

Report on Medicaid Reform Activities
Prepared by Jeffery W. Santema, Legal Counsel
Health and Human Services Committee
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I. Implementation Activities

The Medicaid reform designees continue soliciting input and receiving unsolicited feedback regarding Medicaid reform from various sources. Recent and future meetings include, but are not limited to: the Nebraska Area Agencies on Aging (8-22-05), the Nebraska Medical Association (9-7-05), the Rural Health Advisory Commission (9-7-05), the Nebraska Dental Association (9-12-05), Catholic Charities of Nebraska (9-13-05), a multi-agency Medicaid coalition¹ (9-14-05), the Children and Families Coalition of Nebraska (9-15-05), the Traumatic Brain Injury Advisory Council (9-16-05), the Nebraska Consortium for Citizens with Disabilities (9-19-05), the Mental Health Association of Nebraska consumer work group (9-27-05), the Nebraska Nurses Association (10-7-05), an ad hoc committee of rural health stakeholders (10-11-05), and the Nebraska Minority Health Conference (10-25-05).

Internal HHSS working groups established by Mr. Nelson have now forwarded draft reform recommendations for internal review. A significant body of Medicaid-related research has been accumulated by the Department of Health and Human Services Finance and Support. Various recent national and state reports have also been reviewed. An outline summary of Nebraska Medicaid-related statutes² has been completed and included as an appendix to this report.

Public input meeting(s) in each congressional district have now been scheduled during the two-week period beginning Monday, October 24, 2005.³ Scheduled meeting dates and locations are included at the end of this report. They are also posted on the Nebraska Health and Human Services System (HHSS) Medicaid reform web site, the Nebraska Legislature's Medicaid reform web page, and at www.nebraska.gov/calendar/index.cgi. Additional public forums are also being scheduled.

A second meeting has now been scheduled between the Medicaid reform designees, Nebraska HHSS staff, and the federal Centers for Medicare and Medicaid Services (CMS).

The second meeting of the Medicaid Reform Advisory Council was held on Tuesday, August 23, 2005. The next scheduled meeting of the council is Wednesday, September 21, 2005. Questions regarding the council and its activities may be directed to Senator Jensen's office at (402) 471-2622 or to Senator Don Pederson, chair of the council, at (402) 471-2729. Agendas, meeting dates and locations, and minutes of council meetings will be posted on the Nebraska Legislature's Medicaid reform web page.

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

² Neb. Rev. Stat. §§68-1001 to 68-1086.

³ Public meetings have been scheduled in Omaha (10-25-05), Lincoln (10-26-05), Grand Island (10-27-05), Scottsbluff (11-1-05), and North Platte (11-2-05).

The Nebraska Health and Human Services System Medicaid reform web site is www.hhss.ne.gov/med/reform. The Nebraska Legislature's web page for Medicaid reform planning information is www.unicam.state.ne.us/committees/mrac.htm.

II. Toward a Medicaid Public Policy and Substantive Reform

The State of Nebraska is committed to providing a program of medical assistance for its citizens. The enactment of Medicaid reform legislation raises questions of the appropriate role of government in the provision of such assistance. It also raises significant questions of the nature and scope of Medicaid reforms the State of Nebraska should enact.

A. The current program

Medicaid in Nebraska today is a welfare entitlement program. Since its inception in 1965, the program has been especially influenced by four key factors: (1) changes in society and the health care delivery system generally; (2) available funding; (3) the federal government; and (4) political advocacy.

Simply stated, the Medicaid program pays for the health care and long-term care expenses of eligible persons, and provides limited financial support to "safety net" providers who serve Medicaid recipients.

The Medicaid program is state administered within broadly established federal guidelines. The cost of the program is shared by the state and federal government. Medicaid federal financial participation (FFP) applies to program services and to Medicaid-related administrative expenses. The FFP, calculated as a Federal Medical Assistance Percentage (FMAP), for Medicaid program services in Nebraska is approximately 60%, with 40% of Medicaid costs paid with state General Funds.⁴ The FMAP for Medicaid administration expenses is 50%, with some exceptions.⁵

The federal Balanced Budget Act of 1997 (BBA)⁶ created a new Title XXI under the federal Social Security Act (SSA) to establish a separate state children's health insurance program (SCHIP)⁷, and applied a higher FMAP to such programs.⁸ Under the BBA, states had the option to formulate their SCHIP programs as a Medicaid expansion, a separate children's health insurance plan, or a combination of the two. The Title XXI SCHIP program in Nebraska has been established as a Medicaid expansion.⁹ The combined Title XIX and Title XXI children's health insurance program in Nebraska is called Kid's Connection.

Titles XIX and XXI of the federal Social Security Act and related rules and regulations establish certain minimum mandatory standards for state Medicaid programs. Elements of the

⁴ For federal fiscal year (FFY) 04-05 (October 1, 2004 to September 30, 2005) the federal medical assistance percentage rate for Nebraska is 59.64%. Federal Register, December 3, 2003 (Volume 68, Number 232), pp. 67676 – 67678.

⁵ Some exceptions include design, development, or installation of a Medicaid Management Information System (90% FFP), and compensation and training of skilled professional medical personnel (75% FFP).

⁶ H.R. 2015, Public Law 105-33, signed by President Clinton in August 1997.

⁷ Balanced Budget Act of 1997, H.R. 2015, Public Law 105-33. See 42 U.S.C. §§1397aa – 1397jj.

⁸ For federal fiscal year (FFY) 04-05 (October 1, 2004 to September 30, 2005) the enhanced federal medical assistance percentage rate for Nebraska is 71.75%. Federal Register, December 3, 2003 (Volume 68, Number 232), pp. 67676 – 67678.

⁹ Laws 1998, LB 1063, §§5-10; Neb. Rev. Stat. §§68-1019, 68-1020, 68-1021, 68-1025.01, 68-1037, 68-1037.06.

state Medicaid program must be approved by the federal Centers for Medicare and Medicaid Services (CMS). The Medicaid “state plan” is a comprehensive written document, developed and amended collaboratively with CMS, that describes the nature and scope of the state’s Medicaid program, and gives assurances that the state will administer the program in compliance with federal requirements.¹⁰ The state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets payment rates for services; and administers the program on a day-to-day basis. Core federal requirements applicable to all state Medicaid programs include statewideness,¹¹ comparability,¹² freedom of choice,¹³ and sufficiency in amount, duration, and scope of Medicaid services.¹⁴ Portions of federal Medicaid authorizing legislation may be “waived” to provide states with greater Medicaid flexibility.¹⁵

Nebraska law governing Medicaid is essentially found at Neb. Rev. Stat. §§ 68-1018 to 68-1025. Other Medicaid-related provisions include §§68-1001 to 68-1008,¹⁶ §§ 68-1038 to 68-1043,¹⁷ the Managed Care Plan Act,¹⁸ Aid to Dependent Children (ADC) statutes,¹⁹ the Early

¹⁰ Additional information regarding the Nebraska state Medicaid plan and approved amendments to the plan may be accessed on the World Wide Web at <http://www.cms.hhs.gov/medicaid/stateplans/toc.asp?state=NE>.

¹¹ “Statewide operation. (a) Statutory basis. Section 1902(a)(1) of the Act requires a State plan to be in effect throughout the State, and section 1915 permits certain exceptions. (b) State plan requirements. A State plan must provide that the following requirements are met: (1) The plan will be in operation statewide through a system of local offices, under equitable standards for assistance and administration that are mandatory throughout the State. (2) If administered by political subdivisions of the State, the plan will be mandatory on those subdivisions. (3) The agency will ensure that the plan is continuously in operation in all local offices or agencies through-- (i) Methods for informing staff of State policies, standards, procedures, and instructions; (ii) Systematic planned examination and evaluation of operations in local offices by regularly assigned State staff who make regular visits; and (iii) Reports, controls, or other methods. . . .” 42 CFR 431.50.

¹² “Comparability of services for groups. Except as limited in Sec. 440.250-- (a) The plan must provide that the services available to any categorically needy recipient under the plan are not less in amount, duration, and scope than those services available to a medically needy recipient; and (b) The plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all recipients within the group: (1) The categorically needy. (2) A covered medically needy group.” 42 CFR 440.240.

¹³ “Free choice of providers. (a) Statutory basis. This section is based on sections 1902(a)(23), 1902(e)(2), and 1915 (a) and (b) of the Act. (1) Section 1902(a)(23) of the Act provides that recipients may obtain services from any qualified Medicaid provider that undertakes to provide the services to them. . . . (b) State plan requirements. A State plan, except the plan for Puerto Rico, the Virgin Islands, or Guam, must provide as follows: (1) Except as provided under paragraph (c) of this section, a recipient may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is-- (i) Qualified to furnish the services; and (ii) Willing to furnish them to that particular recipient. This includes an organization that furnishes, or arranges for the furnishing of, Medicaid services on a prepayment basis. (2) A recipient enrolled in a primary care case-management system, an HMO, or other similar entity will not be restricted in freedom of choice of providers of family planning services. . . .” 42 CFR 431.51.

¹⁴ “Sufficiency of amount, duration, and scope. (a) The plan must specify the amount, duration, and scope of each service that it provides for-- (1) The categorically needy; and (2) Each covered group of medically needy. (b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. (c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under Secs. 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition. (d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.” 42 CFR 440.230.

¹⁵ Examples of federal “waivers” available to states include home and community based services waivers (SSA §1915(c)), managed care waivers (SSA §1915(b)), and research and demonstration waivers (SSA §1115), including Health Insurance Flexibility and Accountability (HIFA) waivers.

¹⁶ Assistance to the aged, blind, and disabled.

¹⁷ Spousal impoverishment.

¹⁸ Neb. Rev. Stat. §§ 68-1048 to 68-1063.

Intervention Act for children and toddlers with disabilities,²⁰ the Nebraska Telehealth Act,²¹ §§ 68-1071 to 68-1072,²² the False Medicaid Claims Act,²³ and the Welfare Reform Act,²⁴ among others.

Medicaid in Nebraska is shaped by public policy established by the United States Congress and the Nebraska Legislature and the complex interaction of four interrelated elements: (1) eligibility, (2) services, (3) reimbursement, and (4) administration.

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

Eligibility

The following persons are eligible for medical assistance in Nebraska:²⁵ (1) dependent children under age 19;²⁶ (2) aged, blind and disabled persons,²⁷ (3) persons under age 19 who are eligible under §1905(a)(i) of the federal Social Security Act (SSA),²⁸ (4) children and pregnant women with family incomes up to 185% of the federal Office of Management Budget income poverty guideline (federal poverty line, or FPL),²⁹ (5) medically needy caretaker relatives,³⁰ (6) employed persons with disabilities with incomes up to 250% FPL,³¹ and (7) women under age 65 needing breast or cervical cancer treatment who are not otherwise Medicaid eligible.³² Medicaid coverage is also provided for disabled children,³³ and ADC families.³⁴

Families cannot be “subdivided,” or “stacked,” for purposes of determining Medicaid eligibility,³⁵ and special “spousal impoverishment” provisions apply to allow higher income and asset deductions for “community spouses” of Medicaid-eligible long-term care facility residents.³⁶ An “earned income disregard” of \$100 per month, along with other allowable “disregards,” are also deducted from an applicant’s gross income before using the appropriate federal poverty standard to determine his or her Medicaid eligibility.³⁷

¹⁹ Neb. Rev. Stat. §43-504 et seq.

²⁰ Neb. Rev. Stat. §§43-2501 to 43-2516.

²¹ Neb. Rev. Stat. §§71-8501 to 71-8508.

²² Payment for school Medicaid administrative activities.

²³ Neb. Rev. Stat. §§68-1073 to 68-1086.

²⁴ Neb. Rev. Stat. §§68-1708 to 68-1734.

²⁵ Neb. Rev. Stat. §68-1020.

²⁶ Neb. Rev. Stat. 68-1020(1). For definition of “dependent child,” see Neb. Rev. Stat. §43-504.

²⁷ Neb. Rev. Stat. §68-1020(1), §68-1001 et seq.

²⁸ Neb. Rev. Stat. §68-1020(1); Laws 1984, LB 1127; Laws 2003, LB 411. “Ribicoff children,” named for the former U.S. Senator that sponsored legislation authorizing coverage for this group, are children who meet income and resource requirements for ADC but who otherwise are not eligible for ADC because they do not meet the definition of “dependent child.” Included in this category are often children who are in state-sponsored foster care, or who are institutionalized or inpatients in psychiatric facilities.

²⁹ Neb. Rev. Stat. §68-1020(2); Laws 1988, LB 229; Laws 1998, LB 1063.

³⁰ Neb. Rev. Stat. §68-1020(2), Laws 2002 (Second Special Session), LB 8. Medically needy standard is 133% of the state’s ADC standard, or approximately 32% FPL.

³¹ Neb. Rev. Stat. §68-1020(3), Laws 1999, LB 594, §34.

³² Neb. Rev. Stat. §68-1020(4), Laws 2001, LB 677.

³³ The Early Intervention Act, Neb. Rev. Stat. § 43-2501 et seq.

³⁴ Neb. Rev. Stat. §43-504, and the Welfare Reform Act, §§68-1708 to 68-1734.

³⁵ Neb. Rev. Stat. §68-1020(5), Laws 2002 (Second Special Session), LB 8.

³⁶ Neb. Rev. Stat. §68-1038 to 68-1043.

³⁷ Neb. Rev. Stat. §68-1713.

Services

Medicaid-covered services are addressed in Neb. Rev. Stat. §§ 68-1019 to 68-1019.09. Medical assistance payments are made directly to vendors, and the following services must be covered: (1) care in an institution for mental diseases for persons over 65; (2) inpatient and outpatient hospital care; (3) laboratory and X-ray services; (4) nursing home services; (5) care home services; (6) home health care services; (7) nursing services; (8) clinic services; (9) services by state-licensed practitioners; and (10) drugs, appliances, and health aides prescribed by state-licensed practitioners.³⁸

In 1993,³⁹ the Legislature provided for the establishment of premiums, copayments and deductibles, and limitations on the amount, scope and duration of Medicaid services.⁴⁰ Medicaid payments for hearing screening for infants and newborns,⁴¹ telehealth consultations,⁴² and school Medicaid administrative activities⁴³ are also covered.

Services covered by Medicaid in Nebraska include both federally mandated services and state optional services. Federally mandated services include inpatient hospital, outpatient hospital, rural health clinics, laboratory and X-ray, nursing facility for persons age 21 and older, early and periodic screening for children (EPSDT), family planning services and supplies, physician services, dental medical and surgical, home health, medical supplies, nurse-midwife, and nurse practitioner services.⁴⁴

State optional services include intermediate care facilities for the mentally retarded (ICF-MR), case management for persons with mental retardation/developmental disabilities (MR/DD), MR/DD waiver services, rehabilitation services, medical transportation, prescription drugs, personal care aides, aged and disabled waiver services, chiropractic, dental, durable medical equipment, occupational therapy, optometry, physical therapy, podiatry, speech therapy, vision related services, and home and community-based waiver services.⁴⁵

Reimbursement

The Nebraska Medicaid program provides reimbursement for covered services, generally without the imposition of premiums, copayments, or deductibles.⁴⁶ It includes no lifetime

³⁸ Neb. Rev. Stat. §68-1019.

³⁹ Laws 1993, LB 804; Laws 1993, LB 808.

⁴⁰ Neb. Rev. Stat. §68-1019 (4), (5); Neb. Rev. Stat. §§68-1019.01 to 68-1019.09. Premiums have been established for two groups: those receiving transitional medical assistance (TMA) and employed persons with disabilities. Total premiums collected in FY 2004 were \$51,702 (TMA) and \$535 (employed persons with disabilities). Copayments have been established for 12 Medicaid-covered services: chiropractic office visits (\$1 per visit), dental services (\$3 per specified service), prescriptions (\$2 per person), eyeglasses (\$2 per dispensing fee), hearing aids (\$3 per dispensing fee), occupational therapy (\$2 per specified service), optometric office visits (\$2 per visit), outpatient hospital services (\$3 per visit), physical therapy (\$1 per specified visit), physician office visits (\$2 per visit excluding primary care physicians providing primary care services), podiatrist office visits (\$1 per visit), and speech therapy (\$2 per specified visit). Total "savings" to the Medicaid program for copayments collected in FY 2004: \$3,763,354 (total funds); \$1,401,849 (General Funds). Approximately 91% of copayments received were for prescribed drugs. Nebraska Health and Human Services System.

⁴¹ Neb. Rev. Stat. §68-1019.06; Laws 2000, LB 950.

⁴² Neb. Rev. Stat. §§71-8501 to 71-8508; Laws 1999, LB 559.

⁴³ Neb. Rev. Stat. §§1071 to 68-1072; Laws 1999, LB 548.

⁴⁴ Nebraska Health and Human Services System.

⁴⁵ Nebraska Health and Human Services System.

⁴⁶ See above at note 39.

maximum, no calendar year deductible, no calendar year coinsurance maximum, no maximum/total out of pocket per calendar year, and no overall contract maximum.⁴⁷

The state applies different levels of reimbursement to various Medicaid services. Practitioner services are reimbursed according to a fee schedule based on “relative value data” for the particular services provided. Prescription drugs are reimbursed according to product cost, expressed as a discounted “average wholesale price” (AWP), plus a pharmacy dispensing fee. Urban inpatient hospital services are reimbursed on a “per discharge” basis (based on “diagnostic related group”⁴⁸ classifications). Rural “critical access” hospitals are reimbursed according to a per diem rate based on actual cost and special federal rules applicable to such hospitals. Outpatient services are reimbursed at 85 percent of cost as indicated on the provider’s Medicare cost report. Nursing facility services are reimbursed according to a “prospective payment system,” at reasonable cost as determined from cost reports filed by the provider and using 19 different levels of payment rates based on acuity. Laboratory and radiology services are reimbursed according to a federally established fee schedule. Federally qualified health centers (FQHCs) and rural health clinics (RHCs) are reimbursed according to actual cost per service provided (encounters), at a rate determined from provider Medicare cost reports and adjusted annually. Home and community-based waiver services are reimbursed at “reasonable fees” determined by the Nebraska Department of Health and Human Services Finance and Support. Federal law prohibits waiver payments to exceed provider cost.

Administration

Medicaid in Nebraska is administered by the state Medicaid agency within the Department of Health and Human Services Finance and Support.

Various administrative issues have been addressed in Nebraska law since 1965 to control Medicaid costs, including assignment of rights provisions,⁴⁹ contracting and purchasing guidelines,⁵⁰ nursing facility screening requirements,⁵¹ transfer of assets provisions,⁵² estate recovery requirements,⁵³ the Managed Care Plan Act,⁵⁴ garnishment provisions,⁵⁵ and the False Medicaid Claims Act.⁵⁶ Various cost-saving administrative procedures have also been established and implemented by the department under its broad state and federal statutory authority.

Medicaid eligibility determinations are processed through the Department of Health and Human Services. The Nebraska Department of Justice maintains a separate unit under the False Medicaid Claims Act to identify and investigate cases of alleged Medicaid fraud.

⁴⁷ Nebraska Health and Human Services System.

⁴⁸ Diagnostic related group (DRG) is a medical-based classification, representing 23 major diagnostic categories that aggregates patients into case types based on diagnosis. A diagnosis related group is a subset of a major diagnostic category. See http://www.iversonsoftware.com/reference/psychology/d/diagnostic_related_group.htm.

⁴⁹ Neb. Rev. Stat. §68-1026 to §68-1028; Laws 1984, LB 723.

⁵⁰ Neb. Rev. Stat. §68-1029 to §68-1037; Laws 1984, LB 904.

⁵¹ Neb. Rev. Stat. §81-2269; Laws 1993, LB 801; Laws 1995, LB 406.

⁵² Federal requirement (42 U.S.C. 1396p(c)), see Neb. Rev. Stat. §68-1036.01; Laws 1993, LB 798; repealed Laws 1996, LB 1155.

⁵³ Neb. Rev. Stat. §68-1036.02; Laws 1994, LB 1224.

⁵⁴ Neb. Rev. Stat. §68-1048 to §68-1064; Laws 1993, LB 816.

⁵⁵ Neb. Rev. Stat. §68-1036.03; Laws 1994, LB 1224.

⁵⁶ Neb. Rev. Stat. §68-1073 to §68-1086; Laws 2004, LB 1084.

B. Toward a “reformed” program

LB 709 (2005) calls for “fundamental reform” of the medical assistance (Medicaid) program and “substantive recodification” of Medicaid statutes.⁵⁷ Several guidelines for reform were suggested in the August report.⁵⁸

Medicaid reform is concerned with addressing the health care and related needs of people. The best interests of the people of the State of Nebraska are the primary concern and motivation for reform. The goal of Medicaid reform should be the provision of available medical assistance funding for the greatest benefit to the most people, with maximum flexibility and controlled expenditure growth. If government is unable to meet all of the needs that exist, it should not be asked or expected to do so, and should not attempt to do so. Medicaid reform, therefore, depends on a public-private partnership to do what government alone cannot do.

1. Recodification.

LB 709 (2005) calls for a Medicaid reform plan, and substantive legislation to implement the plan.⁵⁹ The nature and scope of reform will be determined by the Medicaid reform plan and legislation drafted to implement the plan.

Work on preparation of draft Medicaid reform legislation is now underway. Primary goals of recodification are to (1) provide necessary policy guidance for the Medicaid program, (2) update current Medicaid statutes, (3) make identified program changes, and (4) provide for implementation of enacted reforms.

2. Public policy.

The State of Nebraska currently provides a program of medical assistance for its residents, but the underlying public policy of the program is unclear. “Medical assistance” is concerned with matters related to the health of Nebraskans.

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

⁵⁷ Neb. Rev. Stat. §68-1088, §68-1090.

⁵⁸ (1) Conduct a thorough review and critique of current statutes; (2) Consider the impact of reforms on current eligibles and providers of care; (3) Formulate a clear and reasonable articulation of public policy, priorities, and the role of government in the provision of publicly funded medical assistance; (4) Establish a clear roadmap to guide future Medicaid decisions; (5) Consider the non-Medicaid health care environment and avoid the isolation of Medicaid; (6) Challenge past assumptions and practices and demand needed changes; (7) Avoid extremes; (8) Address key issues; and (9) Work closely with the federal Centers for Medicare and Medicaid Services (CMS) to implement desired reforms.

⁵⁹ Neb. Rev. Stat. §68-1091, §68-1094.

Medicaid public policy must also be clarified in several other areas, including, but not limited to, (1) the welfare entitlement structure of Medicaid; (2) eligibility; (3) benefits; (4) administration; (5) funding; (6) personal responsibility; and (7) the private sector.

A host of policy options present themselves in each of these areas, and each area must be carefully considered and addressed, with specific recommendations, in the final Medicaid reform plan. Further public input will be solicited, and specific policy options and recommendations are being prepared for public review.

**Report on Medicaid Reform Activities
Prepared by Richard P. Nelson, Director
Health and Human Services Finance and Support
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COMPARISONS BETWEEN MAJOR COMPONENTS OF THE MEDICAID POPULATION

Introduction

Persons receiving services paid for by Medicaid are not a homogeneous group. Their basis for eligibility varies by a host of factors, including age, income and level of disability. Their service needs also vary. The service needs of a low-income, relatively healthy child, for example, will be different than the service needs of an older person with multiple disabling conditions. These differences need to be acknowledged and considered in deliberations about Medicaid Reform. For this reason, the Health and Human Services System (HHSS) divided the Medicaid population into five relatively homogeneous groups. A work group was formed within HHSS to analyze data and address the issues relevant to each of the five population sub-groups:

- Healthy Children & Pregnant Women
- Children with Disabilities
- Adults
- Adults with Disabilities
- Aged

The primary criteria for classifying Medicaid eligibles into one of the five population sub-groups were: a) age and b) disability status. Persons 65 years of age and older were placed in the Aged category, regardless of disability. Persons under 65 years of age were placed in a group based upon their age and disability status. If the person was 20 years or younger, and if a disabling condition was identified through the formal disability determination process, the person was included in the Children with Disabilities group. If the person was 21 to 64 years of age, and a disabling condition was identified through the formal disability determination process, the person was included in the Adults with Disabilities group. Persons for whom no disabling condition has been identified through the formal disability determination process were classified in either the Healthy Children & Pregnant Women or Adults categories, based on age. Low-income pregnant women were classified with the Healthy Children because the unborn child is the "covered" entity. (It should be noted that there are some children and adults within the Healthy Children & Pregnant Women and Adult populations that have disabling conditions; however, they are included in the Healthy Children and Pregnant Women category because a formal disability determination has not been made.)

The Aged population was covered in the August report. This report focuses on the four remaining categories: Healthy Children & Pregnant Women, Children with Disabilities, Adults, and Adults with Disabilities.

Persons Eligible for Medicaid

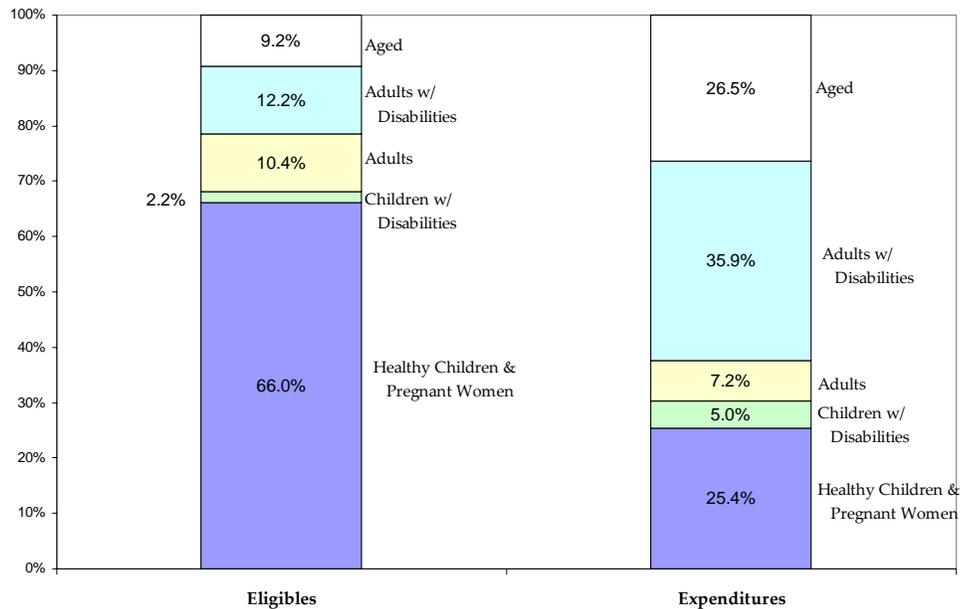
During State Fiscal Year 2005 (SFY05), the average number of monthly eligibles was 200,788⁶⁰. Two-thirds (66.0%) of the average monthly eligibles were in the Healthy Children & Pregnant Women category. The next largest group was Adults with Disabilities (12.2%), followed by Adults (10.5%) and the Aged (9.2%). Only 2.2% were in the Children with Disabilities category.

⁶⁰ Eligibility data in this report are average monthly figures unless otherwise noted. As of June 30, 2005, the monthly average number of Medicaid eligibles is 198,757. However, when retroactive eligibility was included, the average increases to 200,788. Further retroactive eligibility may increase this number.

Expenditures

During SFY05, state and federal Medicaid expenditures⁶¹ totaled almost \$1.4 billion. Adults with Disabilities accounted for 35.9% of the total Medicaid expenditures. The Aged population accounted for 26.5% of total Medicaid expenditures. While Healthy Children & Pregnant Women comprised almost two-thirds of the eligibles, they accounted for only 25.3% of expenditures (Figure 1).

Figure 1



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

Change Over the Past Five Years

Over the past five years, the number of Medicaid eligibles in Nebraska has increased 9.8%, an average of 1.9% a year, while Medicaid expenditures have gone up 48.1%, an average of 8.2% a year (Table 1). The Adults with Disabilities category had the highest percentage growth in eligibles (+16.8%, or 3.2% a year), followed by Healthy Children & Pregnant Women (+15.8%, or 3.0% a year). The Children with Disabilities group and the Aged group showed smaller increases in eligibles over the past five years; 6.3% (or 1.2% year) and 1.8% (or 0.3% a year), respectively. The Adults population decreased 16.7% from SFY00 to SFY05, a decrease of about 3.6% a year.

The largest percentage increase in Medicaid expenditures over the past five years was for the Healthy Children & Pregnant Women group (which increased 69.5%, for an average increase of 11.1% a year), and the Adults with Disabilities group (which increased 57.4%, for an average increase of 9.5% a year). Expenditures for the Children with Disabilities group increased 49.6% (or 8.6% a year). The increases for the Adults and Aged populations were lower: 43.6% (or 7.5% a year) and 23.9% (or 4.4% a year), respectively.

⁶¹ "Expenditures" consists of payments to providers for services.

Table 1
Change in Average Monthly Eligibles and Expenditures by Population Group
SFY00 and SFY05

Population Group	State Fiscal Year 2000		State Fiscal Year 2005		% Change FY00 to FY05	
	Eligibles	Exps.	Eligibles	Exps.	Eligibles	Exps.
Healthy Children & Pregnant Women	114,502	\$208,845,485	132,547	\$354,041,638	+15.8%	+69.5%
Children w/ Disabilities	4,075	46,588,277*	4,330	69,712,266	+6.3%	+49.6%
Adults	25,205	70,429,802	20,984	101,121,518	-16.7%	+43.6%
Adults w/ Disabilities	20,896	318,845,366*	24,405	501,951,861	+16.8%	+57.4%
Aged	18,203	298,523,461	18,522	369,853,967	+1.8%	+23.9%
Total	182,881	\$943,232,391*	200,788	\$1,396,681,250	+9.8%	+48.1%

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

Expenditures by Type of Service

The top four Medicaid expenditure categories in SFY05 were: Nursing Facility Services, which accounted for 18.1% of expenditures; Prescription Drugs, which accounted for 16.9% of expenditures; Home and Community-Based Services Waiver services, which accounted for 10.4% of expenditures; and Inpatient General Hospital services, which accounted for 9.0% of expenditures. Prescription Drugs saw a 90.3% increase from SFY00 to SFY05 – from \$124.3 million to \$236.6 million. Nursing facility services increased 7.1%, from about \$236.4 million in SFY00 to about \$253.1 million in SFY05; and Inpatient General Hospital services increased 33.7%, from about \$93.8 million in SFY00 to \$125.4 million in SFY05. (See Attachment 1 for a breakdown of expenditures by type of service.)

Below are summaries for the four population groups.

I. HEALTHY CHILDREN & PREGNANT WOMEN

As noted earlier, Healthy Children & Pregnant Women comprised two-thirds (66.0%) of the Medicaid eligible population in SFY05, making it the largest Medicaid eligibility group. The average monthly eligibles in this category was 132,547. Collectively, this population accounted for about one-fourth (25.3%) of Medicaid expenditures in SFY05. Most of the people in this category are children under the age of 21 (96.8%); pregnant women, who were eligible because of their pregnancy, comprised only 3.2% percent of this population. For these women, their unborn child is considered the “covered” entity. These women receive prenatal care, and postnatal care until the end of the month 60 days after the end of the pregnancy. They are also eligible to receive any other medically necessary Medicaid-covered service. (The population does not include low-income women who are pregnant and eligible “in their own right.” Those persons are in the Adults category.)

Eligibility

There are many categories through which Healthy Children & Pregnant Women can qualify under Medicaid in Nebraska, including:

- a. children in families receiving ADC (mandatory under Federal and State law)
- b. children in families that meet the ADC eligibility requirements, but do not receive an ADC grant (mandatory under Federal law)
- c. children in families that have income over the ADC standard, but less than the Medically Needy Income Level (mandatory under State law)
- d. children age 18 or younger who are not eligible as an ADC child because they don’t meet the ADC requirements of physical absence of one parent or financial deprivation (mandatory under State law)
- e. unborn children in families with income equal to or less than 185% of the Federal Poverty Level (FPL) (mandatory under State law)
- f. infants up to the age of one whose family income is less than 150% of the FPL (mandatory under State law)

- law)
- g. children ages one through six in families with income equal to or less than 133% of FPL (mandatory under Federal and State law)
- h. school-age children (ages 6 through 18) where the family income is equal to or less than 100% of the FPL (mandatory under Federal and State law)
- i. presumptive eligibility for pregnant women (mandatory under State law)
- j. Transitional Medical Assistance – ADC cases that are ineligible due to earnings, but a member of the unit met ADC standards for three of the proceeding six months, which makes them eligible for Transitional Medical Assistance (mandatory under Federal law)
- k. State Wards and subsidized adoptions

In addition, to be eligible for the State Children’s Health Insurance Program (CHIP), the child’s family income must be below 185% of FPL and the family cannot have creditable health insurance coverage and do not qualify for one of the other Medicaid eligibility groups. (In Nebraska, CHIP is a Medicaid-expansion program, rather than a separate state program.)

Demographic Characteristics

Children aged five and under, including infants and unborn children, accounted for 45.6% of this population in SFY05; 31.4% were school age (ages 6 to 12); 21.5% were adolescents (ages 13 to 18), and 1.5% were 19 to 20 year olds. By basis of eligibility, non-CHIP children accounted for 71.2% of the population, followed by CHIP children (17.9%). Almost five percent (4.8%) were State Wards. Another 2.7% were in a subsidized guardianship or subsidized adoption situation. About 3.2% were women who were eligible because they were pregnant and received services during the prenatal and postnatal period only. Almost half (48.6%) were males; 48.2% were females; and 3.2% were unborn children. About 61.7% were White, non-Hispanic; 14.4% were Black/African American; 3.9% were American Indian; 1.2% were Asian or Pacific Islander; 0.6% were of mixed race; and 18.3% were Hispanic or Latino. Most were living in a home or apartment, including public housing (95.6%); 2.1% were living in a foster home. About half (55.5%) of the persons in this category were eligible for all 12 months of SFY05.

Expenditures/Services Received

The largest category of expenditures for this population in SFY05 was Inpatient General Hospital Services (\$58.7 million; 16.6%), followed by Prescription Drugs (\$46.1 million; 13.0%) and Physician Services (\$42.2 million; 11.9%) (see Attachment 2). Looking at the non-CHIP population, sixteen percent (\$54 million) of the expenditures for non-CHIP eligible children and pregnant women for SFY05 were for Inpatient General Hospital Services. This is not surprising as Medicaid pays for approximately 39.7% of all births in Nebraska. This cost includes delivery and newborn care for mothers and infants.

The second highest expenditure for non-CHIP children and pregnant women was for prescription drugs at \$38 million.

State wards were more likely to have a mental health clinic visit than CHIP or non-state ward eligible children. Over forty percent (43.9%) of the state wards received mental health clinic services, compared to 4.0% of the non-CHIP children and 4.7% of the children in the CHIP program. (Mental health clinic services include individual, family and group therapy visits with a mental health or substance abuse professional.)

State Wards were more likely than other children in this category to receive prescribed drugs; 42.5% of State Wards received prescription drugs, compared to 25.7% of the non-CHIP children and 25.5% of the children in the CHIP program. The top three prescribed drugs for state wards were antidepressants, tranquilizers and anticonvulsants.

Of the \$354 million in expenditures in SFY05 for children and pregnant women, \$23.1 million (6.5 percent) was expended for women eligible because they were pregnant. About thirty-five percent of those dollars (\$8 million) were for inpatient hospital care for the pregnant women.

In SFY05 the average cost per eligible child in this category was \$2,671, up 46.4% from SFY00 (\$1,824). The average cost varied by age (Table 2).

Table 2
Percent of Expenditures and Average Annual Cost
For Healthy Children & Pregnant Women
State Fiscal Year 2005

Age Group	% of Expenditures	Average Cost per Eligible
0–5 years	45.4%	\$2,656
6–12 years	20.9%	\$1,785
13–18 years	31.6%	\$3,919
19–20 years	2.1%	\$3,737
Total	100.0%	\$2,671

High-Cost Recipients

Medicaid expenditures are not equally distributed across all children and pregnant women in this category. In SFY05 the top ten percent of children and pregnant women (in terms of total expenditures) accounted for almost 59% of the Medicaid expenditures for this group. The average annual cost per recipient for those in the top ten percent was almost 13 times higher than the average annual cost for those in the remaining 90% (\$13,055 versus \$1,030). By service type, the top ten percent accounted for the majority of the expenditures for: Inpatient General Hospital (90.4%), Home Health Services (89.3%), Inpatient Mental Hospital services for persons age 21 and under (99.9%), Clinic Services (66.9%), and Physician Services (51.1%). The top ten percent accounted for almost half (49.7%) of prescription drug expenditures for this group and 47.5% of General Hospital Outpatient Services.

Children with mental health diagnoses accounted for 29.6% of expenditures for the high-cost recipients. Newborns accounted for 11.8% of expenditures for the high-cost recipients, and pregnancies with vaginal delivery accounted for 10.2%.

Trends in Expenditures Over the Past Five Years

While the number of eligible persons in this category increased 15.8% from SFY00 to SFY05, total expenditures for this population increased 69.5%. Inpatient General Hospital services, the largest expenditure category, increased 30.8%, from \$44.8 million in SFY00 to \$58.7 million in SFY05. Expenditures for Prescription Drugs more than doubled, from \$18.8 million in SFY00 to \$46.1 million in SFY05. Expenditures for Physician Services increased 62.6% from \$26.0 million in SFY00 to \$42.2 million in SFY05.

II. CHILDREN WITH DISABILITIES

Children with disabilities is a relatively small Medicaid group with regard to enrollment. A disabling condition is identified by the disability determination process at either the Federal (as in the case of Supplemental Security Income (SSI)), or at the State level. The average monthly number of eligibles for this population was 4,330 in SFY05. This is approximately 2% of the total average monthly eligibles. The number of children deemed disabled has increased 6.3%, from 4,075 children in SFY00 to 4,330 children in SFY05.

Eligibility

Medicaid is the primary public medical assistance program for low-income disabled children. There are numerous pathways to eligibility, and these pathways vary due to the many options available. Generally, qualifying for Medicaid can be considered to involve two steps--categorical eligibility and financial eligibility. First, a child has to fit into one of the categorical groups which Nebraska covers for Medicaid. Among others, some of these categorical groups include the Medically Needy (Federal Option); and the Aged and Disabled who receive a Supplemental Security Income (Federally Required). Second, a child (or the child's family) has to pass a financial test. The financial test varies among the categorical groups. Some waivers and program options waive the deeming of parental income and assets for children (e.g., Katie Beckett program, children eligible for ICF-MRs).

Through a number of special eligibility provisions, Medicaid provides benefits to many children with significant health care needs who otherwise would not qualify for Medicaid. This includes children who receive home and community based services under a waiver program and children who are placed in out of home residential settings such as institutions for persons with disabilities.

The Social Security Administration defines disability in children the following way:

A child under age 18 will be considered disabled if he or she has a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

Demographic Characteristics

Children under the age of six accounted for 20.3% of the Children with Disabilities eligible population. Children 6 to 12 years of age accounted for 33.1% of the eligible population; children 13-18 years of age accounted for 31.9% of the eligible population, and youth 19-20 years of age accounted for 14.7% of the eligible population. Over sixty percent were male. Almost three-fourths (72.6%) were White, non-Hispanic; 16.5% were Black/African American; 3.0% were American Indian; 0.7% were Asian; 0.4% were of mixed race; and 6.8% were Hispanic or Latino. Most (91.4%) were living in a home or apartment, including public housing. About 1.6% of the Children with Disabilities are also eligible for Medicare (dual eligible).

Sixty percent (59.7%) of the children in this category who were eligible for Medicaid in SFY05 were eligible for all twelve months of SFY05. About one-fourth (22.8%) of the children in this category were on a waiver, either the Aged & Disabled waiver (17.3% of all children with disabilities) or a Developmental Disabilities (DD) waiver (5.5% of all children with disabilities).

Expenditures/Services Received

Total expenditures, which includes both MMIS payments and Waivers paid through NFOCUS, equaled \$69,712,266 for SFY05. This is 5.0% of the total Nebraska Medicaid Expenditures for SFY05.

Waiver services⁶² accounted for the greatest net expenditure at \$16,316,339 in SFY05, for an average of \$16,468 per person on a waiver. Acute hospitalization accounted for the second largest net payments at \$ 8,191,588. The third largest net payments in SFY05 were for prescription drugs (\$7,857,295), followed by home health services (\$5,741,266) (see Attachment 3). Outpatient services other than physician encounters (including emergency room visits), medications, physical therapy, audiology, hospice, and orthopedic devices accounted for the remainder of the expenditures.

In SFY05, the average annual cost per eligible person in this category was \$16,100, an increase of 40.8% from FY00 (\$11,433). The average cost varied by age, with the under six age group having the highest average annual cost per eligible child (Table 3).

Table 3
Percent of Expenditures and Average Annual Cost
For Children with Disabilities
State Fiscal Year 2005

Age Group	% of Expenditures	Average Cost per Eligible
0-5 years	24.2%	\$19,113
6-12 years	27.9%	\$13,598
13-18 years	32.4%	\$16,353
19-20 years	15.5%	\$17,006
Total	100.0%	\$16,100

⁶² To be eligible for the waiver, the child needs to be eligible for nursing facility or ICF-MR care.

High-Cost Recipients

Within the group of Children with Disabilities and chronic illnesses, a relatively small percentage of individuals account for most of the medical care costs. In SFY05 the top ten percent of recipients in this category accounted for 62.5% of the non-waiver Medicaid⁶³ expenditures for this population. The top ten percent of recipients accounted for the following: 95.3% of Inpatient Mental Hospital (for persons 21 and under) services, 91.8% of Inpatient General Hospital Services, 55.7% of General Hospital Outpatient Services, 55.6% of Physician Services, and 38.0% of Prescription Drugs.

The average annual cost for the top ten percent of recipients was \$59,549, nearly 15 times the average annual cost of \$3,978 for the remaining 90 percent. Mental health disorders, including autism, accounted for 13.2% of expenditures for the high-cost recipients, followed by newborns with/without complications, (6.9%), neurological disorders not elsewhere classified (6.5%), and cerebral palsy (6.4%).

Waiver Services

Waiver programs are administered by two separate, specialized divisions which are accountable to the Medicaid Division. The Developmental Disabilities (DD) Service Waivers are administered by the Developmental Disabilities Services Division, and the Home and Community Based Service (HCBS) waivers are administered by the Home and Community Services Division. Home and Community Based Services include the Aged and Disabled Waiver and the Early Intervention Medicaid Home and Community-Based Waiver. The waiver programs allow Medicaid money to be used to purchase services that are not usually considered "medical". These services include among others: child care, respite care, transportation, housekeeping activities, meal preparation, essential shopping, errand service, escort service and supervision, and training for children in activities of daily living.

Expenditures for waiver services have increased dramatically in the last five years from approximately \$10.5 million dollars in SFY00 to \$16.3 million in SFY05. The percentage of expenditures for home and community based services has increased from 22.8% of total expenditures for this population in SFY00 to 23.4% of total expenditures in SFY05 for this population.

Trends in Expenditures Over the Past Five Years

While the number of eligible persons in the Children with Disabilities category increased only 6.3% from SFY00 to SFY05, expenditures for this category increased 49.6%. Expenditures for Inpatient General Hospital services increased 45.4%, from \$5.6 million in SFY00 to \$8.2 million in SFY05. Expenditures for Prescription Drugs more than doubled, from \$3.7 million in SFY00 to almost \$7.9 million in SFY05. General Hospital Outpatient services more than doubled, from \$1.4 million in SFY00 to \$3.1 million in SFY05. Smaller increases were seen in Home Health Services (up 19.6%, from \$4.8 million in SFY00 to \$5.7 million in SFY05), and in Medical Supplies (up 27.5%, from \$3.2 million in SFY00 to \$4.1 million in SFY05).

III. ADULTS

For the purposes of Medicaid Reform, the Adults group was limited to non-disabled, low-income adults aged 21-64. During SFY05 an average of 20,984 non-disabled Adults were eligible for Medicaid each month. About 82% of the eligible persons in this group are women and, because it is a prerequisite to eligibility, all are caretakers of dependent children. They are the second smallest group of eligible persons covered by Medicaid in Nebraska, and they are the second least expensive in terms of total expenditures.

Eligibility

There are four categories under which non-disabled adults can qualify for Medicaid coverage in Nebraska:

1. ADC Cash Recipient Adults

⁶³ A detailed breakdown of waiver services is not available at this time. That information will be included in the final Plan.

2. Section 1931 Adults
3. Transitional Medical Assistance Adults (this category of eligibility is limited to 12 months)
4. Medically Needy Caretaker Relatives

Demographic Characteristics

Over half of the eligible persons in this category were aged 21-30 years (52.3%); 32.0% were 31-40 years old, 13.5% were 41-50 years old, 2.0% were 51-60 years old, and 0.2% were 61-64 years old. Almost sixty-four percent (63.8%) were White, non-Hispanic; 21.3% were Black/African American; 4.4% were American Indian; 0.9% were Asian or Pacific Islander; 1.0% were of mixed race; and 8.6% were Hispanic or Latino. Nearly all were living in a home or apartment.

Persons in the non-disabled Adults category tend not be on Medicaid for long periods of time. Only 24.5% of the Adult population eligible for Medicaid in SFY05 were eligible for all 12 months of the fiscal year.

Expenditures/Services Received

In SFY05, the largest category of expenditures for the Adults population was Inpatient General Hospital Services (\$18.6 million, or 18.4% of total expenditures for this group); followed by Prescription Drugs (\$16.7 million, or 16.5% of expenditures), HMO payments⁶⁴ (\$15.7 million, or 15.6%), Physician Services (almost \$13.0 million, or 12.8% of expenditures), and General Hospital Outpatient Services (almost \$13.0 million, or 12.8%) (see Attachment 4).

In SFY05, the average cost per eligible Adult was \$4,819. The cost per person trend is increasing for the Adult population and it is increasing at a rate faster than that of the rest of the Medicaid population (up about 72% from \$2,794 in SFY00 to \$4,819 in SFY05). The average cost increases with age (Table 4).

Table 4
Percent of Expenditures and Average Annual Cost
For Adults
State Fiscal Year 2005

Age Group	% of Expenditures	Average Cost per Eligible
21-30 years	45.7%	\$4,211
31-40 years	32.3%	\$4,862
41-50 years	18.3%	\$6,514
51-60 years	3.2%	\$7,890
61-64 years	0.5%	\$12,051
Total	100.0%	\$4,819

Common conditions for which adults receive care include pregnancy and delivery, myocardial infarction, tooth extractions, dental amalgams (fillings), back disorder, joint disorder, and obesity. The number one class of prescribed drugs for this population is antidepressants. Anticonvulsants, analgesics, bronchial dilators, diabetic therapy, and erythromycin are also commonly prescribed.

High-Cost Recipients

Within the group of non-disabled Adults, ten percent of the individuals accounted for just over half (50.9%) of the expenditures. The top ten percent of individuals accounted for: 79.3% of the Inpatient General Hospital Services, 49.1% of Prescription Drugs, 48.7% of Physician Services, 49.9% of General Hospital Outpatient services, and 16.8% of Dental Services.

The average annual cost for the top ten percent of non-disabled Adults was \$14,882, about nine times the average cost for the remaining 90% (\$1,592).

⁶⁴ There is only one capitated program – Share Advantage for medical-surgical services in Douglas, Sarpy and Lancaster counties.

Trends in Expenditures Over the Past Five Years

While the number of eligible persons in this category decreased 16.7% from SFY00 to SFY05, total expenditures for this population increased 43.6%. Inpatient General Hospital services, the largest expenditure category in SFY05, increased 15.0%, from \$16.1 million in SFY00 to almost \$18.6 million in SFY05. Expenditures on Prescription Drugs increased 58.0%, from \$10.5 million in SFY00 to almost \$16.7 million in SFY05. Physician Services increased 22.1%, from \$10.6 million in SFY00 to almost \$13.0 million in SFY05. Outpatient General Hospital services increased 77.2% from \$7.3 million in SFY00 to almost \$13.0 million in SFY05.

IV. ADULTS WITH DISABILITIES

This sub-population of Medicaid eligibles is the second largest group, behind Healthy Children & Pregnant Women. In SFY05, the average monthly eligibles in this group was 24,405 persons, or 12.2% of the total persons eligible for Medicaid. This group encompasses 21 to 64 year olds who have been through a formal disability determination process and determined to be disabled.

The Social Security Administration defines disability in adults as the “inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.”

Once the individual is determined disabled, there is a two-year waiting period for Medicare. Medicaid covers services received during this two-year waiting period.

Demographic Characteristics

Adults between the ages of 21 and 30 accounted for 15.1% of the Adults with Disabilities eligible population. Over half (56.1%) were between the ages of 41 and 60 years of age. Over half were female (55.8%). Almost eighty-one percent (80.8%) were White, non-Hispanic; 12.1% were Black/African American; 2.4% were American Indian; 0.8% were Asian or Pacific Islander; 0.1% were of mixed race; and 3.8% were Hispanic/Latino. Most (79.3%) were living in a home or apartment, including public housing; 6.9% were living in a nursing home.

In this population, 13.8% (3,357 persons) were Medicaid Waiver clients. The waivers are Aged and Disabled waiver (22.7% of waiver eligibles), Adult Developmental Disabilities waivers (three separate waivers, 2,585 persons, constituting 77.0% of waiver eligibles), and 11 persons on the Traumatic Brain Injury waiver (0.3% of waiver eligibles).⁶⁵

Over half (58.2%) of the Adults with Disabilities population are also eligible for Medicare (dual eligible). The amount that Medicaid paid for this population’s Medicare-related payments in SFY05 was \$24,063,957.

About three-fourths (74.1%) of the persons in this category were eligible for all 12 months of SFY05.

Expenditures/Services Received

Expenditures in SFY05 for this population were \$501,951,861, or 35.9% of all Medicaid expenditures. In SFY05, the largest category of expenditures for the Adults with Disabilities population was Home and Community-Based Services Waiver (HCBS) services, accounting for 22.3% of total expenditures (see Attachment 5). HCBS waiver services in total are the largest type of service for this population, spread across five different waivers serving different populations. The Aged and Disabled Waiver accounted for 8.7 percent of the \$111,867,090 of HCBS Waiver expenditures. The average annual cost per recipient was \$14,340. This is in comparison to the average annual cost per recipient in Nursing Facilities of \$43,427 for this population. The Adult Developmental Disabilities Comprehensive Waiver accounted for the largest population of waiver recipients (2,019), the largest amount of expenditures (\$92,780,539) and the highest average annual cost per recipient (\$45,954). This is in comparison to

⁶⁵ A review of records suggests that, because of errors in coding, the number of persons on the TBI waiver is under-reported.

institutional care in an Intermediate Care Facility for the Mentally Retarded (ICF-MR) with an average annual cost per recipient of \$96,211. The remaining DD waivers account for the remaining dollars of the HCBS waiver expenditures.

The next highest categories were: Prescription Drugs (21.0%), Intermediate Care Facility – Mental Retardation (ICF-MR, 10.1%), Nursing Facility Services (8.3%), and Inpatient General Hospital services (7.3%). Overall, Long-term Care constituted 46.3 percent of expenditures for this population in SFY05. These expenditures are split between institutional care (19.9 percent) and alternatives to institutional care (HCBS types of service) which account for 26.4 percent of expenditures.

Among prescribed drugs for disabled adults, the highest categories of expenditures were Ataractics-Tranquilizers (\$21,998,725; 20.8 percent), Psychostimulants-Antidepressant (\$13,952,378; 13.3 percent) and Anticonvulsants (\$13,319,396; 12.7 percent).

In SFY05 the average cost per eligible Adults with Disabilities was \$20,568 (Table 5). Unlike other population groups, the average cost per eligible for Adults with Disabilities did not vary significantly by age.

**Table 5
Percent of Expenditures and Average Annual Cost
For Adults with Disabilities
State Fiscal Year 2005**

Age Group	% of Expenditures	Average Cost per Eligible
21-30 years	16.1%	\$21,907
31-40 years	18.5%	\$19,906
41-50 years	29.7%	\$20,635
51-60 years	26.7%	\$20,648
61-64 years	9.0%	\$19,356
Total	100.0%	\$20,568

High-Cost Recipients

Within the group of Adults with Disabilities, ten percent of the Medicaid recipients accounted for just over half (50.7%) of the non-waiver expenditures in SFY05. The average expenditures per recipient for non-waiver services for the top ten percent of Medicaid recipients in this category was \$68,288, nine times the average for the remaining 90 percent. The top ten percent accounted for 86.6% of Nursing Facility Services, almost all (99.6%) of the ICF-MR services, 71.5% of Inpatient General Hospital services, and 77.0% of Home Health Care.

Trends in Expenditures Over the Past Five Years

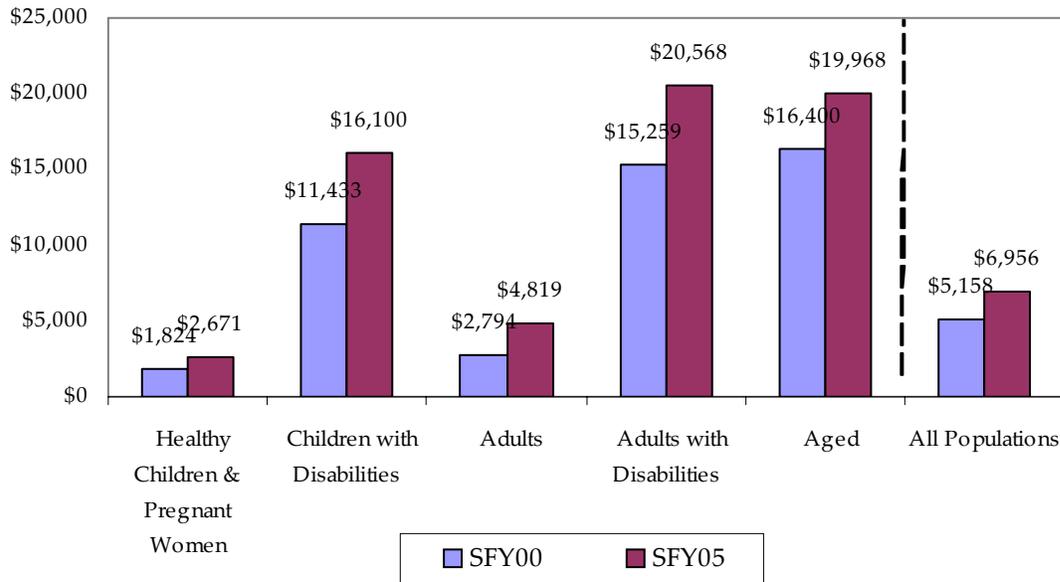
While the number of eligible persons in this category increased 16.8% from SFY00 to SFY05, expenditures for this category increased 57.4% during the same period. Expenditures for Prescription Drugs doubled between SFY00 and SFY05, from \$52.3 million in SFY00 to \$105.3 million in SFY05. Inpatient General Hospital Services increased 52.0%, from \$24.1 million in SFY00 to \$36.7 million in SFY05. Nursing Facility services increased 33.3%, from \$31.4 million in SFY00 to \$41.9 million in SFY05.

SUMMARY

The Medicaid program has grown over the years, both in number of persons eligible and expenditures. The monthly average number of eligibles increased 9.8% from SFY00 to SFY05, while total expenditures increased 48.1%. The combined effect of these increases drove the average expenditures per eligible person up 34.9%, from \$5,158 in SFY00 to \$6,956 in SFY05 (Figure 2). In SFY00, the Aged population had the highest Medicaid cost per eligible (\$16,400). In SFY05, the Adults with Disabilities population assumed first place with an average cost of \$20,568. Children with Disabilities were less costly, on a per person basis, than Adults with Disabilities (\$16,100). Healthy Children & Pregnant Women were the least costly population in both SFY00 and SFY05. Of the five populations,

the average cost per eligible person increased the most for the non-disabled Adults population (72.5%). (See Attachment 6 for a comparison of SFY05 expenditures by type of service and population.)

Figure 2
Average Medicaid Expenditures per Eligible
By Population
SFY00 and SFY05



Medicaid expenditures are not equally distributed across all populations. In SFY05, the top 10% of Medicaid recipients accounted for nearly two-thirds (65.2%) of expenditures. The average expenditures for the highest cost recipients (top 10%) was \$33,131, compared to an average of \$1,961 for the remaining 90% of recipients. The highest 10% of Medicaid recipients accounted for all of the expenditures for ICF-MR services and nearly all Nursing Facility Service expenditures (97.8%) and expenditures for Inpatient Psychiatric Hospital Services for children 21 years of age and under (97.7%). In SFY05, the highest cost recipients accounted for 92.0% of the total expenditures for Home Health Services, nearly three-fourths (72.1%) of the total expenditures for Inpatient General Hospital Services, 56.0% of the total expenditures for Prescription Drugs, and 35.0% of the total expenditures for Physician Services. The percent of total expenditures accounted for by the top ten percent of recipients ranged from 35.4% for the Aged population to 62.5% for the Children with Disabilities population (Figure 3 and Table 6).

Figure 3
Percent of Medicaid Expenditures for the Top Ten Percent of Recipients
By Population
State Fiscal Year 2005

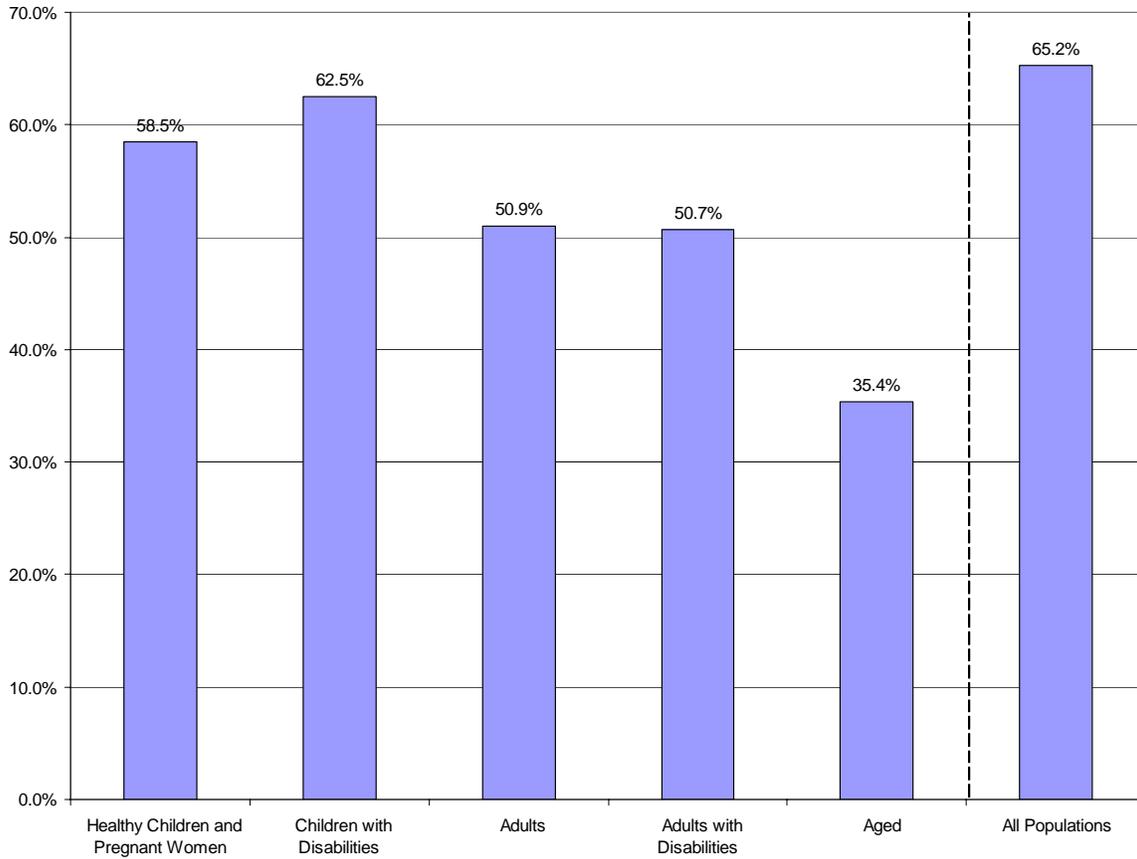
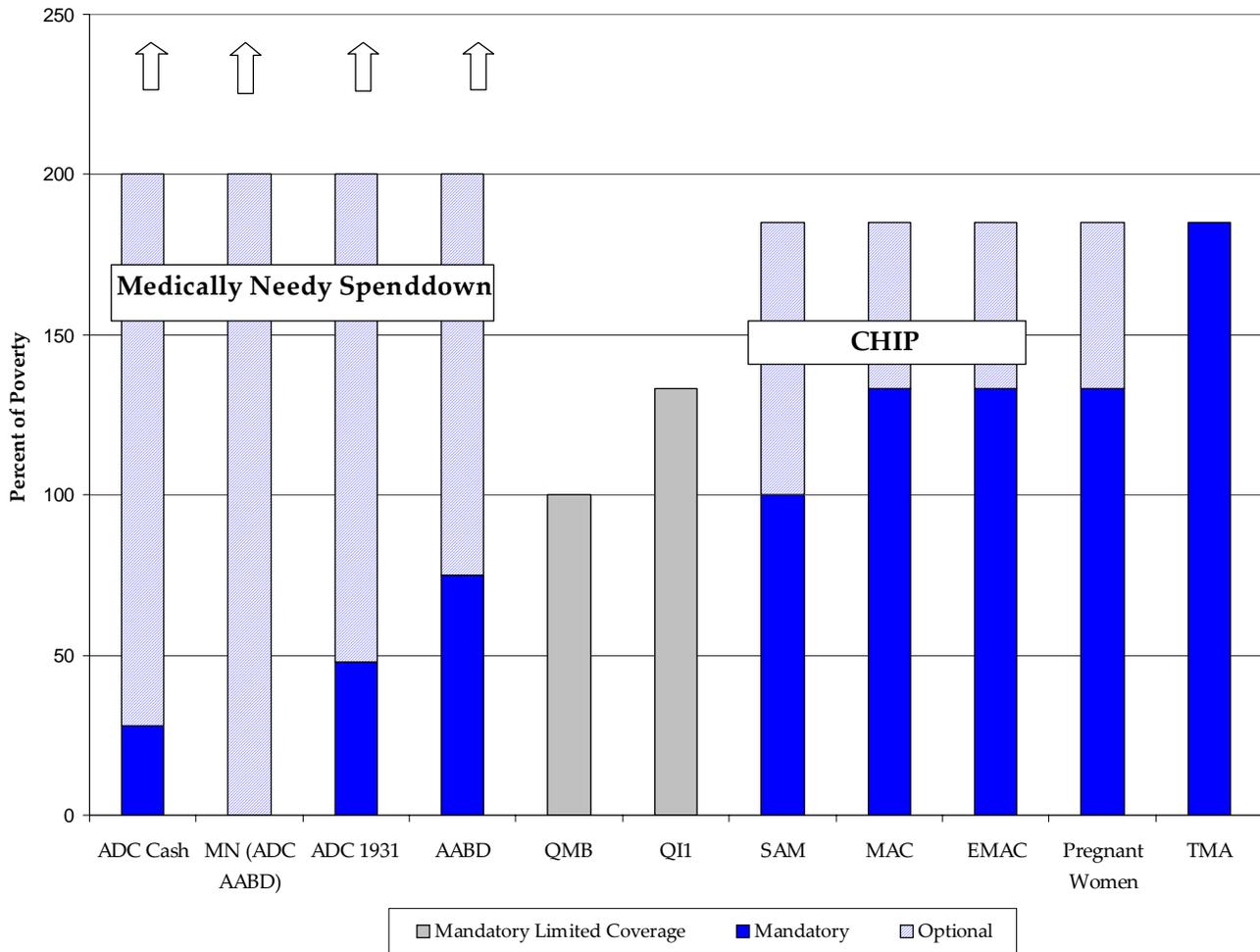


Table 6
Total Expenditures and Expenditures per Recipient for Top 10% of Recipients
By Population
State Fiscal Year 2005

	Healthy Children & Pregnant Women	Children with Disabilities	Adults	Adults with Disabilities	Aged	<i>All Populations</i>
Expenditures for Top 10%	\$207,029,090	\$33,347,205	\$51,521,056	\$197,625,626	\$124,759,700	\$816,606,366
Expenditures/Recipient	\$13,055	\$59,549	\$14,882	\$68,288	\$53,453	\$33,131

Medicaid eligibility is complex. Figure 4 shows the various eligibility categories in relation to the Federal Poverty Level (FPL). Figure 4 also indicates which eligibility categories are mandatory or optional. Descriptions of the acronyms used in the figure can be found in the attached glossary (Attachment 7).

**Figure 4
Medicaid Eligibility**



	ADC Cash	MN (ADC AABD)	ADC 1931	AABD	QMB	QII	SAM	MAC	EMAC	CHIP	Preg Women	TMA
Healthy Children & Pregnant Women	Blue	Grey	Blue				Blue	Blue	Blue	Blue	Blue	Blue
Children with Disabilities				Blue								
Adults	Blue	Grey	Blue									
Adults with Disabilities				Blue	Grey	Grey						
Aged		Grey		Blue								

NEXT REPORT

The report for October will address the following:

1. Medicaid cost projections adjusted for population changes
2. Funding strategies
3. Reform strategies in other states

Attachment 7

Glossary

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

Medicaid Public Input Meetings
Neb. Rev. Stat. §68-1092

<u>Day/Date</u>	<u>Time</u>	<u>City</u>	<u>Location</u>
Tuesday, October 25	7:00 p.m.	Omaha	TAC building, Board Room, 3215 Cumming Street
Wednesday, October 26	7:00 p.m.	Lincoln	State Capitol, Room 1510, 1445 K Street
Thursday, October 27	7:00 p.m.	Grand Island	City Hall, Community Meeting Room, 100 East 1 st Street
Tuesday, November 1	7:00 p.m.	Scottsbluff	Western Nebraska Community College, Harms Advanced Technology Center, 2620 College Park
Wednesday, November 2	7:00 p.m.	North Platte	Mid-Plains Community College, 601 West State Farm Road

Outline Summary of Medicaid-Related Statutes

Neb. Rev. Stat. §68-1001 to §68-1086

September 2005

Assistance to the Aged, Blind, or Disabled

68-1001 to 68-1008⁶⁶

- 68-1001⁶⁷ **istance to the aged, blind, or disabled (AABD) established.**
1. Establishes the program of assistance to the aged, blind or disabled (AABD)
2. Assistance administered by the Department of Health and Human Services (HHS).
3. Assistance consists of money payments to, medical care in behalf of, or any type of remedial care on behalf of needy individuals.
- 68-1001.01⁶⁸ **Director of Health and Human Services; rules and regulations; promulgate.**
For the purpose of adding to the security and social adjustment of former and potential recipients of AABD and medical assistance (MA), the Director of HHHS is authorized to promulgate rules and regulations providing for services to such persons.
- 68-1001.02⁶⁹ **Assistance; action for reimbursement; statute of limitations; when commences to run.**
Statute of limitations does not apply to a claim or cause of action belonging to the county or state on account of the payment of AABD while the recipient, former recipient, spouse, or dependent children of the recipient are living.
- 68-1002⁷⁰ **Persons eligible for assistance.**
AABD eligibility qualifications:
1. Must be a bona resident of Nebraska,
2. Is not receiving care or services as an inmate in a public institution, except as a patient in a medical institution, or 65 and older as a patient in an institution for tuberculosis or mental diseases,
3. Has not deprived himself/herself of any property for the purpose of qualifying for AABD;
4. May receive care in a public or private institution only if the institution is subject to a state authority or authorities responsible for establishing and maintaining standards for such institutions, and
5. Must be in need of shelter, maintenance, or medical care.
- 68-1003⁷¹ **Assistance to the aged; additional qualifications required.**
Aged persons must be at least 65 years old.
- 68-1004⁷² **Assistance to the blind; additional qualifications required.**
Blind persons must have been determined to be blind by an examination by a physician skilled in diseases of the eye or by an optometrist.
- 68-1005⁷³ **Assistance to the disabled; additional qualifications required; department; powers and duties.**
1. Disabled persons must be unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in

⁶⁶ Laws 1965, c. 395.

⁶⁷ Laws 1965, c. 395, § 1, p. 1264; Laws 1982, LB 522, § 36; Laws 1996, LB 1044, § 304.

⁶⁸ Laws 1969, c. 558, § 1, p. 2274; Laws 1996, LB 1044, § 305.

⁶⁹ Laws 1935, Spec. Sess., c. 28, § 13, p. 172; C.S.Supp., 1941, § 68-269; R.S.1943, § 68-216; Laws 1965, c. 395, § 22, p. 1272; R.S.1943, (1990), § 68-216.

⁷⁰ Laws 1965, c. 395, § 2, p. 1264; Laws 1965, c. 396, § 1, p. 1274; Laws 1965, c. 397, § 1, p. 1276; Laws 1967, c. 409, § 2, p. 1273; Laws 1969, c. 343, § 5, p. 1208; Laws 1977, LB 480, § 1; Laws 1996, LB 1044, § 306.

⁷¹ Laws 1965, c. 395, § 3, p. 1265.

⁷² Laws 1965, c. 395, § 4, p. 1265; Laws 1977, LB 311, § 1.

death or which has lasted or can be expected to last for a continuous period of not less than 180 days.

2. In determining eligibility for assistance to the disabled, HHS⁷⁴ may adopt the federal Social Security Administration's determination that a person is or is not disabled for purposes of federal Supplemental Security Income or Old Age Survivors' and Disability Insurance.
3. If the Social Security Administration has denied benefits based on the duration of the person's disability, HHS must perform an independent medical disability review.

68-1006⁷⁵

Assistance to the aged, blind, or disabled; amount authorized per person; payment.

1. Amount of AABD is based on the need and circumstances of each case.
2. When permitted by the federal old age and survivors insurance act, any accumulations of increased benefits under the act may be disregarded when determining need.
3. AABD payments are made by state warrant directly to each recipient.

68-1006.01⁷⁶

Personal needs allowance; amount authorized.

1. HHS must include in the standard of need for AABD at least \$50/month as a personal needs allowance, if the eligible person resides in an "alternative living arrangement."
2. "Alternative living arrangement" includes board and room, a boarding home, a certified adult family home, a licensed assisted-living facility, a licensed group home for children or child-caring agency, a licensed center for the developmentally disabled, or a long-term care facility.

68-1007⁷⁷

Determination of need; elements considered; amounts disregarded.

1. In determining need for AABD, the Director of HHS must consider all other income and resources of the person claiming assistance, and any expenses reasonably attributable to the earning of that income.
2. In making a determination of need for persons who are blind, HHS must disregard
 - a. the first \$85/month of earned income,
 - b. one-half of earned income in excess of \$85/month, and
 - c. for a period of up to 12 months, any additional income and resources necessary for a person with an approved plan for self-support to fulfill such plan.
3. In making such determination with respect to persons who are aged or disabled, the Director of HHS must disregard earned income at least to the extent such income was disregarded on January 1, 1972, as provided in 42 USC 1396a(f).

68-1008⁷⁸

Application for assistance; investigation; notification.

1. Upon the filing of an application for AABD, HHS, the Department of Health and Human Services Regulation and Licensure (HHS R&L), and the Department of Health and Human Services Finance and Support (HHS F&S) must investigate the circumstances of the application as necessary.
2. Each applicant and recipient must be notified in writing of
 - a. the approval or disapproval of any application,
 - b. the amount of payments awarded,
 - c. any change in the amount of payments awarded, and
 - d. discontinuance of payments.

⁷³ Laws 1965, c. 395, § 5, p. 1266; Laws 1976, LB 454, § 1; Laws 1977, LB 311, § 2; Laws 1984, LB 1127, § 1; Laws 1996, LB 1044, § 307.

⁷⁴ Nebraska Department of Health and Human Services.

⁷⁵ Laws 1965, c. 395, § 6, p. 1266; Laws 1965, c. 397, § 2, p. 1277; Laws 1967, c. 410, § 1, p. 1274; Laws 1969, c. 535, § 2, p. 2180.

⁷⁶ Laws 1991, LB 57, § 1; Laws 1996, LB 1044, § 308; Laws 1997, LB 608, § 3; Laws 1999, LB 119, § 1; Laws 2000, LB 819, § 79.

⁷⁷ Laws 1965, c. 395, § 7, p. 1266; Laws 1967, c. 411, § 1, p. 1275; Laws 1969, c. 539, § 1, p. 2189; Laws 1972, LB 760, § 1; Laws 1982, LB 522, § 37; Laws 1987, LB 255, § 1; Laws 1996, LB 1044, § 309.

**Assistance Generally (AABD, ADC, MA, Food Stamps); Appeal of Denial; Violations; Ineligibility
68-1013 to 68-1017.02⁷⁹**

68-1013⁸⁰ **Assistance to the aged, blind, and disabled; not vested right; not assignable; exemption from levy.**

1. A person does not have a vested right to any claim against the county or state for assistance of any kind by virtue of being or having been a recipient of AABD⁸¹, ADC⁸², or MA⁸³ for the aged.
2. Such assistance is not alienable by assignment or transfer, and is not subject to attachment, garnishment or any other legal process.

68-1014⁸⁴ **Assistance; payment to guardian or conservator; when authorized.**

If a guardian or conservator has been appointed for any recipient of AABD, ADC, or MA, such assistance payments must be made to the guardian or conservator upon the filing of a certified copy of his/her letter of guardianship or conservatorship.

68-1015⁸⁵ **Assistance; investigation; attendance of witnesses; production of records; subpoena power; oaths.**

For the purpose of any investigation or hearing, the Director of HHS, the Director of R&L,⁸⁶ and the Director of F&S,⁸⁷ through their authorized agents, may subpoena the attendance and testimony of witnesses and the production of books and papers. Witnesses may be examined on oath or affirmation.

68-1016⁸⁸ **Assistance; appeals; procedure.**

1. The Director of HHS must provide for a fair hearing (before HHSS) to any person whose claim for AABD, ADC, energy assistance, MA, commodities, or food stamp benefits has been denied, not granted in full, or not acted upon with reasonable promptness.
2. Appeal is taken by filing a written notice with the director setting forth the facts on which the appeal is based.
3. The director must notify the appellant in writing of the time and place for the hearing (not less than 1 week nor more than 6 weeks from the date of the notice).
4. Hearings are before the director or his/her duly authorized agent.
5. On the basis of evidence adduced, the director must enter a written order on the appeal, and transmit the order to the appellant.

68-1017⁸⁹ **Assistance; violations; penalties.**

1. It is violation for any person who, by means of a willfully false statement or representation, or by impersonation or other device, obtains or attempts to obtain, or aids or abets any person to obtain or to attempt to obtain
 - a. an assistance certificate of award to which he/she is not entitled,
 - b. any commodity, foodstuff, food coupon, food stamp coupon, electronic benefit, or electronic benefit card, or any payment to which he/she is not entitled or a larger payment than that to

⁷⁸ Laws 1965, c. 395, § 8, p. 1267; Laws 1967, c. 253, § 2, p. 673; Laws 1977, LB 312, § 8; Laws 1982, LB 522, § 38; Laws 1996, LB 1044, § 310.

⁷⁹ Laws 1965, c. 394.

⁸⁰ Laws 1965, c. 394, § 1, p. 1261.

⁸¹ Assistance to the Aged, Blind, or Disabled.

⁸² Aid to Dependent Children.

⁸³ Medical assistance (Medicaid).

⁸⁴ Laws 1965, c. 394, § 2, p. 1261; Laws 1982, LB 522, § 39; Laws 1996, LB 1044, § 311.

⁸⁵ Laws 1965, c. 394, § 3, p. 1262; Laws 1982, LB 522, § 40; Laws 1996, LB 1044, § 312.

⁸⁶ Nebraska Department of Health and Human Services Regulation and Licensure.

⁸⁷ Nebraska Department of Health and Human Services Finance and Support.

⁸⁸ Laws 1965, c. 394, § 4, p. 1262; Laws 1969, c. 540, § 1, p. 2190; Laws 1982, LB 522, § 41; Laws 1989, LB 362, § 9; Laws 1996, LB 1044, § 313; Laws 1998, LB 1073, § 57.

- which he/she is entitled,
 - c. any payment made on behalf of a recipient of MA or social services, or
 - d. any other benefit administered by HHS, or HHS F&S,⁹⁰ or who violates any statutory provision relating to AABD, ADC, social services, or MA (Medicaid).
2. Penalties:
- a. a Class III misdemeanor if the aggregate value of all funds or other benefits obtained or attempted to be obtained is less than \$500, and
 - b. a Class IV felony if the aggregate value is \$500 or more.

68-1017.01⁹¹

Food stamp program; violations; penalties.

1. A person commits an offense if he/she knowingly
 - a. uses, alters, or transfers any food stamp coupons, electronic benefits, or electronic benefit cards or any authorizations to participate in the food stamp program in any manner not authorized by law,
 - b. possesses any food stamp coupons, electronic benefits, or electronic benefit cards or any authorizations to participate in the food stamp program when he/she is not authorized by law to possess them,
 - c. redeems food stamp coupons, electronic benefits, or electronic benefit cards when he/she is not authorized by law to redeem them, or
 - d. redeems food stamp coupons, electronic benefits, or electronic benefit cards for purposes not authorized by law.
2. Penalties:
 - a. a Class III misdemeanor if the value of the coupons, electronic benefits, electronic benefit cards, or authorizations is less than \$500, and
 - b. a Class IV felony if the value is \$500 or more.
3. A person commits an offense if he/she knowingly possesses blank authorizations to participate in the food stamp program when such possession is not authorized by law. Such offense is a Class IV felony.

68-1017.02⁹²

Food stamp benefits; ineligible; when.

1. The State of Nebraska opts out of the provision of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 that eliminates eligibility for food stamps for any person convicted of a felony involving the possession, use, or distribution of a controlled substance.
2. A person is still ineligible for food stamps in Nebraska if he/she
 - a. has had three or more convictions for the possession or use of a controlled substance or
 - b. has been convicted of a felony involving the sale or distribution of a controlled substance or the intent to sell or distribute a controlled substance.
3. A person with one or two felony convictions for the possession or use of a controlled substance may only be eligible to receive food stamp benefits if he/she is participating in or has completed a state-licensed or nationally-accredited substance abuse treatment program since the date of conviction.

⁸⁹ Laws 1965, c. 394, § 5, p. 1262; Laws 1969, c. 541, § 1, p. 2192; Laws 1977, LB 39, § 127; Laws 1984, LB 1127, § 2; Laws 1996, LB 1044, § 314; Laws 1998, LB 1073, § 58.

⁹⁰ Nebraska Department of Health and Human Services Finance and Support.

⁹¹ Laws 1984, LB 1127, § 3; Laws 1998, LB 1073, § 59.

⁹² Laws 2003, LB 667, § 22; Laws 2005, LB 301, §2.

Medical Assistance (Medicaid)

68-1018 to 68-1025⁹³

68-1018⁹⁴

Medical assistance program established.

Establishes in and for the State of Nebraska a program to be known as medical assistance.

68-1019⁹⁵

Covered services; premiums, copays and deductibles; limits on the amount, duration and scope of services.

1. Medical assistance (MA) on behalf of recipients is paid directly to vendors.
2. For recipients over 65, MA must include care in an institution for mental diseases (IMD).
3. For all recipients, MA must include:
 - a. inpatient and outpatient hospital care,
 - b. lab and X-ray services,
 - c. nursing home services,
 - d. care home services,
 - e. home health care services,
 - f. nursing services,
 - g. clinic services,
 - h. practitioner services, and
 - i. drugs, appliances, and health aids prescribed by practitioners.
4. Premiums, copays and deductibles
 - a. Director of F&S⁹⁶ must adopt and promulgate rules and regulations to establish a schedule of premiums, copays, and deductibles.
 - b. The schedule must discourage the abuse of high-cost services and encourage the use of cost-effective services.
 - c. HHS F&S must report to the Governor and the Legislature by December 1 before adopting a schedule of copays, premiums and deductibles or before eliminating or modifying an existing schedule. Changes may not be effective until the following July 1, except for the first year (effective April 1); contents and considerations are provided.
 - d. Vendor is responsible for collecting any applicable copay or deductible from the recipient.
5. Limits on the amount, duration, and scope of services
 - a. Director of F&S must adopt and promulgate rules and regulations to provide limits on the amount, duration, and scope of Medicaid services.
 - b. HHS F&S must report to the Governor and the Legislature by December 1 before adopting such limits. Changes may not be effective until the following April 1.
6. Vendors may not advertise the waiver of the collection of any copay or deductible.

68-1019.01⁹⁷

Limits on services and goods; director; considerations; report; contents.

1. The Director of F&S must consider the effect of proposed limits on the ability of recipients to maintain their health, live independently outside of a medical institution, and to engage in employment, and on long and short term savings to the Medicaid program.
2. The director's report must include the philosophy, standards, and criteria used to develop the proposed limits, taking into consideration the criteria above and any other criteria determined by the director.

⁹³ Laws 1965, c.397 (LB 937), §§1-11, effective July 1, 1966.

⁹⁴ Laws 1965, c. 397, § 3, p. 1277.

⁹⁵ Laws 1965, c. 397, § 4, p. 1277; Laws 1967, c. 413, § 1, p. 1278; Laws 1969, c. 542, § 1, p. 2193; Laws 1993, LB 804, § 1; Laws 1993, LB 808, § 1; Laws 1996, LB 1044, § 315; Laws 1998, LB 1063, § 5; Laws 1998, LB 1073, § 60; Laws 2002, Second Spec. Sess., LB 8, § 1.

⁹⁶ Nebraska Department of Health and Human Services Finance and Support.

⁹⁷ Laws 1993, LB 804, § 2; Laws 1996, LB 1044, § 316.

- 68-1019.02⁹⁸ **Authorized limits on goods and services.**
HHS F&S may place specific limits on the amount, duration, and scope of Medicaid-covered services in the following areas:
1. chiropractic services,
 2. podiatric services,
 3. occupational/physical therapy/speech-hearing-language therapy for adults,
 4. payments for ventilator-dependent recipients,
 5. dental services for adults,
 6. dental services for children,
 7. visual care,
 8. durable medical equipment,
 9. hearing aids,
 10. bioequivalent generic drugs,
 11. transportation services, and
 12. mileage and conference fees for home-based services providers of outpatient psychiatric services for adults.
- 68-1019.03⁹⁹ **Limits on services and goods; department; monitor effect; report.**
1. HHS F&S must develop a mechanism to monitor the effect of limitations imposed under sections 68-1019 to 68-1019.02
 2. HHS F&S must report to the Governor and the Legislature on the extent of shifting by recipients to other services and associated costs.
- 68-1019.04¹⁰⁰ **Single pharmacy usage.**
HHS F&S must restrict each medical assistance (MA) recipient as much as possible to a single pharmacy to monitor prescription utilization by the recipient.
- 68-1019.05¹⁰¹ **Reduction of pharmaceutical expenditures; director; duties; managed care; legislative intent.**
1. Director of F&S must establish a plan to reduce pharmaceutical expenditures under the MA program and implement a point of sale (POS) verification system.
 2. HHS F&S must undertake as much as possible to provide managed care for MA recipients in all areas of the state, in order to provide MA to recipients in a prudent and non-fraudulent manner.
 3. The Legislature intends that management of the MA program through managed care, POS for drugs and other cost-containment initiatives will result in additional savings to the Medicaid program of at least \$1.7 million for FY 94-95.
- 68-1019.06¹⁰² **Hearing screening tests for newborns and infants; how paid.**
1. HHS F&S must provide payment for hearing screening tests for newborns and infants through the MA program if the child is eligible for MA.
 2. Medicaid managed care contracts must include payment for hearing screening test for newborns and infants.
- 68-1019.09¹⁰³ **Waiver of copayments or deductibles; prohibited.**
An enrolled provider in the Medicaid program may not waive copays and deductibles established under sections 68-1019 and 68-1021.

⁹⁸ Laws 1993, LB 804, § 3; Laws 1996, LB 1044, § 317; Laws 2000, LB 819, § 80; Laws 2003, LB 411, § 1.

⁹⁹ Laws 1993, LB 804, § 4; Laws 1996, LB 1044, § 318.

¹⁰⁰ Laws 1993, LB 804, § 5; Laws 1996, LB 1044, § 319.

¹⁰¹ Laws 1993, LB 804, § 6; Laws 1996, LB 1044, § 320.

¹⁰² Laws 2000, LB 950, § 12.

¹⁰³ Laws 1993, LB 808, § 4.

Eligibility.

1. MA must be paid on behalf of
 - a. dependent children,
 - b. aged, blind and disabled persons, and
 - c. all persons under 21 who are eligible under §1905(a) of the federal Social Security Act (SSA).
2. HHS F&S¹⁰⁵ must adopt and promulgate rules and regulations governing the provision of MA benefits to qualified persons who:
 - a. are presumptively eligible as allowed under 42 USC 1396a and §1920A of the SSA,
 - b. have a family income at or below 185 % of the Office of Management and Budget income poverty guideline (federal poverty line, or FPL), without regard to resources, including all children under 19 and pregnant women as allowed under 42 USC 1396a and §2110 of the federal Social Security Act (SSA).
 - i. children under this subsection remain eligible for 6 months from the date of initial eligibility; HHS F&S may review eligibility monthly thereafter pursuant to rules and regulations, and may determine that a child is ineligible after such review.
 - ii. All currently eligible children on August 16, 2002 must have their eligibility redetermined.
 - iii. HHS F&S must report to the Governor and the Legislature quarterly until November 3, 2003 and each December 1 thereafter, until December 1, 2005; contents of report are provided.
 - c. are children for purposes of Title XIX of the SSA (Medicaid) in families with incomes
 - i. at or below 185% FPL (ages 0 to 1)
 - ii. at or below 133% FPL (over age 1 and under age 6)
 - iii. at or below 100% FPL (ages 6 to 18); or
 - d. caretaker relatives as allowed under §1905(a)(ii) of the SSA; HHS F&S must provide MA until June 30, 2003 to caretaker relatives with family incomes at or below 50% FPL who would otherwise be ineligible for MA on and after August 16, 2002.
3. “Medicaid buy-in” for the working disabled. MA must be paid on behalf of disabled persons as allowed under 42 USC 1396(a)(10)(A)(ii) who are in families whose net income is less than 250% FPL, and who but for earnings in excess of limits in 42 USC 1396d(q)(2)(B) would be considered to be receiving federal Supplemental Security Income (SSI)
 - a. HHS must apply for a waiver to disregard any unearned income that is contingent upon a trial work period in applying the SSI standard
 - b. the disabled person is subject to payment of a premium as a percentage of the family’s net income beginning at 200% FPL; the premium payment is graduated based on family income and may not be less than 2% nor more than 10% of family net income.
4. Breast and cervical cancer treatment. MA must be paid on behalf of persons as allowed under 42 USC 1396a(a)(10)(A)(ii) who:
 - a. have been screened for breast and cervical cancer and who need treatment for breast or cervical cancer,
 - b. are not otherwise covered under creditable coverage,
 - c. are under 65 years of age, and
 - d. are not eligible for Medicaid under any mandatory categorically needy eligibility group.
5. Eligibility must be determined under section 68-1020 using an income budgetary methodology that determines children’s eligibility at no greater than 185% FPL, and adult eligibility using adult income standards established pursuant to state or federal law.
6. HHS F&S must adopt and promulgate rules and regulations to implement this section.

¹⁰⁴ Laws 1965, c. 397, § 5, p. 1278; Laws 1984, LB 1127, § 4; Laws 1988, LB 229, § 1; Laws 1995, LB 455, § 6; Laws 1996, LB 1044, § 323; Laws 1998, LB 1063, § 6; Laws 1999, LB 594, § 34; Laws 2001, LB 677, § 1; Laws 2002, Second Spec. Sess., LB 8, § 2; Laws 2003, LB 411, § 2; Laws 2005, LB 301, §3.

¹⁰⁵ Nebraska Department of Health and Human Services Finance and Support.

68-1021¹⁰⁶ **Medical assistance; state accepts federal provisions; Director of Finance and Support; powers.**
1. For purposes of paying medical assistance (MA) as defined in 68-1002, 68-1006, and 68-1018 to 68-1025, the State of Nebraska accepts and assents to all applicable provisions of Title XIX and Title XXI of the federal Social Security Act (SSA).
2. Director of F&S is authorized to adopt and promulgate rules and regulations, to enter into agreements, to adopt fee schedules with regard to MA benefits, rehabilitation services, and any other remedial services, and to adopt copayments and deductibles with respect to such benefits and services if the requirements of 68-1019(4) are met.

68-1021.01¹⁰⁷ **References to federal law.**
All references to federal law in 68-1020, 68-1021, and 68-1037 to 68-1039 refer to the law as it existed on January 1, 2005.

68-1022¹⁰⁸ **Medical assistance payments; by whom paid.**
Except for care in a state institution and care on behalf of persons who have a right of residence on any reservation under federal jurisdiction:
1. Counties pay a percentage of medical assistance (MA) costs for recipients with legal settlement in the county until July 1, 1986 as follows:
a. 18% on and after July 1, 1979,
b. 4.67% on and after July 1, 1985, and
c. 0% on and after July 1, 1986 (costs paid from state and federal funds thereafter).
2. Liability for the payment of MA is based on the date the services were rendered.

68-1023¹⁰⁹ **Department of Health and Human Services Finance and Support; contracts authorized.**
HHS F&S may contract with agencies administering Health Insurance for the Aged in Nebraska, or with any other domestic agency or corporation licensed by the Department of Insurance to engage in the insurance business in Nebraska, to act as fiscal agents for HHS F&S to make payments to vendors providing MA authorized under 68-1018 to 68-1025.

68-1024¹¹⁰ **Rules and regulations; appeals; hearings.**
Authority to adopt rules and regulations and the right to appeal and hearing are the same in the MA program as in the program for assistance to the aged, blind, or disabled (AABD).

68-1025¹¹¹ **Information; confidential.**
Information regarding applicants for or recipients of MA must be safeguarded and may be used only for purposes connected with the administration of MA.

Public Awareness re: Medicaid Children's Health Services

68-1025.01¹¹²

68-1025.01¹¹³ **Medical assistance program; public awareness; public school district; hospital; duties.**
1. Each public school district must annually provide written information from HHS and HHS F&S to every student at the beginning of the school year describing the availability of children's health services provided under the MA program.
2. Each hospital must provide the mother of every child born in the hospital, at the time of birth,

¹⁰⁶ Laws 1965, c. 397, § 6, p. 1278; Laws 1993, LB 808, § 2; Laws 1996, LB 1044, § 324; Laws 1998, LB 1063, § 7; Laws 2000, LB 1115, § 10; Laws 2005, LB 301, §4.

¹⁰⁷ Laws 2002, LB 21, § 1; Laws 2005, LB 301, §5.

¹⁰⁸ Laws 1965, c. 397, § 7, p. 1278; Laws 1967, c. 410, § 2, p. 1274; Laws 1979, LB 138, § 1; Laws 1981, LB 39, § 1; Laws 1982, LB 522, § 42; Laws 1983, LB 604, § 24; Laws 1986, LB 1253, § 1.

¹⁰⁹ Laws 1965, c. 397, § 8, p. 1278; Laws 1967, c. 413, § 2, p. 1278; Laws 1982, LB 522, § 43; Laws 1996, LB 1044, § 325.

¹¹⁰ Laws 1965, c. 397, § 9, p. 1278.

¹¹¹ Laws 1965, c. 397, § 10, p. 1278.

¹¹² Laws 1998, LB 1063.

- written information provided by the Director of HHS and the Director of HHS F&S describing the availability of children's health services provided under the MA program.
3. The Director of HHS and Director of HHS F&S must develop and implement other activities designed to increase public awareness of the availability of children's health services provided under the MA program. Examples listed. Activities must include materials and efforts designed to increase participation in the program by minority populations.

Assignment of Rights 68-1026 to 68-1028¹¹⁴

68-1026¹¹⁵

Medical assistance; application for benefits; assignment of rights; exception.

1. Application for MA benefits under 68-1018 to 68-1025 constitutes an automatic assignment of rights to HHS F&S or its assigns from the date of eligibility; includes the rights of the applicant or recipient and the rights of any other member of the assistance group for whom the applicant or recipient can legally make an assignment.
2. Under this section and subject to 68-1038 to 68-1043, the applicant or recipient must assign to HHS F&S or its assigns
 - a. any rights to medical care support available to him/her, or to other members of the assistance group, under order of a court or administrative agency and
 - b. any rights to pursue or receive payments from any liable third party for the cost of medical care and services arising out of injury, disease, or disability of the applicant or recipient or other members of the assistance group which would otherwise be covered by MA benefits.
3. Medicare benefits may not be assigned under this section.
4. Benefits assigned to HHS F&S or its assigns under this section may be directly reimbursable to HHS F&S or its assigns by liable third parties, as provided by rule or regulation, when prior notification of the assignment has been made to the liable third party.

68-1027¹¹⁶

Applicant or recipient; failure to cooperate; effect.

1. Refusal by the applicant or recipient to cooperate in obtaining reimbursement for medical care or services provided renders the applicant or recipient ineligible for MA for as long as they refuse to cooperate.
2. Cooperation may be waived by HHS F&S upon a determination of the reasonable likelihood of physical or emotional harm to the applicant, recipient, or other member of the assistance group if the applicant or recipient were to cooperate.
3. Eligibility continues for any person who cannot legally assign his/her own rights and who would have been eligible for MA but for the refusal by another person to cooperate, who is legally able to assign his/her rights.

68-1028¹¹⁷

Restoration of rights; when.

If the applicant or recipient or any member of the assistance group becomes ineligible for MA benefits, HHS F&S must restore the rights assigned under 68-1026.

Contracts to Promote the Goal of Medical Cost Containment 68-1029 to 68-1036¹¹⁸

68-1029¹¹⁹

Medical assistance; legislative findings.

The Legislature finds that

1. Products and services provided to recipients of medical assistance (MA) benefits should be

¹¹³ Laws 1998, LB 1063, § 10.

¹¹⁴ Laws 1984, LB 723.

¹¹⁵ Laws 1984, LB 723, § 1; Laws 1988, LB 419, § 15; Laws 1989, LB 362, § 10; Laws 1996, LB 1044, § 326; Laws 1996, LB 1155, § 23.

¹¹⁶ Laws 1984, LB 723, § 2; Laws 1997, LB 307, § 108.

¹¹⁷ Laws 1984, LB 723, § 3; Laws 1997, LB 307, § 109.

¹¹⁸ Laws 1984, LB 904.

obtained at the most favorable prices to the State of Nebraska while ensuring quality of products or services to the recipient and

2. Express authority should be provided for contractual agreements between health care vendors to promote the goal of medical cost containment.

68-1030¹²⁰

Medical assistance; director; contracts authorized.

1. Under authority provided in the Managed Care Plan Act and 68-1021, the Director of F&S may enter into contracts on a bid or negotiated basis with vendors to provide goods and services on behalf of MA recipients as set forth in 68-1019.
2. Contracts may provide for the method of payment (i.e. a negotiated reimbursement rate, fee-for-service, capitation, retainer, prepaid, or other basis).
3. Contracts may also be entered into with health maintenance organizations.

68-1031¹²¹

Contracts; geographic limitation.

1. HHS F&S may limit the offering of a contract under 68-1030 to a specific geographic area.
2. When HHS F&S contracts for a specific type of service covered under 68-1019, in a specific geographic area, reimbursement for that service may be limited to those vendors contracting with HHS F&S.
3. When reimbursement is limited to contracting vendors, sections 68-1029 to 68-1036 do not require noncontracting vendors to provide services for MA recipients.

68-1033¹²²

Joint contracts authorized.

1. Two or more vendors of health care services may enter into agreements with the Director of F&S to contract as a unit for the delivery of health services under 68-1029 to 68-1036.
2. The unit must file an application with the director to be certified as a unit eligible to negotiate contracts for health services.

68-1034¹²³

Joint contracts; certification; denial; appeal; fees.

1. Within 30 days of receipt of an application filed under 68-1033, the Director of F&S must, in writing, either certify the unit or deny certification.
2. Any denial of certification must
 - a. specify the reasons for the denial,
 - b. state that the unit has 15 days to remedy any deficiency in the application, and
 - c. state that a hearing pursuant to the Administrative Procedure Act (APA) will be granted within 30 days if requested by the unit.
3. The decision may be appealed in accordance with the APA.
4. HHS F&S may establish an application fee of no more than \$100 to cover the costs of processing the applications.

68-1035¹²⁴

Contracts; construction of sections.

1. Actions taken pursuant to 68-1029 to 68-1036 are not subject to the Consumer Protection Act and 59-801 to 59-831.
2. The Legislature intends that vendors and contracts complying with 68-1029 to 68-1036 be exempted from the application of federal antitrust laws.
3. Nothing in 68-1029 to 68-1036 prohibits contracts between individual vendors and HHS F&S.

68-1035.01¹²⁵

Interagency agreement for specialized developmental disability (DD) services.

HHS F&S and HHS must enter into an interagency agreement to develop rules and regulations for specialized DD services under the medical assistance (MA) program and for assistance to

¹¹⁹ Laws 1984, LB 904, § 1.

¹²⁰ Laws 1984, LB 904, § 2; Laws 1990, LB 1136, § 125; Laws 1993, LB 816, § 20; Laws 1996, LB 1044, § 327.

¹²¹ Laws 1984, LB 904, § 3; Laws 1986, LB 1254, § 1; Laws 1993, LB 816, § 21; Laws 1996, LB 1044, § 328.

¹²² Laws 1984, LB 904, § 5; Laws 1986, LB 1254, § 3; Laws 1996, LB 1044, § 329.

¹²³ Laws 1984, LB 904, § 6; Laws 1988, LB 352, § 109; Laws 1996, LB 1044, § 330.

¹²⁴ Laws 1984, LB 904, § 7; Laws 1986, LB 1254, § 4; Laws 1996, LB 1044, § 331; Laws 2002, LB 1278, § 35.

administer MA funds designated for specialized DD services pursuant to 68-1018 to 68-1035.

68-1036¹²⁶

Department; rules and regulations.

HHS F&S may adopt, promulgate, amend and repeal rules and regulations regarding powers conferred by 68-1029 to 68-1036, subject to the APA.¹²⁷

Medicaid Estate Recovery and Garnishment

68-1036.02 to 68-1036.03¹²⁸

68-1036.02¹²⁹

Medical assistance recipient; liability; when; claim; procedure; department; powers.

1. The estate of a decedent who received MA is indebted to the Department of Health and Human Services Finance and Support (HHS F&S) for the total amount of MA paid on behalf of the deceased recipient if:
 - a. the recipient was 55 or older when the MA was provided, or
 - b. the recipient resided in a medical institution and, at the time of institutionalization or application for MA, whichever is later, HHS F&S determines that the recipient could not reasonably have been expected to be discharged and resume living at home.
2. The debt accruing under this section arises during the life of the recipient but is held in abeyance until his/her death; no debt exists if the recipient dies and is survived by a spouse or by a child who is either under 21 or is blind or totally and permanently disabled.
3. The debt includes the total amount of MA provided when the recipient was 55 or older or during the period of institutionalization as described above, and does not include interest.
4. In probate proceedings, no additional evidence of foundation is required for admission of the department's payment record if the record bears the seal of HHS F&S, is certified as a true copy, and bears the signature of an authorized representative of HHS F&S.
5. HHS F&S may waive or compromise its claim, in whole or in part, if it determines that enforcement of the claim would not be in the best interests of the state or would result in undue hardship.
6. HHS F&S may adopt and promulgate rules and regulations to carry out this section.

68-1036.03¹³⁰

Department; garnish employment income; when; limitation.

1. HHS F&S may garnish wages, salary, or other employment income of a person for the costs of health services provided to an eligible child under the MA program if
 - a. the person is required by a court or administrative order to provide health care coverage, and
 - b. the person has received third party payment but has not used the payment to reimburse the other parent or guardian or the provider of the services.
2. Garnishment is limited to the amount necessary to reimburse HHS F&S for its expenditures for the costs of services under the MA program.
3. Child support claims take priority over claims for the costs of health services.

Legislative Findings re: Prenatal Care to Pregnant Women and Care to Infants Under MA and Title XXI

68-1037¹³¹

Health care services; legislative findings.

The Legislature finds that

1. It is in the best interests of the State of Nebraska to have health care services available to as many Nebraskans as possible,

¹²⁵ Laws 1991, LB 830, § 27; Laws 1996, LB 1044, § 332.

¹²⁶ Laws 1984, LB 904, § 8; Laws 1986, LB 1254, § 5; Laws 1996, LB 1044, § 333.

¹²⁷ Administrative Procedure Act.

¹²⁸ Laws 1994, LB 1224.

¹²⁹ Laws 1994, LB 1224, § 39; Laws 1996, LB 1044, § 334; Laws 2001, LB 257, § 1; Laws 2004, LB 1005, § 7.

Operative date July 16, 2004.

¹³⁰ Laws 1994, LB 1224, § 71; Laws 1996, LB 1044, § 335.

¹³¹ Laws 1995, LB 455.

2. The MA program and Title XXI of the federal Social Security Act (SSA) should be utilized to the extent possible under federal law to provide health care for low-income children and families in Nebraska,
3. This goal can be met in part by providing prenatal care to pregnant women and care to infants at the maximum level allowed by federal law,
4. The intent of this section and section 68-1020 is to provide such health care services.

Spousal Impoverishment
 68-1038 to 68-1043¹³³

68-1038¹³⁴

Entitlement of spouse; terms, defined.

For purposes of 68-1038 to 68-1043, the following terms are defined:

1. Assets
2. Community spouse monthly income allowance
3. Community spouse resource allowance
4. Department
5. Director
6. Home and community-based services
7. Medical assistance
8. Qualified applicant
9. Qualified recipient
10. Spouse.

68-1039¹³⁵

Amount of entitlement; department; rules and regulations.

1. For purposes of determining medical assistance (MA) eligibility and the right to and obligation of medical support under 68-716, 68-1020, and 68-1026, a spouse is entitled to retain
 - a. assets equivalent to the community spouse resource allowance and
 - b. an amount of income equivalent to the community spouse monthly income allowance.
2. HHS F&S must administer entitlements under this section in accordance with §1924 of the federal Social Security Act (SSA), and must adopt and promulgate rules and regulations to implement and enforce sections 68-1038 to 68-1043.

68-1040¹³⁶

Assets; eligibility for assistance; future medical support; considerations; subrogation.

If aggregate assets are designated in accordance with 68-1042:

1. Only assets not designated for the spouse may be considered in determining eligibility of an applicant for MA,
2. In determining MA eligibility, the Director of F&S may not take account of assets designated for the spouse and may not require proof of adequate consideration for any assignment or transfer made as a result of the entitlement to such assets,
3. Assets designated for the spouse may not be considered to be available to an applicant or recipient for future medical support and the spouse has no duty to provide future medical support to the applicant or recipient from such assets,
4. The Director of F&S or the state may not recover amounts paid for future MA to the applicant or recipient from assets designated for the spouse, and
5. The Director of F&S or the state may not be subrogated to or assigned any future right of the applicant or recipient to medical support from assets designated for the spouse.

¹³² Laws 1995, LB 455, § 5; Laws 1998, LB 1063, § 8; Laws 2005, LB 301, §6.

¹³³ Laws 1988, LB 419.

¹³⁴ Laws 1988, LB 419, § 1; Laws 1989, LB 362, § 11; Laws 1991, LB 244, § 1; Laws 1996, LB 1044, § 336; Laws 1997, LB 608, § 4; Laws 2000, LB 819, § 81.

¹³⁵ Laws 1988, LB 419, § 2; Laws 1989, LB 362, § 12.

¹³⁶ Laws 1988, LB 419, § 3; Laws 1989, LB 362, § 13.

68-1042¹³⁷

Designation of assets; procedure.

1. A designation of assets pursuant to the entitlement provided for in 68-1039 must be evidenced by a written statement listing the assets and signed by the spouse.
2. A copy of the statement must be provided to the Director of F&S at the time of application and must designate assets owned on the date of application.
3. Failure to complete any necessary assignments or transfers to place the designated assets in sole ownership of the spouse within a reasonable time after the statement is signed may render the applicant or recipient ineligible for medical assistance (MA).

68-1043¹³⁸

Department of Health and Human Services; furnish statement.

HHS must furnish to each qualified applicant or recipient a clear and simple written statement explaining the entitlements provided in 68-1039.

Managed Care Plan Act

68-1048 to 68-1063¹³⁹

68-1048¹⁴⁰

Establishes the Managed Care Plan Act

Sections 68-1048 to 68-1063 are known and may be cited as the Managed Care Plan Act.

68-1049¹⁴¹

Legislative findings.

The Legislature finds that

1. Health care costs (federal, state, and local) now exceed and will exceed available public resources,
2. To meet fiscal constraints, Nebraska must develop a method of managing the MA program established in 68-1018 to 68-1025 in a manner that utilizes state and federal resources to the maximum advantage while assuring that the program is operated in a cost-effective and efficient manner and provides quality of care and access to health care services for MA recipients,
3. The use of managed care systems (MCS) has significant potential to reduce the growth of health care costs incurred by the people of this state and by recipients of MA who are an especially vulnerable population and need greater access to health care,
4. The development of a managed care plan for MA recipients is one method of improving health care for those persons.

68-1050¹⁴²

Terms, defined.

For purposes of the Managed Care Plan Act, the following terms are defined:

1. Consumer protection system
2. Department
3. Director
4. Disproportionate-share hospital
5. Managed care system
6. Participating provider
7. Plan
8. Program
9. Program recipient
10. Quality protection system.

¹³⁷ Laws 1988, LB 419, § 5; Laws 1989, LB 362, § 14.

¹³⁸ Laws 1988, LB 419, § 6; Laws 1989, LB 362, § 15; Laws 1996, LB 1044, § 337.

¹³⁹ Laws 1993, LB 816.

¹⁴⁰ Laws 1993, LB 816, § 1; Laws 2000, LB 892, § 1; Laws 2005, LB 301, § 7.

¹⁴¹ Laws 1993, LB 816, § 2.

¹⁴² Laws 1993, LB 816, § 3; Laws 1996, LB 1044, § 339; Laws 2000, LB 892, § 2; Laws 2000, LB 1115, § 11.

68-1051¹⁴³

Managed care system plan; department; duties.

The Department of Health and Human Services Finance and Support (HHS F&S) must develop a plan to implement a managed care system (MCS) as required by 68-1056 to 68-1061. The system must incorporate risk-sharing mechanisms, create incentives for the efficient delivery of health care services, and recognize the special needs of disproportionate-share hospitals.

68-1056¹⁴⁴

Plan; requirements.

1. The managed care plan (plan) must specify
 - a. a structure for the managed care system (MCS) that will provide program recipients with access to comprehensive and coordinated health care delivered in a cost-effective and efficient manner in accordance with applicable federal law and regulation,
 - b. the types of MA that may be provided under the system, and
 - c. the steps for implementing the system (must contain a timeline to implement the system in Nebraska no later than July 1, 1995, subject to sections 68-1062 and 68-1063).
2. To the extent feasible and appropriate, the MCS recommended in the plan must
 - a. establish a primary care case management system,
 - b. promote access to and continuity of health care for program recipients,
 - c. prevent unnecessary utilization of health care services by program recipients,
 - d. educate program recipients on preventive health care and good health habits,
 - e. provide sufficient flexibility to enable the managed care system to be tailored to meet the individual health care needs of program recipients,
 - f. provide reasonable and adequate payment for health care providers participating in the system,
 - g. ensure that disproportionate-share-payment adjustments are made to disproportionate-share hospitals participating in the system and that the payment adjustments are made directly to disproportionate-share hospitals,
 - h. provide that managed care Medicaid days are counted for purposes of determining a hospital's status as a disproportionate-share hospital,
 - i. consider the special circumstances of university medical centers and teaching hospitals,
 - j. specify the program recipients who will be eligible to participate in the system,
 - k. allow for copayments and deductibles for program recipients in the MCS, and
 - l. include a quality protection system and consumer protection system for program recipients.
3. In deciding which program recipients will be eligible to participate in the MCS, HHS F&S must consider whether certain program recipients should be excluded if they have disabilities, chronic infirmities, or other special health care needs which may be more appropriately met outside the system.

68-1057¹⁴⁵

Plan; access to primary care physicians.

The plan must include a comprehensive system to improve access for program recipients to primary care physicians as provided in section 68-1060. The plan must

1. Provide a more equitable distribution of program care throughout the state,
2. Increase timely access to appropriate health care for program recipients,
3. Promote greater collaboration between physicians and public health nurses,
4. Promote a greater continuity of care through a physician-centered, multidisciplinary care system,
5. Decrease opportunities for compliance abuse by program recipients, and
6. Decrease the inappropriate use of emergency room care.

68-1058¹⁴⁶

Plan; high-risk pregnant women and infants; case management services.

1. The plan must include case management services targeted for high-risk pregnant women and infants who are eligible for MA under section 1915(g) of the federal Social Security Act (SSA).
2. In determining risk, HHS F&S must include factors such as the pregnant woman's age,

¹⁴³ Laws 1993, LB 816, § 4; Laws 2000, LB 892, § 3.

¹⁴⁴ Laws 1993, LB 816, § 9; Laws 2000, LB 892, § 4.

¹⁴⁵ Laws 1993, LB 816, § 10; Laws 1999, LB 380, § 1.

- education, alcohol or drug dependency, weight, and medical and psychosocial condition.
3. Case management services means services that will assist eligible persons in gaining access to needed medical, social, educational, and other services.

68-1059¹⁴⁷

Managed care system; administrator; powers and duties.

1. The managed care plan (plan) must identify an entity to act as administrator of the MCS.
2. The administrator must be HHS F&S, a quasi-governmental entity created by the Legislature, or a private, independent entity under contract with HHS F&S.
3. The administrator must have full operational responsibility for the system.
4. The plan may recommend that more than one entity administer certain components of the MCS.

68-1060¹⁴⁸

Plan implementation; geographic priorities.

1. The plan may identify the geographic areas of the state in which a managed care system (MCS) would be most effective.
2. The MCS may be implemented by HHS F&S in a rural area (i.e. counties with a population of less than 100,000 residents) after additional factors are taken into account.

68-1061¹⁴⁹

System; pricing structure requirements.

1. The plan must require the administrator to obtain as favorable a pricing structure with participating providers as possible, either by negotiating contracts or by a bidding process.
2. In contracting with participating providers, the administrator must use its best efforts to contract for MA services to be provided in a manner consistent with managed care principles, techniques, and practices directed at ensuring the most cost-effective and appropriate scope, duration, quality, and level of care, given the nature of the program recipients participating in the system, the services to be provided, and other factors affecting the pricing structure.

68-1062¹⁵⁰

Plan; implementation requirements; federal waiver.

1. After the managed care plan (plan) has been submitted to the Legislature and the Governor, HHS F&S must take all steps necessary to assure that the plan is implemented as expeditiously as possible, and not later than 45 days following the receipt of the required waiver(s).
2. HHS F&S must use its best efforts to obtain federal waiver(s) to implement the MCS.
3. If waivers are not granted, HHS F&S must modify the system to meet the requirements of Title XIX of the federal Social Security Act (Medicaid) before implementing the system.

68-1063¹⁵¹

Implementation; additional waivers.

If HHS F&S is a party to any agreements that limit its ability to implement a MCS, HHS F&S must use its best efforts to seek additional waivers to allow implementation of the system as provided in 68-1062.

Additional Medicaid Managed Care Provisions

68-1067 to 68-1069¹⁵²

68-1067¹⁵³

Medical home for participants.

The purpose of 68-1068 is to ensure quality and continuity of care for Medicaid recipients who participate in a managed care plan established under the MA program by establishing a medical home for participants in the plan which can, by tracking the participant's health history over time, determine the most appropriate care for the participant's health needs.

¹⁴⁶ Laws 1993, LB 816, § 11.

¹⁴⁷ Laws 1993, LB 816, § 12.

¹⁴⁸ Laws 1993, LB 816, § 13; Laws 1999, LB 380, § 2.

¹⁴⁹ Laws 1993, LB 816, § 14.

¹⁵⁰ Laws 1993, LB 816, § 15; Laws 1995, LB 693A, § 1.

¹⁵¹ Laws 1993, LB 816, § 16.

¹⁵² Laws 1997, LB 258.

¹⁵³ Laws 1997, LB 258, § 1.

68-1068¹⁵⁴

Participants; restrictions on enrollment.

Medicaid recipients and their family members participating in a managed care plan established under the medical assistance (MA) program may not, except for good cause:

1. Simultaneously enroll the participant and the participant's family into separate plans or
2. Switch between plans after enrollment, except during an annual 30-day open enrollment period.

68-1069¹⁵⁵

Rules and regulations.

HHS F&S must adopt and promulgate rules and regulations to carry out section 68-1068.

Eligibility for Non-U.S. Citizens

68-1070¹⁵⁶

68-1070¹⁵⁷

Non-United-States citizens; assistance; eligibility.

1. If the following non-U.S. citizens meet income and other requirements for participation in the MA program established under 68-1018 to 68-1026, the program for financial assistance under 43-512, the food stamp program, or the program for assistance to the aged, blind, or disabled (AABD), they will be eligible for those programs or benefits:
 - a. Non-U.S. citizens lawfully admitted into the U.S. for permanent residence,
 - b. Refugees admitted under §207 of the federal Immigration and Naturalization Act, non-U.S. citizens granted asylum under §208 of the act, and non-U.S. citizens whose deportation is withheld under §243(h) of the act, and
 - c. Persons for whom coverage is mandated by federal law.
2. The income and resources of any person who assists a non-U.S. citizen to enter the U.S. by signing an affidavit of support will be deemed available in determining the non-U.S. citizen's eligibility for assistance until they become a U.S. citizen.

Medicaid Administrative Activities by Public Schools and ESUs

68-1071 to 68-1072¹⁵⁸

68-1071¹⁵⁹

Medicaid reimbursement; legislative intent.

It is the intent of the Legislature that in implementing section 68-1072:

1. HHSS F&S seek to access, to the extent possible under federal law, Medicaid funds to reimburse school districts and ESUs¹⁶⁰ for administrative expenses related to administrative activities currently provided to Medicaid-eligible and potentially Medicaid-eligible students,
2. School districts or ESUs are not required to perform any new activities or services, and
3. HHS F&S must coordinate administrative outreach activities provided by schools and ESUs with those provided under contract by other public or private providers.

68-1072¹⁶¹

Medicaid reimbursement; statewide billing system; access to funds; requirements.

1. On and after January 1, 2000, HHS, HHS F&S, and the State Department of Education must jointly develop a statewide billing system to access matching federal Medicaid funds for Medicaid administrative activities that are not reimbursed through the Medicaid reimbursement rates established under section 43-2511.
2. The Director of F&S must apply for and secure any federal waivers and state Medicaid plan amendments required to implement this section. Only administrative activities delivered by school districts or ESUs under contract with the HHS F&S not reimbursed through the

¹⁵⁴ Laws 1997, LB 258, § 2.

¹⁵⁵ Laws 1997, LB 258, § 3.

¹⁵⁶ Laws 1997, LB 864.

¹⁵⁷ Laws 1997, LB 864, § 6; Laws 1998, LB 1073, § 61.

¹⁵⁸ Laws 1999, LB 548.

¹⁵⁹ Laws 1999, LB 548, § 1.

¹⁶⁰ Educational Service Units.

¹⁶¹ Laws 1999, LB 548, § 2.

- reimbursement rates under section 43-2511 are eligible for reimbursement under this section.
3. Before entering into a contract, the school district or ESU must certify
 - a. the administrative activities for which it is seeking reimbursement,
 - b. that it will expend nonfederal funds in an amount sufficient to meet the required nonfederal match,
 - c. that all funds received under this section will only be used to offset costs incurred in providing Medicaid administrative activities under this section,
 - d. compliance with all applicable federal and state rules and regulations, and
 - e. any other certification required by HHS F&S.
 4. School districts or ESUs accessing funds under this section must transfer the greater of 3% or a percentage which corresponds to the department's actual cost of the total amount of funds accessed under this section for initial implementation and annual administrative costs.
 5. HHS F&S must require audits, reports, and certifications to oversee contracts and adopt and promulgate rules and regulations to implement this section.
 6. School districts or ESUs are not required to contract with HHS F&S under this section. HHS F&S may contract with other public and private providers of Medicaid administrative activities.
 7. Federal Medicaid funds provided to school districts or ESUs under this section are not subject to section 43-2515.

False Medicaid Claims Act

68-1073 to 68-1086¹⁶²

68-1073¹⁶³

False Medicaid Claims Act established

Sections 68-1073 to 68-1086 are known and may be cited as the False Medicaid Claims Act.

68-1074¹⁶⁴

Terms, defined.

For purposes of the False Medicaid Claims Act (FMCA or act), the following terms are defined:

1. Attorney General
2. Claim
3. Department
4. Goods or services
5. Knowing or knowingly
6. Medicaid program
7. Person
8. Recipient.

68-1075¹⁶⁵

Presentation of false Medicaid claim; civil liability; civil penalty; costs and attorney's fees.

1. A person presents a false Medicaid claim and is subject to civil liability if he/she
 - a. Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval,
 - b. Knowingly makes or uses, or causes to be made or used, a false record or statement to obtain payment or approval of a false or fraudulent claim,
 - c. Conspires to defraud the state by obtaining payment or approval by the state of a false or fraudulent claim,
 - d. Has possession, custody, or control of property or money used, or that will be used, by the state and, intending to defraud the state or willfully conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate

¹⁶² Laws 2004, LB 1084.

¹⁶³ Laws 1996, LB 1155, § 67; R.S.1943, (2003), § 68-1037.01; Laws 2004, LB 1084, § 1. Effective date July 16, 2004.

¹⁶⁴ Laws 1996, LB 1155, § 68; R.S.1943, (2003), § 68-1037.02; Laws 2004, LB 1084, § 2. Effective date July 16, 2004.

¹⁶⁵ Laws 1996, LB 1155, § 69; Laws 1997, LB 307, § 110; R.S.1943, (2003), § 68-1037.03; Laws 2004, LB 1084, § 3. Effective date July 16, 2004.

- or receipt,
 - e. Buys, or receives as a pledge of an obligation or debt, public property from any officer or employee of the state knowing that the officer or employee may not lawfully sell or pledge the property, or
 - f. Knowingly makes, uses, or causes to be made or used, a false record or statement with the intent to conceal, avoid, or decrease an obligation to pay or transmit money or property to the state.
2. In addition to other remedies prescribed by law, a person who presents a false Medicaid claim is subject to a civil penalty of not more than \$10,000, and damages of three times the amount of the false claim.
 3. If the state is the prevailing party in an action under the act, the defendant must also pay the state's costs and attorney's fees.
 4. Liability under this section is joint and several for any act committed by two or more persons.

68-1076¹⁶⁶

Failure to report.

1. A person violates the False Medicaid Claims Act (FMCA or act), and is subject to civil liabilities in 68-1075, if he/she is a beneficiary of an inadvertent submission of a false Medicaid claim, subsequently discovers it, and knowing the claim is false, fails to report it within 60 days of discovery.
2. The beneficiary does not have to report if more than 6 years have passed since submission of the claim.

68-1077¹⁶⁷

Charge, solicitation, acceptance, or receipt; unlawful; when.

A person violates the FMCA, and a claim submitted for a good or service is deemed false and subjects him/her to civil liabilities in 68-1075, if he/she, acts on behalf of a provider under the Medicaid program and charges, solicits, accepts, or receives anything of value in excess of the amount legally payable for the good or service provided, knowing that the charge, solicitation, acceptance, or receipt is not legally payable.

68-1078¹⁶⁸

Records; duties; acts prohibited; liability; costs and attorney's fees.

1. A person violates the FMCA and is subject to civil liabilities in section 68-1075 and damages as provided in this section if he/she
 - a. submits a claim or receives payment for a good or service under the Medicaid program and knowingly fails to maintain records necessary to fully disclose the nature of the goods or services for which a claim was submitted or payment received, or to fully disclose all income and expenditures upon which rates of payment were based, for a period of 6 years following the date payment was received, or
 - b. knowingly destroys such records within 6 years from the date payment was received.
2. A person who knowingly fails to maintain records or who knowingly destroys records within 6 years from the date payment for a claim was received is subject to damages of three times the amount of the claim submitted for which records were knowingly not maintained or knowingly destroyed.
3. If the state is the prevailing party in an action under this section, the defendant must also pay the state's costs and attorney's fees.

68-1079¹⁶⁹

Penalties or damages; considerations; liability; costs and attorney's fees.

1. In determining the amount of any penalties or damages awarded under the FMCA, the following must be taken into account:
 - a. the nature of claims and the circumstances under which they were presented,
 - b. the degree of culpability and history of prior offenses of the person presenting the claims,

¹⁶⁶ Laws 2004, LB 1084, § 4. Effective date July 16, 2004.

¹⁶⁷ Laws 2004, LB 1084, § 5. Effective date July 16, 2004.

¹⁶⁸ Laws 2004, LB 1084, § 6. Effective date July 16, 2004.

¹⁶⁹ Laws 1996, LB 1155, § 70; Laws 1997, LB 307, § 111; R.S.1943, (2003), § 68-1037.04; Laws 2004, LB 1084, § 7. Effective date July 16, 2004.

- c. coordination of the total penalties and damages arising from the same claims, goods, or services, whether based on state or federal statute, and
 - d. other matters as justice requires.
2. A person who presents a false Medicaid claim is subject to civil liabilities in 68-1075, except when the court finds that
 - a. the person committing the violation furnished state officials responsible for investigating violations of the act with all information known to the person about the violation within 30 days after first obtaining the information
 - b. the person fully cooperated with any state investigation of the violation, and
 - c. at the time the person furnished the state with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under the act with respect to the violation and the person did not have actual knowledge of the existence of an investigation into the violation.
 3. The court may assess not more than two times the amount of the false Medicaid claim submitted because of the action of a person coming within the above exception, and the person is also liable for the state's costs and attorney's fees for a civil action brought to recover any penalty or damages.
 4. Amounts recovered under the FMCA are remitted to the State Treasurer for credit to the Department of Health and Human Services Cash Fund; civil penalties are credited to the permanent school fund.

68-1080¹⁷⁰

Limitation of actions; burden of proof.

1. A civil action under the FMCA must be brought within 6 years after the claim is discovered or should have been discovered and, in any event, no more than 10 years after the date the violation was committed.
2. In an action brought under the act, the state must prove all essential elements of the cause of action, including damages, by a preponderance of the evidence.

68-1081¹⁷¹

Investigation and prosecution.

1. The Attorney General may take full charge of any investigation or advancement or prosecution of any case involving allegations of civil violations or criminal offenses under the FMCA.
2. HHS F&S must cooperate with the state Medicaid fraud control unit in conducting investigations, civil actions, and criminal prosecutions and provide information as requested by the Attorney General.

68-1082¹⁷²

State Medicaid fraud control unit; certification.

The Attorney General must

1. establish a state Medicaid fraud control unit that meets standards prescribed by 42 USC 1396b(q), and
2. apply to the U.S. Secretary of Health and Human Services for certification of the unit under 42 USC 1396b(q).

68-1083¹⁷³

State Medicaid fraud control unit; powers and duties.

1. The state Medicaid fraud control unit must employ attorneys, auditors, investigators, and other personnel as necessary and authorized by law to carry out the unit's duties.
2. The purpose of the state Medicaid fraud control unit is to conduct a statewide program for the investigation and prosecution of Medicaid fraud and violations of all applicable state laws relating to the providing of medical assistance (MA) and the activities of providers of MA.
3. The state Medicaid fraud control unit may review and act on complaints of abuse and neglect of patients at health care facilities receiving Medicaid payments and may provide or refer for the collection of overpayments made under the Medicaid (medical assistance) program.

¹⁷⁰ Laws 1996, LB 1155, § 71; R.S.1943, (2003), § 68-1037.05; Laws 2004, LB 1084, § 8. Effective date July 16, 2004.

¹⁷¹ Laws 2004, LB 1084, § 9. Effective date July 16, 2004.

¹⁷² Laws 2004, LB 1084, § 10. Effective date July 16, 2004.

68-1084¹⁷⁴

Attorney General; powers and duties.

In carrying out his/her duties and responsibilities under the FMCA, the Attorney General may

1. Enter upon the premises of any health care provider participating in the Medicaid program
 - a. to examine all relevant accounts and records in determining the existence of Medicaid fraud,
 - b. to investigate alleged abuse or neglect of patients, or
 - c. to investigate alleged misappropriation of patients' private funds. Accounts or records of nonmedicaid patients may not be reviewed by, or turned over to, the Attorney General without the patient's written consent or a court order,
2. Subpoena witnesses or materials, and, through any duly designated employee, administer oaths and affirmations and collect evidence for possible use in either civil or criminal judicial proceedings,
3. Request and receive the assistance of any prosecutor or law enforcement agency in the investigation and prosecution of any violation of this section, and
4. Refer instances of overpayment to providers to HHS F&S for collection.

68-1085¹⁷⁵

Attorney General; access to records.

1. Notwithstanding any other provision of law, the Attorney General, upon reasonable request, may have full access to all records held by a provider, or by any other person on his/her behalf, that are relevant to the determination of
 - a. the existence of civil violations or criminal offenses under the FMCA or related offenses,
 - b. the existence of patient abuse, mistreatment, or neglect, or
 - c. the theft of patient funds.
2. In examining such records, the Attorney General must safeguard the privacy rights of recipients, avoiding unnecessary disclosure of personal information concerning named recipients.
3. The Attorney General may transmit such information as he/she deems appropriate to HHS F&S and other agencies concerned with the regulation of health care facilities or health professionals.
4. No person holding such records may refuse to provide the Attorney General access to them for purposes described in the act on the basis that release would violate
 - a. a recipient's right of privacy,
 - b. a recipient's privilege against disclosure or use, or
 - c. any professional or other privilege or right.

68-1086¹⁷⁶

Contempt of court.

1. Any person who has been ordered by a court to comply with a subpoena issued under the FMCA, and fails to testify or produce evidence, is in contempt of court.
2. The court may assess a fine of not less than \$100 nor more than \$1,000 for each day the person fails to comply.
3. A person may be found in contempt of court or fined if compliance with the subpoena violates the person's right against self-incrimination.

¹⁷³ Laws 2004, LB 1084, § 11. Effective date July 16, 2004.

¹⁷⁴ Laws 2004, LB 1084, § 12. Effective date July 16, 2004.

¹⁷⁵ Laws 2004, LB 1084, § 13. Effective date July 16, 2004.

¹⁷⁶ Laws 2004, LB 1084, § 14. Effective date July 16, 2004.