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Department of Health & Human Services



*Division of Medicaid and Long-Term Care*

# **Nebraska Medicaid Reform Annual Report**

**September 15, 2010**

**Draft prepared for the Medicaid Reform Council in Accordance  
with Neb. Rev. Stat. § 68-908(4)**

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

I. Introduction..... 3

II. Discussion..... 3

    A. Eligible Recipients..... 3

    B. Covered Services ..... 6

    C. Provider Reimbursement ..... 10

    D. Program Trends and Projections..... 10

    E. Program Budget and Expenditures ..... 15

    F. Medicaid Reform Activities..... 16

    G. Program Changes..... 19

III. Conclusion ..... 21

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## Nebraska Medicaid Reform Biennial Report

### Neb. Rev. Stat. § 68-908(4)

#### I. Introduction

Medicaid reform was mandated by the Nebraska Legislature in LB 709 (2005), the Medicaid Reform Act (Neb. Rev. Stat. §§ 68-1087 to 68-1094; LB 709, §§ 1-8). The Act mandated "fundamental reform" of the state's Medicaid program and a significant rewriting of Medicaid-related statutes. The Nebraska Medicaid Reform Plan was submitted to the Governor and Legislature on December 1, 2005. Following submission of the Nebraska Medicaid Reform Plan, the Legislature adopted the Medical Assistance Act (Neb. Rev. Stat. §§ 68-901 to 68-949; LB 1248 (2006)). The Medical Assistance Act substantially recodified statutes relating to the Medicaid Program with an emphasis on continuing the reform efforts initiated with LB 709 (2005).

The motivation for Medicaid reform remains the same. The findings the Legislature documented in Neb. Rev. Stat. § 68-904 have not changed: many low-income Nebraskans have health care needs and are unable, without assistance, to meet those needs; Medicaid provides essential coverage for necessary health care for eligible low-income Nebraska children, pregnant women and families, aged persons and persons with disabilities; and Medicaid alone cannot meet all the health care needs of all low-income Nebraskans. Nebraska must continue to address the rate of growth in expenditures of the Medicaid program. The program is unsustainable if expenditures regularly grow at a rate faster than General Fund revenues.

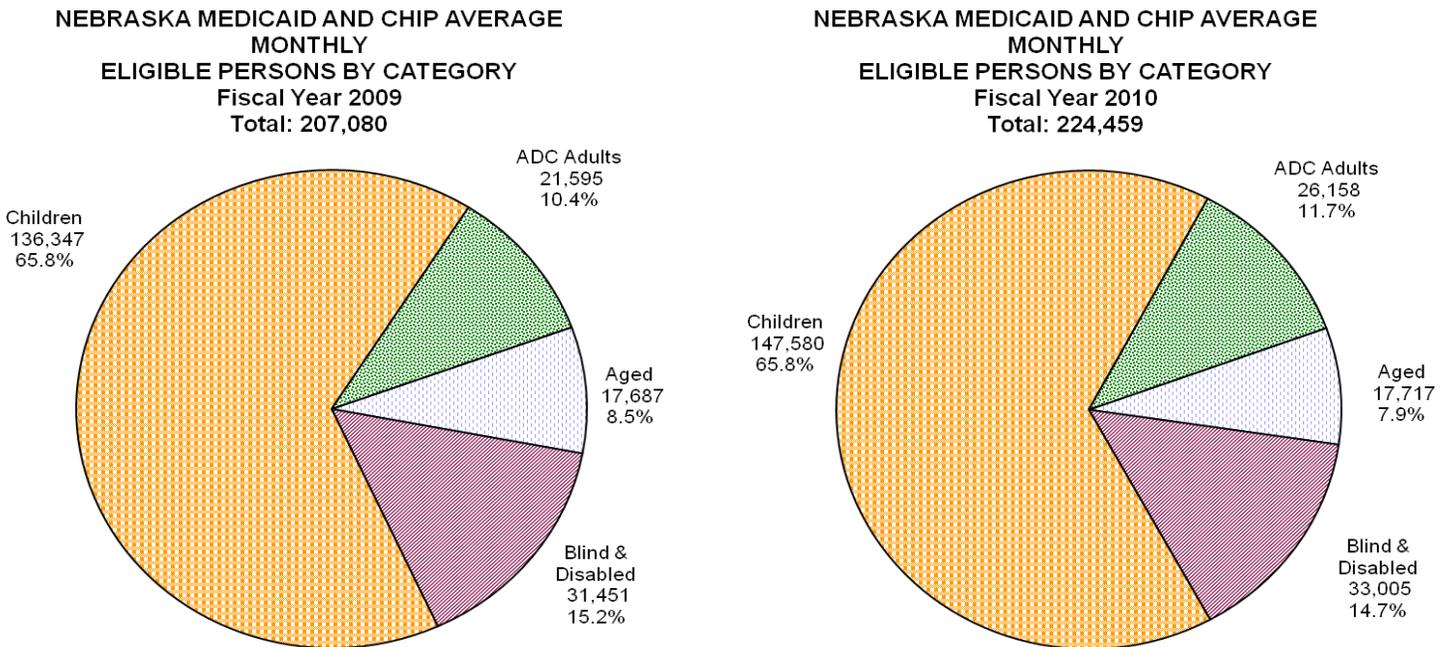
This report meets the reporting requirements of Section 68-908(4) which states that the Department of Health and Human Services (DHHS) shall prepare an annual summary and analysis of the Medicaid Program for legislative and public review, including, but not limited to, a description of eligible recipients, covered services, provider reimbursement, program trends and projections, program budget and expenditures, the status of implementation of the Medicaid Reform Plan, and recommendations for program changes.

#### II. Discussion

##### A. Eligible Recipients

Nebraska Medicaid provides coverage for the following eligibility categories: Children, ADC Adults, Aged, and Blind and Disabled. Figure 1 compares client eligibility by category for State Fiscal Years (SFY) 2009 and 2010.

Figure 1



The total increase in average monthly eligibles from SFY 2009 to SFY 2010 was 8.4%. The largest percentage increase was in the Aid to Dependent Children (ADC) Adults category, which grew 21.1%. Average monthly eligibles in the Blind and Disabled category grew by 4.9%, while the Children increased by 8.2%, and eligibles in the Aged category increased by 0.2%. (Figure 1)

Growth in Medicaid eligibility, which had been moderate from SFY 2006 through SFY 2008, experienced a significant increase in the latter half of SFY 2009 that continued until the first half of SFY 2010. This is likely the result of the economic downturn. Historically, Nebraska has been affected late by such downturns and has then lagged in its recovery. Assuming continued pressure on Medicaid caseloads due to weak economic conditions and factoring in the statutory expansion of Children's Health Insurance Program (CHIP) eligibility to 200% FPL in LB 603, eligibility is projected to increase 6.6% in SFY 2011 and 3.8% in SFY 2012.

**Figure 2**

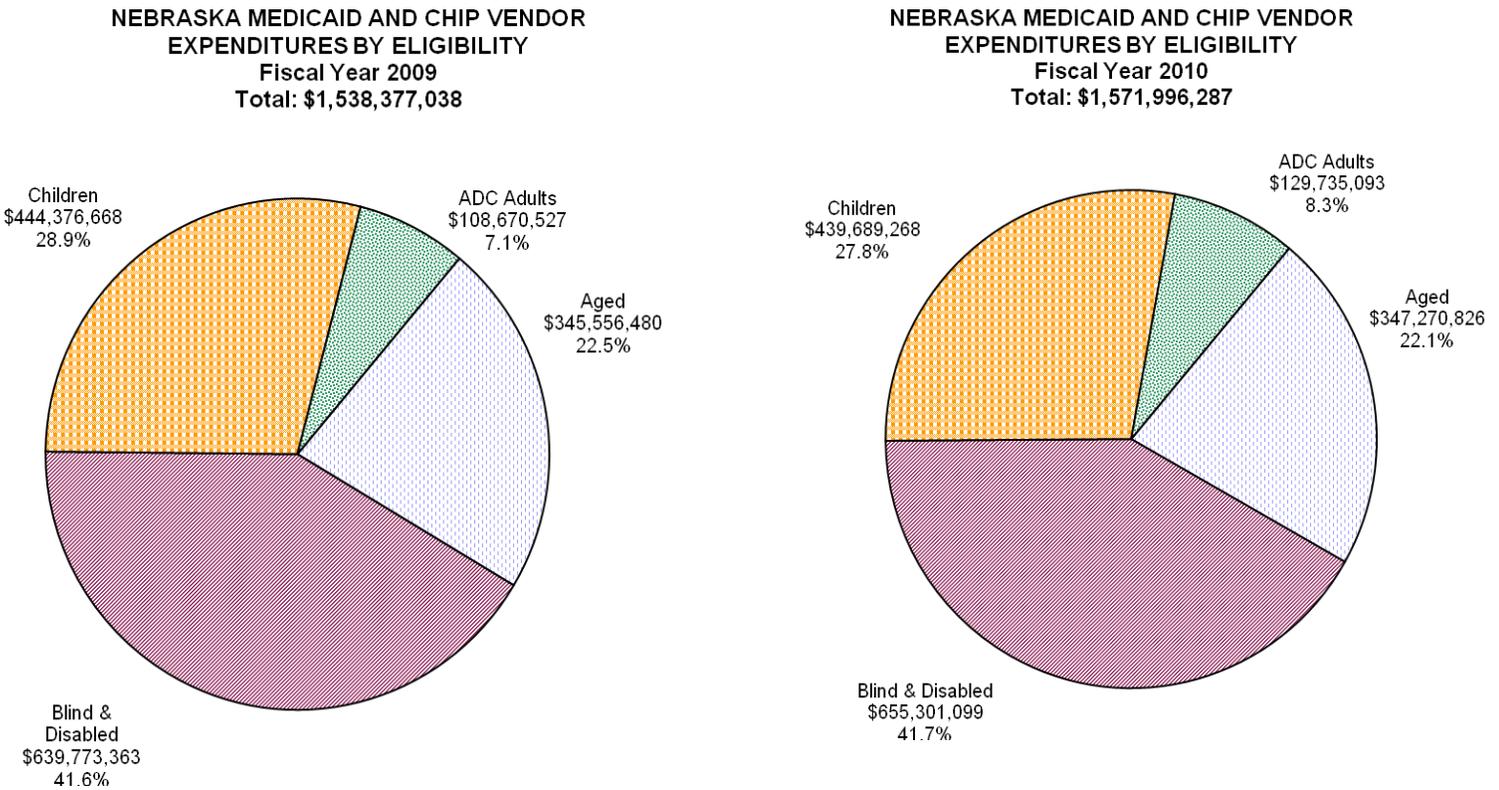


Figure 2 compares vendor expenditures by eligibility category for SFYs 2009 and 2010. The graphic does not account for all Medicaid expenditures, in part because some payments and refunds are not specific to a recipient or eligibility category. Examples of transactions not shown are drug rebates, payments made outside the claims processing systems, and premium payments paid on behalf of persons eligible for Medicare. (See detail on page 7).

Total Medicaid vendor expenditures experienced an increase of 2.2% from SFY 2009 to SFY 2010. The largest increase in expenditures was in the Aid to Dependent (ADC) Adult category, which increased by 19.4% from SFY 2009 to SFY 2010. Blind & Disabled expenditures were the second fastest growing category, increasing by 2.4% from SFY 2009 to SFY 2010, followed by Aged, which increased at 0.5%. Expenditures for Children decreased by 1.1%.

The average monthly cost per eligible decreased 5.7% from SFY 2009 to SFY 2010. The only cost per eligible increase was in the Aged category, which increased by 0.3%, Blind and Disabled decreased by 2.4%. Medicaid expenditures per eligible decreased by 1.4% for ADC Adults and by 8.6% for Children.

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**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 offered in Nebraska.

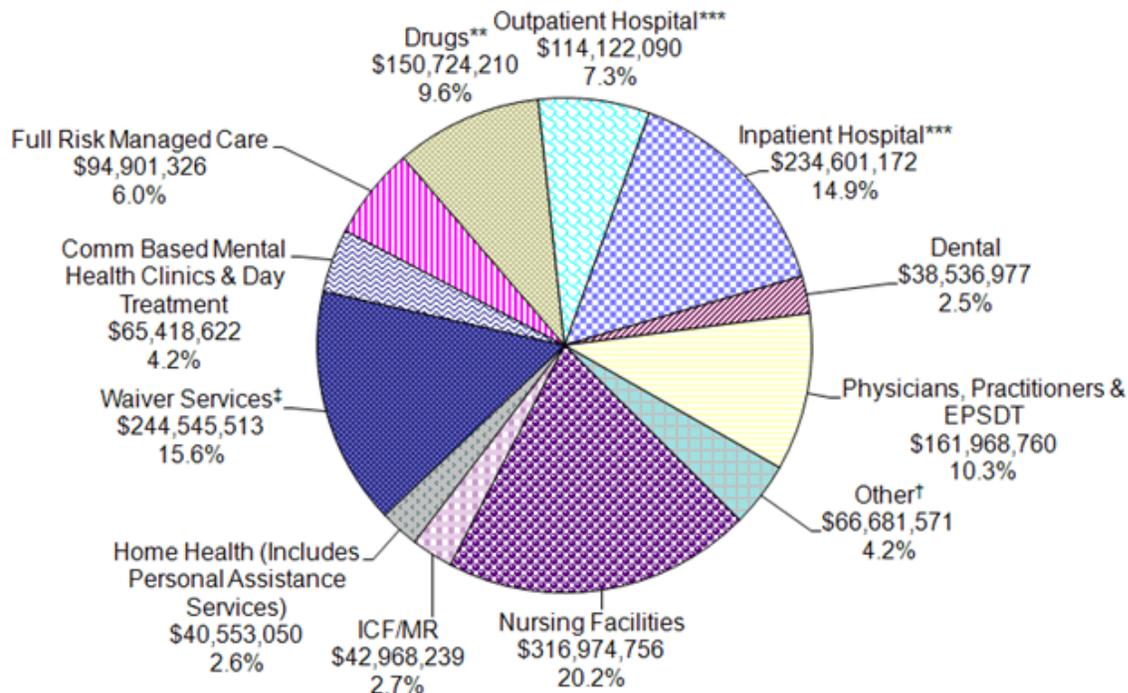
**Federal Medicaid Mandatory and Optional Services Covered in Nebraska**  
**(Neb. Rev. Stat. § 68-911)**

<b>Mandatory Services</b>	<b>Nebraska Optional Services</b>
<ul style="list-style-type: none"><li>• Inpatient and outpatient hospital services</li><li>• Laboratory and x-ray services</li><li>• Nursing facility services</li><li>• Home health services</li><li>• Nursing services</li><li>• Clinic services</li><li>• Physician services</li><li>• Medical and surgical services of a dentist</li><li>• Nurse practitioner services</li><li>• Nurse midwife services</li><li>• Pregnancy-related services</li><li>• Medical supplies</li><li>• Early and periodic screening and diagnosis treatment (EPSDT) services for children</li></ul>	<ul style="list-style-type: none"><li>• Prescribed drugs</li><li>• Intermediate care facilities for the mentally retarded (ICF/MR)</li><li>• Home and community-based services for aged persons and persons with disabilities</li><li>• Dental services</li><li>• Rehabilitation services</li><li>• Personal care services</li><li>• Durable medical equipment</li><li>• Medical transportation services</li><li>• Vision-related services</li><li>• Speech therapy services</li><li>• Physical therapy services</li><li>• Chiropractic services</li><li>• Occupational therapy services</li><li>• Optometric services</li><li>• Podiatric services</li><li>• Hospice services</li><li>• Mental health and substance abuse services</li><li>• Hearing screening services for newborn and infant children</li><li>• School-based administrative services</li></ul>

## Expenditures

Medicaid expenditures to vendors in SFY 2010 totaled \$1,571,996,287. Figure 3 shows the services by vendor type. It does not include drug rebates, payments made outside the claims processing systems, or premium payments made on behalf of Medicare eligibles.

**Figure 3**  
**NEBRASKA MEDICAID AND CHIP VENDOR EXPENDITURES\* BY SERVICE**  
**FISCAL YEAR 2010**  
**Total Vendor Payments \$1,571,996,287**



- \* Includes payments to vendors only, not adjustments, refunds or certain payments for premiums or services paid outside the Medicaid Payment System (MMIS) or NFOCUS.
- \*\* \$51.9 million in offsetting drug rebates is not reflected in the drug expenditures of \$150,724,210
- \*\*\* DSH payments of \$37.7 million are not reflected in Inpatient or Outpatient Hospital Expenditures
- † Includes Speech/ Physical Therapy, Medical/Optical Supplies, Ambulance, and Lab/Radiology
- ‡ Developmental Disabilities, Aged & Disabled, Traumatic Brain Injury, Early Intervention Expenditures may not sum due to rounding.

**\$1,571,996,287 Vendor Payments**

\$46,588,556 Disproportionate Share Hospital/Rate Adjustments  
 \$39,342,080 Medicare Premiums  
 \$ 4,455,687 Intergovernmental Transfer (IGT)  
 \$43,669,288 Other Payments (Managed Care, Transportation, Federal Insurance Contributions Act taxes)  
 (\$57,225,172) Rebates/Refunds  
 (\$89,731,513) General Funds Paid in Other Budget Programs  
 \$33,520,770 Phased Down Contribution

**\$1,592,615,982 Net Medicaid Expenditures**

Total vendor payments increased \$33,619,249, or 2.2%, from SFY 2009 to SFY 2010. From SFY 2009 to 2010 vendor expenditures for Outpatient Hospital Services, Dental Services, and Waiver Services showed significant increases. (Table 1)

**Table 1**

**Nebraska Medicaid and CHIP Vendor Expenditures**

	FY 2009		FY 2010		FY 2009 to FY 2010	
	Expenditures	% of Total	Expenditures	% of Total	Increase	% Increase
Nursing Facilities	\$309,189,085	20.5%	\$316,974,756	20.2%	\$7,785,671	2.5%
Inpatient Hospital	\$232,884,924	14.9%	\$234,601,172	14.9%	\$1,716,248	0.7%
Waiver Services (DD Waivers, Assisted Living)	\$229,216,010	13.9%	\$244,545,513	15.6%	\$15,329,503	6.7%
Physicians, Practitioners & EPSDT	\$154,973,923	10.3%	\$161,968,760	10.3%	\$6,994,837	4.5%
Drugs	\$154,222,842	10.1%	\$150,724,210	9.6%	-\$3,498,632	-2.3%
Outpatient Hospital	\$98,066,819	5.9%	\$114,122,090	7.3%	\$16,055,271	16.4%
Managed Care Capitation	\$87,230,297	5.9%	\$94,901,326	6.0%	\$7,671,029	8.8%
Other	\$65,919,215	4.6%	\$66,681,571	4.2%	\$762,356	1.2%
Comm Based Mental Health Clinics & Day Treatment	\$65,454,432	4.5%	\$65,418,622	4.2%	-\$35,810	-0.1%
ICF-MR	\$67,710,764	4.5%	\$42,968,239	2.7%	-\$24,742,525	-36.5%*
Home Health	\$38,962,768	2.6%	\$40,553,050	2.6%	\$1,590,282	4.1%
Dental	\$34,545,959	2.3%	\$38,536,977	2.5%	\$3,991,018	11.6%
<b>Total</b>	<b>\$1,538,377,038</b>	<b>100%</b>	<b>\$1,571,996,287</b>	<b>100.0%</b>	<b>\$33,619,249</b>	<b>2.2%</b>

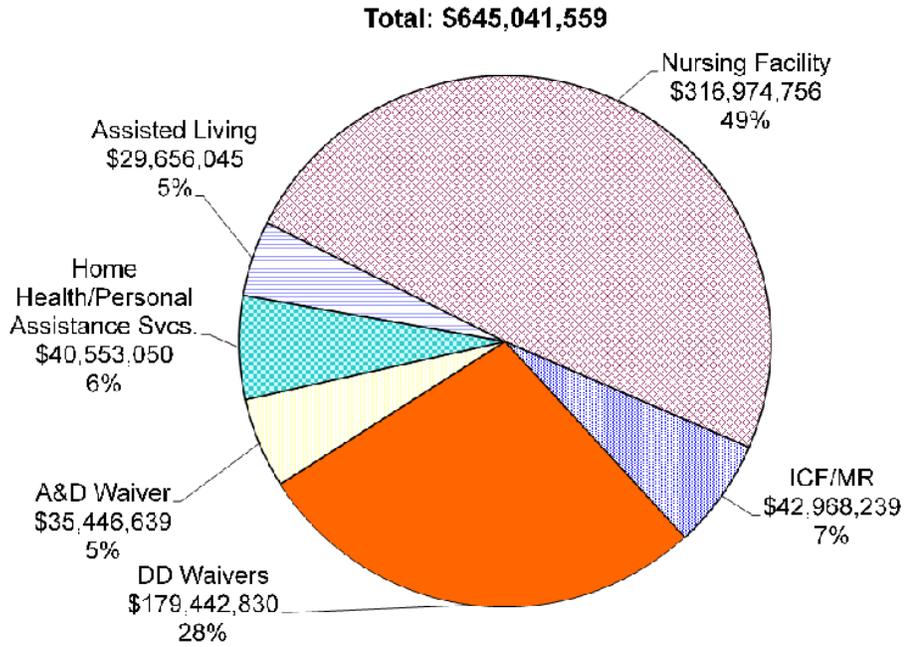
\*Reduction caused by decertification of Beatrice State Developmental Center (BSDC)

**Long-Term Care Services**

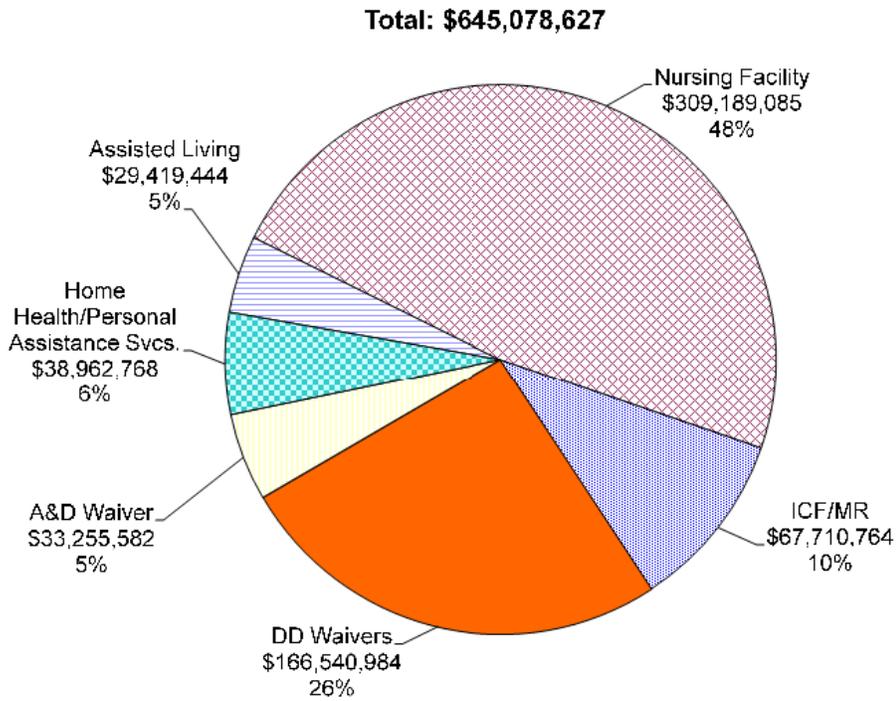
Long-Term Care services support individuals with chronic or ongoing health needs related to age or disability. Services are geared to multiple levels of client need ranging from limited assistance with activities of daily living to complex nursing interventions. Assistance can be offered in a variety 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, as long as a safe plan of care can be established.

Efforts to encourage home and community-based alternatives to facility-based care are resulting in a gradual rebalancing of long-term care expenditures. Comparison of Fiscal Year 2010 spending with Fiscal Year 2009 spending shows a slight decline in the percentage of dollars directed to institutional providers (nursing facilities and ICF/MR) and a corresponding increase in the proportion of spending for services in less restrictive settings. (Figure 4) Institutional payments declined from 58% of total long-term care expenditures in 2009 to 56% in 2010. Home and Community payments increased from 42% of total long-term care expenditures in 2009 to 44% in 2010.

**Figure 4**  
**SFY 2010 Medicaid Expenditures for Long-Term Care Services**



**SFY 2009 Medicaid Expenditures for Long Term-Care Services**



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### C. Provider Reimbursement

DHHS uses different methodologies to reimburse 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 or per diem rate. Critical Access Hospitals are reimbursed a per diem based on reasonable cost of providing the service. Federally Qualified Health Centers are reimbursed on a prospective payment system. Rural Health Clinics 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 a per diem rate based on a cost model. Home and Community-Based Waiver Services, including Assisted Living, are reimbursed at reasonable fees as determined by DHHS.

Table 2 below shows a recent history of provider rate changes by provider type.

**Table 2**

<b>Year-to Year Average Medicaid Provider Rate Increases</b>	<b>SFY 2005</b>	<b>SFY 2006</b>	<b>SFY 2007</b>	<b>SFY 2008</b>	<b>SFY 2009</b>	<b>SFY 2010</b>	<b>SFY 2011</b>
<b>Hospitals</b>	3.80%	2.00%	2.00%	1.95%	1.90%	1.50%	0.50%
<b>Practitioners</b>	2.00%	2.00%	2.00%	1.40%	1.40%	1.50%	0.50%
<b>Nursing Facilities</b>	2.00%	6.00%	3.50%	2.50%	2.50%	1.50%	0.50%
<b>Assisted Living</b>	3.00%	2.00%	2.00%	2.00%	2.00%	1.50%	0.50%
<b>Non-public ICF-MRs</b>	3.00%	2.00%	2.00%	2.50%	2.50%	1.50%	0.50%

For Medicaid recipients participating in at-risk managed care, Medicaid pays a monthly capitation payment to the Managed Care Organization (MCO) based on actuarially determined cost of services and administration per enrollee. Providers are reimbursed by the MCO for services delivered to MCO clients. The MCO independently determines reimbursement methodology and rates for participating providers. As shown in Figure 3, at-risk managed care constitutes approximately \$95 million or 6.0% of vendor expenditures.

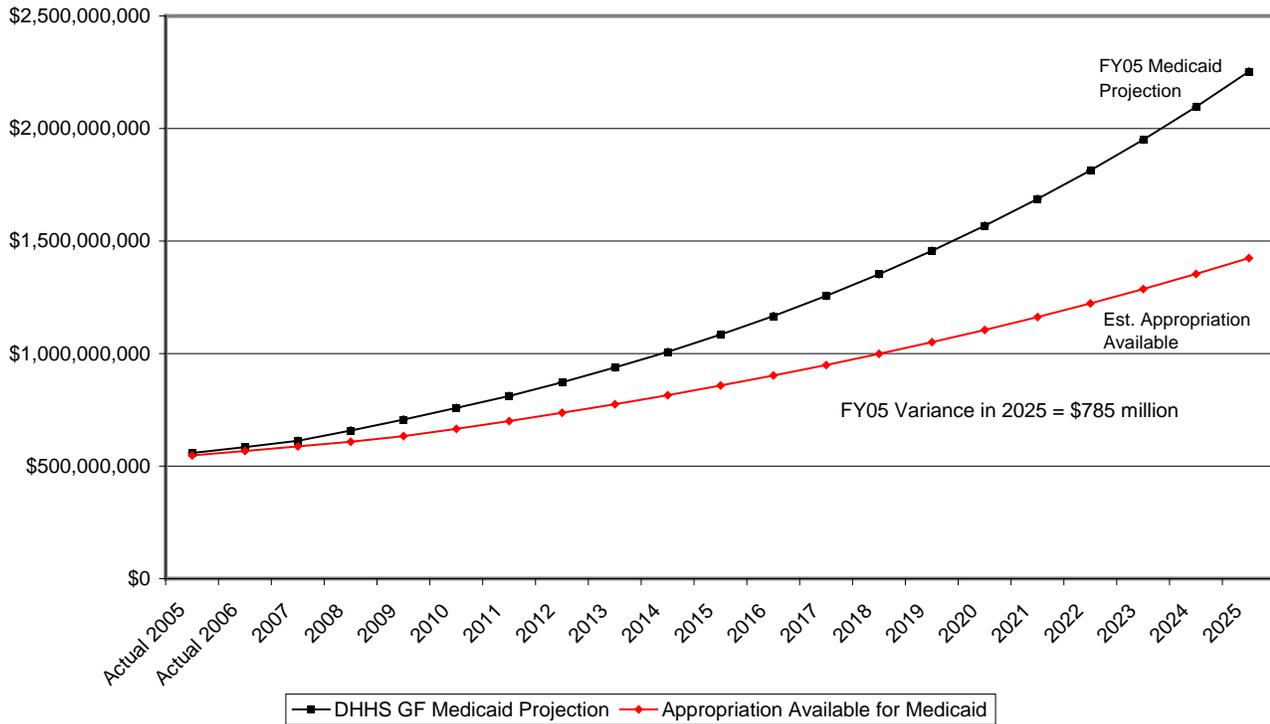
For Medicaid recipients participating in the Primary Care Case Management (PCCM) managed care program, Medicaid paid a monthly payment to the Primary Care Physician (PCP) for care management. Medicaid also paid the PCCM Administrator for administration of the PCCM program. Claims for services provided to recipients were paid directly to providers by the Medicaid program. Nebraska Medicaid paid approximately \$104 million, or approximately 6.6% of vendor expenditures, for PCCM clients for services similar to those covered under the MCO plan. The PCCM program ended July 30, 2010.

### D. Program Trends and Projections

In the Nebraska Medicaid Reform Plan of 2005, DHHS estimated total federal and state Medicaid spending through 2025 by adjusting for demographic changes in the population and

projected medical inflation over the next 20 years. Holding the proportion of General Fund revenues allocated to Medicaid constant, it was projected that, by 2025, there would be a \$785 million gap between projected Medicaid General Fund expenditures and appropriations available for Medicaid. (Figure 5)

**Figure 5**  
**Projected Increase in Medicaid State General Fund Expenditures**  
**and Appropriations Available for Medicaid in Nebraska**  
**SFY2005 - SFY2025**

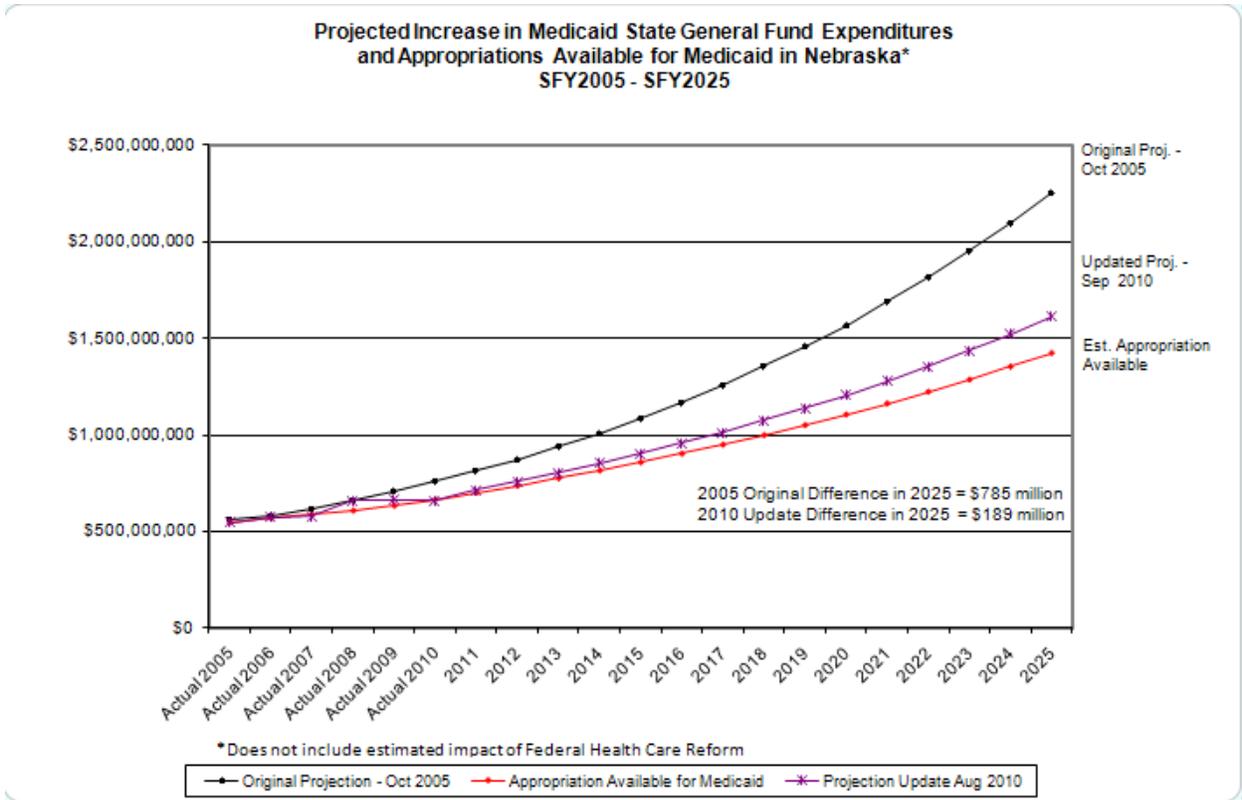


For the 2010 Nebraska Medicaid Reform Annual Report, DHHS forecasts Medicaid eligible persons and costs as follows:

- The average monthly eligible persons by category are updated using final SFY 2010 data.
- Average monthly cost per eligible is the base for forecasting monthly Medicaid costs by eligibility category. Final SFY 2010 averages were used in the calculation. The cost adjustment factor continues to be calculated by blending historical Nebraska Medicaid average cost change rates for the last five years with the national annual medical expenditure per capita projections provided by the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary.

The 2005 base projections previously used were provided by the Center for Public Affairs Research at the University of Nebraska at Omaha. Based on the above revisions, the projected gap between estimated Medicaid General Fund expenditures and available appropriations in 2025 decreased to \$189 million. (Figure 6)

**Figure 6**



The estimate was developed as a product of two projections for each fiscal year: average monthly Medicaid eligibles and average monthly Medicaid expenditures per eligible. The resulting average monthly total Medicaid expenditure projection was multiplied by 12 to reach an annual figure. It was then multiplied by 0.4 to estimate the General Fund portion of the projected total Medicaid expenditures.

The projection of average monthly Medicaid eligibles was also based on two sources: average monthly Medicaid eligibles in SFY 2005 and a projection of Nebraska population growth. The Nebraska population forecast was developed by the Center of Public Affairs Research at the University of Nebraska at Omaha. The report projected future Nebraska population by age. The assumption underlying the eligibility projection was that the ratio of average monthly eligibles in each eligibility category to the total population in the age group corresponding to that category would remain constant. For example, in SFY 2007, there were 128,107 average monthly eligibles in the Children category. This represented 24.3% of children less than 21 years of age in Nebraska. It was, therefore, projected that the average monthly children eligible for Medicaid would be 24.3% of whatever the number of children under 21 was for that year in the population forecast. The same projection was done, through 2025, for average monthly Medicaid eligibles in each category: Aged, Blind and Disabled, Adults, and Children.

The other factor in the projection of Medicaid expenditures was a projected average monthly cost per eligible in each of the five categories. This was developed from two factors: actual growth of average monthly cost per eligible in Nebraska Medicaid from SFY 2000 - SFY 2005, and projections available at the time from the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) on increases in the cost of health care from 2006 to 2014. In particular, the percentage increase applied to the average monthly cost per eligible for each year in the projection was the average of the average growth in actual Medicaid expenditures per eligible in that category SFY 2000 – 2005 and the projected growth in health care costs from the

CMS Office of the Actuary for that time. These average monthly costs per eligible projections were multiplied by the average monthly eligibles projections described above to arrive at the projected Medicaid expenditures used in the charts in question.

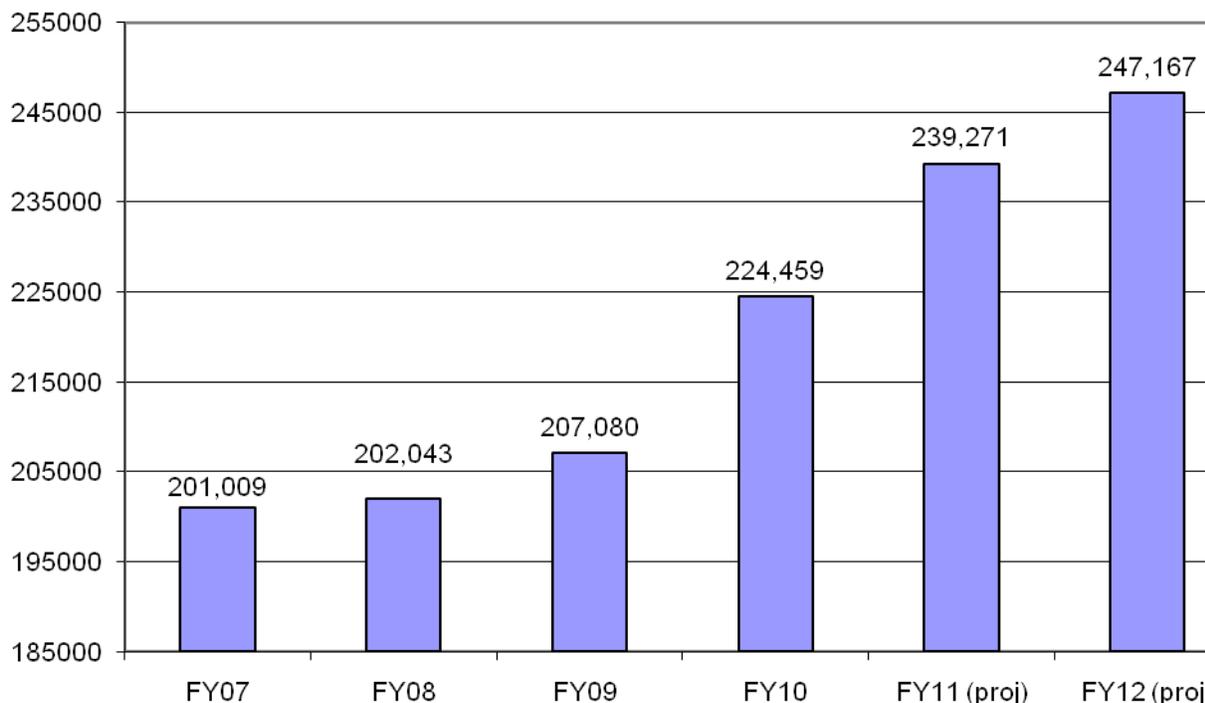
While actual Medicaid eligibles grew faster than projected using the population forecast, the distribution of eligibles was different than projected. In particular, the Medicaid Children category has grown at a faster rate than the general population of children in Nebraska. The Aged and Adult categories have grown at a much slower rate than their corresponding age groups in the general population. This is significant because the Aged group tends to have higher costs, on average, and Children tend to have the lowest costs of any Medicaid eligibility group. While there are slightly more people eligible for Medicaid than anticipated, it has also been a significantly less costly mix of eligibles than anticipated.

Growth in Medicaid eligibility, which had been moderate from SFY 2006 through SFY 2008, experienced a significant increase in the latter half of SFY 2009 that continued until the first half of SFY 2010. Assuming continued pressure on Medicaid caseloads due to weak economic conditions and factoring in the statutory expansion of Children’s Health Insurance Program (CHIP) eligibility to 200% FPL in LB 603, eligibility is projected to increase 6.6% in SFY 2011 and 3.8% in SFY 2012.

As shown in Figure 1, the average monthly number of eligibles in SFY 2010 was 224,459. Figure 7 tracks the annual growth of eligibles. In June 2010, there were 228,482 persons eligible for Medicaid, an increase of 14,737 persons over the same month in 2009.

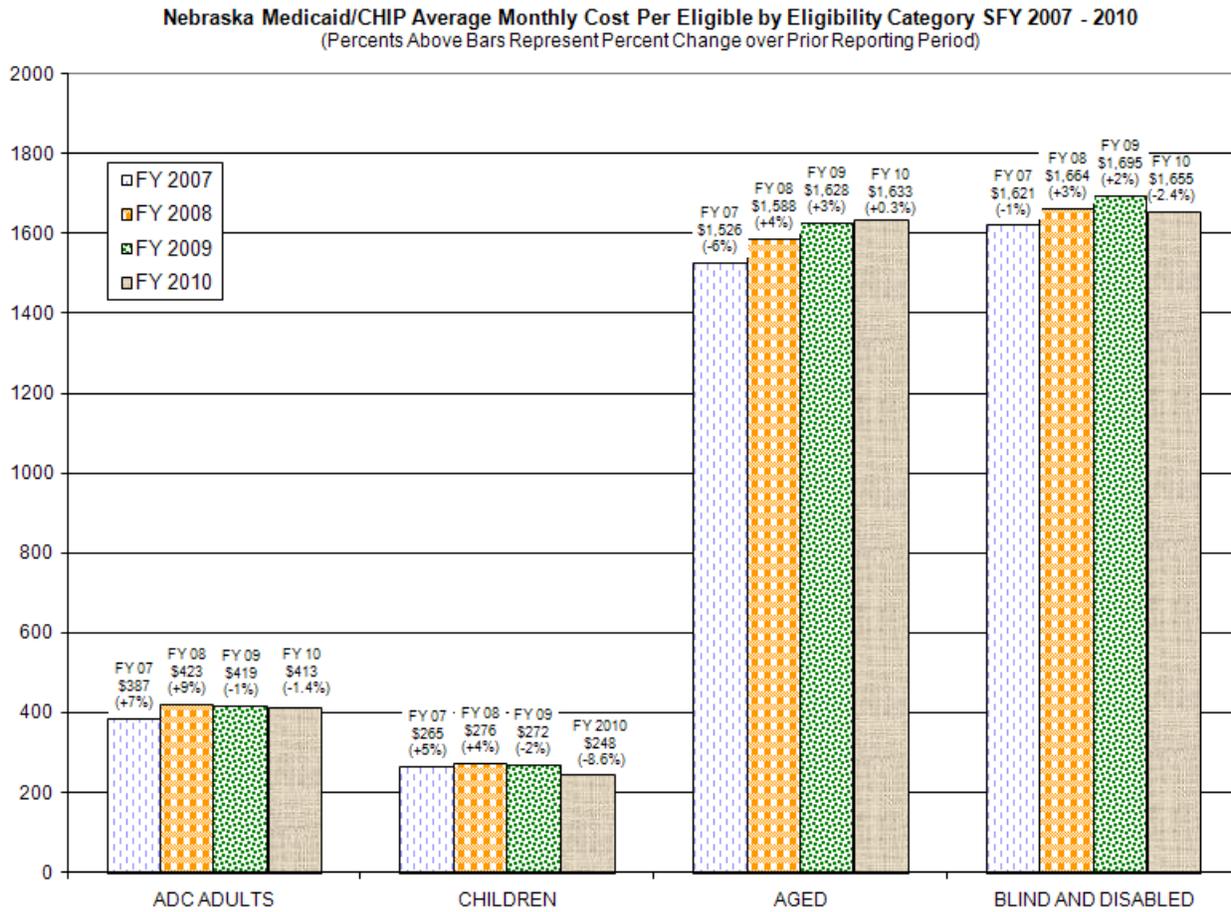
**FIGURE 7**

**Nebraska Medicaid and CHIP Average Monthly Eligibles  
SFY 2007-2010 Actual and SFY 2011-2012 Projected  
Based on Current Economic Predictions**



Equally important to the fiscal sustainability of Medicaid is the trend in cost per Medicaid eligible person. The trends in average cost per category are shown in Figure 8.

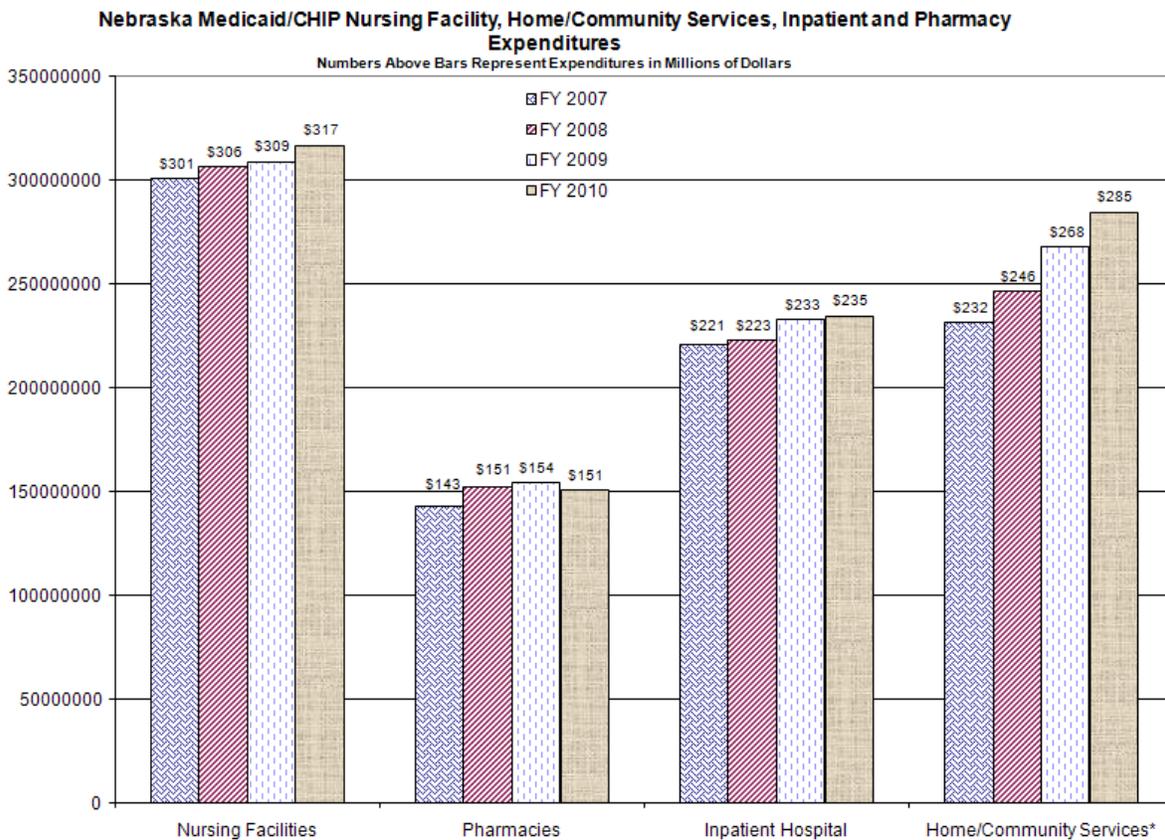
**Figure 8**



These trends are based on vendor payments. The majority of persons in the Aged and the Blind and Disabled categories now have their drug costs paid by Medicare. (Medicare Part D took effect in January 2006, thus Medicare Part D affected only the second half of SFY 2006). The ADC Adult and Children’s categories are unaffected by Part D.

The top four vendor expenditure categories in Medicaid are nursing facilities, pharmacies, home and community services, and inpatient hospitals. The home and community service category consists of home health, personal assistance services and waiver services, including assisted living. The trends are shown in Figure 9.

**Figure 9**



\*Includes HCBS Waiver Services, Home Health Services, and Personal Care Aide Services

Spending for nursing facility services is increasing although declining as a percentage of the overall Medicaid program. Home and community services continue to grow both in terms of dollars and as a percentage of the Medicaid program as more care and services are delivered outside of traditional institutional settings. Expenditures for inpatient hospital services continue to increase.

### **E. Program Budget and Expenditures**

Continuation funding for Medicaid for SFY 2010 and 2011 was enacted in LB 315, the mainline appropriations bill of the 2009 legislative session. The Medicaid appropriation included a rate increase of 1.5% per year for most provider categories as well as an adjustment in the state and federal funding split to reflect enhanced Federal Medical Assistance Percentage (FMAP) funding available to DHHS as a result of the Federal American Recovery and Reinvestment Act (ARRA). Enhanced federal funding is anticipated through June 30, 2011.

Information related to the Medicaid and Long-Term Care budget will be available after September 15, 2010.

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## **F. Medicaid Reform Activities**

### **1. DHHS implemented the Preferred Drug List**

In 2008, the Nebraska Legislature passed the Medicaid Prescription Drug Act, the purpose of which is to provide appropriate pharmaceutical care to Medicaid recipients in a cost-effective manner through the development of a Preferred Drug List (PDL). A committee consisting of physicians, pharmacists and public members determines which medications are to be included on the Preferred Drug List. Comprehensive reviews of the medical literature are conducted to determine which drugs are the most efficacious and safe within therapeutic classes. Medication costs for the State are reduced by 1) supplemental rebate, which are collected from drug manufacturers and 2) increased utilization of less costly medications. The first half of the Preferred Drug List was implemented in the fall of 2009. The second half was implemented in the spring of 2010. Nebraska is now collecting supplemental rebates each quarter.

### **2. DHHS implemented Money Follows the Person Grant**

Nebraska was one of 31 states selected by the Centers for Medicare and Medicaid Services to host a five-year demonstration project called Money Follows the Person. The goal is to help rebalance Medicaid's long-term care spending by decreasing the percentage of funds spent for facility-based care and increasing the percentage spent on home and community-based services. Eligible participants who currently reside in nursing homes or intermediate care facilities for persons with developmental disabilities and who wish to relocate are assisted with their transition from facilities back to their own home or to other suitable community residences, such as houses, apartments, or small group living arrangements. Nebraska's Operational Protocol for Money Follows the Person was approved June 20, 2008. As of June 30, 2010, seventy-two MFP-qualifying individuals have been transitioned into the community.

### **3. DHHS has developed and will implement a Long-Term Care Needs Assessment Tool**

DHHS will implement the Nebraska Home Care Tool for assessing whether clients meet the functional criteria to be eligible for services of the Aged and Disabled Medicaid Waiver or a nursing facility. Programming of the electronic tool and validity is complete. In conjunction, the regulations that address level of care criteria have been revised. Proposed implementation is January 1, 2011.

### **4. DHHS conducted a study for rate setting methodology for Long-Term Care Services**

DHHS contracted with Myers & Stauffer for a study to review and provide recommendations for nursing facility reimbursement structure. The contractor submitted its final report to DHHS in April 2009. The report and its recommendations were presented by the contractors to Nebraska's nursing facility providers in May 2009. A provider workgroup was established for the purpose of discussing potential improvements to Nebraska's nursing facility reimbursement methodology. Effective July 1, 2010, DHHS updated the algorithm used for determining the nursing facility residents' levels of care and corresponding Medicaid reimbursement rates, as Nebraska's prior algorithm would no longer be supported by the Center for Medicare and Medicaid Services after September 30, 2010. The contractor and the provider workgroup recommended this change. Also effective July 1, 2010, Medicaid will only pay the co-insurance amounts for Medicare Part

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A nursing facility claims when the amount already paid on the claim by Medicare is less than the Medicaid rate. This change was also a contractor recommendation.

**5. DHHS implemented enhanced care coordination for high-cost recipient with multiple medical conditions**

DHHS contracted with US Care Management to provide a voluntary Enhanced Care Coordination for high-cost Medicaid recipients who have multiple medical conditions. The program started on July 1, 2008. The contract with US Care Management ended August 31, 2010.

**6. DHHS expanded at-risk managed care for physical health**

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 initiated a procurement process for the purpose of selecting two Managed Care Organizations (MCOs) for the ten county area. Two bids were accepted and contracts were awarded to United Health Care of the Midlands, Inc. (Share Advantage) and to Coventry Health Care of Nebraska, Inc. The two MCO contracts began August 1, 2010. The Primary Care Case Management (PCCM) program ended July 31, 2010. The Physical Health managed care program will cover 95,201 clients.

**7. DHHS is implementing electronic billing by providers**

Electronic claim submission assists DHHS to operate a more efficient payment system. DHHS currently receives over 90% of claims electronically. DHHS' current MMIS is able to accept and process all incoming claim types for services provided to eligible clients. Providers benefit when they submit electronic claims with shorter turnaround time for payments resulting in improved cash flow, improved tracking and monitoring capabilities, and reduced postage and paper handling costs. DHHS has begun an awareness campaign to remind providers of the benefits of electronic claim submission. Other options for reducing paper claims and enhancing electronic options are being reviewed, such as direct data entry of claims data by providers through the creation of a DHHS web portal.

**8. DHHS implemented a new Medicaid card**

In August 2009, DHHS discontinued the monthly mailing to clients of the 8 ½" x 11" document containing person-specific Medicaid eligibility information. All clients now have a permanent wallet-sized plastic identification card issued once, similar to private health insurance. The initiative for doing this was to make it easier for the client to carry as well as reduce significantly the printing and mailing costs. To date, feedback from the clients has been positive. In the first year, a savings of over \$450,000 has been realized. If the volume remains stable, it is anticipated that savings in the second year will be more than \$550,000.

**9. DHHS will utilize a transportation broker for non-emergency medical transportation**

DHHS has determined that centralized management of transportation services would result in program efficiencies. DHHS is in the process of awarding a contract for statewide non-emergency transportation brokerage services.

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## **10. DHHS implemented radiology management services**

DHHS contracted with MedSolutions to provide radiology management services which require prior authorization of high tech outpatient radiology procedures. A State Plan Amendment was submitted to and approved by CMS. The Program was implemented on September 1, 2009. During the first 6 months of 2010, 13.68% of the requested prior authorizations were denied. A 6 month utilization review indicates a distinct reduction in the Medicaid claims paid for advanced radiology procedures from a prior use rate of 125-160 per 1000 to 60-80 per 1000. Claims paid data from three years prior to initiation of this contract was used in this analysis.

## **11. DHHS has begun development of a Program of All-Inclusive Care for the Elderly (PACE)**

The PACE Program provides comprehensive health care services within a defined geographic area for voluntarily enrolled individuals age fifty-five and older. DHHS will make capitated payments to a PACE organization which will utilize Medicare, Medicaid, and private pay revenues to provide coordinated care. The organization will be at-risk for all covered services offered by Medicare and Medicaid.

A minimum period of 18-24 months is required to launch an operational PACE program. DHHS issued a Request for Information (RFI) in late December, 2009, to ascertain interest in and capacity to successfully develop a PACE program. One provider responded with a proposal for two sites: one in Omaha and one to follow in Lincoln approximately 18 months later. The respondent has been invited to submit a PACE application to CMS. In the meantime, DHHS is developing a proposed Medicaid payment rate. The final step in this process will be the execution of a program agreement between CMS, DHHS, and the PACE provider organization.

## **12. DHHS implemented the Behavioral Pharmacy Management Program**

The Behavioral Pharmacy Management program (BPM) evaluates behavioral health pharmacy claims and identifies prescribing patterns that are inconsistent with national, evidence-based guidelines. This program is operated by DHHS with assistance from the Nebraska Medical Association (NMA) and Care Management Technologies (CMT), an independent vendor, who contracts directly with state Medicaid agencies or other third party payers. The Nebraska Medicaid BPM Committee is comprised of Medicaid employees and local Mental Health Professionals (2 Doctors, 3 Pharmacists, an APRN, a Medicaid Manager, and a Medicaid Project Coordinator). The committee is responsible for selecting the Quality Indicators that will be targeted in Nebraska. Educational materials are mailed to doctors who deviate from national prescribing guidelines, and also inform doctors when their patients fail to fill prescriptions in a timely fashion. If physician's prescribing practices do not become more consistent with national evidence based guidelines over time, they are offered a peer consultation to discuss prescribing practices with a NMA physician. The goal of the BPM is to share the latest prescribing best practices for mental health drugs with Nebraska prescribers and, in turn, shape the prescribing practices in Nebraska to more closely align with these national evidence-based guidelines. The first mailing that has a focus on the adult population was sent out July 1, 2010 and the second mailing that focuses on the child population was mailed on August 3, 2010.

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## **G. Program Changes**

### **1. DHHS submitted a State Plan Amendment to receive federal funding to cover LPR children and pregnant women**

In June 2010, DHHS submitted an amendment to the State Plan as required by LB 1106 to obtain federal funds without the current five-year delay to allow for payment for medical services to children who are lawfully residing in the United States and who are otherwise eligible for Medicaid and CHIP. This change also applies to eligible pregnant women who are lawfully residing in the US and who are otherwise eligible for Medicaid.

### **2. DHHS implemented a Site of Service Differential reimbursement system for physician services**

The Medicare Physician Fee Schedule contains two rates for selected procedures. One rate is paid when the procedure is performed in a facility setting (usually a hospital), and a higher rate is paid 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. Nebraska Medicaid implemented a similar site of service differential reimbursement system for physician services effective July 1, 2010.

### **3. DHHS provision of autism services on hold**

DHHS was approved in April 2010 by CMS to operate a Medicaid Home and Community Based Waiver to implement an intensive early intervention service based on behavioral principles for children with Autism Spectrum Disorder who receive such services prior to the age of nine. The legislation regarding the waiver required the receipt of private matching donations to finance the program. DHHS was notified in July 2010 that the primary donor decided not to proceed with its planned financial donation. DHHS remains ready to implement the waiver upon receipt of the private funds required in the statute.

### **4. DHHS continues work on a Medical Home Project (LB 396)**

By January 1, 2011, DHHS will have developed and implemented a two-year medical home pilot program in consultation with the Medical Home Advisory Council in one or more geographic regions of the state. 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. A Request for Interest process will determine the selection of the participating practices. The payment methodology includes a per-member-per-month (PMPM) with an option to meet advanced medical home to receive an additional reimbursement incentive. 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 will be evaluated for improved health care access and improved health outcomes for patients, Medicaid cost containment, patient satisfaction, and provider satisfaction.

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**5. DHHS will maximize federal funding with University of Nebraska Medical Center Physicians**

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) 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. A state plan was submitted to CMS on February 23, 2010 and approved on August 26, 2010.

**6. DHHS will establish reimbursement for Pediatric Feeding Disorder services (LB 342)**

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.

**7. DHHS has added Secure Residential mental health services (LB 603)**

DHHS submitted a State Plan Amendment (SPA) to provide Medicaid payments for Secure Residential Services. Secure Residential is a 24-hour residential program that provides intensive mental health services for adults as an alternative to long-term psychiatric hospitalization or upon discharge from the Regional Center. The SPA was approved by CMS March 19, 2010. Corresponding regulations have been promulgated and providers are being enrolled.

**8. DHHS will implement Health Information Technology provisions of Federal law**

DHHS will implement the Medicaid EHR Incentive Program in order to provide federal payments to eligible Medicaid professionals and hospitals for efforts to adopt, implement, upgrade, or meaningfully use certified electronic health record (EHR) technology.

**9. DHHS reviews the Coordination of Benefits, Third Party Liability and Health Insurance Premium Payment (HIPP) programs for efficiencies**

DHHS is reviewing options on how to make the Coordination of Benefits (COB) and Third Party Liability (TPL) activities for the Department's COB/TPL unit and Nebraska's Health Insurance Premium (HIPP) program more efficient through practices such as automated data matching to identify commercial coverage; medical support enforcement; casualty recovery; and efficiencies in the administration of the HIPP program.

**10. DHHS contracted for statewide utilization management and quality control of Medicaid home health and private-duty nursing services**

Effective April 1, 2010, DHHS contracted with Qualis Health to perform prior authorization reviews of all home health and private-duty nursing services, in order to improve the efficiency and consistency of this process and gather accurate and complete utilization data. Initial data

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indicated areas of misuse of Medicaid reimbursement, which have been addressed through provider education, policy clarification and process changes.

#### **11. DHHS implemented a higher resource allowance for Medicare Savings Programs (MSP) as required by federal law**

The Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individual (QI) programs are federal Medicare Savings Programs (MSPs) which help low-income elders and younger Medicare beneficiaries access Medicare benefits. On January 1, 2010, DHHS implemented a higher resource allowance for QMBs, SLMBs and QIs, raising the resource allowance to \$6,600 for an individual and \$9,910 for a couple, as required by the Medicare Improvements for Patients and Providers Act (MIPPA). MSP/QMB individuals have income of less than 100% of the federal poverty level (FPL) and are eligible for Medicaid payment of co-insurance and deductibles on Medicare claims, as well as payment of Medicare Part B premiums. SLMB and QI individuals have income between 100% and 135% of FPL and are eligible for Medicaid payment of Medicare Part B premium only.

### **III. Conclusion**

In the years since the publication of the Medicaid Reform Plan, DHHS has undertaken significant steps to implement the recommendations it contains. Many of the recommendations have become a part of the Medicaid Program. To slow the growth of the Medicaid Program and ensure fiscal sustainability the strategies discussed in this report have been developed to make Medicaid more efficient and cost effective through better management of services, better delivery of care, more appropriate services, and improved administration of the program. Due to current economic conditions, Medicaid eligibility has been increasing steadily. This growth is anticipated to continue in the coming year. However, the Medicaid Reform initiatives that are being undertaken will help to mitigate this growth.

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