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# Medicaid Alternative Benefit Structure Recommendations Report

State of Nebraska

**FINAL**

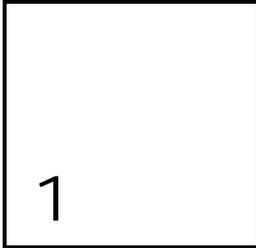
**MERCER**



MARSH MERCER KROLL  
GUY CARPENTER OLIVER WYMAN

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## Executive Summary

### Project Overview

The State of Nebraska (State) Medicaid budget continues to expand, and the number of eligibles continues to grow. Nebraska expended approximately \$1.45 billion on its Medicaid program during state fiscal year (SFY) 2007 on an average of 202,531 eligible persons each month during the year. To maintain the fiscal sustainability of the program, the Nebraska Department of Health and Human Services (DHHS) contracted with Mercer Government Human Services Consulting (Mercer) to assist in developing a series of reports related to alternative benefit structures that are consistent with State public policy, feasible for the State to implement and promote long-term savings.

Table A summarizes the State Medicaid incurred expenditures during SFY 2007 as provided through the State's Medicaid Management Information System (MMIS).

**Table A: SFY 2007 Nebraska Medicaid Incurred Expenditures**

Category of Service	SFY 2007 Dollars	Distribution of Dollars
Inpatient Hospital	\$218,831,495	15.1%
Outpatient Hospital	\$87,805,811	6.1%
Clinics and Day Treatment	\$65,732,310	4.5%
Physician	\$147,551,300	10.2%
Dental	\$33,923,684	2.4%
Nursing Facility	\$294,182,465	20.3%
Home Health	\$33,705,829	2.3%
Waiver Services	\$195,024,490	13.5%
ICF-MCR	\$66,131,281	4.6%
Pharmacy	\$142,595,372	9.9%
Other	\$83,988,240	5.8%
Managed Care Organization Capitation	\$76,617,789	5.3%
<b>Total</b>	<b>\$1,447,090,066</b>	<b>100.0%</b>

Based on the continuing pressures on the State budget, the legislature authorized the establishment of the Medicaid Reform Council which made recommendations for reform in many areas of the Medicaid program including benefits, cost sharing, nursing facilities and pharmacy. These recommendations were made to address the two main goals of the Medicaid Reform Council:

- Long-term cost savings
- Fiscal sustainability of the Medicaid program

One specific area of focus addressed by the Medicaid Reform Council is to explore options for the State that modify or replace the current defined benefit structure of the Medicaid program. With the passage of the Deficit Reduction Act of 2005 (DRA), and with increasing Medicaid budgets, several states have begun efforts to reform their Medicaid programs and implement defined contribution plans. The DRA has provided states with many new alternatives in designing their Medicaid programs without needing to use waiver authorities. In this report, information on various state initiatives is provided, as well as recommendations for Nebraska to consider when looking at alternative benefit structures.

## Recommendations

Information on defined contribution plans, Medicaid requirements around these plans and implementation considerations is provided in Section 2. In addition, Sections 3 and 4 outline the draft recommendations for alternative benefit structures for the Nebraska Medicaid program. While the quality of services provided, and access to those services are critical components of providing health care, the focus of these recommendations is on cost effectiveness first and finding ways to improve quality and access, if at all possible.

Section 3 of the report outlines recommendations focused on the delivery system used to provide Medicaid benefits. Those recommendations are briefly described below.

- **Recommendation 1 – Mental Health and Substance Abuse (MH/SA) Services:** Convert the existing administrative services only (ASO) delivery system to a full-risk managed care program.
- **Recommendation 2 – Long-Term Care (LTC) Services:** Convert the existing fee-for-service (FFS) delivery system for the services to a voluntary managed care program.
- **Recommendation 3 – Acute Care Mandatory Full-Risk Managed Care:** Transition the existing mandatory managed care program with a primary care case management (PCCM) option to a full-risk, capitated program with no PCCM option.
- **Recommendation 4 – Acute Care Statewide Managed Care:** Expand the existing managed care program with a PCCM and managed care organization (MCO) option statewide.

- **Recommendation 5 – Transportation Services:** Implement a fully capitated transportation broker model.
- **Recommendation 6 – Durable Medical Equipment (DME) Services:** Purchase DME through a competitive bidding process.
- **Recommendation 7 – Dental Services:** Establish an ASO for the provision of dental services.

Each of these recommendations includes an overview of the recommendation and the current delivery system, a financial impact analysis, implementation considerations and experience from other programs. A high-level outline of each of these recommendations can be found in Section 3 in Table D: Delivery System Recommendations.

Section 4 includes recommendations related to the Medicaid benefit design. These recommendations include similar evaluations to the delivery system recommendations. Table H: Benefit Recommendations in Section 4 highlights the following three recommendations:

- **Recommendation 8 – Modify Existing Copays:** Implement nominal copays to the level allowed by the Centers for Medicare and Medicaid Services (CMS).
- **Recommendation 9 – Copays and Premiums by Income:** Use new federal authority to implement cost sharing that varies by Federal Poverty Level (FPL) bands.
- **Recommendation 10 – Tiered Benefit Plan Design:** Use new federal authority to design benefit plans that vary by service need and may look more like commercial benefit plans.

Section 5 includes other options for the State to consider that could have a positive impact on the cost of the program and the quality of the services provided. These options include considerations for DME, home health services, assisted living services, in-hospital avoidable services and the State's Medicaid Integrity Program.

Legislative Bill 1248 of the 2006 Nebraska Legislative session required DHHS to develop recommendations for further modification of the defined benefit structure of the Medicaid program. Mercer developed this Medicaid Alternative Benefit Structure Recommendations Report to assist DHHS in complying with legislative requirements. This report presents the final recommendations for Medicaid Alternative Benefit Structures based on review of the Draft Medicaid Alternative Benefit Structure Recommendations Report by DHHS, the Medicaid Reform Council, and the Health and Human Services (HHS) Legislature Committee with consideration of public comments.

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## Defined Contribution in Medicaid

In 2005, the State undertook a study of its current Medicaid program to determine areas that could be reformed to ensure the long-term fiscal sustainability of the program. A resulting recommendation is to study the possibility of moving Nebraska's current Medicaid program, which exists as a defined benefit model, to a defined contribution model.

While employing defined contribution principles in various arenas can limit the financial liability to the program sponsor, federal Medicaid requirements limit the extent to which states can employ these principles. Therefore, the State has expanded the scope of this report to include an analysis of the potential impacts of making other structural changes to the program that could contribute to long-term fiscal sustainability. However, in this section of the report, there is a detailed overview of the implications of a defined contribution approach in Medicaid.

## Defined Benefit versus Defined Contribution

The State's current Medicaid program – like other traditional Medicaid programs – operates under a defined benefit model. Anyone meeting the eligibility requirements of the program is entitled to receive a certain set of established benefits. Under this model, costs vary based on the number of persons eligible and the amount of benefits they use. Under a defined contribution model, the State could pay a fixed amount per individual and benefits can vary, either by eligibility group or from one year to the next. This can help to stabilize costs to the State as the amount of expenditures does not change with increased utilization and/or unit costs.

Many employers in the private sector have moved towards defined contribution models in providing health insurance benefits. For example, many employers have adopted Health Savings Accounts (HSAs) in which an employer (or the individual in the case of an individual policy) contributes a certain amount of money to an account that can be spent on health services. This account is coupled with a lower cost, high-deductible

insurance policy to ensure coverage for catastrophic events. Employers can limit their liability by contributing a set amount to the account. Arguably, it is much easier for private sector employers to move to such a model than for a Medicaid program to do so. Because Medicaid is a program that covers many vulnerable populations, there are many legal and regulatory requirements in providing services to eligible individuals and restrictions on costs borne by Medicaid recipients.

## Medicaid Requirements

Federal requirements limit the flexibility that states are granted in adopting a defined contribution program. There are certain key requirements of Medicaid state plans that must be addressed when considering a move from a defined benefit model to a defined contribution model. These considerations include:

- Which population may be included in a defined contribution program?
- Which benefits may be included in the program?
- How will the State address the requirements for statewideness and comparability of benefits?

The following outlines the requirements around Medicaid eligibility and services to illustrate the specific areas that limit a defined contribution approach in a Medicaid program.

### ***Eligibility for Medicaid***

In considering a defined contribution model, states must recognize that flexibility is dependent upon the population covered. States are mandated to cover certain populations,<sup>1</sup> and the flexibility for implementing a defined contribution model is limited for these groups. For example, states have very limited flexibility in changing the services they provide to pregnant women and children. States also have the option of covering additional groups beyond the mandatory eligibility groups.<sup>2</sup> These groups

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<sup>1</sup> Mandatory populations include: limited-income families with children; most Supplemental Security Income (SSI) recipients; infants born to Medicaid-eligible pregnant women; children under age 6 and pregnant women at or below 133% of the federal poverty level (FPL); children under age 19 at or below 100% of the FPL; recipients of adoption assistance and foster care; certain people with Medicare; and other special protected groups.

<sup>2</sup> States have the option to cover populations with income limits beyond the federally mandated minimums. States can also cover certain other groups, including infants under age 1 and pregnant women whose family income is below 185% of the FPL; optional targeted low-income children; certain aged, blind, or disabled adults who have incomes below 100% of the FPL; children under age 21 who meet income and resource requirements for aid to families with dependent children (AFDC), but who otherwise are not eligible for AFDC; certain institutionalized individuals; recipients of state supplementary payments; certain low-income Tuberculosis-infected persons; and low-income, uninsured women in need of treatment for breast or cervical cancer.

represent the eligibility groups with the most flexibility for states in terms of implementing a defined contribution approach.

### ***Services Covered***

One approach states have taken to move towards a defined contribution model is to limit the benefits offered to certain populations. The implementation of a defined contribution model must take into consideration the fact that services for pregnant women and Early Periodic Screening, Diagnosis and Treatment (EPSDT) must be fully covered. Other mandatory services must be sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished.<sup>3</sup>

### ***Statewideness and Comparability***

Defined contribution approaches generally rely on limiting benefits for certain populations; however, states cannot implement such changes without consideration of current Medicaid laws and regulations. Specifically, states must receive a waiver or work within existing laws to implement defined contribution approaches that would not meet the statewideness and comparability criteria.

The statewideness criterion mandates that coverage of State Plan services cannot differ based on geography within the state. State Plan services must meet the comparability criterion in which the amount, duration and scope of benefits does not vary across populations. Given that limiting benefits for specific populations is a key component of most defined contribution models, states must address this criterion either through a waiver or through the use of exceptions in current law.

## Options for Implementing Defined Contribution Approaches

Two options states have considered for implementing defined contribution approaches include:

- 1115 Demonstration Waivers
- State Plan Amendments (SPAs) Under the DRA

Each of these vehicles has different limitations and levels of flexibility with regard to Medicaid regulations.

Because the goal of this report is to look at options that will promote the long-term fiscal sustainability of the Nebraska Medicaid program, the following provides an overview of

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<sup>3</sup> Mandatory services include inpatient and outpatient hospital services, laboratory and x-ray services, nursing facility services, home health services, nursing services, clinic services, physician services, medical and surgical services of a dentist, nurse practitioner services, nurse midwife services, pregnancy-related services, medical supplies, and EPSDT services for children.

defined contribution approaches that do not expand coverage and have the potential to decrease costs.

### ***1115 Demonstration Waivers***

One mechanism for providing a defined contribution approach in a Medicaid program is to apply for an 1115 demonstration waiver. 1115 waivers allow states a large degree of flexibility in waiving statutory and regulatory requirements under Section 1902 of the Social Security Act, as well as providing funding for individuals, services or payment methodologies that do not meet current federal requirements. Through 1115 waiver authority, states can apply for the ability to expand eligibility, modify benefits, impose cost sharing, restrict provider choice, expand managed care, provide premium assistance and implement programs in limited geographic areas. CMS can also grant states a waiver of comparability for mandatory and optional groups, with the exception of pregnant women and children, under 1115 waiver authority.

Historically, CMS granted waivers of comparability to provide different eligibility groups with additional benefits not available to all groups. Florida received a waiver of comparability that allows the state to offer different benefits to different eligibility groups with the goal of stabilizing costs while providing benefits to the populations in need. Florida is the only state that has a waiver of comparability in which it can create a flexible benefit package, as opposed to offering additional benefits to certain groups.

There is no pre-print for 1115 research and demonstration waivers. Each 1115 demonstration waiver is written by the state applying for waiver approval. As a result, developing 1115 demonstration waivers usually requires a significant amount of time. However, because states negotiate individually with CMS, there may be an opportunity to propose more novel approaches. As described later in this paper, Florida opted to apply for an 1115 waiver to implement its defined contribution model.

### ***State Plan Amendments (SPAs) Under the DRA***

Another vehicle for providing a defined contribution approach to Medicaid is to design a SPA under the DRA. States can use SPAs to provide flexibility in benefit packages without regard to statewide, comparability or freedom of choice for certain eligibles. The DRA contains specific legislation related to benchmark plans and defined contribution programs. Section 6044 of the DRA allows states to change their Medicaid benefit packages to mirror certain commercial insurance packages through the use of benchmark plans. The benchmark plans are the same as those allowed in State Children's Health Insurance Program (SCHIP); the DRA builds on SCHIP authority to move people into healthcare delivery systems that do not mirror the State Plan benefit package.

In addition to benchmark plans, Section 6082 of the DRA provides for ten states to operate demonstration programs to test alternative systems to deliver Medicaid benefits through a Health Opportunity Account (HOA) in combination with a high-deductible health plan. The HOA portion of the DRA provides an opportunity for states to pursue a

defined contribution approach that mirrors HSA programs in the private market. By using HOAs in conjunction with high-deductible health plans, states can limit their liability for current Medicaid eligibles more so than by using other Medicaid reform vehicles. HOAs are similar to HSAs available in the private sector. HOAs combine a health expenditure account with a high-deductible health plan. The DRA allows contributions to be made to HOAs by states and/or charitable organizations, although federal match is provided only for contributions made by states. States may impose limitations on the total balance and the total annual contributions to an HOA. In addition, the DRA requires that the total annual contribution (state and federal shares) to an HOA must not exceed \$2,500 for adults and \$1,000 for children. If states exceed these limits, the excess state contributions are not eligible for federal match. These dollar limits will be adjusted each year to account for inflation.

HOAs may only be used for payment of medical care or for the purchase of health insurance coverage. If a recipient with an HOA becomes ineligible for benefits, then no additional contributions can be made to the HOA, the balance of the account is reduced by 25%, and the remaining funds are made available to the recipient until three years after the end of eligibility.

In addition to benchmark plans and HOAs, SPAs under the DRA have several characteristics that differ from the other vehicles for Medicaid reform. DRA SPAs allow states to charge premiums for certain enrollees (including children) above 150% of FPL and to implement cost sharing up to 20% of medical costs. Also, DRA SPAs allow states to make payment of premiums and copayments enforceable (i.e., providers can deny services without payment of copayment). The total premium and cost sharing levels are limited to 5% of family monthly or quarterly income.

SPAs under the DRA also have several limitations. First, wrap-around benefits are required for children under 19 covered by the State Plan. Second, DRA SPAs are not a mechanism for expanding coverage; the flexibility provided by the DRA is limited to groups covered prior to February 8, 2006. Third, many eligibility groups cannot be required to enroll in alternative benefit (benchmark) plans, including pregnant women, the Social Security Income (SSI) population and dual eligibles.

More detail on these approaches is provided in Section 4 of this report.

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## Delivery Systems

### Overview

In evaluating alternative benefit structures for the Nebraska Medicaid program, Mercer considered the delivery systems currently being used by the State to provide Medicaid benefits. This section of the report provides recommendations on changes to the current delivery systems for certain services and/or populations. These recommendations are offered as options to assist the State in achieving its Medicaid Reform goals of long-term savings and fiscal sustainability of the program.

These alternative delivery systems may benefit the State by reducing costs, managing the rate of expenditure growth, improving quality and access, centralizing administrative functions and providing additional fraud and abuse management. Each recommendation includes an outline of the current delivery system, a description of the recommendation, the financial impact of the recommendation, implementation considerations and the experience of other programs. The recommendations for alternative delivery systems are listed below. Table D at the end of this section also summarizes each recommendation in terms of the implementation considerations, the financial impact and other items to consider for feasibility in the State.

- Recommendation 1 – Mental Health and Substance Abuse (MH/SA) Services
- Recommendation 2 – LTC Services
- Recommendation 3 – Acute Care Mandatory Full-Risk Managed Care
- Recommendation 4 – Acute Care Statewide Managed Care
- Recommendation 5 – Transportation Services
- Recommendation 6 – DME Services
- Recommendation 7 – Dental Services

Currently, Nebraska utilizes a managed care program in Douglas, Sarpy and Lancaster counties to provide the basic benefit plan of medical/surgical services. The managed care program provides recipients the option between a PCCM network and an MCO.

Dental and pharmacy services are carved-out of the managed care program and are reimbursed to providers on a FFS basis by the State. Outside of Douglas, Sarpy and Lancaster counties, and for all services except MH/SA, the State operates a FFS Medicaid program.

The State also provides MH/SA services through a statewide specialty physician case management (SPCM) system under 42 CFR 431.55(c)(1)(ii) and a 1915(b)(1) and 1915(b)(4) waiver. Participation in the MH/SA SPCM is mandatory for specific clients in the medical/surgical program as well as clients with private insurance, dual Medicare/Medicaid enrollees and those participating in the Subsidized Adoption program. Under this delivery system, claims payment is the responsibility of DHHS. DHHS also provides contract management and program oversight. The SPCM is responsible for all other aspects of the program management.

## Recommendation 1: Mental Health and Substance Abuse (MH/SA) Services

Mercer recommends Nebraska consider implementing a full-risk managed Medicaid behavioral health program for all Medicaid beneficiaries.

### **Overview**

The State currently reimburses for MH/SA services on a FFS basis. For prior authorization and utilization review, the State contracts with Magellan Behavioral Health on an ASO basis. The ASO arrangement has been in place since 2002, with the current contract in force until 2010. Prior to 2002, the State operated a full-risk managed behavioral health program.

Nebraska currently spends approximately \$120 million dollars on Medicaid MH/SA services per year. This cost has increased 8% from 2005 to 2007. Many states have turned to managed care to help control cost increases for behavioral health services.

To operate a full-risk managed Medicaid behavioral health program, the State would need to procure the services of a behavioral health managed care organization (BH-MCO). The State would reimburse the BH-MCO on a capitated basis, where the State would pay a fixed amount per member per month (PMPM). The BH-MCO would provide all medically-necessary covered behavioral health services and retain all financial risk for the services covered under the contract.

### **Financial Impact**

Managed Medicaid behavioral health programs have generally saved states money. The savings are generated by redirecting services from inpatient or 24-hour levels of care to

outpatient or community settings, where appropriate. In addition, BH-MCOs also employ prior authorization and utilization review of inpatient and outpatient services to ensure all services are medically necessary and of the appropriate scope or duration. Under managed care, the administrative costs of the BH-MCOs are greater than under an ASO or FFS program to finance the additional contract responsibilities and care management.

In 2007, Nebraska spent approximately \$50 PMPM on MH/SA services in Medicaid. In addition, Nebraska reimbursed the ASO contractor approximately \$1 PMPM for utilization management responsibilities. These costs are similar to a number of states that have pursued behavioral health managed care. Other states have saved 15%-20% on behavioral health service expenses upon implementation of managed care. The actual program savings are lower due to the additional administrative expenses under managed care. These administrative expenses are related to the BH-MCO administrative expenses as well as state contracts for actuarial services, external quality review organizations (EQROs) and other services necessary to operate a managed care program. Based on Mercer's experience, the administrative costs for the BH-MCO and other state contracts may range from 10% to 12% for programs of similar size to Nebraska. This would put program savings between 3% and 10% of behavioral health expenses.

Since the Nebraska program currently operates under an ASO contract, where prior authorization and utilization review of inpatient care is occurring, Mercer estimates the savings related to behavioral health managed care to be at the lower end of the range or 3% to 5% of program expenses. Based on SFY 2007 spending of \$120 million, this translates into \$3 to \$6 million in savings.

Much of this savings is accrued in the first few years of the program. Over the long term, managed behavioral health programs also slow the rate of expenditure growth. Based on Mercer's experience, the mitigation of long-term trends could be worth an additional 1% in annual program savings.

In the first year of transition from the current ASO program to the full-risk program, the State will need to consider the increased cash flow requirements as a result of claims payment timing changes. While the capitation payments to BH-MCOs begin immediately upon program implementation, the State will still be paying for claims incurred previous to the implementation date for enrollees new to the BH-MCOs. The ultimate cost to the State is unchanged, but the capitation structure effectively pushes the claim payment timing up. The State could expect the ongoing payment of FFS claims to be about 15% of annual claim costs. This would equate to an approximate \$18 million in additional cash flows. There are strategies to help mitigate this increased cash flow.

## ***Implementation***

To implement a behavioral health managed care program, the State will need to obtain the necessary authority from CMS, determine the program requirements and procure the services of a BH-MCO.

Nebraska currently operates the SPCM program under a 1915(b) waiver. This waiver would need to be amended to obtain approval for a full-risk capitated behavioral health program. This should be straightforward as this was the structure of the previous Nebraska waiver, and similar to other states' managed care waivers. CMS would likely require a similar waiver review timeline as they have for the previous SPCM renewals.

To operate full-risk capitated managed care, the State will need to contract for actuarial services to develop rates in accordance with federal regulations. The State will also need to procure the services of an EQRO to perform required quality reviews of the managed care program. In addition, the State will need to create the specifications for encounter data collection to support monitoring and rate-setting analyses. These additional State expenses have been reflected in the savings estimate for this recommendation.

The State will need to consider a number of issues in determining the design and coverage considerations of a managed Medicaid behavioral health program.

- **Should program enrollment be mandatory?** With the notable population exceptions to mandatory enrollment identified in federal regulation, Mercer recommends a mandatory enrollment policy. This will ensure the program covers the broadest population and prevents risk selection issues associated with voluntary programs.
- **Should dual eligibles be included in managed care?** Most states include dual eligibles in managed Medicaid behavioral health programs. Medicare coverage of behavioral health services is limited, so the duals benefit from the coordination of care offered under a managed care arrangement.
- **What services should be included in the full-risk capitation?** Most states include all MH/SA services covered in the State Plan. Nebraska would also want to include the 1915(b)(3) services covered under the waiver. Behavioral health prescription drugs are typically carved-out of the capitation payment and reimbursed either through a physical health MCO or FFS.
- **Should a risk-sharing mechanism be used in the contract?** Risk sharing is an option for the State and the MCO to share in the financial gains and losses of the managed care program. These arrangements may help attract MCOs concerned about the financial risks of the contract, and also provide protection to the State in the event of high initial profits. Other states use these arrangements for a transitional phase in the initial years of a managed care contract. The main drawback is the potential settlement payment after the close of the year as well as additional program oversight, which may reduce the potential for savings.
- **How many MCOs should be contracted for this program?** Mercer recommends the State seek a single contractor for managed Medicaid behavioral health services. Given the size and rural nature of some of the program, multiple contractors would likely not be a feasible option.

The implementation process would typically take 12 to 18 months to complete. The process would include a request for proposal (RFP) to procure the services of a

BH-MCO. This timeline could coincide with the end date of the current ASO contract in June 2010.

### ***Experience of Other Programs***

Many states have designed and implemented managed Medicaid behavioral health programs. These states rely on capitated payment systems to reimburse contractors for providing the services covered under the contract. The main differences are whether the contract is statewide versus county or regional based and which entity serves as the primary contractor.

- **Statewide, Private BH-MCO Contract** – The State of Iowa operates a managed Medicaid behavioral health program under a single contract with a private BH-MCO. Given the size and demographic similarities of the programs, this seems like the most feasible option for Nebraska.
- **County or Regional-Based Contracts** – The Commonwealth of Pennsylvania has operated their managed Medicaid behavioral health program through county-based contracts, where the State makes capitation payments to the county programs who either operate the managed care program themselves or subcontract to a private BH-MCO. This program has been phased in over a period of ten years. The State of North Carolina also operates a regional managed care pilot with a five county program operating as the BH-MCO.
- **Involvement of Community Mental Health Centers (CMHCs)** – The State of Colorado operates a managed care program with regional contracts with private BH-MCOs. Many of the BH-MCOs in this model subcontract a majority of the capitation rate to the CMHCs. The State of Kansas also involves the CMHCs directly in the contracting for behavioral health services through an ASO model.

While these programs have different designs, each program has operated successfully and generated savings for the states. Again, based on the characteristics of the Nebraska program, a statewide, private BH-MCO contract would be the recommended option.

## Recommendation 2: Long-Term Care (LTC) Services

Mercer recommends Nebraska explore the feasibility of Managed Medicaid LTC (MMLTC) by issuing a Request for Information (RFI) to gauge interest of qualified vendors. If the potential bidder input from the RFI confirms managed LTC as a viable option for the bidders and the State, Mercer recommends Nebraska consider implementing a voluntary MMLTC program.

### ***Overview***

The State currently reimburses for LTC services on a FFS basis. LTC services consist of nursing facility services, home and community-based waiver services (HCBS), assisted living services and services provided in an intermediate care facility for mental retardation. In 2007, Nebraska spent over \$500 million on LTC services. Across all LTC

programs, Nebraska spends 65% of spending on nursing facility and Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) services and 35% on HCBS and home health services for individuals with physical health needs and developmental disabilities. Managed LTC programs are traditionally designed to focus on the physical health needs of older adults and persons with physical disabilities.

For older adults and persons with physical disabilities, Nebraska spends 84% of LTC funds on nursing facility services and 16% on HCBS. The national average is 75% of LTC funds on nursing facility services and 25% on HCBS. Nebraska has made strides from 2001 to 2006 to rebalance this spending from 9% on HCBS in 2001 to 16% on HCBS in 2006. Other states have taken more aggressive approaches to rebalance their LTC spending. Minnesota has increased HCBS spending from 19% of LTC in 2001 to 40% in 2006. This is largely driven by additional LTC spending in HCBS services rather than significant reductions in nursing facility services.<sup>4</sup>

Nebraska continues to focus on LTC rebalancing efforts, as evidenced by the planned LTC initiatives. Nebraska was awarded a \$27 million Money Follows the Person grant from CMS to enhance the access to LTC options. This grant aims to transition an additional 900 individuals from nursing facilities and ICF/MRs into HCBS. Nebraska is also conducting a review of the nursing facility reimbursement rates, which could impact the nursing home spending as well. The State has also received approval to increase the number of people served in their Aged and Disabled waiver by approximately 50% from 2007 to 2011.

LTC services will continue to be a costly expense category for the state and taxpayers. Due to the aging population, the overall utilization and cost of LTC services will increase. MMLTC presents an option to help control cost increases in this category and provide care to the population in need in the most cost-effective manner possible. There are four primary MMLTC models utilized by states.

1. **Program of All-inclusive Care for the Elderly (PACE)** – These programs capitate managed care plans specifically for the frail elderly population and integrate service delivery with Medicare. The capitated program covers all Medicaid services for individuals 55+ who meet nursing facility level of care criteria. Mercer understands the State is developing an RFP for the implementation of a PACE site in Omaha. Based on this ongoing activity, and that PACE eligibility is not just limited to Medicaid eligibles, Mercer did not explore this option for recommendation of an alternative benefit structure.
2. **Pre-PACE Programs** – These programs are capitated for Medicaid services only. These are transitional programs that are expected to eventually become PACE programs.

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<sup>4</sup> Kassner, Enid, Susan Reinhard, Wendy Fox-Grage, Ari Houser and Jean Accious – AARP Public Policy Institute with Coleman, Barbara and Dann Milne – Consultants. "A Balancing Act: State Long-Term Care Reform," AARP, July 2008.

3. **MMLTC Non-Integrated Plans** – These plans do not coordinate services between Medicaid and Medicare. Rather, Medicaid services are provided by a Medicaid MCO, while Medicare services are reimbursed FFS or by a Medicare Advantage plan. The populations covered are broader than PACE programs.
4. **MMLTC Integrated Plans** – These plans coordinate services between Medicaid and Medicare both of which are capitated. The beneficiary is enrolled in the same managed care plan for both programs. Again, these programs cover a broader population than PACE.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 provides for a more coordinated approach for LTC for dual eligibles through the establishment of Medicare Advantage Special Needs Plans (SNPs). These integrated plans provide for better coordination between Medicaid and Medicare, and focus on preventive services and improved administrative efficiencies. Many states have been exploring the opportunities for enrollment of dual eligibles in SNPs as a way to manage LTC services. As of December 2007, two SNPs were operating in Nebraska and may be potential vendors for MMLTC.

In order to operate a full-risk MMLTC program, the State would need to procure the services of a MCO. In the past, Nebraska has had challenges attracting MCOs to participate in the State's Medicaid program. Mercer recommends issuing a RFI to gauge the interests of potential vendors in the MMLTC marketplace, and solicit feedback on the implementation considerations outlined later in this recommendation section. Interested vendors may include the UnitedHealth Evercare plan that currently operates the SNP plan in Omaha.

### ***Financial Impact***

MMLTC care programs are still relatively new programs in the managed care landscape. As a result, the financial impact of these programs is still being evaluated. The published research indicates MMLTC has resulted in decreases to certain high-cost services including inpatient hospital, emergency room (ER) and nursing facility stays. These utilization changes result in reduced medical service expenses. MMLTC programs involve managed care administrative responsibilities of the MCO as well as state contracts for actuarial services and EQRO, which offset much of the medical services savings. The research suggests initial annual savings in the range of 0% to 2% of PMPM costs. These savings are largely a moderation of future cost increases rather than an actual reduction in program expenses. Mandatory managed care programs can generate greater annual savings as the programs mature.

As LTC demand and costs continue to rise, MMLTC provides a mechanism to help states control the rate of expenditure growth by ensuring appropriate services are provided in the most cost-effective setting. The major areas of medical cost savings are as follows:

- **Managed Care Savings** – Resulting from the management of acute and LTC service utilization and reduced future medical trends.

- **Medicare Integration Savings** – For integrated MMLTC, savings are achieved through reduced duplication of services and potential funding of certain Medicaid services by Medicare depending on the levels of Medicare reimbursement.
- **Nursing Home Diversion** – MMLTC addresses care needs earlier to delay transition from the community to an institution and accelerate transition from the institutions to the community.

For a voluntary MMLTC program, Mercer would estimate potential savings as 1% of current LTC spending. Depending on the range of LTC services covered under MMLTC, and whether the program is piloted in select counties or implemented statewide, this 1% savings would equate to a range of \$2 to \$5 million dollars in potential savings for the State. The ability to achieve these savings is contingent on finding a viable contractor to participate in the managed care program.

As discussed in Recommendation 1, the State will need to consider the increased cash flow requirements due to claims payment timing changes as a result of a transition to full-risk managed care. The ultimate cost to the State is unchanged, but the capitation structure effectively pushes the claim payment timing up. The State could expect the ongoing payment of FFS claims to be about 15% of annual claim costs. This would equate to an approximate \$75 million in additional cash flows. There are strategies to help mitigate this increased cash flow.

### ***Implementation***

To implement a successful managed LTC program, the State will need to allocate sufficient time for the RFI and program design process (between 18 and 24 months). After completion of the RFI and identification of interested MCO partners, the State should begin the design and RFP process at least 12 to 18 months prior to program implementation. There are a number of decisions that would need to be addressed and potential waiver authority requested from CMS.

Nebraska currently operates a CMS-approved 1915(c) waiver for the Aged and Disabled population. The State will need to discuss with CMS whether a separate 1915(c) waiver is necessary for a managed LTC program. The State will also need to obtain 1915(a) authority to operate a voluntary program or 1915(b) authority to operate a mandatory program. 1915(a) authority would require a SPA. 1915(b) authority would require an amendment to the State's 1915(b) waiver to add a Medicaid eligibility group for the new managed care program.

To operate capitated managed care, the State will also need to contract for actuarial services to develop rates in accordance with federal regulations. In addition, the State will need to procure the services of an EQRO to perform required quality reviews of the managed care program. Many programs rely on individual assessments of clients to determine whether the client meets the nursing facility level of care criteria, and therefore, meets eligibility requirements for the program. To the extent the State designs their MMLTC based on assessments, this may increase the burden on the entity

performing the assessments. The State will also need to create the specifications for encounter data collection to support monitoring and rate-setting analyses. These ongoing program costs were reflected in the savings analysis provided earlier for this recommendation.

In planning a managed LTC program, it is helpful, if not imperative, to have a high level of political support for the program. In addition to political support from elected and appointed government officials, strong stakeholder support of a managed LTC program can be very helpful to its success. By involving stakeholders early, they may become partners in developing the program.

The State will also need to consider a number of issues in determining the design and coverage considerations of a MMLTC program.

- **Should program operate statewide or be piloted in select counties?** Managed LTC is very limited outside of urban and suburban areas. While other states have implemented programs statewide, participation has largely been limited to urban and suburban areas. Nebraska may wish to consider a similar pilot as the current MCO contract which operates in three counties.
- **Should program enrollment be mandatory?** Many programs operate under the authority provided under 1915(a) for voluntary contracts. Recently, states have begun to implement mandatory managed care programs, which cover the broadest population and provide for additional cost saving opportunities.
- **Which populations should be included in MMLTC?** Should the State limit enrollment to beneficiaries meeting a certain level of need (nursing facility or HCBS)? Or, should the program cover a broader population, which could provide opportunities for management of conditions before LTC services are needed? Many states focus these programs on older adults and persons with physical disabilities.
- **What services should be included in the full-risk capitation?** Including LTC, acute and behavioral health in the same benefit package allows for comprehensive care and prevents cost-shifting to other payors.
- **Should a risk-sharing mechanism be used in the contract?** Risk sharing is an option for the State and the MCO to share in the financial gains and losses of the managed care program. These arrangements may help attract MCOs who may be concerned about the risks of the contract and also provide protection to the State in the event of high profits.
- **Should the State focus on integrated plans with Medicare?** This provides the most coordinated option for dual eligibles and may provide additional savings to the State depending on the Medicare reimbursement and benefit package the SNP is offering.

These issues are critical to the design of an effective MMLTC program that attracts viable MCO partners to serve the Nebraska LTC population. The State should consider these questions as they develop the RFI for MMLTC.

## ***Experience of Other Programs***

Given the cost pressures related to LTC programs, states have explored managed care options to help control LTC expenses. To date, fewer than ten states have implemented MMLTC outside of PACE programs. The two states with MMLTC programs that most closely align with Nebraska demographics and population size are Minnesota and Wisconsin. Both of these states have operated MMLTC programs for the last ten years. The following are brief descriptions of each program, with a focus on the implementation issues discussed above.

### ***Minnesota***

Minnesota has made significant strides in rebalancing spending on LTC services by significantly increasing the proportion of spending on HCBS for older adults and persons with physical disabilities from 20% in 2001 to 40% in 2006.<sup>5</sup> Minnesota has managed the cost increases of this HCBS expansion through the operation of two MMLTC programs.

Minnesota Senior Health Options (MSHO) provides services to people ages 65 and older who are dually eligible for Medicare and Medicaid. The eligible populations include all dual eligibles including “healthy” duals and the nursing home certifiable population. This program covers comprehensive services including acute care and LTC through a capitation rate. Enrollment in the program is voluntary and is integrated with Medicare. Medicaid eligibles who choose not to enroll in MSHO are automatically enrolled in Minnesota Senior Care (MSC). MSC and Senior Care Plus provide a similar benefit package to the elderly population who choose not to enroll in MSHO. Most Medicaid eligibles choose to enroll in MSHO because of the integrated model with Medicare, especially for prescription drug coverage. For those eligibles who choose not to enroll in MSHO, the MSC enrollees must sign up with a separate Medicare Part D plan to receive prescription drug coverage.

### ***Wisconsin***

Wisconsin has taken a piloted approach to managed LTC. The Family Care program has operated as a demonstration project in five counties since 1998. This program has contributed to rebalancing of spending on LTC services by increasing the proportion of spending on HCBS from 23% in 2001 to 27% in 2006.<sup>6</sup> The State is considering plans to expand the program on a statewide basis.

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<sup>5</sup> Kassner, Enid, Susan Reinhard, Wendy Fox-Grage, Ari Houser and Jean Accious – AARP Public Policy Institute with Coleman, Barbara and Dann Milne – Consultants. “A Balancing Act: State Long-Term Care Reform,” AARP, July 2008.

<sup>6</sup> Kassner, Enid, Susan Reinhard, Wendy Fox-Grage, Ari Houser and Jean Accious – AARP Public Policy Institute with Coleman, Barbara and Dann Milne – Consultants. “A Balancing Act: State Long-Term Care Reform,” AARP, July 2008.

Family Care covers LTC services for older adults and persons with disabilities through a capitated rate to Care Management Organizations. The program does not include acute care services, which has been a complaint by the Care Management Organizations in the past. Enrollment in the program is voluntary. The program is not integrated with Medicare.

Studies of the Family Care program have indicated savings on medical services compared to the population served under the FFS program. These savings were primarily related to the management of the LTC services, since the other acute care services were not included in the capitated rate.

### Recommendation 3: Acute Care Mandatory Full-Risk Managed Care

Mercer recommends Nebraska consider transitioning the current mandatory managed care program with a PCCM option to a full-risk, capitated program without a PCCM option. This will require contracting with at least one other MCO in the three counties currently served through mandatory managed care.

#### **Overview**

The State currently operates a mandatory managed care program with an option between an MCO program alongside a PCCM network in Douglas, Sarpy and Lancaster counties. Cost of, quality of and/or access to care would potentially be improved by moving to a fully capitated MCO program with no PCCM option. For the mandatory managed care program to support the MCO capitation model; however, the State will need to contract with more than one MCO.

In order to attract additional MCOs to participate and determine the overall feasibility of the program, the State could perform an RFI process, soliciting comments and concerns from potential MCOs and other stakeholders. From the responses, the State may identify appropriate steps to take to make program participation more attractive to additional MCOs.

#### **Financial Impact**

Medicaid managed care programs have generally saved states money. The savings are generated by redirecting services from inpatient or 24-hour levels of care to outpatient settings, where appropriate. In addition, MCOs also employ prior authorization and utilization review of services to ensure all services are medically necessary and of the appropriate scope or duration. Disease management and case management programs help to coordinate and encourage appropriate and effective treatment and treatment compliance. Under MCOs, the administrative costs are greater than under a PCCM or FFS program to finance the additional contract responsibilities and care management.

Mercer generally expects savings for children and parents moving into full-risk managed care to be in the range of 4% to 8% of costs. Savings for the non-dual eligible disabled

adult population are typically slightly higher. In the more urban Nebraska counties, Mercer estimates the savings to be in the middle of this range. Savings associated with enrollees for whom the State only pays Medicare premium and/or cost sharing would likely be negligible or negative. Mercer estimates this savings to be between \$5.2 and \$6.9 million.

Additionally, comparison between the trends for the full-risk managed care program and the PCCM program for similar services show the full-risk program trending at a slower rate than the PCCM program. This slower trend rate could result in another 1%-2% reduction annually in the claim costs for the people moved to a fully capitated MCO.

In the first year of implementation, there would be a one-time increase in cash flows associated with claims payment timing. While the capitation payments to MCOs begin immediately upon program implementation, the State will still be paying for claims incurred previous to the implementation date for enrollees new to the MCOs. The ultimate cost to the State is unchanged, but the capitation structure effectively pushes the claim payment timing up. This additional cost in the first year could be 15% of annual claim costs for new MCO enrollees, considering the claim payment speed Mercer saw in rate setting for SFY 2009 MCO rates. This would equate to \$13 million in increased cash flow in one SFY. This amount could be spread across SFYs depending on implementation strategies used by the State.

### ***Implementation***

The success of implementing this option hinges on the interest of other MCOs in participating, since the State currently only has one MCO participating in the full-risk managed care program. Limiting the mandatory managed care program to full-risk MCO participation and, as a result, increasing the size of the population going into full-risk managed care may be enough incentive to attract an additional MCO. However, it may be beneficial for the State to release an RFI to gauge interest in the program and solicit feedback from potential MCOs on contract requirements, covered populations and services, auto assignments, reimbursement structures and other incentives to attract additional interest.

Completing the RFI and RFP processes and implementing the program would take 18 to 24 months from the start of the process. There should not be significant additional administration or MMIS costs associated with this option since one MCO is already contracting with the State in these counties. There may be some administrative cost savings associated with the elimination of the PCCM program in these counties, as well. There may also be significant stakeholder pushback to limiting the mandatory managed care program to full-risk MCOs, which would require large education efforts and could also increase the timeframe.

Significant modifications to the 1915(b) waiver would need to be made and approved by CMS during this process, which could extend the timeline. However, if the current program was modified to be consistent with the existing program and only changed for a

fully capitated delivery system, CMS approval should be in line with existing waiver renewal reviews.

### ***Experience of Other Programs***

Medicaid managed care programs are commonly administered with MCOs being the only option within managed care. Generally, the decision to offer managed care only through MCOs is based on geographic area and/or populations that will be enrolled in managed care combined with the existing program authority. It is more common to see fully capitated MCO programs in metropolitan areas of a state, with PCCM managed care programs more common in rural areas. This is the result of the availability and familiarity with MCOs in metropolitan areas and the availability of providers in establishing networks.

Ohio now has a managed care program that is offered through fully capitated MCOs statewide, but previously the state successfully converted many of their regional managed care programs that included options between FFS and an MCO to full-risk MCO only programs.

## Recommendation 4: Acute Care Statewide Managed Care

Mercer recommends Nebraska consider expanding the current mandatory three-county full-risk managed care program statewide. The State could either expand its PCCM program statewide, alongside the MCO program, or it could continue its newly implemented Enhanced Care Coordination program for FFS enrollees in the current non-managed care counties.

### ***Overview***

As mentioned in the previous recommendation, the State currently operates a mandatory managed care program with an option between an MCO program and a PCCM network in three counties. Cost of, quality of and/or access to care would potentially be improved for enrollees statewide who participate in a full-risk MCO program. In order to attract MCOs to participate in a broader geographic region, the State could perform an RFI process as described in Recommendation 3.

One possible way to encourage broader MCO participation would be to eliminate or significantly limit provider claim risk for the early years of the contract. This would enable MCOs to get a better feel for the number of enrollees opting into the MCOs and for the more rural Medicaid stakeholders and environment in Nebraska before having the large financial risk associated with claim expenses. The MCOs would effectively be working under an ASO arrangement and would perform and be capitated for all expected administrative requirements including provider networking and credentialing, claim adjudication, care management, member relations and other activities. Full claim risk could be immediately implemented at some point or be phased in over several years.

## ***Financial Impact***

As mentioned in Recommendation 3, Medicaid managed care programs generally save states money. The cost savings for full-risk managed care is often greater in more urban areas however, due to difficulties with a lack of economies of scale and provider competition in rural areas. Literature review findings are limited in this area, with some states believing that rural managed care savings are happening. Other states leave the delivery system in rural areas as FFS. The savings associated with implementing a statewide, mandatory managed care program with an option alongside an MCO would likely be towards the lower end of the 4% to 8% range quoted in Recommendation 3. Mercer estimates this savings to be between \$2.8 and \$3.5 million dollars.

Additionally, comparison between the trends for the full-risk managed care program and the PCCM program for similar services show the full-risk program trending at a slower rate than the PCCM program. This slower trend rate could result in another 1% reduction annually in the claim costs for the people moved to a full-risk MCO.

For any years that MCO contracting is done on an ASO basis, the incentive to perform optimal care management is decreased along with savings to the State. To alleviate this concern, the State could develop financial incentives (e.g., annual cost targets and shared savings) in the years before claim risk is transferred to the MCOs.

During the year that transition is done from an ASO arrangement to a full-risk capitation, the State will need to account for the additional cash flow associated with paying capitations in addition to the FFS claims runout as described in Recommendation 3. This would equate to \$10 million in increased cash flow in one SFY. This amount could be spread across SFYs depending on implementation strategies used by the State.

## ***Implementation***

The success of implementing this option hinges on the interest of at least one MCO in participating statewide. An RFI could be released prior to procurement and implementing an ASO to gauge interest as discussed in Recommendation 3. In addition, the State may want to get feedback on how to phase in the program from ASO to full-risk capitation.

Completing the RFI and RFP processes and implementing the program would take 18 to 24 months from the start of the process. There would be some additional administration and MMIS work associated with these counties, but depending on the complexity and number of contracts, these could be handled by existing staff. There may also be significant stakeholder pushback to implementing managed care in new counties, which would require large education efforts and could also increase the timeframe.

Modifications to the 1915(b) waiver would need to be made to expand the applicable geography for the existing managed care program. Depending on the contracting approach with the MCOs, CMS approval should not delay the projected timeframe.

## ***Experience of Other Programs***

Recently, the states of Ohio and Missouri have expanded their full-risk managed care programs. Ohio expanded its program to a statewide, fully capitated MCO program. However, prior to this Ohio managed its program on a county basis and transitioned counties from FFS, to a FFS and MCO option, to fully capitated MCOs. Missouri has expanded its managed care program twice to add counties to its mandatory MCO program.

## Recommendation 5: Transportation Services

Mercer recommends the State consider implementing a full-risk capitated transportation broker program to provide transportation services statewide to the Medicaid population.

### ***Overview***

Currently, the Nebraska Medicaid program provides transportation services through the FFS, PCCM and SPCM programs on a FFS reimbursement basis. Transportation is provided to full-risk MCO members through the MCO and is paid for through the monthly MCO capitation rate. Although the State has general oversight of the transportation program in the FFS and PCCM populations, the day-to-day management of the program, provider rate negotiations and benefit interpretations are conducted at the local level. This structure can result in disjointed and inconsistent administration of transportation services across the state.

A transportation broker manages the cost and utilization of transportation services by shifting utilization to the most cost effective mode of transportation while considering the needs and limitations of the Medicaid client. A transportation broker may provide the following services:

- Educate the Medicaid client on the transportation options available and how to access them
- Coordinate a network of transportation providers
- Verify Medicaid eligibility, the medical need for transportation services and that no other transportation is available to the client
- Operate dispatch and call centers for providers and clients
- Authorize and schedule trips based on the least costly, yet appropriate, mode of transportation
- Administer contracts and payments to transportation providers
- Monitor the program for quality and access
- Report costs, trips and other program management measures to the states<sup>7</sup>

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<sup>7</sup> Raphael, David and Community Transportation Association of America. "Medicaid Transportation: Assuring Access to Health Care, A Primer for States, Health Plans, Providers and Advocates." January 2001.

Reimbursement through the transportation broker could be through a fee schedule with an administrative fee added for the additional services provided consistent with the above list or paid a monthly capitation rate for each Medicaid eligible individual similar to the payment of the MCO in the full-risk managed care program. To best incent the transportation broker to provide transportation in the least costly, most appropriate manner, Mercer recommends the broker be reimbursed through a monthly capitation payment.

### ***Financial Impact***

In SFY 2007, the State spent approximately \$9 million on transportation services for Medicaid eligibles not enrolled in the MCO and excluding transportation services provided to special needs eligibles through various waiver programs. The State's PMPM expenditures are in line with other programs that are using brokers for transportation services. It is difficult to assess the complete impact of a broker on the Nebraska program without more detailed analysis of the services being provided and where they are being provided. It is understood by the industry that these brokers are effective at shifting services to more cost effective and appropriate modes of transportation and in managing fraud, abuse and waste. However, the brokers are also effective at developing networks which tends to increase access and, as a result, increase utilization. In addition, the broker will increase cost due to the administrative expense needs of the program management of the providers and the dispatching and scheduling of trips.

When considering the savings these brokers can generate in transportation costs with the increased cost of administration for the broker and the increased utilization, it is difficult to estimate the overall savings, if any, to the Nebraska program. Assuming utilization does not increase by more than 10%, Mercer estimates that the broker program could save the State between 5% and 10% of current transportation expenditures for the population not enrolled in the MCO. This would equate to savings between \$455,000 and \$915,000. If utilization increases by 15% rather than 10%, the broker program would be close to budget neutral for the State. These estimates do not reflect including transportation services in the brokerage arrangement for special needs populations enrolled in various waiver programs. The inclusion of these services in the broker contract may generate additional savings for the State.

In addition to potential program savings in the initial year, it is likely the transportation broker could reduce annual trends by up to 1% as a result of continued monitoring of fraud, abuse and waste, and of redirection of transportation to the most cost effective and appropriate mode of transportation.

As with the other programs moving from FFS to full capitation, the State could face an issue with cash flow, since FFS claims runout continues to be paid while capitation payments are made to the transportation broker.

## ***Implementation***

Implementation of a full-risk transportation broker could be done through either a SPA or a waiver. Mercer recommends the State implement this program through a modification to its existing 1915(b) waiver. The waiver authority allows the State additional flexibilities not available under the State Plan authority. Using the 1915(b) waiver, the State does not have to meet additional requirements of independence between the broker and actual transportation providers or restrictions on governmental agencies brokering or providing transportation services.

The full-risk broker arrangement under the waiver will require that a separate Medicaid eligibility group be added to the existing 1915(b) waiver. It may also require actuarially sound capitation rates be developed. In addition, the State will need to update provider manuals and education materials, potentially make modifications to the information system for broker payments, write a contract, procure the services and conduct a readiness review of the new contractor. Most of these services could be provided through existing staff. It is anticipated the State would need 12 to 18 months to implement a transportation broker.

## ***Experience of Other Programs***

Transportation brokers have been implemented in several states. These programs have been successful in producing cost savings by using the most cost effective and appropriate mode of transportation and in controlling fraud and abuse in the programs. The program could experience an increase in costs due to the additional administrative cost paid to the broker for the administration of the program and the potential for increased access. However, the combination of the management of the program and the full-risk capitation has been able to offset these additional expenses.

In Missouri, the transportation broker is responsible for providing all transportation services to the non-managed care population. The MCOs are responsible for transportation services to their members and are paid through the monthly capitation rate for those services. Missouri has used a transportation broker for many years. Initially, the broker was reimbursed through a fee schedule plus an administrative load. A few years ago, Missouri decided to move to a fully capitated arrangement and reprocurd the contract. As a result of this full-risk model and the rebid, Missouri was able to reduce \$32 million in transportation costs to \$27 million, an 18.5% reduction in costs.

Transportation brokers have also been implemented statewide in states with rural populations. Unlike other managed care programs where full-risk programs struggle to be implemented, transportation brokers have been successful in developing networks in rural areas. Georgia, Missouri, Oklahoma and Utah are all examples of states, with significant rural areas, able to implement a full-risk broker model statewide.

States are generally split between carving transportation services in or out of their existing managed care programs. Generally, states prefer to limit the carve outs of

capitation rates for MCOs so that incentives to manage most, if not all, health care for Medicaid eligibles lie with the MCOs.

## Recommendation 6: Durable Medical Equipment (DME)

Nebraska may want to consider implementing a competitive bidding process for awarding contracts to supply DME. These arrangements have helped programs to save money and manage fraud, abuse and waste. However, the programs are struggling with the potential displacement of small, independent suppliers.

### **Overview**

Presently, the State pays for DME services on a FFS basis to a large number of providers that are willing to participate in Medicaid. Because of this, the State may be spending more for DME than it would if providers were approved beforehand and required to conform to set pricing parameters. Using a competitive bidding approach would reduce the number of providers, ensure they are willing to commit to a fee schedule, and help to reduce fraud, abuse and waste of these services.

By only contracting with providers who are approved based on competitiveness, the State forms a *de facto* preferred provider network as a result of the bid process. In the competitive bidding process, there are at least two ways of determining eligibility for reimbursement. In the first approach, providers submit a fee schedule to the State for approval. The State would then work with providers whose fees are sufficiently close to price ranges determined reasonable (several such schedules are available from other private and government organizations). Alternatively, the State can publish a fee schedule and allow providers to furnish DME if they agree to the published rates.

### **Financial Impact**

During SFY 2007, Nebraska spent approximately \$30 million on DME services for the PCCM and FFS programs. The annual trend in expenditures for these services from SFY 2005 to SFY 2007 was 8.5%, which is significantly higher than the overall Medicaid program experience during this same time period. Based on the experience in other programs described below, we would expect the State could save an estimated 6% to 9% of DME expenditures through the competitive bidding process. This would equate to approximately \$1.8 to \$2.7 million in savings from the current expenditures.

We further expect the use of a limited number of providers that are accredited would be able to reduce the annual trend experienced on DME services up to 1%. The savings and trend estimates assume the State is able to competitively bid with DME vendors with fee schedules that closely approximate the existing Nebraska Medicaid DME schedule.

Administratively, the State would need to procure for services, develop a contract, possibly modify the current information system to address the fee schedules, and have staff to oversee the contract, review medical necessity criteria and prior authorizations,

and provide physician education. It is anticipated the State will be able to handle these requirements through existing staff with no additional administrative costs.

### ***Implementation***

The competitive bidding for DME services can be a statewide contract that would cover the various programs of the State: FFS, PCCM and full-risk managed care. However, the recommendation for Nebraska is to target the competitive bidding to the FFS and PCCM programs. Currently, DME services for the full-risk managed care program are included in the monthly capitation rates to the MCO. This provides the MCO with an incentive to manage these services for reasonable pricing and for fraud, abuse and waste. If the program is not well managed, the MCO takes the financial risk associated with the lack of management of these services.

Section 1915(a) allows the State to competitively bid for DME providers without amending the State Plan or obtaining a waiver. Under CFR 431.51(d), the State is required to certify that adequate medical devices are available under the contract. This certification process is the same process that is used in establishing lock-in restrictions on clients over-utilizing Medicaid services, such as prescription drugs. These provisions also allow the State to include certain requirements that bidders must meet in order to provide DME services. The State may wish to require that vendors are accredited by a certifying organization such as the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Commission for Health Care. Since approval by CMS is not required, steps toward implementation could be taken immediately and may take effect in 9 to 12 months.

Depending on the specificity of the State Plan and the State Regulations, it may be necessary to modify the State Plan and/or State Regulations to make changes to the purchasing of DME services. Changes to the State Plan and/or State Regulations may increase the time needed to implement.

### ***Experience of Other Programs***

On the Medicare front, CMS has selected ten metro regions (including Kansas City, MO) for its pilot DME competitive bidding program, with several dozen more to come online by 2010. The preliminary results seem to verify that competitive bidding lowers expenses. For example, California rolled out its bidding program in fiscal year 2004-2005 with an estimated savings on DME expenses of 8%-9%.<sup>8</sup> Similar savings have resulted in Florida, New York and Texas from their competitive bid process. Demonstration projects conducted by CMS in Florida and Texas showed savings of 17%-22% on DME with no significant loss of service or quality.<sup>9</sup> The competitive bidding process will significantly decrease the number of providers to monitor (by perhaps 80%), and it

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<sup>8</sup> Department of Health Services. "Fiscal Year 2002/03 DHS Budget Change Proposal FLMC-08." Pg. 3.

<sup>9</sup> Centers for Medicare and Medicaid. "Final Report to Congress: Evaluation of Medicare's Competitive Bidding Demonstration for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies." 2004.

should also increase the likelihood that providers are well-established and reliable.<sup>10</sup> Although the number of providers is reduced, these providers are still able to provide the access necessary to meet the certification required by 1915(a).

States also benefit from prior authorization and competitive bidding by reducing the number of erroneous or fraudulent claims. A report issued by the U.S. Department of Health and Human Services estimated that there were errors in almost 29% of DME claims paid under Medicare in 2006.<sup>11</sup> Payment errors, both fraudulent and accidental, could be costing hundreds of millions of dollars per year for DME alone. For example, the Government Accountability Office found that Medicare has paid nearly \$100 million since 2000 to DME suppliers submitting prescriptions from physicians who are dead.<sup>11</sup>

When considering competitive bidding, one important issue to consider is the impact of competition on small, independent providers. Many of Nebraska's DME providers may be unable to compete with the large national providers. With Medicare, implementation of the DME competitive bid process was scheduled to begin in the spring of 2008. A law was passed on July 15, 2008 (Medicare Improvements for Patients and Providers Act of 2008) to delay the competitive bid process until the concerns of small providers have been addressed. CMS has been tasked by Congress with conducting a study on how the bidding program will impact small DME suppliers. Although CMS is still awarding contracts to successful bidders, they have suspended the requirement that all providers within the test areas win contracts through competitive bidding. The State will want to consider the results of this CMS study, when available, to understand the impact on the independent providers and possible resolutions if it chooses to competitively bid for DME supplies.

To Mercer's knowledge there is no Medicaid program that has moved forward with this option, although several states have considered competitive bidding. This reluctance may be a result of the concerns over the small, independent providers and the concern that the allowance under Section 1915(a) could be interpreted to cover only medical devices and may not be interpreted to address DME supplies.

## Recommendation 7: Dental Services

Mercer recommends the State consider implementing an ASO model for dental services. An ASO delivery model could provide the State with greater program and cost control.

### **Overview**

The State currently reimburses for dental services on a FFS basis. Nebraska's 2007 Medicaid dental expenditures totaled \$33.9 million, \$22.6 million of which were for

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<sup>10</sup> Consortium for Citizens with Disabilities. "Impact of DME Competitive Bidding on Medicare Beneficiaries with Disabilities and Chronic Conditions." Presented to the House Ways and Means Committee on May 5, 2008.

<sup>11</sup> Lee, Christopher. "Report Faults Medicare Audits." Washington Post. August 26, 2008.

children's services. Dental expenditures increased 7.9% from 2005 to 2006 and 5.5% from 2006 to 2007.

In an ASO arrangement, a private contractor would perform prior authorization and utilization review and the State would retain all financial risk for dental costs. A key advantage of implementing an ASO model is the enhanced utilization management that can be provided. Additionally, ASOs can reduce administrative duties for state staff while educating and improving the health of targeted populations.

### ***Financial Impact***

In 2007, the overall Nebraska FFS dental PMPM was \$17, which may provide the State with a savings opportunity. Other states are experiencing PMPMs in the \$7-\$11 range. Some of these states pay on a FFS basis, while others capitate their MCOs. While Nebraska's dental PMPM is high, the percentage of total dental cost is reasonable compared to other states and represents 2.5% of total Medicaid expenditures.

While Nebraska's PMPM is relatively high, its dental fees are comparatively low. Based on a dental fee schedule analysis using Nebraska dental codes, there appears to be a limited opportunity for cost savings to the existing program through fee schedule reductions. Comparison of Nebraska's fee schedule using dental codes reflective of 60% of total spend to comparative states, including Colorado, Iowa, Kansas, Missouri, Oklahoma and Utah, indicates the Nebraska fee schedule is in the lower half of these states.

Further analysis of additional data is needed to determine if Nebraska's cost per user is driven by mix of services delivered or by high utilization for those accessing care. This may be an opportunity for the State to achieve cost savings through utilization management of services delivered. To the extent that the PMPM is high due to high utilization, a managed care or ASO model could address this potential issue much more effectively than a FFS delivery model. Without performing the aforementioned data analysis, Mercer estimates implementing an ASO model will likely result in no savings or could result in a 4% increase in costs. This is based on a 7% fee for ASO services for claims processing and utilization management accompanied by at least a 3% reduction in utilization. In total, the financial impact range is \$0 to \$1.4 million increase for implementing an ASO model.

Given the State's fee schedule, we believe that in order to develop actuarially sound rates (as required of full-risk managed care programs), the State may need to increase funding. Due to the strong possibility of increasing costs, we are not recommending a statewide dental managed care model or carving dental back in the MCO service array, rather, the State may want to consider an ASO model which has fewer administrative costs as compared to a MCO model.

## ***Implementation***

To implement an ASO program, the State will need to obtain the necessary authority from CMS, determine the program requirements and procure the services of a private contractor. Nebraska currently operates the SPCM program under 1915(b) waiver authority. This waiver should not need to be amended to obtain approval for an ASO dental program. Rather, CMS would likely need to approve any contract over \$100,000.

The State will need to consider a number of issues in determining the feasibility of implementing an ASO model.

- **Is there vendor interest?** The likely level of vendor interest will help the State determine the viability of a successful procurement. Higher levels of interest typically lead to more competitive bids in terms of both pricing and services.
- **Will the ASO need to meet state and/or federal requirements for network access? What are the cost implications to build the network?** This depends on the ASO arrangement. If the ASO contractor is just performing administrative duties, they would likely rely on the existing Medicaid dental provider network and would not be subject to any additional network access requirements. In this instance, there would not be additional costs incurred by the State or the ASO contractor in developing a provider network.
- **What is the State's role in managing the ASO?** The State's role would be similar to all other contractor relationships currently in place. Currently, the State provides general monitoring of the Behavioral Health ASO. A dental ASO would entail similar levels of monitoring.
- **How will member's access to services be impacted?** There should not be any disruption to member's access to services. Providers should have a 60-90 day transitional period to adapt to working with an ASO, during which there should be no further review of existing prior authorization requirements. For members, there should be continuity of care provisions to ensure that care is not affected during the transition. The main reason for this provision is for orthodontia services which have a duration of 2 to 3 years.

The implementation process would typically take 9 to 15 months to complete. The process would include development and distribution of a RFP, evaluation of the RFP responses and the selection and implementation of the winning vendor.

## ***Experience of Other Programs***

In performing this assessment of Nebraska's dental program, Mercer researched other state programs and found there is a fairly even split between states which carve out dental benefits from capitated programs and those which provide dental services as part of their capitated programs.

A recent Medicaid dental program trend is the movement of states to increase access to dental services. States desiring to increase access to services have increased their fee schedules anywhere from 25% to 100% above the national Medicaid norms. This has

typically resulted in a similar increase to access as reflected in utilization of services. Table B provides a high level summary of initiatives taken by five states.

**Table B: State Dental Reforms**

State	What led to reform?	What was done?	Outcomes
Alabama	Change in Medicaid leadership	<ul style="list-style-type: none"> <li>▪ Fee schedule raised to 100% of BCBS fees</li> <li>▪ \$1 million in private funds for outreach</li> <li>▪ Collaborated with dental association</li> <li>▪ Improved administration/billing processes</li> </ul>	<ul style="list-style-type: none"> <li>▪ 76% increase in utilization</li> <li>▪ 76% increase in number of providers</li> </ul>
Michigan	Key legislators led reform after success of SCHIP	<ul style="list-style-type: none"> <li>▪ Capitated with Delta Dental Premier plan</li> <li>▪ Paid 100% of usual charges</li> <li>▪ Piloted operation in 22 rural counties</li> </ul>	<ul style="list-style-type: none"> <li>▪ Expanded to 59 of 83 counties after a successful pilot program</li> <li>▪ Moved to Delta Preferred Option</li> <li>▪ Paid lower rate which led to 14% decline in providers</li> <li>▪ 43% increase in utilization</li> </ul>
South Carolina	Special needs advocates and coalitions spurred change	<ul style="list-style-type: none"> <li>▪ Fee schedule raised to 75% of commercial</li> <li>▪ Robert Wood Johnson Foundation grant for outreach and patient navigator model</li> <li>▪ Streamlined PA's</li> <li>▪ Standardized claim forms</li> </ul>	<ul style="list-style-type: none"> <li>▪ 54% increase in utilization</li> <li>▪ 93% increase in number of providers</li> </ul>
Tennessee	Lawsuit and court order to expand access	<ul style="list-style-type: none"> <li>▪ Carved out to Doral Dental</li> <li>▪ Rates increased to 75% of regional fees</li> </ul>	<ul style="list-style-type: none"> <li>▪ 38% increase in utilization</li> <li>▪ 112% increase in number of providers</li> </ul>
Virginia	Close partnership of Medicaid Director and Executive Director	<ul style="list-style-type: none"> <li>▪ Carved out to Doral Dental</li> <li>▪ 28% increase to fee schedule</li> <li>▪ Additional 2% increase in 2006 for oral surgery</li> </ul>	<ul style="list-style-type: none"> <li>▪ 33% increase in utilization</li> <li>▪ 62% increase in number of providers</li> </ul>

These states also noted the following lessons learned through the reform process:

1. Rate increases are necessary, but not sufficient to improve access
2. Education and case management for patients and families reduce problematic behavior
3. State dental associations' and individual dentists' involvement as active partners ease implementations
4. State oral health coalitions help make rate increases about patients, not providers

### **Other Considerations**

There is limited opportunity for cost savings in the FFS dental program without adversely affecting access to services. The two most likely cost savings methods available in FFS that would guarantee savings are: 1) lower provider reimbursement and 2) remove coverage for SSI adults. The cost analysis and review of Nebraska’s data and program design, coupled with comparative state experiences, indicate that lowering the reimbursement levels will likely decrease the number of participating providers and further limit access to services.

Table C provides a summary of service coverage in select Midwestern states. Whereas the majority of comparative Midwest states do not cover adult dental services, Nebraska could move in this direction at the expense of providing coverage to the adult SSI population. Removing the adult dental benefits would result in limited savings and may result in overly negative stakeholder reaction.

**Table C: State Dental Benefits**

Benefit/Limit	Nebraska	Comparative States (CO, IA, KS, MO, OK and UT)
Children Benefits	Comprehensive under EPSDT	Comprehensive under EPSDT
Children Cap	No cap on services	No cap on services
Adult Benefits	Routine evaluation once every 12 months limited to Indian Health Service, FQHC qualifier, and Special Needs populations	* Limited benefits. To increase enrollment, some MCOs voluntarily cover dental for adults
Adult Cap	\$1,000 per SFY	N/A
Copays	Nominal for adults	Nominal for adults

Note: Literature review suggests evidence of increased dental compliance results in medical savings for other services as poor oral health affects general health. For instance, periodontal (gum) disease is associated with pre-term delivery and/or low birth weight, atherosclerosis and vascular disease, diabetes, and increased prevalence and severity of gingivitis and periodontitis. Preventive measures can help minimize the impact of future morbidity.

**Table D: Delivery System Recommendations**

Recommendations	Qualities								
	Implementation				Financial		Other		
	Timing	Requirements	State Administration Impact	Current MMIS Feasibility	Estimated (Savings)/ Cost	Risk for Claims Cost	Statewide Feasibility	Quality	Access
Recommendation 1: MH/SA Services	12 - 18 mths	Amend 1915(b) and procurement	Similar to current program	Yes	(\$3 - \$6 million)	Vendor	High	Enhanced	Enhanced
Recommendation 2: LTC Services	18 - 24 mths	Voluntary need 1915 (a), Mandatory need 1915(b), may need to modify 1915(c) and procurement	State oversight and contract management needed	Yes	(\$2 - \$5 million)	Vendor	Low	Enhanced	Enhanced
Recommendation 3: Acute Care Mandatory Full-Risk Managed Care	18 - 24 mths	Modify 1915(b) and procurement	Similar to current program	Yes	(\$5.2 - \$6.9 million)	Vendor	Medium	Enhanced	Enhanced
Recommendation 4: Acute Care Statewide Managed Care	18 - 24 mths	Modify 1915(b) and procurement	Similar to current program	Yes	(\$2.8 - \$3.5 million)	Vendor - MCO and State - PCCM/FFS	Low	Enhanced	Enhanced
Recommendation 5: Transportation Services	12 - 18 mths	Modify 1915(b) and procurement	State oversight and contract management needed	Yes	(\$455,000 - \$915,000)	Vendor	High	Enhanced	Enhanced
Recommendation 6: DME Services	9 - 12 mnths	CMS access adequacy certification and procurement	State oversight and contract management needed	Yes	(\$1.8 - \$2.7 million)	State	Medium	Enhanced	No Impact
Recommendation 7: Dental Services	9 - 15 mths	CMS approval for contracts over \$100,000 and procurement	State oversight and contract management needed	Yes	\$0 - \$1.4 million increase	State	High	Enhanced	No Impact

# 4

## Benefits

### Overview

In further evaluating alternative benefit structures for the Nebraska Medicaid program, Mercer considered the current State Medicaid benefit design and the flexibility now available to states under the DRA. The DRA provides states with the ability to increase “nominal” copayments for eligible populations based on the cost of services. The DRA also allows more flexibility in varying copays and implementing premiums based on income levels. In addition, the DRA established options for providing alternative benefit designs based on benchmark plans similar to what has been allowed for SCHIP.

This section of the report provides recommendations on changes to the current benefit design for certain services and/or populations. These recommendations are offered as options to assist the State in achieving its Medicaid Reform goals of long-term savings and fiscal sustainability of the program. Each recommendation includes an outline of the current delivery system, a description of the recommendation, the financial impact of the recommendation, implementation considerations and experience of other programs. The recommendations for alternative benefit design are as follows. Table H at the end of this section also summarizes each recommendation in terms of the implementation considerations, the financial impact and other items to consider for feasibility for the State.

- Recommendation 8 – Modify Existing Copays
- Recommendation 9 – Copays and Premiums by Income
- Recommendation 10 – Tiered Benefit Plan Design

Nebraska’s Medicaid program includes recipients eligible under Title XIX and a Medicaid expansion of eligibility through Title XXI or the State’s children’s health insurance program (CHIP). In establishing the CHIP as a Medicaid expansion, Nebraska was able to use the same delivery system, benefit plan, provider network, payment levels and MMIS as the Nebraska Title XIX program. The CHIP 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.

Nebraska’s CHIP provides a full range of health coverage using the same benefit plan as is available through the Title XIX program. Nebraska’s CHIP does not currently include premiums or cost sharing, as federal rules prohibited cost sharing for children in CHIP until the passage of the DRA. The DRA now allows Nebraska to continue to take advantage of the operational efficiencies gained through the Medicaid expansion, but also gives the State the ability to vary copays, premiums and benefits within these two populations based on income level.

## Recommendation 8: Modify Existing Copays

Mercer recommends Nebraska consider implementing the maximum allowed level of nominal copays for copay-eligible Medicaid beneficiaries. This includes adjusting existing copays and adding inpatient copays and split preferred/non-preferred pharmacy copays.

### Overview

The State currently collects “nominal” copays from eligible adult Medicaid PCCM and FFS beneficiaries (not including pregnant women and others) for several categories of service, not including inpatient. The maximum value of the nominal copays currently allowed varies by the cost of the service and is set by regulation. The copays in effect in Nebraska have not been updated for some time to reflect increases in the costs of service. In addition, recent regulation increased the maximum copays slightly and indexed those copays to the Consumer Price Index for Urban Customers (CPI-U). This regulation also allows prescription drug copays to vary by whether the drug is on a preferred drug list (PDL) or not. Table E shows the current Nebraska copays and the recommended copays based on the maximum allowed.

**Table E: Copayment Recommendations for Nominal Amounts**

	Current	Recommended
<b>Copayment</b>		
Inpatient Hospital	\$0.00/day	\$3.20/day
Outpatient Hospital	\$3.00/visit	\$3.20/visit
Physician Services	\$2.00/visit	\$3.20/visit
Dental Services	\$3.00/specified service	\$3.20/specified service

## ***Financial Impact***

There are two sources of potential savings associated with increased nominal copays: 1) fee schedule reductions to reflect increased copays and 2) changes to enrollee behavior. Copays can be structured to encourage enrollee usage of the most appropriate levels of care. These savings are limited to the portion of the Medicaid population that is subject to copays.

Updating the nominal copays on existing services for the revised costs of service and CPI-U indexing would have a minimal impact on costs, since the increases from the current levels are small. We would not expect service utilization patterns to be measurably affected by this change. Our estimate of annual additional copays collected from adults not in managed care, using SFY 2007 maximum copays, is approximately \$900,000. These copay changes could be implemented using the existing MMIS and the savings could be realized immediately.

Adding a \$3.20 per day copay to inpatient stays for non-managed care adults would result in approximately \$300,000 annual savings to the program. In addition, the existence of inpatient copays may incent some participants to receive care in a less expensive outpatient setting. Implementing a new copay on inpatient services may be difficult under the current MMIS. The State will want to address this flexibility when developing the MMIS update.

Finally, differentiating the pharmacy copays between preferred and non-preferred drugs would drive utilization to the most appropriate and cost-effective drugs for the State. Estimates of the expected savings associated with increased utilization of preferred drugs could be estimated in a detailed utilization study once the PDL is complete. The savings associated with the differentiated copay will be limited to adults whose drugs are covered solely through Medicaid. We do not recommend the total expected levels of pharmacy copays be increased when the differentiated copays are developed in order to minimize the impact of members not receiving needed care. The difference between the two copays is more important than the level of copays, as the difference can drive changes in utilization towards less costly drugs. In addition, based on review of unit costs for pharmacy services, the maximum "nominal" copay the State could require would be \$2.10. Currently, this tiered copay structure cannot be implemented under the existing MMIS, and the flexibility would need to be developed in the MMIS update.

## ***Implementation***

Updating the nominal copay values for the State's existing copay structure should be a straightforward exercise. Provider fee schedules will also need to be lowered to reflect the additional copay revenue and generate the estimated savings for the State. Nebraska's MMIS should be able to easily accommodate these changes since these updates would impact only services that are currently assessed a copay. No additional administrative costs should be necessary beyond updating MMIS and amending the State Plan. Getting approval from CMS of a SPA simply addressing revised copays should be relatively straightforward, and should take from three to six months.

Stakeholder education and training would need to be performed ahead of time. There may be significant pushback even on small increases in copays, which could delay implementation.

The implementation of inpatient and differentiated pharmacy copays would be more difficult because of MMIS limitations. Updates to the MMIS that might allow for this change are scheduled to be completed in SFY 2011.

**Experience of Other Programs**

Of the Medicaid programs in six states near Nebraska, five require cost sharing for inpatient stays and five have varying levels of prescription drug copays for some Medicaid or SCHIP beneficiaries.

**Table F: State Copay Comparison**

State	Inpatient Copay	Differentiated Rx Copays
Colorado	Y	Y
Iowa	N	Y
Kansas	Y	N
Missouri	Y	Y
Nebraska	N	N
Oklahoma	Y	Y
Utah	Y	Y

**Recommendation 9: Copays and Premiums by Income**

Mercer recommends Nebraska consider implementing copays and/or premiums that vary by FPL for eligible Title XXI enrollees. Title XIX enrollees would still be subject to nominal copays as outlined in Recommendation 8.

**Overview**

Currently, Nebraska charges all FFS and PCCM copay-eligible participants the same level of copays. No premiums are collected from most participants. The DRA allows premiums to be collected from certain enrollees over 150% of FPL and alternative cost sharing to be collected from certain enrollees over 100% of FPL. The total premium and cost sharing levels are limited to 5% of family monthly or quarterly income.

Several Medicaid categories of individuals may not be required to pay premiums or copays including:

- Pregnant women
- Children with mandatory Medicaid coverage, including foster care
- Hospice recipients

- Institutionalized individuals required to contribute to the cost of care
- Disabled children (Parental fees charged for child participation in Medicaid waivers, where family income exceeds eligibility limits, is a separate issue from DRA premiums.)

Most of the enrollees subject to premiums and alternative cost sharing will be part of the Title XXI program because of the income eligibility requirements. Most children and adults covered through Title XIX have family incomes under 100% of FPL, which exempts them from premiums and alternative cost sharing. For this reason, we recommend that the nominal copay structure described in Recommendation 8 be maintained for Title XIX enrollees.

### ***Financial Impact***

Through the DRA, the State has additional flexibility in varying copays and premiums by FPL with the maximum allowable levels also varying by FPL. The cost sharing (premiums and other cost sharing) under the DRA is limited by the following:

**Table G: DRA Maximum Cost Sharing**

Income Level	Premiums	Maximum Cost Sharing
Below 100% FPL	Not Allowed	Nominal Copays Only
100% – 150%	Not Allowed	10% of cost of service (limited to 5% of family income)
Above 150%	Allowed	20% of cost of service (combined premiums and cost sharing limited to 5% of family income)

The financial impact of modifying the copay and premium structure for Title XXI enrollees was estimated in several scenarios in previous analyses performed by Mercer for the State in the fall of 2007. However, these estimates also assumed savings associated with reduced levels of benefit coverage, which is not part of this recommendation. Savings are still generated through increased levels of enrollee premiums and cost sharing and through fewer enrollees participating.

The level of enrollee premium and cost sharing can result in savings of 15%-20% of Title XXI costs (\$2 to \$3 million) if the full flexibility allowed under the DRA is utilized through maximum enrollee cost sharing. Some of the savings associated with point-of-service (POS) copayments is associated with lower service utilization. Under DRA rules, providers are allowed to refuse clients at the POS if the copayment is not paid. Research has shown that copayment requirements can cause low-income populations to delay seeking needed care. Implementation of full cost sharing may produce results that are not desirable, even considering cost savings maximization. The savings estimates assume maximum cost sharing and premiums allowed by the DRA are implemented. If lesser enrollee cost sharing and premiums are implemented, savings will decrease accordingly.

Based on other states' experience with implementing premiums and copayments in their SCHIP programs, it is expected Nebraska's CHIP enrollment would drop with these options. The magnitude and duration of the enrollment decrease would be affected by a variety of factors, including the size of the premiums and copayments, whether there is an enrollment "lock-out period" after premium non-payment, and the method of billing and collecting premiums. We estimate that enrollment could drop from 0.5% to 4.0%, resulting in an additional decrease in costs of up to \$600,000. Utilizing maximum cost sharing would likely generate an enrollment drop at the high end of this range.

### ***Implementation***

The implementation of premiums and/or alternative copays based on income level is currently unfeasible because of MMIS limitations. In addition, premium collection is currently manually intensive. Mercer assumes updates to the MMIS that would allow for most of these changes could be completed in SFY 2011 with the MMIS update. Reducing provider fee schedules for increased cost sharing collection is feasible with MMIS currently, but an analysis would need to be performed to reflect the impact of the 5% of family income limit.

Administration of the tracking of the family premium and cost sharing expenditures versus the limit of 5% of income could be manually intensive. One possible approach would be to employ the "shoe box" approach in determining whether or not the cost-sharing limit has been met. Using this tracking approach, the family tracks out-of-pocket costs. Once the family submits evidence they have reached the 5% cap, the state notifies providers that no more cost sharing may be charged to the family. Several states utilize this methodology.

Approval of the DRA SPA will need to be pursued during the time of MMIS enhancements. The State will need to develop the DRA SPA and submit it to be approved by CMS. Mercer estimates this process will likely take 12 to 18 months, but should be able to be completed in line with the implementation of the MMIS update in SFY 2011.

In addition, stakeholder education and training would need to be performed ahead of time. There would likely be significant pushback on implementing enrollee premium and copays, which could delay implementation.

### ***Experience of Other Programs***

The only states to implement alternative cost sharing arrangements are those that have restructured their benefits using authority granted under the DRA. Examples of these programs are described in the "Experience of Other Programs" section under Recommendation 10. Roughly half of the state CHIP programs charge premiums or copays, which are allowed for stand-alone or 1115 waiver CHIP arrangements.

## Recommendation 10: Tiered Benefit Plan Design

The State may want to consider implementing a tiered benefit design through a DRA SPA to transition the current defined benefit Medicaid structure to a more defined contribution approach. Prior to implementing any type of defined contribution approach, the State should review the experience of other states that have implemented DRA benchmark plan SPAs to determine whether these reforms have resulted in long-term cost savings.

### **Overview**

Nebraska may want to consider implementing a defined contribution approach to its Medicaid program through a DRA SPA, but only after states that have already implemented such programs have demonstrated the ability of these programs to promote long-term savings.

As described in Section 2 of this report, the DRA allows states to establish benchmark plans that replace the standard Medicaid benefit package for certain populations. These benchmark plans can be tiered so that they tailor the benefits available to the populations covered. For example, states can choose to provide a different benefit package for generally healthy individuals than they offer for individuals with certain disabilities. Examples of existing tiered benefit packages in several states are provided later in this section.

Mercer does not recommend that Nebraska pursue an 1115 research and demonstration waiver to implement a defined contribution program. As discussed previously, 1115 research and demonstration waivers provide states with the most flexibility in terms of implementing a defined contribution approach, but they are the most labor and time intensive. Additionally, CMS has encouraged states to pursue the DRA SPAs rather than 1115 waivers. To date, Florida is the only state that has an approved 1115 waiver to implement its defined contribution program. While CMS has approved a SPA that allows South Carolina to implement some of the reforms it proposed under its original 1115 program, the state has yet to receive approval of the remainder of the program that is proposed in its 1115 waiver application.

### **Financial Impact**

Mercer recommends that Nebraska take a “wait and see” approach on implementing a tiered benefit program through a DRA SPA because there is little evidence as to the cost-effectiveness of current programs in other states. Some of the first states to receive CMS approval for a DRA SPA, Kentucky and West Virginia, did not implement their programs until well in 2006; therefore, there is limited information available on the results of the programs. It is difficult to determine the level of cost savings Nebraska could anticipate as a result of implementing such a program.

## ***Implementation***

In addition to the unknown financial implications of implementing a tiered benefit structure, Nebraska will need to have the information system infrastructure to support the administration of a tiered benefit package. One of the major challenges in implementing a tiered benefit package is ensuring that individuals can access the right set of benefits. For example, if an individual changes eligibility categories and is now entitled to a different set of benefits, the State must have the capability to make those kinds of changes in its eligibility and claims systems. In addition, many of the states that have implemented tiered benefit packages have also offered enhanced benefits for healthy behaviors. The State must have the infrastructure to track individual “credits” and ensure individuals can access the enhanced benefits. Currently, Nebraska does not have the information systems infrastructure to support these functions; however, as the State designs its new information system, consideration could be given to incorporating enough flexibility to implement these defined contribution designs. Current timing for system enhancements is targeted for SFY 2011.

Nebraska may also benefit from learning from the experiences of the first states that have implemented the tiered benefit programs. These states have encountered implementation issues, such as a lack of consumer information, that have led to criticisms of the programs. To the extent Nebraska can learn from these implementation experiences, the State may avoid some of the pitfalls experienced by other states.

## ***Experience of Other Programs***

Several states have begun incorporating defined contribution approaches into their Medicaid reform plans. However, no state has fundamentally changed its program to a pure defined contribution model. Florida is using 1115 waiver authority to move to a premium-based defined contribution model. Kentucky and West Virginia are using SPAs under the DRA to incorporate defined contribution models into their Medicaid programs. South Carolina is trying to use the 1115 waiver and options available under the DRA to incorporate a defined contribution approach into its Medicaid reform plans; however, South Carolina has received approval from CMS only for the DRA approaches and is awaiting approval of its 1115 waiver application.

### ***Florida***

The Florida program seeks to develop a more predictable and sustainable rate of growth by moving to a premium-based system. Under this model, the state sets aside a specific amount of money for each person enrolled in Medicaid. Each managed care entity’s premium is risk adjusted for health status to better reflect utilization of medical services by its enrollees. Additionally, Florida established an overall maximum benefit limit similar to private insurance. Therefore, the Florida model seeks to move to a premium-based system similar to the private market by providing a specific allocation to individuals with an overall maximum coverage benefit.

Under Florida Medicaid Reform, mandatory and optional adults in two counties are required to participate. Specifically, Temporary Assistance for Needy Families (TANF) and TANF-related eligibility groups, as well as the aged and disabled eligibility group, must participate in the demonstration if they reside in a pilot county. Other eligibility groups are currently excluded from mandatory participation during the initial phase and may voluntarily participate in the program at this time. Certain individuals are excluded indefinitely from mandatory participation.

To accomplish the goal of moving to a defined contribution plan, Florida moved to a premium-based reimbursement system and obtained a waiver of comparability and statewideness. The Secretary waived Section 1902(a)(1), Statewideness/Uniformity, to enable Florida to operate the demonstration and provide managed care plans or certain types of managed care plans, including provider-sponsored networks, only in certain geographical areas. In addition, the Secretary waived Section 1902(a)(10)(B) to enable Florida to vary the amount, duration and scope of services offered to individuals regardless of eligibility category, and to permit Florida to offer different benefits to the demonstration population than to the categorically needy group.

Under its Medicaid Reform program, Florida can vary benefit packages. This is done by grouping the services into three categories: services that must be covered up to State Plan limits, services that must be covered up to a certain historical limit (e.g., 98% of historical utilization for prescribed drugs for the aged, blind and disabled group) and services with no minimum threshold (e.g., chiropractic visits). The legislature identifies how much funding is available for services covered under the capitation rate. If the premium is reduced in subsequent years by the legislature and is not sufficient to cover services at the previously specified levels, then the service levels can be revised to give plans additional flexibility in developing a benefit plan. The capitation rates still must be certified by an actuary.

Health plans are provided the flexibility to develop customized benefit packages targeted to specific Medicaid enrollees. The plans are defined locally with the goal of taking advantage of varying strengths of the providers in that community. In that way, the plans are designed to be more appropriate to the needs of the particular target population. Such packages more closely resemble private plans, yet are actuarially equivalent to the current Medicaid benefit package.

The customized benefit packages must cover all mandatory services specified in the State Plan including medically necessary services for pregnant women and EPSDT services for children under age 21. In addition, the plans cover needed optional services. However, the amount, duration and scope of all covered services, mandatory and optional, may vary to reflect the needs of the population. The plans, authorized by Florida, cannot have service limits more restrictive than authorized in the State Plan for children under the age of 21, pregnant women and emergency services, as the waiver of comparability does not apply to children and pregnant women.

In addition to selecting a customized benefit package, individuals have the option of using their premium allocation to pay for their share of employer-sponsored insurance (ESI). This component of the program is referred to as the Opt-Out program and is a voluntary option. Under this component, individuals have access to the premium that the State would use to pay a Medicaid plan. Individuals who enroll in the Opt-Out program must do so with the understanding that their coverage will be limited to the benefits offered under ESI and cost sharing is consistent with the ESI plan, which may exceed traditional Medicaid cost sharing limits. Florida Medicaid does not provide wrap-around services to individuals in ESI or assistance with paying cost sharing under the ESI plan. This applies to children as well as adults.

Because Florida is operating its program under an 1115 waiver, it is required to have an evaluation, which includes a test of its cost-effectiveness. The evaluation of the program is currently underway, and there is no definitive data on the cost-effectiveness of the program. However, in an initial comparison of costs one year prior and four months post implementation, researchers found a 3% decrease in PMPM spending. Further study is needed to determine whether the program has truly been cost effective.

### *Kentucky*

In May 2006, the State of Kentucky received SPA approval from CMS to move forward on plans to redesign its Medicaid program using DRA flexibility rather than using an 1115 approach like Florida. The new plan, KyHealth Choices, offers four different benefit packages tailored to specific populations, provides an optional ESI program for adults, increases cost sharing, and expands access to community-based LTC. The new targeted benefit plans replace the Medicaid benefit package with “Secretary-approved” coverage. Kentucky’s liability is limited under these new plans in that not all benefits are offered, either in total or to the same degree, to all populations, as under the previous State Plan.

The four plans are:

- **Global Choices** – Global Choices is targeted to pregnant women, working parents up to 68% of the FPL, foster children, medically fragile children, SSI-related groups and women with breast and cervical cancer. Global Choices coverage includes basic medical services. However, under Global Choices, there are greater limitations on benefits and increased cost sharing than in the previous State Plan. Global Choices excludes LTC services.
- **Family Choices** – Family Choices is aimed at most children, including children enrolled in the SCHIP program. Family Choices includes the same benefits as Global Choices except there are no prescription drug limitations and coverage for vision care is increased.
- **Optimum Choices** – Optimum Choices is targeted to individuals with developmental disabilities with an LTC service need. It includes all the benefits in Global Choices but also includes three levels of LTC services.

- **Comprehensive Choices** – Comprehensive Choices is designed for the elderly and individuals with disabilities in need of nursing home level of care. It includes the same benefits as Global Choices, as well as two levels of LTC, including services offered through Kentucky’s current HCBS waiver programs.

In June 2006, Kentucky also implemented new cost-sharing requirements. However, preventive services are not subject to copayments, and pregnant women and mandatory children are exempt from cost sharing requirements. Under KyHealth Choices, certain benefits have more limits than under the previous State Plan requirements; however, if individuals require services beyond the current benefit limits, these services may be approved through a prior authorization process.

KyHealth Choices also includes an ESI option. Participants can choose to receive a subsidy from Kentucky to purchase private health insurance that meets coverage and cost criteria. However, participants opting for the ESI option are not eligible for wrap-around coverage. Participants can move back to one of the Medicaid plans at any time.

KyHealth Choices also includes “Get Healthy Benefits.” This component of the program offers additional benefits to enrollees with certain diseases if the individuals agree to take part in a disease management program for one year. These additional benefits include vision, dental, smoking cessation and nutrition visits, and must be used within six months. Get Healthy Benefits are lost after disenrollment from Medicaid.

Because Kentucky implemented KyHealth Choices under a DRA SPA, there is no requirement for the State to conduct an independent evaluation of the program. In its quarterly reports, the KyHealth Choices program has indicated that it has demonstrated savings through the implementation of the program; however, the state’s auditor found that data used to determine these cost savings estimates did not support the savings indicated. Therefore, it is difficult to determine whether the KyHealth Choices program has resulted in cost savings.

### *West Virginia*

In May 2006, the State of West Virginia received CMS approval of its plan to reform its Medicaid program. West Virginia is using the SPA process under the DRA to implement these changes. The implementation began in July 2006 and extends for four years. The West Virginia plan, Mountain Health Choices, creates two health plans for healthy children and parents:

- **Basic Plan** – The Basic Plan covers all mandatory and some optional services; however, there are greater limits on these benefits than there were under the previous version of the State Plan. All required EPSDT services are provided for children. Enrollees do have the option of gaining coverage for additional services if they sign a member agreement which states that the member will comply with a set of requirements aimed at promoting healthy behaviors. By signing the member agreement, enrollees move into the Enhanced Plan.

- **Enhanced Plan** – The Enhanced Plan is for individuals who have signed a member agreement. This plan includes all services covered in the Basic Plan as well as mental health services, diabetes care and prescription drugs above the four-drug limit in the Basic Plan. The Enhanced Plan is comparable to West Virginia’s previous Medicaid benefits package.

The critical elements of West Virginia’s plan are the member agreement and the Healthy Rewards pilot program. As described above, enrollees who sign a member agreement are enrolled in the Enhanced Plan. West Virginia also plans for these members to receive a fixed amount of credits per quarter in a Healthy Rewards account. The credits can be used to cover medical and pharmaceutical copays and bonus credits are added for meeting certain health goals. Individuals who do not meet their responsibilities are moved to the more limited Basic Plan.

Recently, advocacy groups have criticized the Mountain Health Choices program for not providing the benefits intended under the program. Specifically, they have criticized the lack of information to assist participants in accessing the Enhanced Plan, as participants are automatically enrolled in the Basic Plan. In particular, advocates cite difficulties in accessing mental health services due to the limits instituted in the Basic Plan. Advocates also note that West Virginia has yet to implement the Healthy Rewards Accounts, which was supposed to encourage healthy behaviors.

Because West Virginia implemented Mountain Health Choices under a DRA SPA, the state is not required to conduct a program evaluation and has not issued any estimates on the cost impact of the program.

### *South Carolina*

In October 2004, the State of South Carolina submitted an 1115 waiver proposal to CMS that sought to restructure the Medicaid program to increase consumer involvement in health care purchasing. The proposal, entitled “South Carolina Healthy Connections,” was later revised and re-submitted to CMS. Waiver approval is still pending; however, the state has received approval from CMS to institute benchmark plans under a DRA SPA and to develop a HOA program as one of ten states allowed to conduct such a demonstration under the DRA.

The HOA program is a pilot in Richland County that began in May of 2008. Each year, the state provides funds (\$2,500 for adults and \$1,000 for children) in the individuals’ HOA for Medicaid covered services. Costs for preventive care are not deducted from the account. If participants spend all the money in their account before the end of the year, they are required to pay an out-of-pocket deductible (\$250 for adult and \$100 for child) or they can disenroll from the HOA program. Participants use accrued contributions, even if they are no longer eligible for Medicaid, for services such as job training, education or other health care expenses. The benchmark plan allows participants to enroll in a high-deductible health plan that is similar to options offered to state employees.

**Table H: Benefit Recommendations**

Recommendations	Qualities								
	Implementation				Financial		Other		
	Timing	Requirements	State Administration Impact	Current MMIS Feasibility	Estimated (Savings)/ Cost	Risk for Claims Cost	Statewide Feasibility	Quality	Access
Recommendation 8: Modify Existing Copays	3 - 6 mths	Modify State Plan	Same as current program	Yes	(\$900,000)	State	High	No Impact	Slight deterrent to services
Recommendation 9: Copys and Premiums by Income	SFY 2011	DRA SPA	Automation through MMIS and enhancement of capabilities	No	(\$2 - \$3 million)	State	High	No Impact	Deterrent to services
Recommendation 10: Tiered Benefit Plan Design	SFY 2011	DRA SPA	Enhancement to MMIS; staff training; assessment tools	No	NA	State	High	No Impact	Limits benefits for certain populations

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## Other Program Considerations

### Overview

In addition to changes in delivery systems or benefit designs, Mercer has identified other considerations for the State that would not involve significant changes to the current Medicaid program. However, these options could still produce long-term savings for the State, improving the fiscal sustainability of the program. Various reviews could be done around program management on the FFS, PCCM and managed care programs to identify inappropriate utilization, areas for improved contract or policies/procedures compliance, areas of further education and clarification in policies/procedures and opportunities for additional recoveries through the State's Medicaid Integrity Program.

Areas presented for the State's consideration in this section of the report are:

- Durable Medical Equipment
- Home Health Services
- Assisted Living Reimbursement
- Avoidable In-Hospital Services
- Medicaid Integrity Program

### Durable Medical Equipment (DME)

Managing the expenses of DME demands a multi-faceted approach. The service management should consider medical necessity criteria, prior authorization requirements and reasonable costs of equipment. Even if the State chose to competitively bid for the purchase of DME, it would still be necessary for the State to maintain and implement medical necessity criteria and prior authorizations and review fee schedules or requests for changes to fee schedules.

Medical necessity criteria could be supported in a variety of manners. Medicare has established criteria and supplemental bulletins that could be used to maintain and update the State's existing medical necessity criteria. The State will need to consider and review Medicare medical necessity regulations versus Medicaid regulations to address any differences that may exist. Also, there are standard medical necessity criteria tools that can be purchased with associated annual fees for regular updates, such as the Milliman Care Guidelines. Another resource for the State on DME medical necessity criteria could be the MCO managing the full-risk managed care program. Typically, MCOs establish criteria consistent with the state programs, but also have detailed medical necessity criteria in place.

A cursory review of the State's DME prior authorization policies indicates a comprehensive program with requirements consistent with other states. However, the process for monitoring and tracking equipment use once prior authorized is cumbersome. The State may want to consider enhancements in this area while it is currently in the process of developing the MMIS update for SFY 2011.

To evaluate the State's current DME fee schedule and payments for equipment, the State may want to review its own Medicaid experience data and review the range in costs for similar equipment. Based on these ranges and percentile distributions, the State could establish reasonable ranges for DME pricing and require prior authorizations for costs outside of these ranges. In addition, Medicare has established pricing by HCPCS for its competitive bidding program. This pricing includes a floor and ceiling price for each code by jurisdiction (compilation of states for the bidding process). Nebraska is in Jurisdiction D where Noridian Administrative Services (NAS) is the awarded contractor for Medicare DME Medicare Administrative Contractor. Through NAS' Medicare website, it is possible to get the fee schedule that Noridian is using in the State and compare that to the floor and ceiling prices established by Medicare for Jurisdiction D. The State could use this Medicare pricing information to develop a standard fee schedule or to establish reasonable ranges in prices for DME.

Depending on the specificity of the State Plan and the State Regulations, it may be necessary to modify the State Plan and/or State Regulations to make changes to medical necessity criteria, prior authorization requirements or fee schedules. Changes to the State Plan and/or State Regulations would increase the time needed to implement these DME considerations.

## Home Health Services

Similar to DME services, there are many areas for managing the services and costs of a home health program. Some concerns Nebraska expressed regarding its existing program relate to the definition of medical necessity, the scope of benefits provided and the limits on services provided. These areas for concern are typically only broadly defined by CMS for the Medicaid program.

For Medicaid, each state is allowed to develop its own definition of medical necessity. Some states define this for medical services in general, while other states may define this specific to home health. Examples are included below.

- Arizona – “Medically necessary” means a covered service is provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability or other adverse health conditions or their progression, or to prolong life.
- Connecticut – “Medical necessity” or “medically necessary” means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition or to prevent a medical condition from occurring.<sup>12</sup>
- Connecticut (home health specific) – “Medical appropriateness” or “medically appropriate” means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities.<sup>12</sup>

Similarly, states vary greatly in how they address the scope and limits of benefits, including services for children, the responsibility of the parents or caretaker, the locations permissible for home health care, the limitations on the number of hours and the use of Licensed Practical Nurses and Registered Nurses. Nebraska may want to conduct a separate, detailed study of home health programs in other states to identify areas where more clarification is available to help manage its own home health services.

Medical necessity criteria could be supported in a variety of manners. Medicare has established criteria and supplemental bulletins that could be used to maintain and update the State’s existing medical necessity criteria. The State will need to consider and review Medicare medical necessity regulations versus Medicaid regulations to address any differences that may exist. Also, there are standard medical necessity criteria tools that can be purchased with associated annual fees for regular updates, such as the Milliman Care Guidelines. Another resource for the State on home health medical necessity criteria could be the MCO managing the full-risk managed care program. Typically, MCOs establish criteria consistent with the state programs, but also have detailed medical necessity criteria in place.

Depending on the specificity of the State Plan and the State Regulations, it may be necessary to modify the State Plan and/or State Regulations to make changes to medical necessity criteria or prior authorization requirements. Changes to the State Plan and/or State Regulations would increase the time needed to implement these home health considerations.

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<sup>12</sup> Connecticut Medical Assistance Programs. “Home Health Services Policy/Regulation.” Chapter 7 accessible online at <http://www.ctmedicalprogram.com/prmanuals/ch7homehealth.pdf>

## Assisted Living

The State currently reimburses for assisted living services according to a variable rate structure. The ongoing monthly rates vary between rural and urban counties as well as between single occupancy and multiple occupancy dwellings. Room and board is paid by the client. The rate structure includes special considerations for the admission and discharge months as well.

Many states have incorporated additional adjustments in their assisted living reimbursement structures to account for patient acuity or complex cases. This results in an additional tiering of the rates. Most tiered rate structures differentiate rates into three to five payment levels based on either activities of daily living (ADLs), cognitive status or health needs. A few states have taken the acuity adjustments a step further and made specific case mix adjustments based on a risk assessment.

While Nebraska may not want to explore complicated case mix adjustment, the State may want to consider incorporating a tiered payment structure based on ADLs, cognitive status or health needs. The tiered payment structure could be developed to be budget neutral when compared with the existing reimbursement structure. The benefit of the tier structure would be to better match payment with resource utilization. The States of Ohio and Indiana are candidates for further study if the State is interested in pursuing this further.

Depending on the specificity of the State Plan and the State Regulations, it may be necessary to modify the State Plan and/or State Regulations to make changes to the assisted living reimbursement structure. Changes to the State Plan and/or State Regulations would increase the time needed to implement a new assisted living reimbursement structure.

## Avoidable In-Hospital Services

### ***Low Acuity Non-Emergent (LANE) Emergency Room (ER) Visits***

ER visits are expensive, costing two to three times as much as visits in a physician's office. Visits to the ER continue to increase at an alarming rate, with a significant portion of these visits being related to LANE conditions. In general, there are many causes of this increased ER utilization, including but not limited to:

- Access and network availability
- Transportation issues
- Lack of patient education/self-management skills
- Inadequate case management programs
- Drug-seeking behavior
- Health care coverage issues

Each of these causes can be addressed and appropriately managed, thus mitigating a person's inclination to seek care in an ER setting. The State currently has a program in place to address these ER visits. Using specific criteria, the State will only pay 50% of the ER facility cost for non-emergent visits.

In addition to the State's current program, a review of historical claims experience can be used to identify situations where ER visits were potentially preventable based on a review of the primary diagnosis and procedure code(s) associated with the visits. Costs are associated with each of these potentially preventable visits and savings are estimated based on the cost of these visits provided in a more appropriate setting or alternative provider, such as a primary care physician or nurse consultation.

Analyzing the impact of the potentially avoidable visits can be done for the FFS, PCCM and MCO programs. To realize the potential savings from these visits, a mechanism must be in place for care coordination services. In Nebraska, contract requirements and pay for performance programs could be developed for the PCCM contract to manage these services. In the FFS program, the State could utilize the newly implemented Enhanced Care Coordination program to implement similar contract requirements and pay for performance measures as in the PCCM program.

Under the MCO, the savings can more readily be realized by reducing the capitation rates to ensure the appropriate care coordination is occurring and reflecting the State's expectation that the MCO is managing these types of services. Detailed claims data for the MCO would be necessary to conduct the LANE analysis.

Based on analyses conducted in other states, it is realistic to expect that 5%-15% of ER spending can be saved as a result of potentially avoidable visits. The cost of the LANE analyses can range from \$75,000 to \$225,000, depending on the programs reviewed and the implementation steps included for follow-up actions.

### ***Avoidable In-Hospital Admissions***

Many hospital admissions represent missed ambulatory care opportunities and could have been avoided. The Agency for Healthcare Research and Quality (AHRQ) states that 18%-22% of Medicaid hospital admissions are potentially preventable.<sup>13</sup> These hospitalizations are the result of exacerbations of chronic illnesses such as asthma, diabetes and hypertension, as well as acute conditions that have not been properly diagnosed or treated in the ambulatory environment such as appendicitis, dehydration, angina and gastroenteritis. Each preventable hospitalization is an inefficient utilization of precious resources, as well as poor quality health care. These failures can be measured and tied to contracting, pay for performance, reimbursement rates and quality management requirements, as well as identification of more efficient health plans and providers.

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<sup>13</sup> AHRQ's Guide to Prevention Quality Indicators. October 2001. AHRQ Pub. No. 02-R0202, Revision 3 (January 9, 2004), Version 2.1. [www.qualityindicators.ahrq.gov](http://www.qualityindicators.ahrq.gov)

Prevention Quality Indicators, developed by the AHRQ, are a set of measures that can be used with hospital inpatient discharge data to identify Ambulatory Care Sensitive Conditions (ACSCs).<sup>14</sup> ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization. The AHRQ has identified 16 ACSCs.<sup>15</sup> Chronic conditions include diabetes, pediatric asthma, chronic obstructive pulmonary disease, hypertension, congestive heart failure, uncontrolled diabetes, adult asthma and diabetic lower extremity amputation.

Acute conditions include perforated appendix, pediatric gastroenteritis, dehydration, bacterial pneumonia, urinary tract infections, angina without procedure and pregnancy/low birth weight. Many hospitalizations for each of these conditions are preventable with proper ambulatory care.

Similar to the LANE analysis, historical claims experience is used to identify the potentially avoidable admissions and project savings based on alternative and appropriate care. Capitation rates can be adjusted for the MCO and contract requirements and pay for performance measures can be implemented in the FFS, Enhanced Care Coordination and PCCM environments. Savings for the avoidance of these hospital admissions can be expected to range from 3% to 6% of inpatient expenditures, with costs for the review similar to the ER visits review.

## Medicaid Integrity Program

As budgetary pressure for state and federal matching funds increases, assuring state Medicaid programs are effectively purchasing services and managing expenditures continues to gain heightened attention on the state and national level. The increased emphasis on budget restraints, the DRA and the CMS initiatives have placed Medicaid integrity as a top priority for the detection, prevention, recovery and elimination of waste.

Effectively leveraging and integrating data information across organizations and developing a culture of awareness to the detection and prevention of waste, fraud, and abuse is the foundation to a successful Medicaid integrity program. To ensure the State is effectively collecting recoveries where it is eligible, the State may want to consider an onsite review of its Medicaid Integrity Program. This review could encompass the areas of Third Party Liability, Coordination of Benefits, Fraud and Abuse and Estate Recoveries. The review would provide a gap analysis of the Medicaid Integrity Program to ensure the State program is aligned with CMS Medicaid Integrity Regulations and all opportunities for recoveries are being identified. As a result of the gap analysis, best

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<sup>14</sup> AHRQ's Guide to Prevention Quality Indicators. October 2001. AHRQ Pub. No. 02-R0202, Revision 3 (January 9, 2004), Version 2.1. [www.qualityindicators.ahrq.gov](http://www.qualityindicators.ahrq.gov)

<sup>15</sup> AHRQ's Guide to Prevention Quality Indicators. October 2001. AHRQ Pub. No. 02-R0202, Revision 3 (January 9, 2004), Version 2.1. [www.qualityindicators.ahrq.gov](http://www.qualityindicators.ahrq.gov)

practices can be developed for identification and collection of fraud, abuse and waste. Staff training can also be developed to ensure consistent application of best practices.

These reviews vary in cost based on the areas included for review as well as if Medicaid claims data are reviewed to help identify potential gaps. The return for the State, as experienced in other programs, is a more effective and efficient Medicaid Integrity Program at identifying and collecting recoveries due to the State. These reviews and gap analyses can be conducted for the State PCCM/FFS programs as well as on the MCO(s) managing the full-risk managed care program.

Depending on the specificity of the State Plan and the State Regulations, it may be necessary to modify the State Plan and/or State Regulations to make changes to the Medicaid Integrity Program. Changes to the State Plan and/or State Regulations would increase the time needed to implement these considerations.

# MERCER



MARSH MERCER KROLL  
GUY CARPENTER OLIVER WYMAN

Government Human Services Consulting  
333 South 7th Street, Suite 1600  
Minneapolis, MN 55402-2427  
612 642 8600

Consulting. Outsourcing. Investments.