

November 29, 2007

Medicaid State Children's
Health Insurance Program
(Title XXI)
Recommendation Report

State of Nebraska

MERCER



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Executive Summary

Project Overview

The State of Nebraska Department of Health and Human Services (DHHS) contracted with Mercer Government Human Services Consulting (Mercer), services provided by Mercer Health & Benefits LLC, to assist in developing a series of reports related to Title XXI programs as required by State Statute. Similar to other states, program expenditures for Medicaid (Title XIX) and the State Children’s Health Insurance Plan (Title XXI) in Nebraska continue to increase. In an effort to ensure long-term savings and program stability for the Title XXI program, the legislature recognized the necessity for change. Section 68-949(2)(a) of the Nebraska Revised Statutes requires DHHS to “...develop recommendations relating to the provision of health care and related services for Medicaid-eligible children under the state children’s health insurance program as allowed under Title XIX and Title XXI of the federal Social Security Act. Such study and recommendations shall include, but not be limited to, the organization and administration of such program; the establishment of premiums, copayments and deductibles under such program; and the establishment of limits on the amount, scope and duration of services offered to recipients under such program.”

This report presents the final recommendation of a separate State Children’s Health Insurance Program (SCHIP) based on the review of the Draft Recommended Alternatives Report by DHHS, the Medicaid Reform Council and the Health and Human Services (HHS) Legislative Committee. Additional details regarding the program design and advantages and limitations with this option are outlined in this Recommendation Report.

Title XXI Background

Under Federal regulations, as authorized by Title XXI of the Social Security Act, states are allowed the flexibility to select one of three program types for their State Children’s Health Insurance Program:

- Medicaid Expansion Program (MCHIP)

- Separate State Children's Health Insurance Program (SCHIP)
- Combination Program, which includes both a MCHIP and SCHIP

Since the implementation of Title XXI of the Social Security Act and the State's Title XXI program, changes have occurred in Federal regulation that allow states additional flexibility in designing and managing their Title XIX and Title XXI programs. The recommended SCHIP option presented in this report reflects an option available to the State at this time. At the time of production of this report, Title XXI reauthorization continues to be debated by Congress and the President. This recommendation may be impacted by the final outcome of Title XXI reauthorization or other federal changes that may occur.

Nebraska's current children's health insurance program, under Title XXI, is a Medicaid expansion program, or MCHIP. In developing a MCHIP, Nebraska was able to use the same delivery system, benefit plan, provider network, payment levels and Medicaid Management Information System (MMIS) as the Nebraska Title XIX program. The MCHIP expansion also meant that all Medicaid-eligible children in a family received the same benefits. Administration of the program is further eased by the use of consistent eligibility determinations such as no asset test and the same treatment of income between the Title XIX and Title XXI programs. These consistencies between the programs result in reduced administration and per child costs when compared to other state SCHIP programs.

Nebraska's MCHIP program provides health care coverage to targeted low-income uninsured children, from birth through age 18, in families with incomes at or below 185 percent of the Federal Poverty Level (FPL). For reference, 185 percent of FPL is equal to an adjusted monthly income of \$38,203 for a family of four¹. Specifically, the State's MCHIP covers:

- Under age 1 between 150 and 185 percent of the FPL
- Ages 1 to 5 between 133 and 185 percent of the FPL
- Ages 6 to 18 between 100 and 185 percent of the FPL

Nebraska's MCHIP provides a full range of health coverage using the same benefit plan as is available through the Title XIX program. Nebraska's MCHIP does not currently include premiums or cost sharing, as federal rules prohibited cost sharing for children in MCHIP until the passage of the Deficit Reduction Act (DRA) of 2005.

The MCHIP also allows the State to utilize the same delivery system as the Title XIX program. The Title XIX and XXI programs utilize two models for service delivery for managed care, a Primary Care Case Management (PCCM) network and a health maintenance organization (HMO), in a designated geographic area including Douglas, Sarpy and Lancaster counties. These models provide the basic benefit plan of medical/surgical services. Dental services and pharmacy services are carved out and are reimbursed to providers on a fee-for-service (FFS) basis by Nebraska. Medical-surgical services are delivered via FFS in all other counties.

¹ See <http://www.cms.hhs.gov/MedicaidEligibility/downloads/POV07ALL.pdf>

The Nebraska managed care program also provides managed care for mental health and substance abuse (MH/SA) services. Effective January 2002, Nebraska changed the management of the MH/SA component from a capitated/risk model to a non-risk model. The new MH/SA program structure operates as a Specialty Physician Case Management (SPCM) system under 42 CFR 431.55(c)(1)(ii) and a 1915(b)(1) and 1915(b)(4) waiver.

Recommendation

Throughout this Title XXI study, various options were explored for the administration of the children's health insurance program. These options included continuing with the current MCHIP structure and adding flexibility through waivers, enhancing coordination between the public and private health care markets and developing a State Plan Amendment (SPA) through the DRA. In addition, the option of reforming the current MCHIP to establish a separate program (SCHIP) was explored. Although each of these options has its own advantages and limitations, DHHS chose to further consider the option of establishing a separate SCHIP program.

Under this recommended option, the State would convert the current MCHIP into a SCHIP. This would provide the greatest flexibility and control over the Title XXI program to assist DHHS in achieving its goals of creating a program with long-term fiscal and program sustainability. The SCHIP option eliminates the entitlement that currently exists for this population through the MCHIP, which assists in maintaining fiscal sustainability. Key considerations of the SCHIP option are provided below, with additional detail included in Section 3, "Recommendation".

- Allows flexibility to design benefit plans that more closely mirror the commercial health care market. This type of program allows states to offer SCHIP program enrollees commercially-oriented products without Title XIX requirements such as early and periodic screening, diagnostic and treatment (EPSDT) or compliance with managed care regulations.
- Provides for implementation of cost sharing (co-payments and/or premiums), while also addressing the income limitations and medical needs of the children served through Title XXI.
- Allows the State to maintain the current provider reimbursement structure which is critical to ensuring long-term sustainability of the SCHIP option. Although the SCHIP is a separate program from the Title XIX Medicaid program, DHHS could continue to provide reimbursement as allowed under the Title XIX fee schedules.
- Allows the establishment of enrollment caps and waiting lists to assist the State in managing expenditures within its SCHIP allotment. Unlike the MCHIP under Title XXI, once the Title XXI SCHIP allotment is expended, there is no further federal match available.
- Requires additional administration needs to address the separate program and the differences in benefits and cost sharing.

To evaluate the impact of a SCHIP program, the commercial benefit design of the State Employee Health Benefit Program was modeled with a moderate level of cost sharing and a level of cost sharing in line with the maximum levels allowed by CMS. In addition, the SCHIP program was modeled assuming DHHS administration of the program, as well as the administration being outsourced by DHHS.

In the SCHIP program, health insurers will be responsible for most of the program administration including provider network development, claims processing and payment and member services. Under both administration scenarios, the health insurer responsibilities are the same. In the scenario where DHHS administers the program, DHHS would be responsible for program oversight, enrollee education and any community/media information needs, capitation payment, encounter data collection, eligibility and enrollment services and premium collection. The outsourced administration scenario reflects DHHS contracting out the eligibility and enrollment services and premium collection.

The SCHIP scenarios modeled are outlined below:

- Scenario 1A: SCHIP with moderate cost sharing and administration by DHHS
- Scenario 1B: SCHIP with moderate cost sharing and outsourced administration
- Scenario 2A: SCHIP with maximum cost sharing and administration by DHHS
- Scenario 2B: SCHIP with maximum cost sharing and outsourced administration

The following table presents the comparison of the enrollment and financial impact of each scenario as compared with the projected MCHIP enrollment and expenditures for state fiscal year (SFY) 2009 with no changes to the current program. Figures in Table 1 include the federal and State shares of the total revenues and expenditures, except for the last row, which highlights the impact on the State expenditures taking federal participation into account. Federal participation is assumed to be 50 percent for Administration Expenses, 58 percent for Title XIX and 71 percent for Title XXI in FY 2007.² The projected estimates assume federal participation will continue at these levels.

Table 1: SCHIP Impact Summary

Description	SFY 2009 MCHIP Baseline	Scenario 1A	Scenario 1B	Scenario 2A	Scenario 2B
Enrollment ³	24,400	23,434	23,434	22,214	22,214
Total Costs	\$48,796,527	\$47,747,332	\$50,436,683	\$36,372,588	\$38,317,678
Total Overall (Savings) Costs Versus Baseline	N/A	\$(1,049,195)	\$1,640,156	\$(12,423,939)	\$(10,478,849)
State Share of Overall (Savings) Costs Versus Baseline	N/A	\$(273,339)	\$1,071,336	\$(3,587,248)	\$(2,614,703)

² See <http://aspe.os.dhhs.gov/health/fmap07.htm>

³ Projected average monthly enrollment based on actual enrollment from July 2006 through June 2007.

In each scenario, it is expected that enrollment will be reduced as fewer children are expected to participate in a program with premium requirements. The enrollment reduction is greater with higher levels of cost sharing. In addition, premium revenue is collected in each scenario to help offset additional program costs.

Scenario 2 provides the greatest opportunity for overall savings. These savings are driven by decreases in enrollment and lower per-capita costs resulting from maximum cost sharing provisions. Scenario 1 provides slight savings when the administrative functions are performed in-house, and results in higher total expenditures when these functions are outsourced.

Scenario 1B is the only option projected to cost more than the current MCHIP. In addition, the State share of those costs is significantly greater than in the other scenarios. This portion of the State share is the result of a significant increase in administration expenditures with a federal participation rate of 50 percent, and only minimal savings in medical expenditures with a much higher federal participation rate. A more detailed presentation of the expenditures is included in Table 7.

As can be seen, projected expenditures are higher in Scenario 1. This is due to several factors including higher expected enrollment, lower cost sharing, and administration assumptions for the health insurer built into the capitations for the SCHIP program. The administration allowance provided for in the carrier capitation standardly includes consideration for claims payment expenses, risk margins and reasonable profit loads. Risk margins are included to cover claims expenses that may exceed expected claims costs assumed in the development of the capitations. The cost of the carrier administration more than exceeds reductions in claims costs due to the reduction in enrollment and moderate cost sharing for Scenario 1.

The additional administration expenses for the carriers are also included in the capitations for Scenario 2, but the higher levels of member cost sharing and more significant decreases in enrollment more than offset the additional expenses resulting in a reduction in total medical expenditures.

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Background

Nebraska Title XXI Background

Similar to other states, the expenditures for the Medicaid (Title XIX) and Title XXI programs in Nebraska continue to increase. As discussed, Nebraska's Title XXI program is an MCHIP and provides health care coverage to targeted low-income uninsured children, from birth through age 18, in families with incomes at or below 185 percent of the FPL. Children enrolled in MCHIP are eligible for all Title XIX program benefits including EPSDT. EPSDT are benefits which focus on prevention, immunization and early diagnosis and treatment of health problems for children. Nebraska's MCHIP does not currently include premiums or cost sharing as it is tied to the benefit structure of the Title XIX Program. Refer to Appendix A for additional details on Nebraska's MCHIP program.

The average number of eligible children in MCHIP on a monthly basis in SFY 2006 was 23,700. During federal fiscal years (FFY) 2004 through 2006, costs and eligibility have remained fairly stable with total expenditures (federal and State general funds) of \$49,549,579 for MCHIP in FFY 2006. The administration portion of the FFY 2006 expenditures is \$2,814,032 for both the federal and State portions. Refer to Appendix B for more information on Nebraska's Title XXI expenditures.

Project Approach

Mercer initially provided DHHS with a comprehensive review of all available options under Title XXI in a Feasibility and Options Report. Mercer considered three key components in that report.

- Nebraska's current Title XXI, Title XIX and other programs
- Title XXI program types and authority options
- Title XXI program types and designs utilized in other states

In developing this report, Mercer conducted a comprehensive review of Nebraska's current Title XXI program and program types and authorities utilized in other states. DHHS and Mercer then held an onsite meeting to confirm Mercer's understanding of Nebraska's current Title XIX and

Title XXI programs, gather additional information on the administrative oversight, discuss the vision and challenges DHHS faced with this program and select a number of states for program comparisons.

After the first onsite meeting, research continued on programs implemented in other states and the feasibility of each option for Nebraska. In total, 15 different state programs were reviewed. Mercer also collected data summaries from DHHS to gain an understanding of underlying trends and program costs by category of service (COS). Finally, Mercer communicated with DHHS to gather additional information to support the analysis included in the report. A summary of the options, comparison of the advantages and limitations of each option and description of the 15 state programs were included in the Options and Feasibility Report.

After completing the Options and Feasibility Report, Mercer conducted a second onsite meeting to discuss the available program options with DHHS. During this meeting, Nebraska selected three program options for Mercer to more fully develop. Mercer expanded on the advantages and limitations of each option, including more emphasis on implementation issues and costs that could be experienced by Nebraska under each model.

The Draft Recommended Alternatives Report identified three alternative options for Nebraska to consider under Titles XIX and XXI of the Social Security Act, including new options allowed under the DRA of 2005. Although each of these options has its own advantages and limitations, DHHS chose to further consider the option of establishing a SCHIP. This final report further outlines the considerations of establishing a separate program including multiple scenarios addressing different levels of cost sharing and options for the administration of the SCHIP program.



3

Recommendation – Separate Child Health Insurance Plan (SCHIP)

Description

Under this recommended option, the State would convert its current MCHIP into a separate, stand-alone SCHIP. This option provides the maximum flexibility to the State for administering its Title XXI program. There are several advantages to implementing a SCHIP:

- A SCHIP is not an entitlement and allows the establishment of separate eligibility rules. In addition, a SCHIP may limit its own annual contribution, create waiting lists or stop enrollment once the program funds have been exhausted.
- Although SCHIPs must comply with statutory benefit standards, the benefits are more flexible (e.g., do not require EPSDT coverage) and may mirror commercial benefit designs.
- SCHIPs may impose limited cost sharing through premiums, co-payments or enrollment fees for children in families with incomes above 150 percent of the FPL up to 5 percent of family income, annually. In addition to the 5 percent cost-sharing limit, cost sharing is not permitted for well-baby and well-child services, Native American and Alaska Natives, and is limited to nominal Medicaid limits for families with income between 101 and 150 percent of the FPL.

For a SCHIP, the State must establish a benefit plan based on one of the following benchmark plans:

- **Benchmark Plan:** A benefit plan consistent with the Federal Employees Health Benefits Program (FEHBP) BlueCross BlueShield Standard Option (coverage generally available to Federal employees), coverage generally available to state employees or coverage under a state's HMO with the largest insured commercial, non-Medicaid enrollment.
- **Benchmark-Equivalent Plan:** A benefit plan including basic coverage for inpatient and outpatient hospital, surgical and medical physician, laboratory and x-ray and well-baby and well-child care, including age-appropriate immunizations. The health benefits coverage must have an aggregate value that is at least actuarially equivalent to the coverage under one of the benchmark plans.

- **Secretary-Approved Plan:** A benefit plan consisting of coverage determined appropriate for targeted low-income children. Secretary-Approved coverage can include, but is not limited to, coverage provided under the Medicaid state plan; coverage provided under a Medicaid 1115 demonstration waiver; benchmark coverage plus additional coverage; existing comprehensive state-based coverage; or coverage substantially equivalent to, or greater than, coverage under a benchmark plan.

This type of program allows states to offer SCHIP enrollees commercially-oriented products without Title XIX requirements such as EPSDT or compliance with the Title XIX managed care regulations. Many states implement this program by mirroring the State Employee Health Benefit Plan, which allows for some economies of scale by pooling enrollment and using current administrative processes such as contracting and competitive bidding between plans.

Authority

A SCHIP is a program for which a state receives a federal funding allotment under an approved plan that meets the requirements of Title XXI. A SCHIP does not create an entitlement for individuals meeting eligibility requirements, and thus, waiting lists, enrollment caps, open enrollment periods or other limitations are available to assist a state in balancing program financing with available federal funds. To implement this recommendation, the State would need to apply for a SCHIP SPA. A SCHIP also allows the State to provide commercial-like benefit coverage and implement premiums and co-payments.

Advantages and Limitations

The following table outlines the advantages and limitations of the recommended SCHIP option.

Table 2: SCHIP Advantages and Limitations

Advantages	Limitations
<ul style="list-style-type: none"> ▪ Flexibility: Allows a state to obtain additional flexibility in administering a Title XXI program by choosing a benefit plan that is not equal to the Medicaid state plan. ▪ Cost Sharing: Authority allows the assessment of premiums, enrollment fees and co-payments. ▪ Appropriate Health Care: Allows for variation of amount, duration and scope of benefits based on a benchmark, benchmark equivalent or Secretary-approved plan. ▪ Appropriate Utilization: Allows for variation of amount, duration and scope of benefits as long as benefits are at least actuarially equivalent to the benchmark plan. ▪ Personal Responsibility and Accountability: Authority allows coverage to resemble private insurance. ▪ Fiscal Sustainability: Allows a state to introduce premiums, cost sharing and commercial benefits. ▪ Review: There is a timeframe in which CMS must review and approve or disapprove a request for a SCHIP SPA. In addition, there is less oversight over contracts in SCHIP. A waiver is not required to operate a managed care program. 	<ul style="list-style-type: none"> ▪ Delivery System: States typically contract with a commercial plan to provide coverage, which provides limited ability to build upon the current Medicaid delivery system without major modifications in the Title XIX or Title XXI system. ▪ Coordination with Private Insurers: Due to the crowd-out requirements, it is difficult to coordinate with employer-sponsored insurance or other third-party insurers without a waiver. ▪ Administration: Many states must hire additional staff to manage the programs and also need to contract for certain administration services.

SCHIPs are more flexible than MCHIPs around benefit design, cost sharing and enrollment limits. SCHIPs are also more comparable to private insurance, while MCHIPs must adhere to the same rules as Title XIX programs.⁴

Benefit Design and Cost Sharing

Benefit Design

The SCHIP option provides coverage to children whose parents have income less than 185 percent of the FPL. The benchmark plan selected is the State Employee Health Plan PPO, with cost sharing customized to work within SCHIP constraints. The benchmark benefit package was modeled under two different premium and point-of-service cost sharing scenarios.

Medicaid EPSDT services are not specifically included in this benefit design. However, the State Employee Health Plan does include benefits for preventive and routine care such as well-baby and well-child visits. The benefit package also covers routine immunizations for children through age six. The benefits covered by each scenario are the same, and include:

- Inpatient Services

⁴David Bergman, "Perspectives on Reauthorization Separate Child Health Insurance Program Separate Child Health Insurance Program Directors Weigh In," National Academy for State Health Policy, (June 2005).

- Outpatient Services
- Physician Services
- Preventive and Routine Services
- Emergency Care Services
- Dental Services
- Optical Services
- Prescription Drugs
- Mental Illness and Substance Abuse Treatment Services
- Outpatient Rehabilitation Services
- Diagnostic Lab and X-Ray Services

Additional benefit detail is included in Tables 5 and 6 on the following pages.

Cost Sharing

SCHIP regulations⁵ stipulate limitations on cost sharing that can be imposed by a state on enrollees. These limitations are summarized in the table below.

Table 3: SCHIP Cost Sharing Regulations

Cost Sharing Provision	Family Income Less than 150% FPL	Family Income Greater than 150% FPL
Aggregate Monthly Premiums	No greater than \$15.00 per family	No Limit Specified
Co-payments	Not Allowed	No Limit Specified
Maximum Annual Aggregate	5% of Family Income	5% of Family Income

Regardless of family income, co-payment limits apply per 42 CFR 457.555 and are prohibited on well-child care and for Native Americans and Alaskan Natives.

Two scenarios of cost sharing for the SCHIP program were modeled for the State's consideration. In each scenario, the enrollee financial obligation cannot exceed 5 percent of the total household income, including premiums and point-of-service cost sharing. The scenarios for cost sharing are as follows:

- Scenario 1 provides coverage for moderate cost sharing (e.g., moderate premiums with no point-of-service cost sharing)
- Scenario 2 requires maximum cost sharing (e.g., higher premiums and some enrollee financial responsibility at the point-of-service)

The assumed monthly premiums for the different FPL eligibility groups are summarized in Table 4 for each scenario.

⁵ See 2 CFR 457.515 through 42 CFR 457.570

Table 4: Monthly Premiums

SCHIP Eligibility Group	Scenario 1	Scenario 2
100% – 150% of FPL	\$5.00	\$12.00
150% – 185% of FPL	\$12.00	\$25.00

There is no point-of-service (POS) cost sharing in Scenario 1 so there is no further financial liability once the enrollee has satisfied the premium requirement. For Scenario 2, some services require a nominal co-payment while others require co-insurance participation of 15 percent. There is no deductible for either scenario. POS cost sharing provisions are outlined in the following tables.

Table 5: Scenario 1 – Moderate Premium With No Point-of-Service Cost Sharing (Moderate Cost Sharing)

	100%-150% FPL	150%-185% FPL
Average Monthly Premium	\$5.00	\$12.00
Calendar Year Deductible	None	
Maximum Out-Of-Pocket Each Calendar Year, Combined with Premium	5% of household income	
Inpatient Services, Skilled Care, Physical Rehab and Long Term Acute Care	No co-pay	No co-pay
Outpatient Hospital, Outpatient Services, Outpatient Surgical Centers	No co-pay	No co-pay
Diagnostic Lab and X-Ray (regardless the facility)	No co-pay	No co-pay
Physician Office Visit and Physician Services		
▪ Office Visits/ Consultations/Specialist	No co-pay	No co-pay
▪ Maternity and Family Planning Services	No co-pay	No co-pay
▪ Allergy Testing/Shots	No co-pay	No co-pay
▪ Surgery	No co-pay	No co-pay
▪ Radiology and Lab (office)	No co-pay	No co-pay
▪ Chemotherapy	No co-pay	No co-pay
▪ All Other Physician Services	No co-pay	No co-pay
Preventive/Routine Services		
▪ Well Baby and Well Child Visits	No co-pay	No co-pay
▪ Routine Immunizations for Children Through Six Years of Age	No co-pay	No co-pay
▪ Other Preventive/Routine Services	No co-pay	No co-pay
Emergency Care Services		
▪ Ambulance	No co-pay	No co-pay
▪ Urgi-Center (minor medical clinic) Services	No co-pay	No co-pay
▪ Hospital Emergency Room Services – Co-pay Waived for Emergency or if Admitted as Inpatient for the Same Diagnosis Within 24 Hours	No co-pay	No co-pay
Durable Medical Equipment, Home Health, Organ Transplant	No co-pay	No co-pay
Prescription Drugs	No co-pay	No co-pay
Hospice	No co-pay	No co-pay
TMJ Treatment (\$5,000 benefit maximum)	No co-pay	No co-pay
Dental (preventive care, fillings, extractions and dental surgery)	No co-pay	No co-pay
Vision (routine eye exam, yearly corrective lenses)	No co-pay	No co-pay
Outpatient Rehabilitation Services (maximum of 60 combined sessions per calendar year)		
▪ Occupational, Physical and Speech Therapy, Chiropractic and Osteopathic Physiotherapy, Spinal Manipulations/Adjustments	No co-pay	No co-pay
Inpatient Mental Illness and Substance Abuse Treatment – Benefits Subject to a 60-Day Maximum per Calendar Year (benefits for serious mental illness are not subject to this maximum)	No co-pay	No co-pay
Outpatient Mental Illness and Substance Abuse Treatment – Benefits Subject to a 60-Day Maximum per Calendar Year (benefits for serious mental illness are not subject to this maximum)		
▪ Therapy Visits	No co-pay	No co-pay
▪ Misc. Charges (i.e., lab)	No co-pay	No co-pay

Point-of-service cost sharing is prohibited for Native Americans and Alaskan Natives.

Table 6: Scenario 2 – Higher Premium With Point-of-Service Cost Sharing (Maximum Cost Sharing)

	100%-150% FPL	150%-185% FPL
Average Monthly Premium	\$12.00	\$25.00
Calendar Year Deductible	None	
Maximum Out-Of-Pocket Each Calendar Year, Combined with Premium	5% of household income	
Inpatient Services, Skilled Care, Physical Rehab and Long Term Acute Care	15% co-insurance, up to \$500 per admit for inpatient	15% co-insurance
Outpatient Hospital, Outpatient Services, Outpatient Surgical Centers	\$5 co-pay	15% co-insurance
Diagnostic Lab and X-Ray (regardless the facility)	\$5 co-pay	15% co-insurance
Physician Office Visit and Physician Services		
▪ Office Visits/ Consultations/Specialist	\$3 co-pay	\$10 co-pay
▪ Maternity and Family Planning Services	No co-pay	No co-pay
▪ Allergy Testing/Shots	\$3 co-pay	\$10 co-pay
▪ Surgery	\$3 co-pay	\$10 co-pay
▪ Radiology and Lab (office)	\$3 co-pay	\$10 co-pay
▪ Chemotherapy	\$3 co-pay	\$10 co-pay
▪ All Other Physician Services	\$3 co-pay	\$10 co-pay
Preventive/Routine Services		
▪ Well Baby and Well Child Visits	No co-pay	No co-pay
▪ Routine Immunizations for Children Through Six Years of Age	No co-pay	No co-pay
▪ Other Preventive/Routine Services	No co-pay	No co-pay
Emergency Care Services		
▪ Ambulance	No co-pay	No co-pay
▪ Urgi-Center (minor medical clinic) Services	\$5 co-pay	\$15 co-pay
▪ Hospital Emergency Room Services – Co-pay Waived for Emergency or if Admitted as Inpatient for the Same Diagnosis Within 24 Hours	\$10 co-pay if non-emergent	\$50 co-pay if non-emergent
Durable Medical Equipment, Home Health, Organ Transplant	\$5 co-pay	15% co-insurance
Prescription Drugs	\$5 per script	\$10 per script
Hospice	\$5 co-pay	No co-pay
TMJ Treatment (\$5,000 benefit maximum)	\$5 co-pay	15% co-insurance
Dental (preventive care, fillings, extractions and dental surgery)	15% co-insurance	15% co-insurance
Vision (routine eye exam, yearly corrective lenses)	\$3 co-pay	\$10 co-pay
Outpatient Rehabilitation Services (maximum of 60 combined sessions per calendar year)		
▪ Occupational, Physical and Speech Therapy, Chiropractic and Osteopathic Physiotherapy, Spinal Manipulations/Adjustments	\$3 co-pay	15% co-insurance
Inpatient Mental Illness and Substance Abuse Treatment – Benefits Subject to a 60-Day Maximum per Calendar Year (benefits for serious mental illness are not subject to this maximum)	\$3 co-pay	15% co-insurance
Outpatient Mental Illness and Substance Abuse Treatment – Benefits Subject to a 60-Day Maximum per Calendar Year (benefits for serious mental illness are not subject to this maximum)		
▪ Therapy Visits	\$3 co-pay	\$10 co-pay
▪ Misc. Charges (i.e., lab)	\$3 co-pay	15% co-insurance

Point-of-service cost sharing is prohibited for Native Americans and Alaskan Natives.

Impact on Enrollment and Expenditures

Program Impact

The enrollment and expenditure impact associated with the SCHIP option can be quite varied, depending on how the program is designed. To assist policymakers with understanding the range of possible results, two scenarios were modeled that varied based on cost sharing requirements. Scenario 1 represents moderate premiums and no POS cost sharing, while Scenario 2 represents higher premiums and more aggressive POS cost sharing as allowed under the Title XXI regulations. In addition, the State wants to consider the impact on program costs if the SCHIP was administered by DHHS or if the program administration was completely outsourced. This adds two additional scenarios for modeling which will be denoted as follows:

- Scenario 1A: SCHIP with moderate cost sharing and administration by DHHS
- Scenario 1B: SCHIP with moderate cost sharing and outsourced administration
- Scenario 2A: SCHIP with maximum cost sharing and administration by DHHS
- Scenario 2B: SCHIP with maximum cost sharing and outsourced administration

All scenarios reflect the benefits covered under the State Employee Health Benefit Plan, represent a service delivery model where a health insurer provides the benefits statewide through either an indemnity model or an HMO and reimburse providers at Medicaid levels. An indemnity model provides the State with additional options of health insurers that are not available under the HMO model. Indemnity health insurers are risk-bearing entities, as are HMOs, but indemnity health insurers have separate licensing requirements from HMOs. In general, there are two main differences between the indemnity insurers and HMOs that provide advantages to the State for the SCHIP program:

- Indemnity insurers typically have much broader networks, while HMOs typically have closed-panel networks. Therefore, the indemnity insurers have networks to cover rural areas and can provide care on a statewide basis more readily.
- Indemnity insurers typically take on less risk than HMOs due to the plan designs they offer. These insurers offer preferred provider organizations (PPO) and POS products that include premiums, deductibles and co-insurance while HMOs frequently only have co-payment requirements. These plan designs are more in line with the benefit scenarios modeled after the State Employee Health Benefit Plan. The indemnity insurers generally have the systems in place to manage benefits of this type and adjudicate claims with limited to no system modifications needed. HMOs may need to make system changes to deal with varying co-payments and/or co-insurance requirements.

As SCHIP allows premium application to the enrollees above 100 percent of the FPL, the enrollment effects can be significant. For example, the moderate premiums modeled in Scenario 1 could produce an enrollment decrease of 4 percent, as compared to SFY 2009 projections for the current MCHIP program. The higher premiums used for Scenario 2 could result in 9 percent fewer children covered under the program.

The lower projected enrollment levels and the premium revenue available to offset expenditures are significant drivers for the estimated budgetary savings opportunities for the State. Highlights of the expenditure impact are provided below:

- Scenario 1A is projected to decrease the State share of MCHIP expenditures by almost 2 percent (\$275,000 for SFY 2009).
- Scenario 1B is projected to increase the State share of MCHIP expenditures by about \$1.1 million (7 percent for SFY 2009). The significant portion of the change in State share in this scenario is the result of a large increase in administration expenditures where the State is responsible for 50 percent of the costs, and a slight reduction in medical expenditures where federal participation is much greater.
- In Scenario 2A, the State share of program expenditures could be reduced by \$3.6 million (25 percent). As noted earlier, this savings is achieved by covering 9 percent fewer children at more aggressive premium and co-payment levels.
- In Scenario 2B, the State share of program expenditures could be reduced by \$2.6 million (18 percent). In this option, the additional costs to outsource the administration are more than offset by the savings in medical costs resulting from higher cost sharing and the reduction in projected enrollment.

These projected expenditures by scenario reflect additional State administrative costs to manage the separate program and handle increased premium collection needs. The following table summarizes anticipated enrollment, medical expenditures, administrative costs, premium revenue and the State share impact of each scenario compared to the projected expenditures of continuing the MCHIP program into SFY 2009. Federal participation is assumed to be 50 percent for Administration Expenses, 58 percent for Title XIX and 71 percent for Title XXI in FY 2007.⁶ The projected estimates assume the federal participation will continue at these levels.

Table 7: SCHIP Enrollment and Financial Impact Comparison

Description	SFY 2009 MCHIP Baseline	Scenario 1A	Scenario 1B	Scenario 2A	Scenario 2B
Enrollment ⁷	24,400	23,434	23,434	22,214	22,214
Member Months	292,801	281,213	281,213	266,573	266,573
Medical Expenditures	\$47,146,403	\$48,298,535	\$48,298,535	\$39,505,905	\$39,505,905
Administration Expenditures	\$1,650,124	\$1,797,398	\$4,486,749	\$1,724,858	\$3,669,947
Premium Revenue	\$0	\$(2,348,602)	\$(2,348,602)	\$(4,858,174)	\$(4,858,174)
Total Costs	\$48,796,527	\$47,747,332	\$50,436,683	\$36,372,588	\$38,317,678
Total Overall (Savings) Costs Versus Baseline	N/A	\$(1,049,195)	\$1,640,156	\$(12,423,939)	\$(10,478,849)
State Share of Overall (Savings) Costs Versus Baseline	N/A	\$(273,339)	\$1,071,336	\$(3,587,248)	\$(2,614,703)

The following section describes the assumptions and methodology used to develop the SCHIP impact by scenario.

⁶ See <http://aspe.os.dhhs.gov/health/fmap07.htm>

⁷ Projected average monthly enrollment based on actual enrollment from July 2006 through June 2007.

Methodology

Overview

In order to quantify the potential change in expenditures associated with each scenario for the SCHIP option, Mercer conducted a series of modeling exercises using Nebraska MCHIP historical claims data, Nebraska MCHIP SFY 2009 budget projections, other states' historical claims and enrollment experience and other commercial and national benchmarks as appropriate. To identify the potential changes in expenditures for the SCHIP program, which involve changes to benefit design and cost sharing, actuarial cost models based on Nebraska's MCHIP claims experience and service utilization patterns were used.

First, the baseline enrollment and costs were established for the current program using the actual SFY 2005 and SFY 2006 member months (MM) and costs provided by DHHS. The enrollment, per capita costs, State administration expenses and premium revenue in SFY 2009 were then estimated for each scenario. Finally, the impact of each scenario was determined by calculating the difference between the projected baseline and projected scenario total costs. In the discussion that follows, the development of the baseline and the components of the projections for each scenario are outlined.

The modeling performed and estimates produced for this analysis are high-level budget estimates specifically for Nebraska and are not appropriate for other purposes. To develop these estimates, we have relied on data and other information provided by the State. We have not audited the information, but did review it for reasonableness. If that data and information are inaccurate or incomplete, our results may require revision.

Base Data

SFY 2005 and SFY 2006 expenditure and eligibility data were summarized for Nebraska's MCHIP program and per member per month (PMPM) expenditures by COS were calculated. The total expenditures for SFY 2005 and SFY 2006 were \$40,764,488 (PMPM of \$147.00) and \$42,768,503 (PMPM of \$150.55) respectively and the total MM for the two years were 561,391. The expenditure data provided was not reduced for pharmacy rebates; therefore, the pharmacy claims in the base data were reduced by 17 percent based on information received from the State.

Using available commercial data for children, we estimated the utilization and calculated the unit cost from the PMPMs for each COS in order to apply assumptions related to changes in cost sharing and utilization for each of the scenarios. The resulting base data allowed us to calculate the impact of the changes in enrollment and expenditures and also model the impact of the benefit changes, cost sharing and changes in state administration costs for the SCHIP option.

Baseline and Projected Enrollment

A 1 percent trend was used to estimate the enrolled population in SFY 2009 for the current MCHIP program, based on State projections. This trend was applied to the SFY 2007 actual enrolled MM (287,032) to estimate the projected SFY 2009 enrolled MM (292,801), assuming no change to the program. The number of children enrolled in the SCHIP program (based on

average monthly enrollment) is expected to increase from 23,919 in SFY 2007 to 24,400 in SFY 2009, assuming no change in the MCHIP program.

By converting the current MCHIP to a SCHIP and introducing premiums and POS cost sharing, the enrollment is expected to decrease by 4 percent in Scenarios 1A and 1B and 9 percent in Scenarios 2A and 2B. Refer to Table 7 for the MM by scenario and comparison to the projected baseline. These projections were developed based on reviews of published studies on the enrollment impacts of introducing premiums to other publicly-sponsored health coverage programs. The potential adverse selection impact on expenses was estimated using Mercer's proprietary participation/selection model. Projected enrollment does not vary between the A and B administration scenarios.

Baseline and Projected Per Capita Costs

Data received from the State was used to establish the SFY 2009 PMPM expenses by adjusting the pharmacy costs for the 17 percent rebate and dividing the projected expenditures by the projected enrollment as calculated above. The resulting baseline medical PMPM, assuming no changes to the program, is \$161.02 for SFY 2009. The PMPM cost for the SCHIP program was then modeled, including the impact of the State Employee Health Benefit Plan modified for SCHIP cost sharing. The imposition of POS cost sharing is a significant driver in lowering the State's projected expenses. The expected PMPM medical cost for this program falls between \$148.20 for Scenario 2 and \$171.75 for Scenario 1. These PMPMs include administrative costs of the contracting entity, but do not include State administrative expenses. Even though the PMPM medical expense for the SCHIP option may be higher than the MCHIP baseline, the State should realize total cost savings due to the expected reduction in enrollment. Projected per capita costs do not vary between the A and B administration scenarios.

Baseline and Projected State Administration Costs

Additional administrative expenses for each option were estimated by developing estimates of additional staff and vendor requirements and collecting costs associated with those services. These additional expenses were based on Nebraska's wage information and the administrative costs of operating the current Title XIX and Title XXI programs. Information from other states implementing similar programs was also reviewed.

To establish the baseline administration expenses for the State, administration costs of 3.5 percent of the medical cost were assumed, consistent with overall Medicaid state administration cost assumptions used in waiver cost effectiveness calculations. To estimate the projected administration costs for each scenario, the baseline State administration PMPM expense was assumed to remain constant and the total administration cost was estimated based on the projected population.

These and other additional state administrative costs are summarized in the table below.

Table 8: Additional State Administration Costs Assuming In-House Administration

Scenario	Item	Description	Total Cost
1A	4 additional State staff	Premium Collection Support	\$204,000
	Basic Education and Informing	\$1.01 PMPM (281,213 MM) equal to 25% of the current State Medicaid managed care broker costs on a statewide basis ⁸	\$284,026
	Actuarial Consulting Contract	Rate Setting Support	\$200,000
	Total for Scenario 1A		
2A	4 additional State staff	Premium Collection Support	\$204,000
	Basic Education and informing	\$1.01 PMPM (266,573 MM) equal to 25% of the current State Medicaid managed care broker costs on a statewide basis	\$269,239
	Actuarial Consulting Contract	Rate Setting Support	\$200,000
	Total for Scenario 2A		

The total additional administration cost for the administrative services is expected to be about \$700,000, assuming the State manages the program (Scenario “A”). Total administration costs including the baseline administration of 3.5 percent of medical costs are reflected in Table 7.

Should the State decide to outsource the management of the SCHIP program (Scenario “B”), total administration costs are estimated at about 8.5 percent of the total costs of the program. This estimate includes all costs related to the management of the SCHIP program including premium collection, enrollment, claims payment, State staff for oversight, carrier premium payment, encounter data collection, etc. This assumption is based on a limited review of similar programs serving similar populations. Total administration costs are reflected in Table 7. All administration costs for the SCHIP program are annual, on-going expenses.

Baseline and Projected Premium Revenue

The State does not collect premium in the current MCHIP; therefore, the baseline premium revenue is \$0.00. The projected premium revenue associated with the SCHIP program is expected to fall between \$18.22 PMPM for Scenario 2 and \$8.35 PMPM for Scenario 1. These premiums reflect an average by scenario across FPL levels as outlined in Table 4. The expected enrollment distribution for each scenario is 52 percent in the 100 percent FPL to 150 percent FPL range and 48 percent in the 150 percent to 185 percent FPL range. The projected premium does not vary between the A and B administration scenarios.

⁸ The State currently pays AccessMedicaid \$4.05 PMPM for education, informing, choice counseling, community health nursing and quality monitoring. Under SCHIP, the State would only need to have an entity perform the education, informing and choice counseling functions. Mercer assumed the State would be able to contract these services at about 25 percent of the AccessMedicaid rate.

Implementation Considerations and Timing

Implementation Timing

The implementation of SCHIP would require a Title XXI SPA to modify the existing MCHIP program into an SCHIP program. The SPA in Kansas could serve as a template for State staff use in developing/implementing this modification. Based on the following implementation process, it is anticipated the SCHIP will take 24 to 36 months to implement.

- Writing of SPA – estimated at 3 to 6 months
- CMS approval process – allows for 3 full 90-day review periods
- Competitively bid procurement process including writing contracts and procuring for health insurers – estimated at 9 to 12 months
- If the State chooses to fully outsource the SCHIP program, a second procurement may be needed for enrollment and premium collection. This procurement could occur simultaneously with the health insurer procurement .

Because Legislative Bill (LB) 1063 mandated implementation of a Medicaid expansion MCHIP program, legislation is necessary to implement a SCHIP program. The process to change statutory authority will likely add 6 to 9 months to the implementation timing.

Depending on the level of administration functions outsourced for the SCHIP program, Nebraska SCHIP staff would have to oversee the new plan option and be able to provide capitation payments to the health insurers and collect their encounter data at a minimum. The State currently has the MMIS capabilities from the administration of the managed care program to conduct these activities. It is expected that the current MMIS and the planned MMIS for 2011 will be able to accommodate the SCHIP with minimal system changes.

Delivery System

Currently, the State uses a PCCM, an HMO and FFS to administer its Title XXI program, just as it does its Title XIX program. With the SCHIP program, it is recommended that DHHS contract with health insurers across the State to limit its risk and provide protection to members and the State in a situation where the SCHIP allotment may be exhausted. These contracts would provide for a monthly capitation payment to the health insurers for each member and allow the State better budget predictability to determine the necessary enrollment cap to stay within the SCHIP allotment. This payment mechanism also protects the State from unexpectedly exceeding the allotment due to higher trends (or other factors) than anticipated and from unpredictable high-risk claims that may be incurred just prior to exhaustion of the allotted funds. Under the SCHIP program, the State would be fully responsible for any payments beyond the SCHIP allotment. By contracting with the health insurers, the State limits its risk to any monthly capitation payments beyond the allotment.

Many states, including Iowa, Kansas, Kentucky, Utah and Wyoming, use this contracting approach to provide medical services and reimburse the health insurers. In some cases, the states contract with HMOs similar to the current approach in Douglas, Lancaster and Sarpy counties. Other states have used indemnity companies allowing for broader networks and accessibility of services in rural areas. Nebraska could choose to provide services through an

indemnity insurer statewide or through a indemnity across the State, except in Douglas, Lancaster and Sarpy counties where a combination of indemnity and HMO offerings could be provided, similar to the current PCCM and HMO combination offering in the State.

Based on the anticipated volume of children in this program, the State should contract with only one vendor that can provide the necessary coverage statewide. The size of this SCHIP population borders on being too small to maintain a viable program that can absorb outlier, high dollar claims and may not be attractive to health insurers not currently participating in the Nebraska Medicaid and SCHIP market. However, Iowa manages a similar SCHIP program with a slightly smaller enrollment. At a minimum, the State should expect the PCCM and HMO vendors for the current Medicaid and Title XXI programs to compete for this program. They will both want to maintain their current Title XXI enrollment and bid for the opportunity to expand their enrollment from areas in the State where they are not currently enrolling SCHIP eligibles. Other states use plans that must participate in both Medicaid and SCHIP (e.g., Colorado) which would increase volume levels and the viability of the program, but may not provide an incentive for health insurers beyond those currently participating.

The health insurers would be responsible for most of the program administration, including provider network development, claims processing and payment and member services while the State would be responsible for program oversight, enrollee education and any community/media information needs, capitation payment and encounter data collection. Services for enrollment and premium collection could be administered by the State as they are today or they could be contracted out to qualified vendors. As previously discussed, the SCHIP option has been evaluated considering either scenario for the enrollment and premium collections administration.

Another advantage of contracting with health insurers is the flexibility it provides in meeting the SCHIP administration limit of 10 percent of the State's SCHIP annual allotment. Any administration for the insurer reimbursed by the State in capitation payments are not counted toward the 10 percent limit as those payments are considered to be medical payments. Only administration services provided by the State and/or outsourced, such as to enrollment and premium collection vendors, would be measured against the 10 percent requirement.

Enrollment

With a separate program for Title XXI, additional considerations need to be made for the administration of the SCHIP program. Although the Medicaid and SCHIP programs are separate programs, processes can be developed to simplify and streamline enrollment. As in Kansas, a simplified application/enrollment form can be used to access both Medicaid and SCHIP coverage. Eligibility is determined for either Medicaid or SCHIP based on income level and age. All applications are first reviewed for potential Medicaid eligibility. Those found ineligible for Medicaid are immediately screened for SCHIP eligibility. In addition, the form is used to ascertain current health insurance coverage as well as access to state employee coverage. Children found to have current health coverage are denied eligibility for SCHIP coverage.

If Nebraska chooses to outsource the SCHIP enrollment process, steps will be needed to ensure coordination between the State Medicaid enrollment staff and the contracted SCHIP enrollment vendor. For example, Kansas does outsource the enrollment process for the SCHIP program. Kansas has set up a central clearinghouse responsible for the initial processing and

eligibility determination for both Medicaid and SCHIP. The Medicaid state agency administers the portion of the clearinghouse responsible for the Medicaid determination and case maintenance. Contracted staff is responsible for all SCHIP processing and determinations, as well as ongoing case management.

Premium Collection

As outlined above under “Cost Sharing”, the SCHIP program design includes a premium for all children regardless of FPL. Under the current Title XXI program, there are no premiums. Therefore, additional support will be necessary to manage premium collection. This support can be provided through additional State staff or can be contracted out to a qualified vendor. Regardless of how the collection process is managed, the State will need to decide how frequently to require premium payment by families. The size of the premium and the frequency of the payment can be a deterrent to enrollment and also has a direct impact on the additional administrative support needed.

Other states have provided flexibility to their SCHIP families by allowing them the option of paying premiums on a monthly, quarterly or any other basis convenient to the family. Enrollment in these states is generally continuous for 12 months and redetermined annually. Under this situation, an enrollee’s family has a full year to meet their premium obligation. Notices are sent monthly outlining the amounts paid or due. At 45 days before the end of the eligibility period, a final notice is sent informing the enrollee that if the premium is not paid in full, coverage ends. An enrollee must pay all delinquent premiums, or provide information they are no longer in a premium paying status, before eligibility is redetermined.

Currently, Nebraska has six months of initial continuous eligibility and requires enrollees to notify the State on a monthly basis of any changes impacting eligibility after the initial six months. It is assumed the premiums will be collected on a quarterly basis, making premium collection less intensive and keeping payments for families at a reasonable level. The State may require an initial quarterly premium be paid up front with full payment of the initial six months due prior to the completion of the initial continuous eligibility period. The State will need to decide on a process for determining premium delinquency and allowing families the opportunity to pay their premiums in full before losing coverage after the first six months. It should be noted that statewide insurers may request the State consider on-going 6 month continuous eligibility in order to make the enrollment more predictable.

An additional component of premium collection relates to a federal requirement mandating that total cost sharing cannot exceed 5 percent of the family’s annual income. For the scenarios with moderate cost sharing, the premiums were established to ensure that the aggregate cost sharing for a family would not exceed this federal limit. However, for the scenarios with maximum cost sharing a mechanism will need to be established to monitor a family’s cost sharing against the 5 percent limit.

Many states have chosen to implement what is known as the “shoe-box” approach to monitoring cost sharing. Under this process, the individual is responsible for keeping track of cost sharing and submitting documentation to the state when the limit is reached. Once the state obtains and verifies the information, the state can update the medical card or provide a sticker for the card to reflect the limit has been reached.

Program Administration

While Medicaid eligibility must be performed by state employees, SCHIP eligibility can be performed by contract workers. This provides states with additional flexibility in the design of their SCHIP program administration. Many states have restrictions or freezes on FTE counts and have found it easier to use contract workers to manage enrollment and premium collection functions. When examining the option of outsourcing the administrative functions for the SCHIP program, the State should explore the following important considerations.

- **Ability to obtain additional State staff:** If the State is unable to obtain approval to increase staffing to accommodate the additional FTEs required to perform SCHIP administrative tasks, the State may have no choice but to outsource these functions. If the State outsources the SCHIP enrollment and premium collection functions, it will still be necessary to provide program oversight staff. It may be possible to use the current MCHIP resources in this capacity.
- **Number of program participants:** If there is not sufficient enrollment in the SCHIP program, it may be difficult to attract potential vendors willing to manage the enrollment and premium collection for the SCHIP program for a reasonable fee. The State currently has a contract for similar functions for other programs, and may be able to amend this contract to expand services to the SCHIP program without undue difficulty and at a more affordable level.
- **Administrative Efficiencies:** Depending on how centralized the administrative functions are within the state, it may be possible for the State to perform these activities more efficiently than an external vendor. The State may want to consider how easily the additional administrative tasks can be integrated into current functional processes.
- **Added Administrative Costs:** Outsourcing services is typically more costly than providing the services in house. Outside vendors are faced with different market demands as private firms in terms of compensation and benefits than is typical of the public sector. In addition, the outside vendors charge a fee for their services in addition to the direct cost of the service being provided. The State will want to consider if this is a necessary cost in light of the pressures of the other considerations above.



Appendix A

Nebraska's Medicaid Programs

MCHIP Program Summary

Implemented in two phases, Nebraska's MCHIP program provides health care coverage to targeted low-income uninsured children, from birth through age 18, in families with incomes at or below 185 percent of the FPL. Phase I of the MCHIP, implemented May 1, 1998, expanded Title XIX eligibility for children age 15 through 18, to 100 percent of the FPL. Phase II, implemented September 1, 1998, was a Title XXI expansion of the Medicaid program, raising income eligibility for uninsured children, from birth through age 18, to 185 percent of the FPL. In expanding through a MCHIP, Nebraska was able to use the same delivery system, benefit plan, provider network, payment levels and MMIS as the Nebraska Title XIX Program.

With the implementation of MCHIP, Nebraska adopted the name Kids Connection and began an aggressive outreach plan to enroll uninsured children into the MCHIP program. The re-naming of Title XIX for children under age 19 to Kids Connection was an intentional effort by DHHS to remove the stigma of the Title XIX program being associated with welfare programs and may also have had a positive impact on the number of families applying.

Under Title XXI, CMS encouraged states to implement changes to reduce barriers to enrollment for children in state medical programs including presumptive eligibility for children, reducing documentation requirements, eliminating asset requirements and allowing 12-month continuous eligibility. Nebraska adopted these changes for both the MCHIP and Title XIX programs for children with the implementation of the MCHIP program. Nebraska's Legislature reduced 12-month continuous eligibility for children to 6-month continuous eligibility upon initial eligibility, with month-to-month eligibility after the initial 6-month period, in a special Legislative session in July, 2002. Presumptive eligibility for children was then eliminated during the 2003 Legislative session.

To streamline the process, the Nebraska application for MCHIP and Title XIX was reduced from an 11-page form to a 1-page form, front and back. The application was revised to include brochure information and was created in color as a marketing tool for the program.

For MCHIP eligibility, a child must be a resident of Nebraska, under 19 years of age, not covered by health insurance (including Title XIX) and a US national, citizen, legal alien or permanent resident. In addition, the child must meet certain household annual income standards, which vary by age.

Nebraska’s Title XIX Medicaid program covers:

- Children under age 1 up to 150 percent of the FPL
- Children ages 1 to 5 up to 133 percent of the FPL
- Children ages 6 to 18 years of age up to 100 percent of the FPL

Nebraska’s Title XXI covers children with income over the Medicaid limits up to 185 percent of the FPL. Table 9 provides a summary of income standards for 2007 by family size and percentage of the FPL. There is no resource test for children in the Nebraska MCHIP program.⁹ Income eligibility is compared to the family’s countable income.

**Table 9: 2007 Poverty Level Guidelines¹⁰
(all states except Alaska and Hawaii, including DC)**

Family Size	Percent of Poverty		
	133%	150%	185%
1	\$13,579	\$15,315	\$18,889
2	\$18,208	\$20,535	\$25,327
3	\$22,836	\$25,755	\$31,765
4	\$27,465	\$30,975	\$38,203
5	\$32,093	\$36,195	\$44,641
6	\$36,721	\$41,415	\$51,079
7	\$41,350	\$46,635	\$57,517
8*	\$45,978	\$51,855	\$63,955

*For family units of more than 8 members, add \$3,480 for each additional member.

MCHIP eligible children are currently not subject to cost sharing in the form of co-payments, premiums, deductibles or co-insurance. Children in MCHIP are eligible for all the benefits of the Title XIX program, including EPSDT.

The average number of eligible children in MCHIP on a monthly basis in SFY 2006 was 23,700. The average monthly enrollment of MCHIP eligible children in Nebraska’s managed care program was 8,815 in SFY 2006. Table 10 presents Nebraska’s average monthly MCHIP eligibility in FFY 2006.

⁹ Nebraska MCHIP SPA, p. 22.

¹⁰ See <http://www.cms.hhs.gov/MedicaidEligibility/downloads/POV07ALL.pdf>

Table 10: MCHIP Monthly Eligibility for FFY 2006

Month	Count	Month	Count
October 2005	23,740	April 2006	23,527
November 2005	23,936	May 2006	23,411
December 2005	24,097	June 2006	23,194
January 2006	24,155	July 2006	23,099
February 2006	24,106	August 2006	23,145
March 2006	23,922	September 2006	23,499

From FFY 2002-2004, Nebraska's MCHIP program experienced large increases in eligibility and program costs. These increases resulted from a change in income treatment. As a result, 24,000 older children with higher income levels lost Title XIX eligibility and many of those children became eligible for MCHIP. From FFY 2004-2006, costs and eligibility have remained fairly stable, with total expenditures (federal and State general funds) of \$49,549,579 for MCHIP in FFY 2006. The administrative portion of the FFY 2006 estimate is \$2,814,032 for both the federal and State portions. While trends from FFY 2004-2005 continued to be high, the trend from FFY 2005-2006 has been flat. The categories with the largest trends include outpatient hospital, dental, therapies (occupational and speech) and laboratory and radiology. The majority of the program expenditures are generated in the 6 to 18 age group. The less than 1 and the 1 to 5 age groups combined account for about 25 percent of total cost, and the overall trend has been negative for these two age groups.

Appendix B includes exhibits summarizing MCHIP expenditures based on medical expenditures from Nebraska's Title XXI CMS 64 Report and administrative expenditures as outlined in the Nebraska Title XXI Annual Report for FFYs 2002 through 2006.

Nebraska Medicaid Reform

Medicaid expenditures in Nebraska have mirrored the experience of other states. Nebraska's expenditures for Title XIX and MCHIP have increased by 41.9 percent in the last five years. Medicaid and MCHIP consumed 17.2 percent of the Nebraska General Fund appropriations in SFY 2004-2005. In 2005, the State Legislature recognized the necessity for change and mandated Medicaid Reform through LB 709. In 2006, LB 1248 incorporated the reform suggestions into law.

The Medicaid program in Nebraska developed a set of Reform Initiatives, detailed in a final report submitted to the Legislature December 1, 2005. The purpose of Medicaid Reform is long-term savings to Nebraska and fiscal sustainability of all programs, including MCHIP. The bill also required DHHS to develop recommended alternatives regarding the provision of health care and related services for Medicaid-eligible children under MCHIP, as allowed under Title XIX and Title XXI of the Social Security Act. The study and recommended alternatives shall include, but not be limited to, the organization and administration of Title XXI; the establishment of premiums, co-payments and deductibles; and the establishment of limits on the amount, scope and duration of services offered to program recipients.

Covered Services

Nebraska's MCHIP provides health care coverage for qualified children age 18 years and younger. The program provides well care for children to help prevent disease, find and treat problems early and maintain good health and development. Regular check-ups include:

- Baby check-ups and immunizations
- Yearly check-ups for school age children, including school and sports physicals
- Immunizations for school age children
- Dental check-ups and dental sealants
- Vision and hearing tests

MCHIP also provides medical care for injuries and illnesses. Treatment includes:

- Doctor's visits
- Medications
- Hospital care
- Lab tests and x-rays
- Dental treatment
- Eyeglasses
- Specialty services for children with disabilities or chronic health conditions
- MH/SA assessment and treatment services
- Counseling

Currently there are no cost-sharing requirements for MCHIP enrolled children. If Nebraska chooses to implement cost sharing, including assessment of premiums, Nebraska already has a mechanism for collecting premiums. Nebraska has two eligibility groups for which premiums are collected; individuals receiving Transitional Medicaid Assistance with household incomes above 100 percent of the FPL, and Medical Insurance for the Working Disabled. For both groups, the family is billed at the beginning of the month. Premiums must be received by the 21st of the following month. A family is permitted to pay the premiums two to three months in advance.

Currently, all claims for the MCHIP children not enrolled in the capitated HMO are paid through Nebraska's MMIS. A new MMIS is planned for implementation by Nebraska in 2011.

Summary of Managed Care Program

Nebraska's managed care program was implemented on July 1, 1995. The program utilizes two models, a PCCM network and a HMO, in a designated geographic area. The geographic area includes Douglas, Sarpy and Lancaster counties. These models provide the basic benefit plan of medical/surgical services. Dental services and pharmacy services are carved-out and are reimbursed to providers on a FFS basis by Nebraska.

Enrollment in Nebraska's managed care program is mandatory for specified clients. In both models, the client chooses a primary care physician and a managed care plan in the enrollment

process. Nebraska contracts with one PCCM network administered by BCBS of Nebraska and one MCO, United Health Care of the Midlands (now an AmeriChoice product), known as ShareAdvantage. The community health nursing contractor/enrollment broker, Access Medicaid, provides enrollment and related activities through an interagency agreement with the Lincoln/Lancaster County Health Department. Of the total SFY 2006 MCHIP enrolled children, on average 8,815 children in Douglas, Sarpy and Lancaster were enrolled in one of the medical/surgical Medicaid managed care plans in a month.

The Nebraska managed care program also provides managed care for MH/SA services. Effective January 2002, Nebraska changed the management of the MH/SA component from a capitated/risk model to a non-risk model. The new MH/SA program structure operates under a contract with Nebraska Magellan Behavioral Health (MBH) as a SPCM system under 42 CFR 431.55(c)(1)(ii) and a 1915(b)(1) and 1915(b)(4) waiver. Changes to the programmatic and operational structure were minimal, with the exception of claims payment that became the responsibility of DHHS. Participation in the MH/SA SPCM is mandatory for specific clients in the medical/surgical program as well as clients with private insurance. Of the total SFY 2006 MCHIP enrolled children, on average 23,700 children were enrolled monthly in the MH/SA managed care plans.



Nebraska Title XXI Expenditures

Total Costs

Cost of Approved SCHIP	FFY 2002	FFY 2003	FFY 2004	FFY 2005	FFY 2006
Medical Service Costs from CMS 64	\$ 16,028,217	\$ 34,045,772	\$ 47,903,003	\$ 46,497,218	\$ 46,735,547
Administration Costs (Title XXI Annual Report)	\$ -				
Personnel	\$ 433,890	\$ 367,710	\$ 267,089	\$ 1,732,838	\$ 1,856,527
General Administration	\$ -	\$ -	\$ -	\$ -	\$ -
Contractors/Brokers (e.g., enrollment contractors)	\$ -	\$ -	\$ -	\$ -	\$ -
Claims Processing	\$ 120,934	\$ 468,290	\$ 835,572	\$ 906,908	\$ 881,199
Outreach/Marketing costs	\$ -	\$ -	\$ -	\$ -	\$ -
Other General administrative overhead	\$ 40,164	\$ 35,779	\$ 57,705	\$ 48,294	\$ 76,306
Health Services Initiatives	\$ -	\$ -	\$ -	\$ -	\$ -
Total Administration Costs	\$ 594,988	\$ 871,779	\$ 1,160,366	\$ 2,688,040	\$ 2,814,032
Total Costs of Approved CHIP Plan	\$ 16,623,205	\$ 34,917,551	\$ 49,063,369	\$ 49,185,258	\$ 49,549,579

CMS 64	FFY 2002	FFY 2003	FFY 2004	FFY 2005	FFY 2006
Premiums					
Up To 150% - Gross Premiums Paid	\$ -	\$ -	\$ -	\$ -	\$ -
Up To 150% - Cost Sharing Offset	\$ -	\$ -	\$ -	\$ -	\$ -
Over 150% - Gross Premiums Paid	\$ -	\$ -	\$ -	\$ -	\$ -
Over 150% - Cost Sharing Offset	\$ -	\$ -	\$ -	\$ -	\$ -
Medical Services					
Inpatient Hospital Services - Reg. Payments	\$ 2,077,917	\$ 5,297,900	\$ 7,023,234	\$ 5,510,246	\$ 5,615,976
Inpatient Hospital Services - DSH	\$ -	\$ -	\$ -	\$ -	\$ -
Inpatient Mental Health - Reg. Payment	\$ 511,165	\$ 1,360,720	\$ 1,883,042	\$ 2,106,457	\$ 2,196,988
Inpatient Mental Health - DSH	\$ -	\$ -	\$ -	\$ -	\$ -
Nursing Care Services	\$ 35,514	\$ 15,703	\$ 12,506	\$ 35,611	\$ 13,274
Physician/Surgical	\$ 2,139,282	\$ 4,463,120	\$ 5,953,726	\$ 5,913,603	\$ 5,805,151
Outpatient Hospital Services	\$ 1,696,801	\$ 3,222,935	\$ 4,017,742	\$ 4,555,743	\$ 4,939,921
Outpatient Mental Health	\$ -	\$ -	\$ -	\$ -	\$ -
Prescribed Drugs	\$ 2,982,033	\$ 6,796,323	\$ 10,997,228	\$ 9,841,986	\$ 9,889,713
Drug Rebate - National	\$ -	\$ -	\$ (874,298)	\$ (2,659,748)	\$ (2,958,611)
Drug Rebate - State	\$ -	\$ -	\$ -	\$ -	\$ -
Dental Services	\$ 1,921,638	\$ 3,482,238	\$ 3,784,626	\$ 4,515,099	\$ 4,786,587
Vision Services	\$ -	\$ -	\$ -	\$ -	\$ -
Other Practitioners	\$ 663,299	\$ 1,220,324	\$ 1,445,590	\$ 1,518,389	\$ 1,507,154
Clinic Services	\$ 1,236,559	\$ 3,270,842	\$ 6,941,786	\$ 7,164,261	\$ 6,514,989
Therapy Services	\$ -	\$ -	\$ -	\$ -	\$ -
Laboratory/Radiological Services	\$ 314,528	\$ 597,347	\$ 706,557	\$ 791,271	\$ 824,810
Medical Equipment	\$ 198,248	\$ 357,319	\$ 578,676	\$ 718,335	\$ 780,755
Family Planning	\$ 16,269	\$ -	\$ -	\$ -	\$ -
Abortions	\$ -	\$ -	\$ -	\$ -	\$ -
Screening Services	\$ 313,511	\$ 705,453	\$ 854,969	\$ 1,052,972	\$ 1,047,231
Home Health	\$ 12,690	\$ 69,524	\$ 277,885	\$ 102,655	\$ 43,970
Medicare Payments	\$ -	\$ -	\$ -	\$ -	\$ -
Home And Community	\$ -	\$ 1,750	\$ -	\$ -	\$ -
Hospice	\$ -	\$ -	\$ -	\$ -	\$ -
Medical Transport	\$ -	\$ -	\$ -	\$ 7,848	\$ 9,163
Case Management	\$ 1,155,563	\$ 1,281,047	\$ 2,577,733	\$ 3,249,918	\$ 3,470,437
Other Services	\$ 753,200	\$ 1,903,227	\$ 1,722,001	\$ 2,072,572	\$ 2,248,039
Total	\$ 16,028,217	\$ 34,045,772	\$ 47,903,003	\$ 46,497,218	\$ 46,735,547

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