Medicaid and CHIP Expenditures**

Not all Medicaid/CHIP expenditures are captured in Figure 4. Medicaid/CHIP vendor expenditures totaled $1,602,347,345 in SFY 2012. The net program expenditures for this same time period totaled $1,588,493,780. Several of these manual transactions are highlighted below.

Drug rebates refer to reimbursements made by pharmaceutical companies to Medicaid/CHIP that bring down individual drug cost to a more competitive or similar price that is being offered to other large drug payers, such as insurance companies. In SFY 2012, Medicaid received $81.8 million in Drug Rebates, an increase of 11% compared to the $73.7 million received in SFY 2011.

Medicaid pays the Medicare Part B premium for clients that are dually eligible for Medicare and Medicaid. In SFY 2012, Medicaid paid $43,376,690 for Medicare Premiums, an 8% decrease from the $47,134,300 paid in SFY 2011. This reduction is directly related to a reduction in the Part B premium amount from $115.40 in calendar year (CY) 2011 to $99.90 in CY 2012. CY 2013 premium amounts have not yet been released.

Disproportionate Share Hospital (DSH) payments are an add-on to hospitals that serve a high number of Medicaid and uninsured patients. In SFY 2012, Medicaid paid $50,240,316 through the DSH program, a 10% increase compared to $45,638,700 paid in SFY 2011.

Intergovernmental Transfers are payments made to public providers that have 40% or higher Medicaid utilization and whose direct nursing or direct support costs have exceeded the Medicaid maximum allowable rate. In SFY 2012, Medicaid paid $4,673,462 for Intergovernmental Transfers, a slight increase of 2% from the $4,573,772 paid in SFY 2011.

Part D Clawback payments are made to CMS to cover the State's share of prescription drugs for persons dually eligible for both Medicare and Medicaid. In SFY 2012, Clawback payments totaled $46,673,462, a 33% increase from the $34,960,645 paid in SFY 2011. The Clawback payment amount per person is based on a complex formula that takes into account the cost of

drugs and the Federal Medical Assistance Percentage (FMAP). Nebraska's FMAP has been steadily decreasing since FFY 2011.

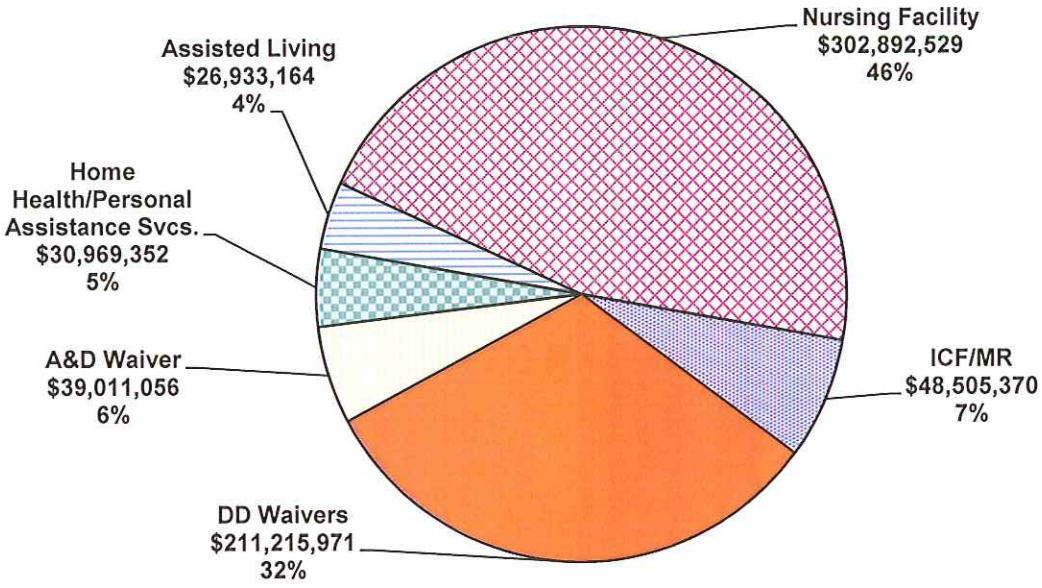
LONG-TERM CARE SERVICES

Long-Term Care Services support individuals with chronic or ongoing health needs related to age or disability. Services are geared to multiple levels of client need ranging from limited assistance with activities of daily living to complex nursing interventions. Assistance can be offered in a variety of settings from care in an individual's home, to care in small group settings with community supports, to care in a nursing facility or intermediate care facility for persons with mental retardation.

In general, home and community based care is less expensive and offers greater independence for the consumer than facility based care. For these reasons, state and federal initiatives encourage the development of care options in the community as an alternative to institutional care. Efforts to encourage home and community based alternatives to facility based care are resulting in a gradual rebalancing of long-term care expenditures. Figure 7 compares Long-Term Care Services expenditures in Fiscal Year 2007 and in Fiscal Year 2012. Although the percentage of expenditures in institutional settings has decreased in the last five years, much work needs to still be done to continue the shift to community-based care from institutional care.

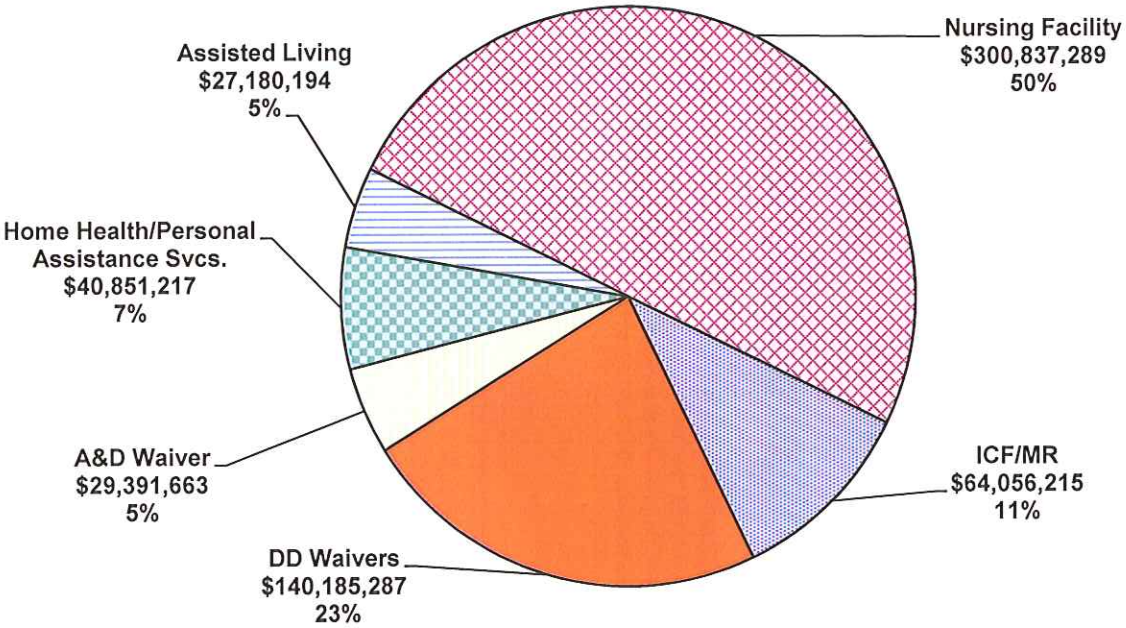
Figure 7
SFY2012 Medicaid Expenditures for Long-Term Care Services

Total: $659,527,443



SFY2007 Medicaid Expenditures for Long-Term Care Services

Total: $602,501,865



C. PROVIDER REIMBURSEMENT

Medicaid purchases health services for clients on a fee for service basis or, increasingly, by paying premiums to managed care plans which coordinate provider networks and provider reimbursements.

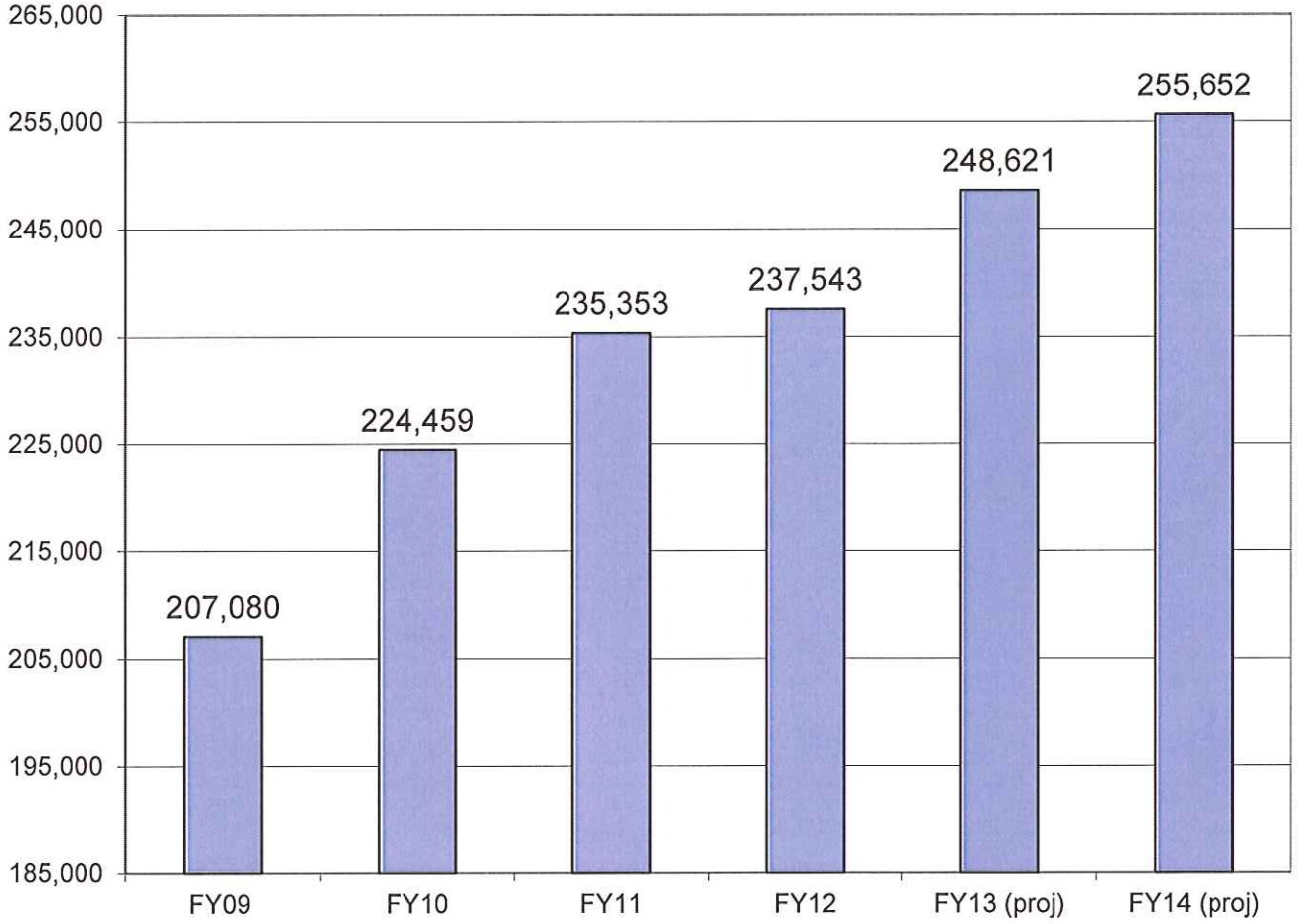
The Nebraska Medicaid Program uses different methodologies to reimburse different Medicaid services. Practitioner, laboratory, and radiology services are reimbursed according to a fee schedule. Prescription drugs are reimbursed according to a discounted product cost calculation plus a pharmacy dispensing fee. Inpatient Hospital services are reimbursed based on a prospective system using either a diagnosis related group (DRG) or per diem rate. Critical Access Hospitals are reimbursed a per diem based on reasonable cost of providing the services. Federally Qualified Health Centers (FQHCs) are reimbursed on a prospective payment system. Rural Health Clinics (RHCs) are reimbursed cost or a prospective rate depending on whether they are independent or provider-based. Outpatient Hospital reimbursement is based on a percentage of the submitted charges. Nursing Facilities are reimbursed a daily rate based on facility cost and client level of care. Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) are reimbursed on a per diem rate based on a cost model. Home and Community Based Waiver services, including Assisted Living costs, are reimbursed at reasonable fees as determined by Medicaid.

In many states, budget and enrollment pressures on Medicaid have led to cuts in provider rates. Nebraska Medicaid providers have received increased rates every year from 2005 through 2011. Effective July 1, 2011, rates for all provider types, excepting primary care services, were decreased by 2.5%. Effective July 1, 2012, the rates that were decreased were increased 1.54%.

D. PROGRAM TRENDS AND PROJECTIONS

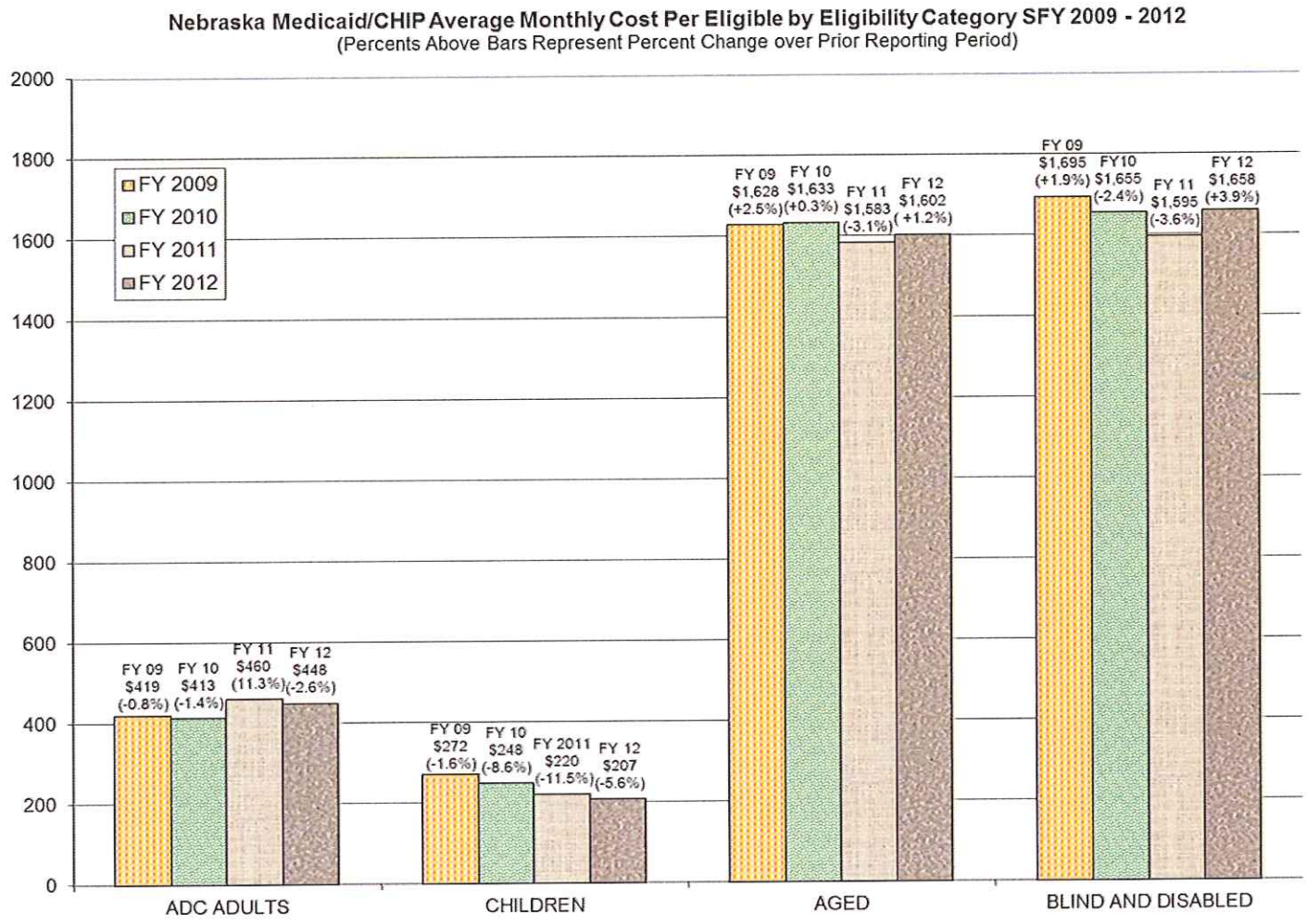
Figure 8

Nebraska Medicaid and CHIP Average Monthly Eligibles
SFY 2009-2012 Actual and SFY 2013-2014 Projected
Based on Current Economic Predictions
(Does not include Federal Health Reform)



Growth in Medicaid/CHIP eligibility was moderate from SFY 2006 through SFY 2008. As depicted above, Nebraska experienced a significant increase in eligible the latter half of SFY 2009 that continued until the first half of SFY 2010. Increase from SFY 2011 to SFY 2012 was a modest 1.7% with the increase attributed in part to the statutory expansion of the Children's Health Insurance Program (CHIP) eligibility to 200% FPL and to the national economy. Projections for SFY 2013 predict an overall increase of 4.7%. Based on historical trends, the ADC Adult population is expected to increase 1.5%, the Aged population is expected to remain flat with no increase and both the Blind/Disabled and Children groups are expected to increase by 5%.

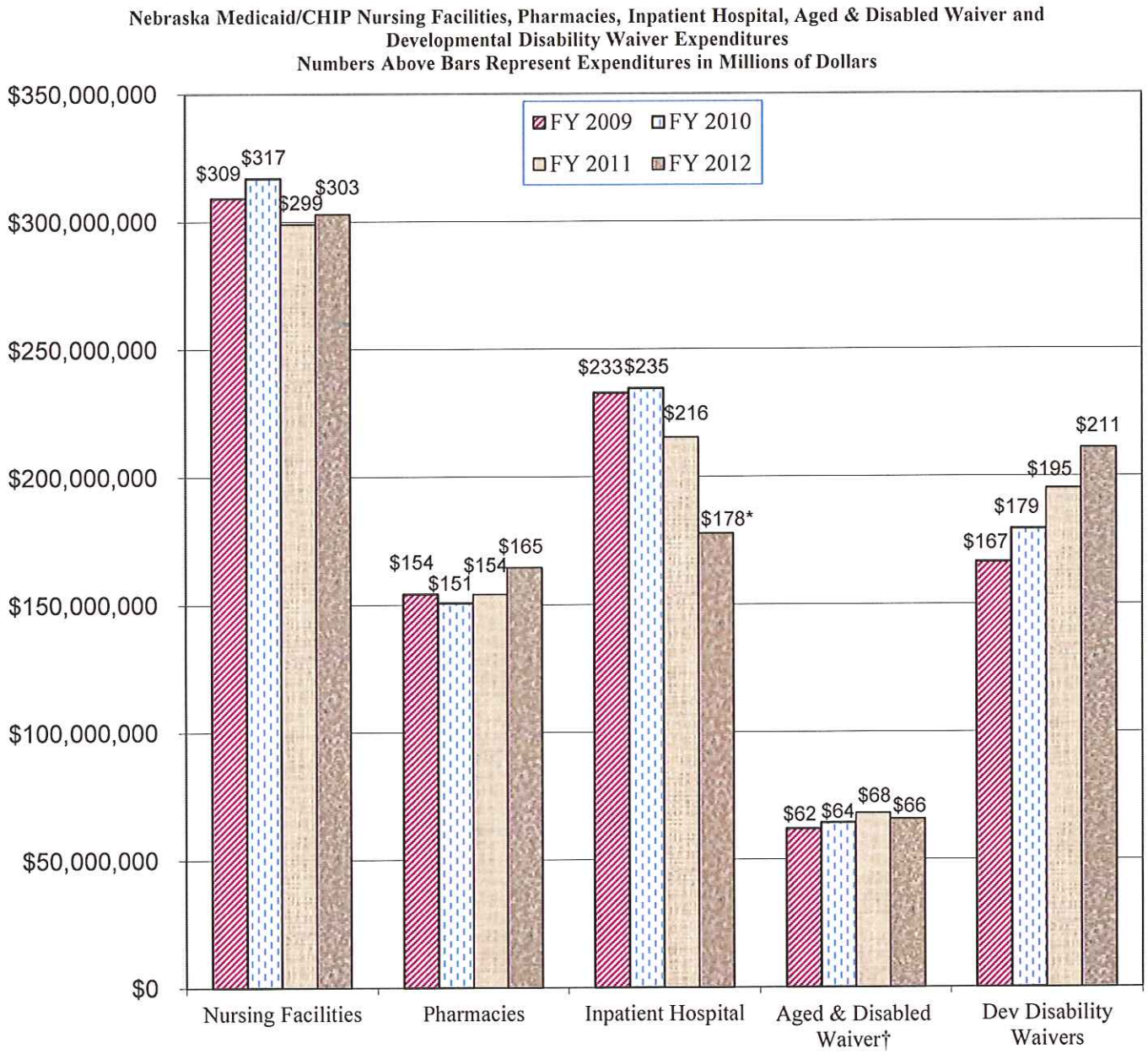
Figure 9



The average monthly cost per eligible (Figure 9) increased 0.7% overall from SFY 2011 to SFY 2012. The largest cost per eligible increase was in the Blind & Disabled category, which increased by 3.9%. The Aged category increased by 1.2%. The ADC Adult category decreased by 2.6% and the Children category decreased by 5.6%. As noted previously, decreases in expenditures in the Adult and Children categories appear to be related, in large part, to the increasing inclusion of those clients in managed care.

The top four vendor expenditure categories in Medicaid/CHIP (excluding managed care capitation payments) are nursing facilities, pharmacies, inpatient hospital and home and community services. The home and community service category consists of home health, personal assistance services and waiver services, including assisted living. Figure 9 (previous page) reflects the trends in these categories from SFY 2009 through SFY 2012. The drop in Inpatient Hospitalization expenditures reflects inclusion under managed care.

Figure 10



*Effective 8-1-11, Full-Risk Managed Care was expanded to 10 counties. Inpatient Hospital is included in Managed Care.
†A&D Waiver includes expenditures under the Traumatic Brain Injury waiver (FY12 = $638,782).

E. SFY 2012 INITIATIVES

Highlighted below are some of the major projects during SFY2012.

Managed Care for Physical Health, Statewide Expansion

Full-risk managed care was implemented statewide effective July 1, 2012. The two MCO health plans that were awarded the contracts for the additional 83 counties were AmeriHealth Nebraska, Inc./Arbor Health Plan, and Coventry Health Care of Nebraska, Inc./CoventryCares.

Residential Treatment for Children

Nebraska Medicaid has undertaken a number of changes to ensure compliance with federal Institute for Mental Disease (IMD) laws. An IMD is defined as a hospital, nursing facility or other institution of more than 16 beds where more than 50% of the residents have a mental health or substance abuse diagnosis. An IMD primarily engages in providing diagnosis, treatment or care of persons with mental disease, including medical care, nursing care or any other related services. Persons residing in an IMD are not eligible for Medicaid benefits unless the IMD serves a population of residents age 18 or younger and the facility is a Psychiatric Residential Treatment Facility (PRTF) or if the residents are 65 years of age or older. Providers of children's residential services finalized their compliance plans by June 30, 2012.

Discontinuation of Nursing Facility Turnaround Documents

As a part of the effort to become HIPAA 5010 compliant by January 1, 2012, Medicaid discontinued generating Turnaround Documents (TADs) previously used by nursing facilities to bill for monthly Medicaid client services. Nursing facilities now have two options for billing Nebraska Medicaid: electronic billing or standard paper claim. The electronic billing option eliminates the need for manual data entry and results in quicker processing and payment times.

Durable Medical Equipment and Supplies for Clients in Nursing Facilities and ICF/MRs

In May of 2011, CMS made Nebraska Medicaid aware of the need to correct the payment of durable medical equipment and supplies for clients residing in nursing facilities and ICF/MRs. Medicaid established a transition plan whereby payments formerly made to Durable Medical Equipment (DME) suppliers will instead be made to the facilities. Medicaid developed new reimbursement methodology to comply with federal requirements and notified the DME providers and the facilities of these changes. Communication between DME providers, facilities and MLTC continues as full compliance is attained.

Electronic Health Record (EHR) Incentive Payment Program

A provision of the 2009 federal American Reinvestment and Recovery Act (ARRA) known as the HITECH act established, among other health information technology-related initiatives, the Electronic Health Record (EHR) Incentive Payment Program. This program, which is administered both through the federal Medicare program and by individual states through their

Medicaid programs, provides payments to eligible providers and hospitals when they acquire and ultimately become "meaningful users" of certified electronic health record technology. For providers, the payments can total a little over $63,000 over 6 years; hospital payments, made over three years, are determined by a number of factors, beginning with a base rate of $2 million which can be increased or decreased by discharge numbers and growth rate trends. Incentive payments are 100% federal funds and administration of the program by Nebraska Medicaid is matched with 90% federal funding. Enrollment in Nebraska Medicaid's EHR Incentive Program opened May 2012 and by the end of SFY 2012, 15 eligible providers and 5 eligible hospitals had been paid incentives totaling $2.2 million. An estimated 450 providers and 30 hospitals will qualify for approximately $25 million in Nebraska Medicaid EHR Incentive payments in SFY 2013. HITECH funds this program through 2021.

Enhanced Provider Enrollment and Screening Requirement

CMS published the Medicaid Program Integrity final rule on enhanced provider enrollment and screening requirements in February 2011. MLTC continues to work on implementing the enhanced requirements. Risk levels have been established for all provider categories and all providers are subject to additional screening requirements prior to enrollment. All prescribing, referring, and ordering providers are included in the requirements.

HIPAA 5010

In the Health Insurance Portability & Accountability Act of 1996 (HIPAA) regulations, the Secretary of Health and Human Services (HHS) adopted certain standard transactions for Electronic Data Interchange (EDI) of health care data, including exchanges between Medicaid providers and Medicaid. An update of the transactions to HIPAA Version 5010 was mandated for implementation by January 1, 2012 and the MMIS implemented the 5010 version of HIPAA electronic transactions on that date. CMS extended the enforcement of the effective date to June 30, 2012, to accommodate providers and clearinghouses who weren't 5010 compliant by January 1. In addition to assisting providers and clearinghouses with problem-solving 5010 issues, claims staff experienced an unprecedented influx of paper claims as a result of the 5010 challenges, which impacted the ability to process claims in a timely fashion.

Increase and Add Co-Payments for Medicaid Services

Medicaid increased co-payments for Medicaid services within SFY 2012. The services impacted include inpatient hospital admissions, durable medical equipment with payment greater than $50, mental health/substance abuse service visits and brand name drugs.

Medicaid IT Architecture (MITA) Self-Assessment

The Medicaid IT Architecture (MITA) is a CMS initiative to establish national guidelines for technologies and processes that improve program administration for the State Medicaid Enterprise. All technology-related funding requests from Medicaid to CMS must now reference MITA status and explain how MITA maturity will be enhanced through the funded work. The Division completed a formal State Self-Assessment (SS-A) describing the extent to which the current Medicaid Management Information System (MMIS) aligns with the MITA framework and how requested changes will advance the transformation into the new architecture.

Medicaid Patient-Centered Medical Home Pilot

Medicaid implemented the Medicaid Patient-Centered Medical Home Pilot in February 2011. The pilot concludes in February 2013. Two practices are participating in the pilot: Kearney Clinic, Kearney (20 providers) and Plum Creek Medical Group, Lexington (10 providers). Both practices receive a per-member-per-month (PMPM) payment based on meeting the basic Tier 1 standards. As an option, if they choose to meet the advanced Tier 2 standards, they will receive an additional reimbursement incentive. The practices receive funding for a Care Coordinator staff position and DHHS provided comprehensive technical assistance to work with the clinics as they transformed into medical homes. The average number of Medicaid clients in the pilot by end of SFY 2012 was 7300, up 200 from the previous year. The pilot will be evaluated for improved health care access, improved health outcomes for patients, Medicaid cost containment, patient satisfaction and provider satisfaction.

Money Follows the Person (MFP)

The Money Follows the Person (MFP) program is a grant-funded initiative now in its fourth year in Nebraska. MFP is designed to facilitate the transition of individuals living in nursing facilities and intermediate care facilities into community living settings. A transition from a facility to community living requires a broad array of supports. An individual may require assistance securing housing, acquiring furnishings and supplies, setting up health care services and coordinating support. Nebraska's MFP has assisted 176 individuals with their transition from facility care to community living settings, 70 of those in SFY 2012. Cost analysis at 90 days post-discharge demonstrates a 50% savings in Medicaid costs for individuals transitioning from nursing facilities and a 19% savings for individuals moving from intermediate care facilities for people with developmental disabilities.

National Correct Coding Initiative (NCCI)

Medicaid implemented the pre-payment review of claims for compliance with the National Correct Coding Initiative (NCCI) in November 2011 to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. The NCCI edits initially focused on the procedure codes that were similar to those from Medicare. Those edits led to a cost avoidance of $951,284.82 for Medicaid claims processed November 2011 through March 2012. Beginning October 2012, additional NCCI edits will be added.

Nebraska Regional Poison Center

LB 525 directed the department to apply to permit unused administrative cap funds in the CHIP program to be used to match funds from the Nebraska Regional Poison Center to assist in funding the Poison Center. This legislation applies only if there are unused funds available. This State Plan Amendment describing this change was approved by the CMS in June of 2012.

Non-Emergency Medical Transportation Broker

Medicaid provides non-emergency medical transportation and non-medical transportation for Medicaid recipients. Medicaid contracted with American Medical Response/Access2Care (AMR/A2C) effective May 1, 2011 to serve as a Medicaid non-emergency medical transportation broker for eligible clients and manage the transportation benefit in a consistent,

efficient and cost effective manner. The first year of the brokerage yielded $4 million in cost savings.

Nursing Facility Quality Assurance Act

LB 600, passed by the Nebraska Legislature in 2011, directed Medicaid to assess a tax on nursing facility patient days. Once collected this assessment is paid back to the facilities and qualifies for federal matching funds at the FMAP rate. Nursing facility rates were adjusted to reflect the increased funding due to the tax, which will yield approximately $13,800,000 annually and will result in approximately $17,500,000 in additional federal funds.

Provider Validation

In SFY 2012, Medicaid completed a provider validation project that required all Medicaid Providers to validate the pertinent data in Medicaid's Provider Database. The National Provider Identifier (NPI) is an Administrative Simplification standard of the Health Insurance Portability & Accountability Act of 1996 (HIPAA). An NPI is a unique identification number for covered health care providers. The provider validation project included a review, validation and update of more than 11,400 provider accounts. This effort included requiring all Medicaid providers to validate current information and provide NPI, taxonomy and nine digit zip code for each Medicaid provider account.

Trading Partner Update

In the second quarter of CY 2011, mass adjustments of retroactive crossover claims were initiated by Medicare, which caused an extensive backlog of manual adjustments having to be processed. Multiple System Change Requests (SCRs) for the MMIS were created and implemented over a period of months to automate as many of these adjustments as possible, and updates to Medicaid's Trading Partner Agreement with its Medicare intermediary eliminated receipt of claims in which MLTC has no financial responsibility. Ultimately these changes greatly reduced the backlog of claims and allowed the Department to focus on new claims and regular adjustments.

599 CHIP

599 CHIP was implemented as a separate stand-alone CHIP program on July 19, 2012 as instructed by Legislative Bill (LB) 599. 599 CHIP is only for the unborn children of pregnant women who are ineligible under Nebraska's Medicaid program. The program provides health coverage for an eligible unborn child through labor and delivery when the mother is uninsured and has income at or below 185% FPL.

F. SFY2013 PROJECTS

Change to Timely Filing Requirements

In SFY 2013, MLTC will be changing the timely filing requirements for Medicaid claims from the existing 12 months to six months (180 days). Data analysis revealed that in recent years nearly 85% of current providers have already been filing claims within 180 days of the date of services provided, so this change is not expected to adversely impact the normal course of

business for providers. Ultimately, timelier filing will result in a faster rate of processing and payment for providers. Exceptions to the current timely filing requirements (for example, retroactive eligibility, Medicare denials, casualty insurance, and health insurance, referenced in 471 NAC 3.004.06) will remain unchanged.

Full Risk Behavioral Health Managed Care

Medicaid will move to a statewide full risk behavioral health managed care program. An RFP for a Managed Care Organization to provide these services will be released in the fall of 2012 with an implementation the fall of 2013. This change will result in cost-savings and will address the compliance issues related to IMDs.

ICD-10

The US DHHS has mandated a shift from the International Classification of Diseases version 9 (ICD-9) to ICD-10 for all entities covered under HIPAA (health care providers, payers, and clearinghouses). Conversion to the new ICD-10 code sets will impact the entire health care industry and every aspect of Medicaid operations. In SFY 2012, MLTC performed a broad spectrum impact assessment, hosted a site visit from CMS/Noblis to support planning and awareness and initiated internal educational and communications activity. The ICD-10 project will proceed with system remediation design, development and testing in SFY 2013.

Medicaid Payment for Primary Care Services at Medicare Rates

Effective January 1, 2013 Medicaid payment rates for primary care services furnished by certain physicians in CYs 2013 and 2014 cannot be not less than the Medicare rates. This minimum payment level applies to specified primary care services furnished by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. For 2 years, funding is 100 percent Federal for the difference in payment from the amounts that would be due for these services under the provisions of the State Plan as of July 1, 2009.

MMIS Alternatives Analysis

Nebraska's Medicaid Management Information System (MMIS) was created in 1977 and is one of the oldest still-functioning systems in the country. The programmatic and technological challenges of Medicaid's past few years have been taxing and resource-intensive for this system. Nebraska Medicaid began an alternatives analysis process near the end of SFY 2012, examining the options for upgrading/replacing the MMIS.

New Diagnosis Related Group (DRG) Grouper Software

Work on adoption of a new Diagnosis Related Group (DRG) grouper software for Medicaid use began in SFY 2012 and will continue into SFY 2013. Medicaid contracted for the purpose of reviewing options and recommending and/or developing a DRG grouper software, in addition to determining state-specific weights, average length of stay (ALOS) and case mix index for stable DRGs.

Program of All-Inclusive Care for the Elderly (PACE)

Program of All-Inclusive Care for the Elderly, known as PACE, provides comprehensive, coordinated health care services within a defined geographic area for voluntarily enrolled individuals age 55 and older who meet nursing facility level of care criteria, enabling them to remain in a community setting. PACE provides another alternative along the continuum of available long-term care services. An application to become a PACE provider was submitted to MLTC by an organization and forwarded to CMS in late April, 2012. One of the next steps in the provider approval process will be for DHHS to conduct an assessment of the organization's readiness to become a PACE provider. A final step in the process includes executing a program agreement between CMS, DHHS, and the PACE organization. An operational program is expected to be launched in early 2013. The service area for this first PACE initiative will be metro Omaha.

Recovery Audit Contractor (RAC)

Nebraska Medicaid released a request for proposals in June of 2012 in order to contract with a Recovery Audit Contractor (RAC). RAC objectives are to reduce erroneous payments, identify and recover overpayments, and identify underpayments in the Medicaid program. The RAC will audit post-payment claims to identify erroneous payments (includes both overpayments and underpayments). As allowed by state and federal law, the Nebraska Medicaid RAC will be paid on a contingency basis from actual amounts recovered.

III. CONCLUSION

The Department of Health and Human Services, Division of Medicaid & Long-Term Care strives to operate a Medicaid program which addresses the health care needs of eligible low-income Nebraska residents in a cost-effective and deliberately planned manner. The number of Medicaid eligible recipients has increased in recent years due to economic conditions. Concurrently, the program and policies referenced in this Annual Report work to moderate the growth of Medicaid expenditures. These policies and initiatives slow the growth of the Medicaid program and further fiscal sustainability by making the program more efficient and more cost-effective through careful management of services, better delivery of care, more appropriate services, and improved administration of the program.

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