

December 1, 2008 Letter to the Governor, Legislature, and Medicaid Reform Advisory Council

As you are aware, Medicaid reform was mandated by the Nebraska Legislature in LB 709 (2005), the Medicaid Reform Act. The act mandated the preparation of a Medicaid reform plan to make specific recommendations for “fundamental reform” of the State’s Medicaid Program.

On October 6, 2008, the Draft Biennial Medicaid Reform Report and Draft Medicaid Alternative Benefit Structure Recommendations Report were presented to the Medicaid Reform Council. The Biennial Medicaid Reform Report provided status of the Department’s progress in implementing the recommendations of the 2005 Medicaid Reform Plan. Both reports provided strategies that go beyond those in the initial Medicaid Reform Plan to slow the growth of the Medicaid Program and ensure fiscal sustainability.

The Division of Medicaid and Long-Term Care proposes to implement the following proposals contained in the 2008 Draft Biennial Medicaid Reform Report and Draft Medicaid Alternative Benefit Structure Recommendations Report. The Department intends to amend Medicaid regulations and the Medicaid State Plan and waivers to implement the following changes effective July 1, 2010:

1. Requirement of premium payments for families whose income exceeds 185% of the federal poverty level (FPL). This change applies to children whose eligibility determination disregards parental income.
2. Limit of 52 visits per year on outpatient mental health/substance abuse therapy for adults.

The above changes are more fully explained in the attachments to this letter including the effect of the changes on Medicaid recipients and estimates of the cost savings that will be achieved by implementation of the changes.

Additionally, the Department intends to amend Medicaid regulations and the Medicaid State Plan to limit subacute psychiatric hospital services to clients who have been committed. This service was added to the Medicaid program in April 2008. The purpose of adding the service was to provide Medicaid matching funds for services which were solely funded by the Division of Behavioral Health. The regulation, as adopted, and the State Plan which is pending before the Centers of Medicare and Medicaid Services (CMS) do not make a distinction between Medicaid clients who are committed to a psychiatric hospital and those who are voluntary. This was an unintended expansion of services as the Division of Behavioral Health only funded committed clients. Therefore, the Department proposes to limit subacute psychiatric hospital services to Medicaid clients who are committed.

This information is being provided to the Governor, the Legislature and the Medicaid Reform Council in compliance with Neb. Rev. Stat. Sections 68-909(2) and 68-912(4).

Additionally, although notice is not required by the statutes referenced above, the Department provides notice of the following changes it intends to make:

1. Payment for disability childcare will be made only for those costs exceeding traditional childcare. This change is being implemented to comply with federal requirements that the services must be based on medical necessity. Costs which would be incurred by parents regardless of their child's disability will be the responsibility of the parent.

The Department also intends to implement the following changes related to delivery of services:

1. There is currently mandatory managed care for specified Medicaid populations in Lancaster, Sarpy. Clients have the option of enrolling with a Managed Care Organization (MCO) which accepts full-risk for providing all specified services or have the option of enrolling in the Primary Care Case Management (PCCM) program where claims are paid, on a fee-for-service basis by the Department.

The Department will amend its managed care waiver to create a mandatory managed care program in the counties referenced above where the clients will have the option of enrolling in one of two MCOs. The Department will be able to accomplish this strategy only if at least two MCOs submit acceptable bids in the procurement process.

Data analysis by the Department indicated that the MCO program was more cost effective than the PCCM program and either was more effective than non-managed care. The comparison revealed that, for services rendered in CY 2006, the Department paid \$206.42 per member per month (PMPM) for clients in the MCO, \$208.70 PMPM for the same services for clients in the PCCM plan. For the non-managed care clients in the counties contiguous to the current managed care program, the Department paid \$211.18 PMPM.

In the "Medicaid Alternative Benefit Structure Recommendation Report," Mercer estimates savings resulting from children and parents moving into full-risk managed care may be 4% to 8% of costs. Savings for the non-dual eligible disabled adult population are typically slightly higher. Mercer estimates savings to the Department to convert the current mandatory managed care program to two MCOs range between \$5.2 and \$6.9 million.

2. The Department also intends to expand mandatory managed care to the counties contiguous to the current mandatory managed care program. This includes: Cass, Dodge, Gage, Otoe, Saunders, Seward and Washington Counties. Expanding mandatory managed care to the counties contiguous to the current mandatory managed care program can improve cost of, quality of and/or access to care for enrollees. In addition, adding the potential of 116,853 member months (9,738 average monthly eligibles) in the contiguous counties will assist the Department in attracting potential MCOs.

The Department has estimated that expanding the current mandatory managed care program to the contiguous counties could result in a potential savings of \$885,000 to \$2.7 million.

3. The Department will explore contracting with a transportation broker for non-emergency medical transportation as well as non-medical transportation. Medicaid currently reimburses non-emergency transportation services on a fee-for-service basis. The exception is in the MCO program where non-emergency medical transportation is included in the MCO's PMPM rate. Administration of the current non-emergency medical transportation program has been fragmented and inconsistent with several entities involved in rate setting and authorizing services for eligible clients across the state.

A transportation broker manages the cost and utilization of non-emergency transportation services by shifting services to the most cost effective mode of transportation while considering the needs and limitations of the client. In addition, a transportation broker can assist to monitor the program for quality and access. The Department will review data in order to determine whether this strategy will assist in providing consistency and access in a fiscally sustainable manner.

Should you have any questions, do not hesitate to contact me at (402) 471-2135 or Vivianne.Chaumont@nebraska.gov.

Sincerely,



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

Attachments

Premium Payments

Premium Payments for families whose income exceeds 185% of the Federal Poverty Level (FPL). This applies only to children whose Medicaid eligibility is determined without regard to parental income.

The Department proposes to impose a premium payment requirement on a sliding fee schedule for families of children in specialized categories whose income exceeds 185% of the Federal Poverty Level (FPL). The Department will implement this proposal by submitting an amendment to the Medicaid State Plan and to the current Home and Community-Based Waivers.

This proposal affects children in the following specialized categories: Katie Beckett and Home and Community-Based Waivers. Neither of these categories, according to federal regulations, considers the family's income in determining Medicaid eligibility. Eligibility is determined based on the child's disabilities and medical needs. Only the income of the child is considered; parental income is disregarded. As a result, children can be eligible for the program even though family income may far exceed the federal poverty limit. The proposed change does not change the eligibility requirements. The change only requires cost sharing through payment of a premium.

The DRA requires the premium amount to be related to monthly income and family size and does not allow the premium to exceed 5% of gross income. Premiums will be imposed on a monthly basis and premiums must be paid to ensure Medicaid eligibility. Addendum A sets forth the proposed sliding fee schedule.

Estimated impact:

As of June 2006, there were approximately 800 children eligible for Medicaid in the Katie Beckett and Home and Community-Based Waiver categories. Under this recommended program change, almost half of the children would continue to be eligible without the family paying a premium.

The Department estimates more than \$83,000 will be collected per month in premiums with this proposal. Annually, the program will generate almost \$1 million in premiums. The majority of families with Medicaid-eligible children who will be subjected to a premium payment will have income in the 185% to 300% FPL range. This change is estimated to reduce Medicaid's General Fund expenditures \$426,430 in FY 2011.

Addendum A

2008 Monthly Premiums: Family of Three

<u>%FPL</u>	<u>Annual Gross Income</u>		<u>Monthly Premium Due</u>	<u>% of Gross</u>
185%	\$31,765	\$35,198	\$26.47	1.00%
205%	\$35,199	\$38,632	\$36.67	1.25%
225%	\$38,633	\$42,066	\$48.29	1.50%
245%	\$42,067	\$45,500	\$61.35	1.75%
265%	\$45,501	\$48,934	\$75.83	2.00%
285%	\$48,935	\$52,368	\$91.75	2.25%
305%	\$52,369	\$55,802	\$109.10	2.50%
325%	\$55,803	\$59,236	\$127.88	2.75%
345%	\$59,237	\$62,670	\$148.09	3.00%
365%	\$62,671	\$66,104	\$169.73	3.25%
385%	\$66,105	\$69,538	\$192.80	3.50%
405%	\$69,539	\$72,972	\$217.31	3.75%
425%	\$72,973	\$76,406	\$243.24	4.00%
445%	\$76,407	\$79,840	\$270.61	4.25%
465%	\$79,841	\$83,274	\$299.40	4.50%
485%	\$83,275	\$86,708	\$329.63	4.75%
505%	\$86,709	\$90,142	\$361.29	5.00%
525%	\$90,143	\$93,576	\$375.59	5.00%
545%	\$93,577	\$97,010	\$389.90	5.00%
565%	\$97,011	\$100,444	\$404.21	5.00%
585%	\$100,445	\$103,878	\$418.52	5.00%
605%	\$103,879	\$107,312	\$432.83	5.00%
625%	\$107,313	\$110,746	\$447.14	5.00%
645%	\$110,747	\$114,180	\$461.44	5.00%
665%	\$114,181	\$117,614	\$475.75	5.00%
685%	\$117,615	\$121,048	\$490.06	5.00%
705%	\$121,049	\$124,482	\$504.37	5.00%
725%	\$124,483	\$127,916	\$518.68	5.00%
745%	\$127,917	\$131,350	\$532.99	5.00%

MENTAL HEALTH/SUBSTANCE ABUSE OUTPATIENT

Nebraska Medicaid Coverage: No limits.

Surrounding States' Medicaid Coverage:

Colorado: Mental health outpatient therapy limited to 35 visits per year; Substance abuse treatment limited to 25 visits per year.

Iowa: No limits.

Kansas: No limits.

Missouri: Mental health outpatient therapy limited to 30 hours per year; Substance abuse treatment limited to 30 hours per year.

South Dakota: Mental health outpatient therapy limited to 40 hours per year; Do not cover substance abuse for adults.

Wyoming: No limits.

Other States' Medicaid Coverage:

States with Limited Mental Health: Colorado (35 visits/year); Idaho (26 visits); Missouri (30 hrs/yr); New Hampshire (\$1,800/year); New York (40 visits/year); South Dakota (mental health 40 hours/year); Virginia (up to 52 visits in the 1st year; 26 visits/year thereafter);

States with No Substance Abuse: Idaho, Louisiana, New Hampshire, South Dakota, Utah

States with Limited Substance Abuse: Colorado (25 visits/year); Kentucky (Limited to pregnant women); Maine (30 weeks); Missouri (30 hrs/yr); Oklahoma; Tennessee (\$30,000 limit/lifetime for substance abuse); Virginia (up to 52 visits/1st year; 26 visits/year thereafter); Wisconsin (Substance abuse 15 hours or \$500/year).

Nebraska State Employees Health Insurance Plan Coverage:

Outpatient services limited to 60 visits per year, excluding treatment for serious mental illness.

Recommendation: 52 visits per year

FY 07 = \$9,700,311 (10,031 clients). Adults < 52 = 9560. Adults > 52 = 471.
Average number of visits per client = 16.5.

FISCAL NOTE: General Fund savings in 2011 = \$251,261.