Nebraska Department of Health and Human Services

Division of Medicaid and Long-Term Care

Nebraska Medicaid Reform Biennial Report

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Prepared in Accordance with Neb. Rev. Stat. § 68-908(4)

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

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

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I. Introduction

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

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

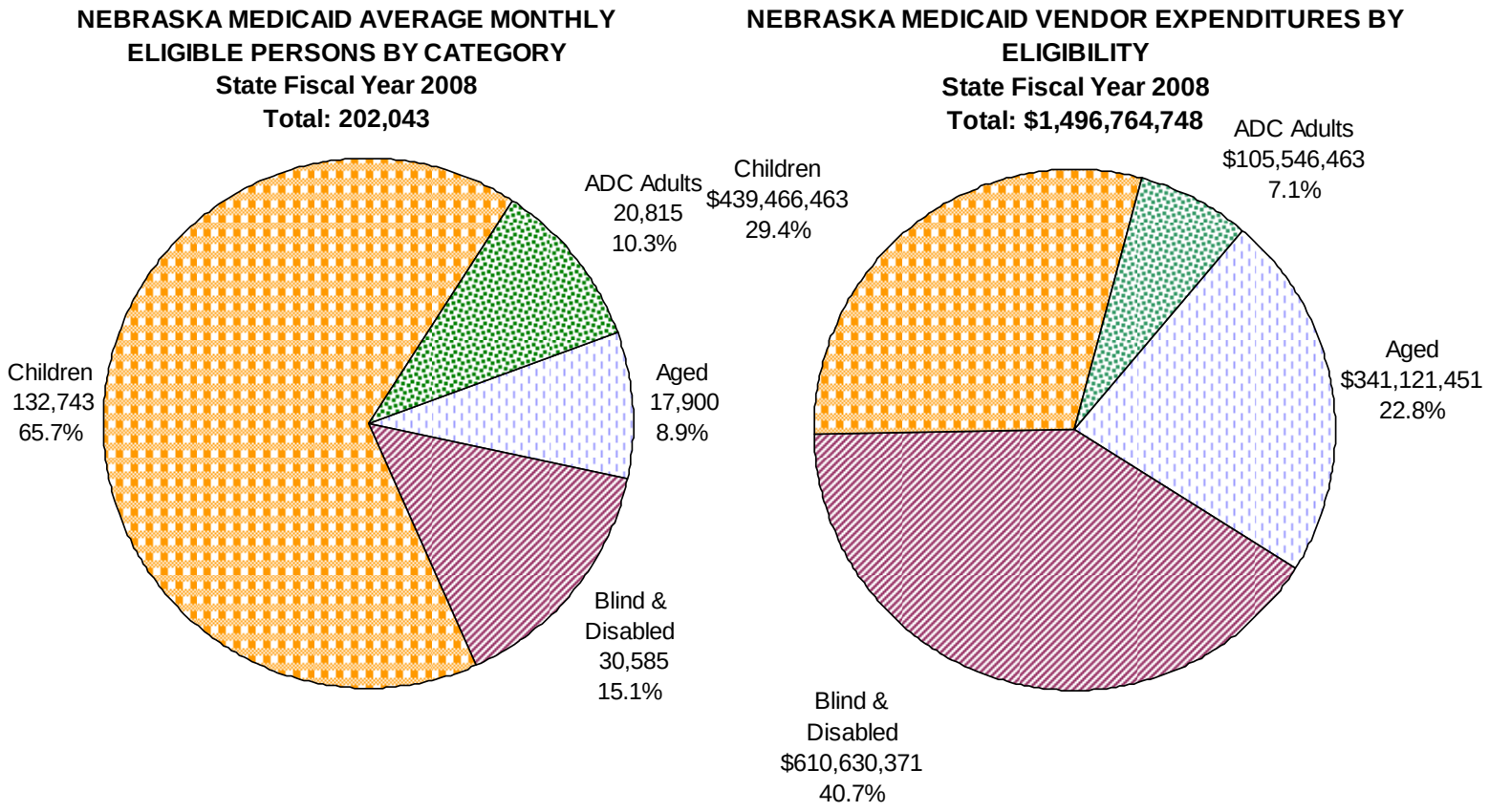
This report meets the reporting requirements of Section 68-908(4) which states that the Department of Health and Human Services (DHHS) shall prepare a biennial summary and analysis of the Medicaid Program for legislative and public review, including, but not limited to, a description of eligible recipients,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

II. Discussion

A. Eligible Recipients

Figure 1 displays the makeup of the Medicaid eligible population in State Fiscal Year (SFY) 2008 by eligibility category and the percentage of expenditures by those same eligibility categories. The graphic does not account for all Medicaid expenditures, in part because some payments and refunds are not specific to a recipient or eligibility category. Examples of transactions not shown are drug rebates, payments made outside the claims processing systems, and premium payments paid on behalf of persons eligible for Medicare.

Figure 1



The total increase in average monthly eligibles from SFY 2007 to SFY 2008 was less than 1%. The largest single increase was in the Children category which grew 2%. Average monthly eligibles in the Blind and Disabled category grew by 1.5%, while Aid to Dependent Children (ADC) Adults decreased by 8% and eligibles in the Aged category decreased by 1.7%. (Figure 1)

Total Medicaid vendor expenditures experienced an increase of 4% from SFY 2007 to SFY 2008. The largest increase in expenditures was also in the Children category, which increased by 6% from SFY 2007 to SFY 2008. Blind and Disabled expenditures were the second fastest growing category, increasing by 4.2% from SFY 2007 to SFY 2008, followed by Aged, which increased at 2.3%. Expenditures for ADC Adults grew by only 0.35%.

The average monthly cost per eligible increased 3.5% from SFY 2007 to SFY 2008. The largest cost per eligible increase was in the ADC Adult category, which increased by 9.5%, followed by Aged and Children, both at 4%. Medicaid expenditures per eligible increased by 2.64% for Blind and Disabled eligibles.

B. Covered Services

Federal Medicaid statutes mandate states to provide certain services and allow states the option of providing a choice of others. The Nebraska Medical Assistance Act delineates the mandatory and optional services offered in Nebraska.

Federal Medicaid Mandatory and Optional Services Covered in Nebraska

(Neb. Rev. Stat. § 68-911)

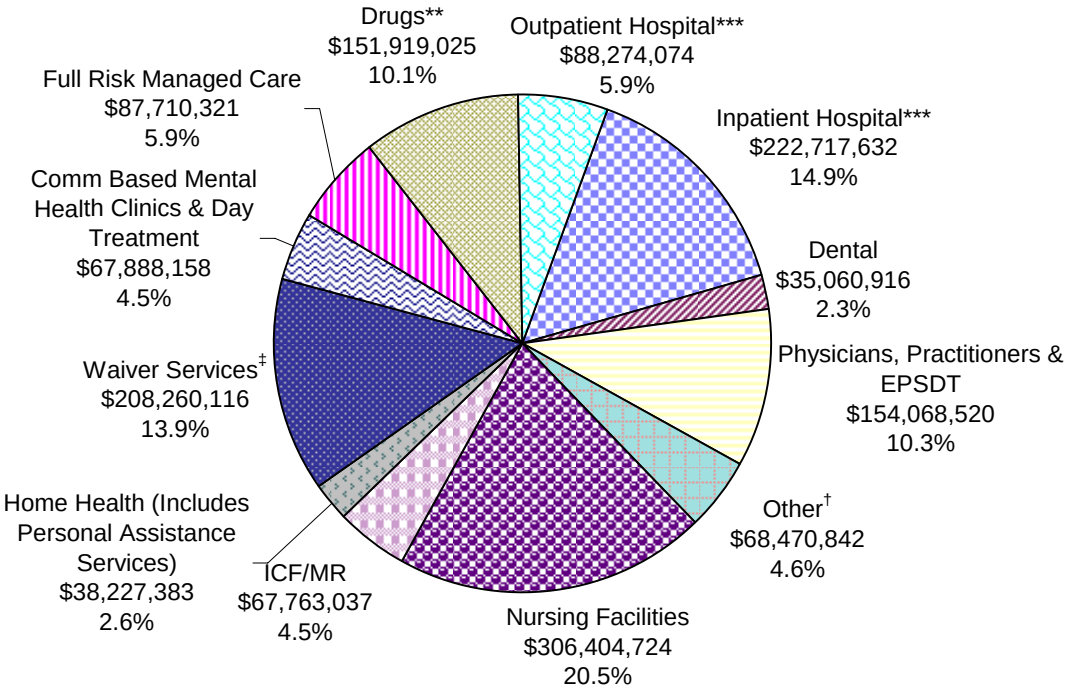
Mandatory Services	Nebraska Optional Services
• Inpatient and outpatient hospital services • Laboratory and X-ray services • Nursing facility services • Home health services • Nursing services • Clinic services • Physician services • Medical and surgical services of a dentist • Nurse practitioner services • Nurse midwife services • Pregnancy-related services • Medical supplies • Early and periodic screening and diagnosis treatment (EPSDT) services for children	• Prescribed drugs • Intermediate care facilities for the mentally retarded (ICF/MR) • Home and community-based services for aged persons and persons with disabilities • Dental services • Rehabilitation services • Personal care services • Durable medical equipment • Medical transportation services • Vision-related services • Speech therapy services • Physical therapy services • Chiropractic services • Occupational therapy services • Optometric services • Podiatric services • Hospice services • Mental health and substance abuse services • Hearing screening services for newborn and infant children • School-based administrative services

Expenditures

Medicaid expenditures to vendors in SFY 2008 totaled $1,496,764,748. Figure 2 shows the consumption of services by vendor type. It does not include drug rebates, payments made outside the claims processing systems, or premium payments made on behalf of Medicare eligibles.

Figure 2

NEBRASKA MEDICAID VENDOR EXPENDITURES* BY SERVICE
State FISCAL YEAR 2008
Total Vendor Payments $1,496,764,748



* Includes payments to vendors only, not adjustments, refunds or certain payments for premiums or services paid outside the Medicaid Payment System (MMIS) or N-FOCUS

** $58.0 million in offsetting drug rebates is not reflected in the drug expenditures of $151,919,025

*** DSH payments of $25.3 million are not reflected in Inpatient or Outpatient Hospital Expenditures

† Includes Speech/ Physical Therapy, Medical and Optical Supplies, Ambulance, and Lab/Radiology

‡ Developmental Disabilities, Aged and Disabled, Traumatic Brain Injury, Early Intervention

$1,496,764,748	**Vendor Payments**
$31,387,820	Disproportionate Share Hospital Payments
$31,151,820	Medicare Premiums
$15,018,716	Intergovernmental Transfer (IGT)
$33,483,895	Other Payments (Managed Care, Transportation, Federal Insurance Contributions Act taxes)
($61,082,140)	Rebates/Refunds
($87,804,728)	General Funds Paid in Other Budget Programs
$39,588,381	Medicare Part D Clawback
$1,498,508,512	**Net Medicaid Expenditures**

Total vendor payments increased $57,981,671, or 4%, from SFY 2007 to SFY 2008. The amount paid to each vendor group increased from SFY 2007 to SFY 2008. Full risk managed care capitation payments, home and community based waiver services, and home health services all increased as a share of total Medicaid expenditures, while other categories, most notably nursing facility services and hospital services, both inpatient and outpatient, decreased as a share of total Medicaid expenditures. (Table 1)

Table 1

Nebraska Medicaid Vendor Expenditures

	SFY 2007		SFY 2008	
	Expenditures	**% of Total**	**Expenditures**	**% of Total**
Nursing Facilities	$300,837,289	20.9%	$306,404,724	20.5%
Inpatient Hospital	$221,110,948	15.4%	$222,717,632	14.9%
Waiver Services	$196,757,144	13.7%	$208,260,116	13.9%
Physicians, Practitioners & EPSDT	$148,042,375	10.3%	$154,068,520	10.3%
Drugs	$142,527,958	9.9%	$151,919,025	10.1%
Outpatient Hospital	$87,123,761	6.1%	$88,274,074	5.9%
Full Risk Managed Care Capitation	$72,433,051	5.0%	$87,710,321	5.9%
Other	$68,787,886	4.8%	$68,470,842	4.6%
Community Based Mental Health Clinics & Day Treatment	$67,410,242	4.7%	$67,888,158	4.5%
ICF/MR	$64,056,215	4.5%	$67,763,037	4.5%
Home Health	$34,876,634	2.4%	$38,227,383	2.6%
Dental	$34,819,574	2.4%	$35,060,916	2.3%
Total	$1,438,783,077	100%	$1,496,764,748	100%

Long-Term Care Services

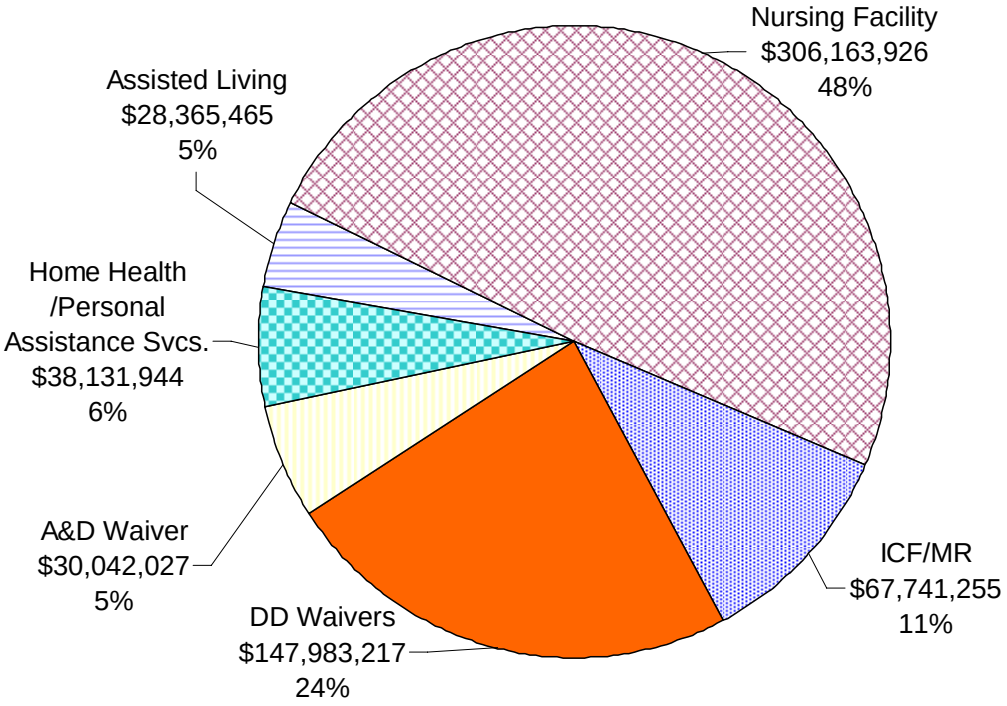
Long-Term Care services support individuals with chronic or ongoing health needs related to age, physical disability, or developmental disability. Services are geared to multiple levels of client need ranging from limited assistance with activities of daily living to complex nursing interventions. Assistance can be offered in a variety of settings from care in an individual's home, to care in small group settings with community supports, to care in a nursing facility or intermediate care facility for persons with mental retardation. In general, home and community-based care is less expensive and offers greater independence for the consumer than facility-based care. For these reasons, state and federal initiatives encourage the development of care options in the community as an alternative to institutional care, as long as a safe plan of care can be established.

Efforts to encourage home and community-based alternatives to facility-based care are resulting in a gradual rebalancing of long-term care expenditures. Comparison of Fiscal Year 2008 spending with Fiscal Year 2006 spending shows a slight decline in the percentage of dollars directed to institutional providers (nursing facilities and ICF/MR) and a corresponding increase in the proportion of spending for services in less restrictive settings. (Figure 3) Institutional payments declined from 63% of total long-term care expenditures in 2006 to 59% in 2008. Home and Community payments increased from 37% of total long-term care expenditures in 2006 to 41% in 2008.

Figure 3

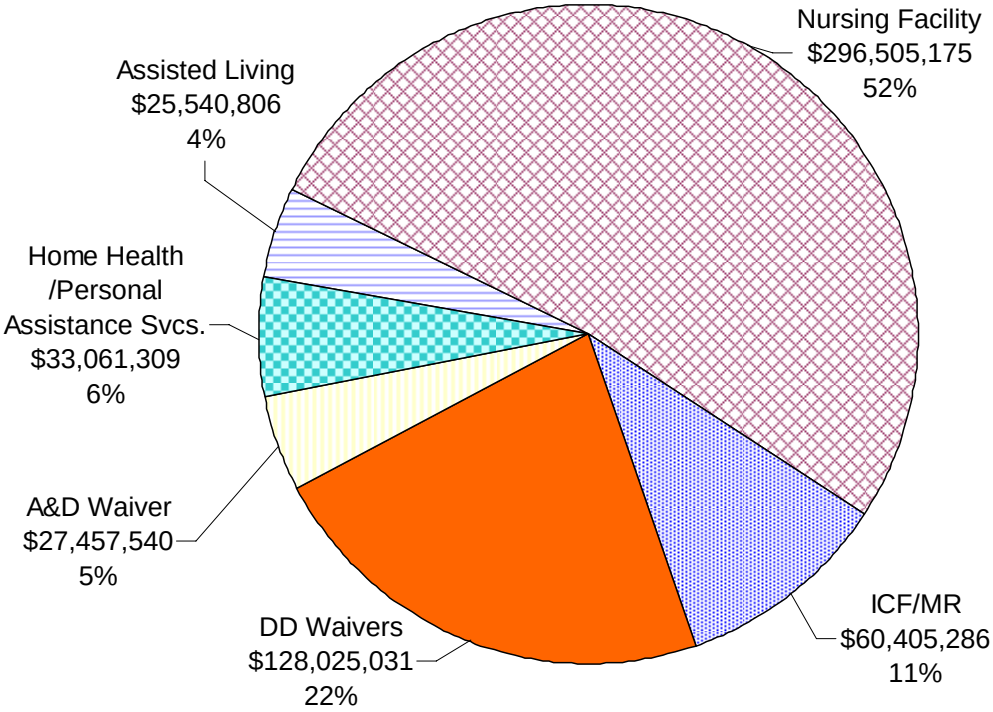
SFY2008 Medicaid Expenditures for Long-Term Care Services

Total: $625,412,323



SFY2006 Medicaid Expenditures for Long Term-Care Services

Total: $570,995,147



C. Provider Reimbursement

DHHS uses different methodologies to reimburse Medicaid services. Practitioner, laboratory, and radiology services are reimbursed according to a fee schedule. Prescription drugs are reimbursed according to a discounted product cost calculation plus a pharmacy dispensing fee. Inpatient Hospital services are reimbursed based on a prospective system using either a diagnosis related group or per diem rate. Critical Access Hospitals are reimbursed a per diem based on reasonable cost of providing the service. Federally Qualified Health Centers are reimbursed on a prospective payment system. Rural Health Clinics are reimbursed cost or a prospective rate depending on whether they are independent or provider based. Outpatient Hospital reimbursement is based on a percentage of the submitted charges. Nursing Facilities are reimbursed a daily rate based on facility cost and client level of care. Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) are reimbursed a per diem rate based on a cost model. Home and Community-Based Waiver Services, including Assisted Living, are reimbursed at reasonable fees as determined by the Nebraska Department of Health and Human Services.

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

Table 2

Biennial Budget Rate Increases Funded	SFY 2002	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007	SFY 2008
Hospitals	3.00%	3.17%	-3.13%	3.20%	3.40%	3.70%	1.95%
Practitioners	4.00%	0.00%	2.00%	2.00%	2.00%	2.00%	1.40%
Nursing Facilities	6.00%	5.42%	2.00%	2.00%	6.00%	3.50%	2.50%
Assisted Living	2.73%	3.28%	-2.00%	3.00%	2.00%	2.00%	2.00%
ICF/MRs	4.02%	5.42%	-2.00%	3.00%	2.00%	2.00%	2.50%

For Medicaid recipients participating in at-risk managed care, a monthly payment is made to the Managed Care Organization (MCO), by the Medicaid program, based on actuarially determined cost of services and administration per enrolled person. Providers are reimbursed by the MCO for services delivered to MCO clients. The MCO independently determines reimbursement methodology and rates for participating providers. As shown in Figure 2, page 6, at-risk managed care constitutes about $88 million or 6% of vendor expenditures.

For Medicaid recipients participating in the Primary Care Case Management (PCCM) managed care program, a monthly payment is made, by the Medicaid program, to the Primary Care Physician (PCP) for care management and referrals to specialists. An additional payment is made, by the Medicaid program, to the PCCM Administrator for administration of the PCCM program. Claims for services provided to recipients are paid directly to providers by the Medicaid program. Nebraska Medicaid paid approximately $125 million, or approximately 8% of vendor expenditures, for PCCM clients.

In SFY 2008, DHHS conducted a comparison of MCO costs to costs for the same set of services for PCCM clients, including care management and administrative PCCM payments, and services provided to non-managed care clients in seven counties contiguous to the current managed care program. The comparison revealed that, for services rendered in CY 2006, DHSS paid $206.42

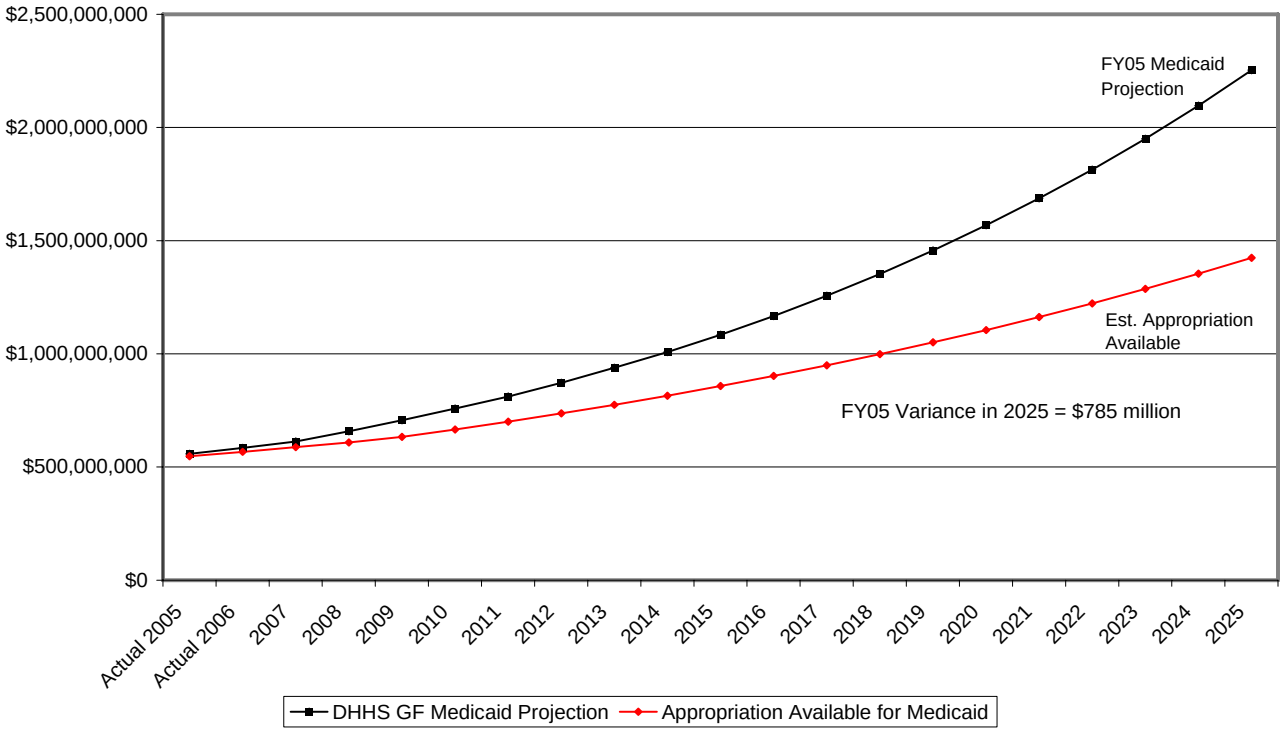
per member per month (PMPM) for clients in the MCO, and $208.70 PMPM for the same services for clients in the PCCM plan. For the non-managed care clients in the counties contiguous to the current managed care program, the Department paid $211.18 PMPM.

D. Program Trends and Projections

In the Nebraska Medicaid Reform Plan of 2005, DHHS estimated total federal and state Medicaid spending through 2025 by adjusting for demographic changes in the population and projected medical inflation over the next 20 years. Holding the proportion of General Fund revenues allocated to Medicaid constant, it was projected that, by 2025, there would be a $785 million gap between projected Medicaid General Fund expenditures and appropriations available for Medicaid. (Figure 4)

Figure 4

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



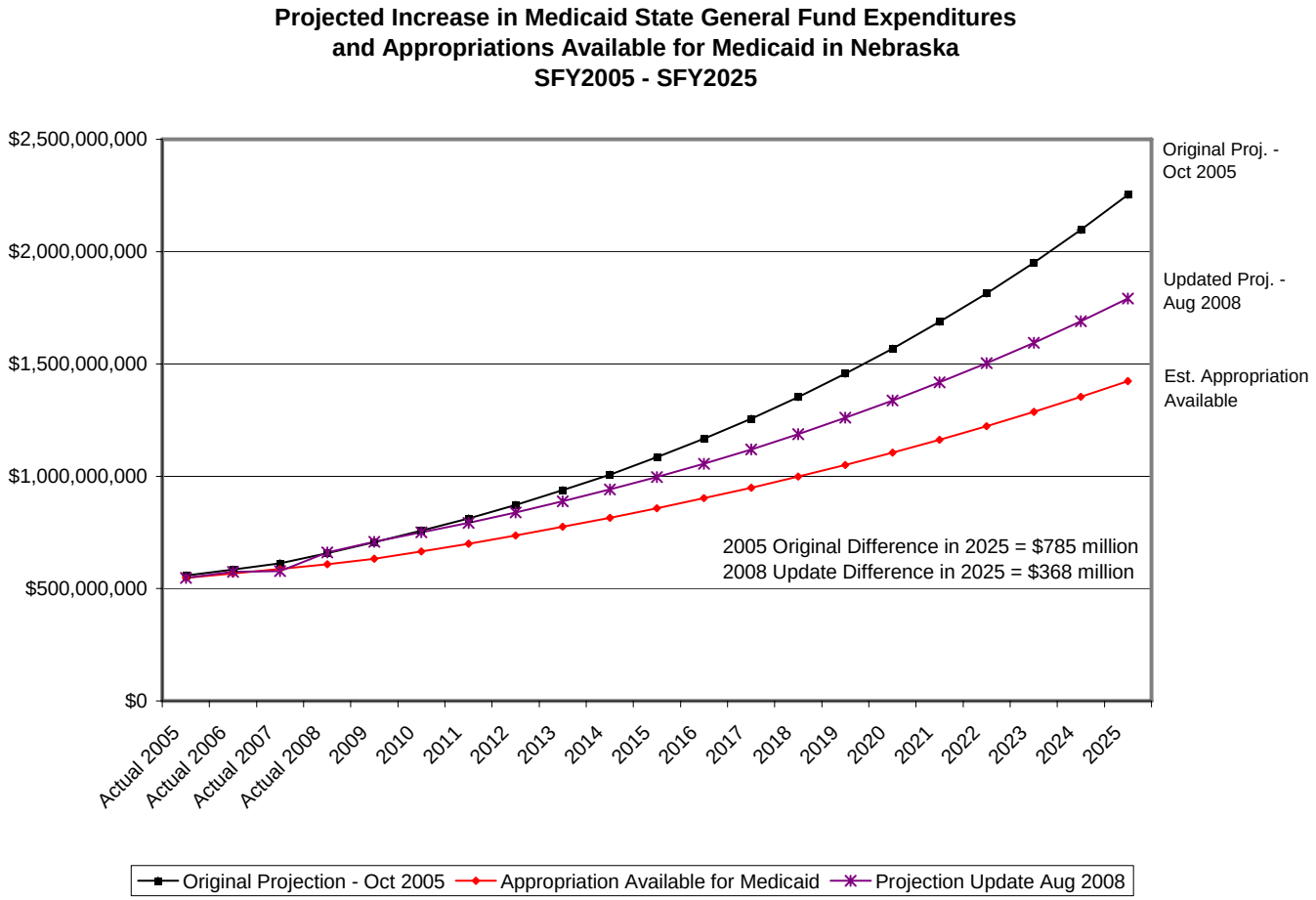
For the 2008 Nebraska Medicaid Reform Biennial Report, DHHS has revised forecasts of Medicaid eligible persons and costs as follows:

- The average monthly eligible persons by category are updated using final SFY 2008 data. Actual Medicaid caseload for 2007 and 2008 was lower than projected.
- Average monthly cost per eligible is the base for forecasting monthly Medicaid costs by eligibility category. Final SFY 2008 averages were used in the calculation. The cost adjustment factor continues to be calculated by blending historical Nebraska Medicaid average cost change rates for the last five years with the national annual medical expenditure per capita projections provided by the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary.

- Available appropriations were projected by using revenue forecast projections for General Funds. 3.6% growth was used for the SFY 2006 projection. From SFY 2010 forward, the percentage used for projections is 5.2%.

Population forecasts did not change. The 2005 base projections previously used were provided by the Center for Public Affairs Research at the University of Nebraska at Omaha. Based on the above revisions, the projected gap between estimated Medicaid General Fund expenditures and available appropriations in 2025 decreased to $368 million. (Figure 5)

Figure 5



A Response from Nebraska Consumer Advocates & Providers was presented at the Medicaid Reform Council meeting on October 6, 2008. As to the projections noted in Figures 4 and 5, the Response states that the charts were developed "looking back 20 years to identify an average grown in Medicaid spending and applied that rate of growth 20 years into the future." This statement is incorrect.

The projection of Medicaid General Funds expenditures developed during Medicaid reform was not developed by looking at an average growth based on 20 years of Medicaid expenditures as stated in the Response. Instead, the estimate was developed as a product of two projections for each fiscal year: average monthly Medicaid eligibles, and average monthly Medicaid expenditures per eligible. The resulting average monthly total Medicaid expenditure projection

was multiplied by 12 to reach an annual figure. It was then multiplied by 0.4 to estimate the General Fund portion of the projected total Medicaid expenditures.

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

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

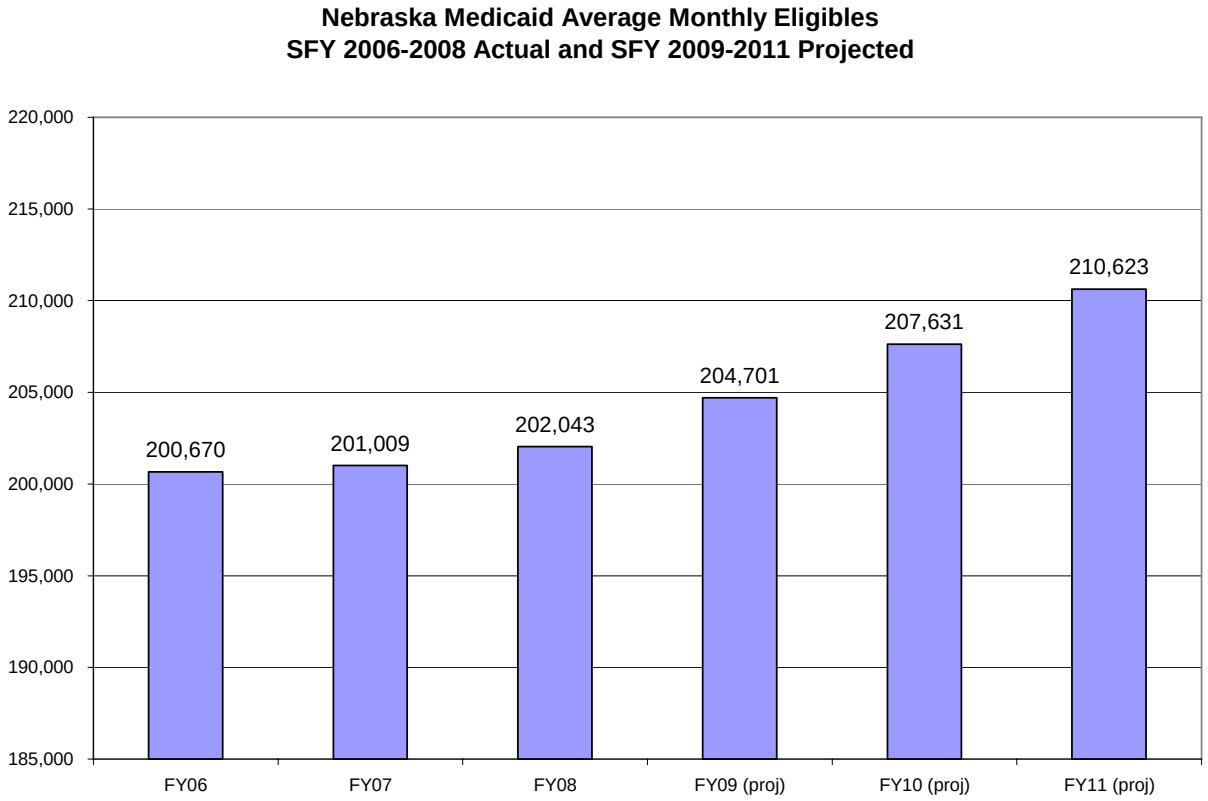
While actual Medicaid eligibles grew faster than projected using the population forecast, the distribution of eligibles was different than projected. In particular, the Medicaid Children category has grown at a faster rate than the general population of children in Nebraska. The Aged and Adult categories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

The average cost per eligible of Medicaid coverage was lower than estimated. Contrary to the assertion in the Response, this did not result from inclusion of the introduction of the State Children's Health Insurance (CHIP) program. The data did not look back that far and the average cost per eligible would not show a large increase as a result of the addition of new eligibles. The lower than estimated average cost is also not due to the introduction of Medicare Part D. Although Nebraska Medicaid no longer pays claims to pharmacies for drugs covered under Part D, the Medicaid program was required to pay CMS a clawback payment which amounted to $39 million and $40 million in General Funds in SFY 2007 and SFY 2008, respectively. The clawback payment largely offsets the reduction in pharmacy expenditures. Medicare Part D explains a fraction of the difference between projected costs and those actually realized. Additional factors would include legislatively funded rate increases, lower than expected increases in intensity of utilization, and Medicaid Reform initiatives.

Until late in 2002, Nebraska experienced substantial growth in eligible populations primarily driven by program expansions. Since 2004, the growth in Medicaid eligibility has moderated to an average annual rate less than 1%. In particular, eligibility increased 0.17% from SFY 2006 to 2007, and 0.51% from SFY 2007 to SFY 2008. Based on Nebraska population projections, eligibility is expected to increase by 1.8% in SFY 2009, and 1.7% in SFY 2010.

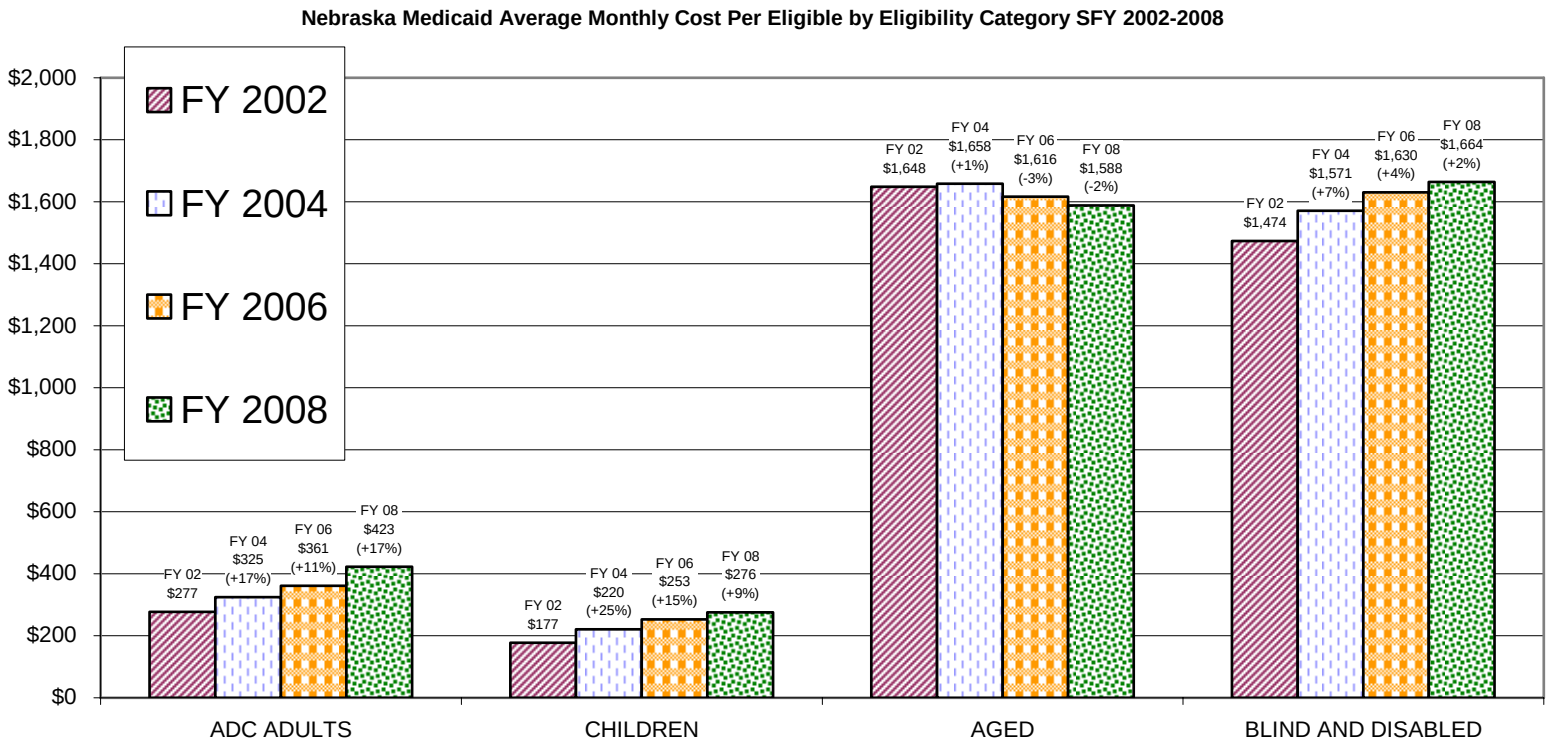
As shown in Figure 1 on page 4, the average monthly number of eligibles in SFY 2008 was 202,043. Figure 6 tracks the annual growth of eligibles. In June 2008, there were 202,674 persons eligible for Medicaid, an increase of 1,525 persons over June 2007.

Figure 6



Equally important to the fiscal sustainability of Medicaid is the trend in cost per Medicaid eligible person. The trends in average cost per category are shown in Figure 7.

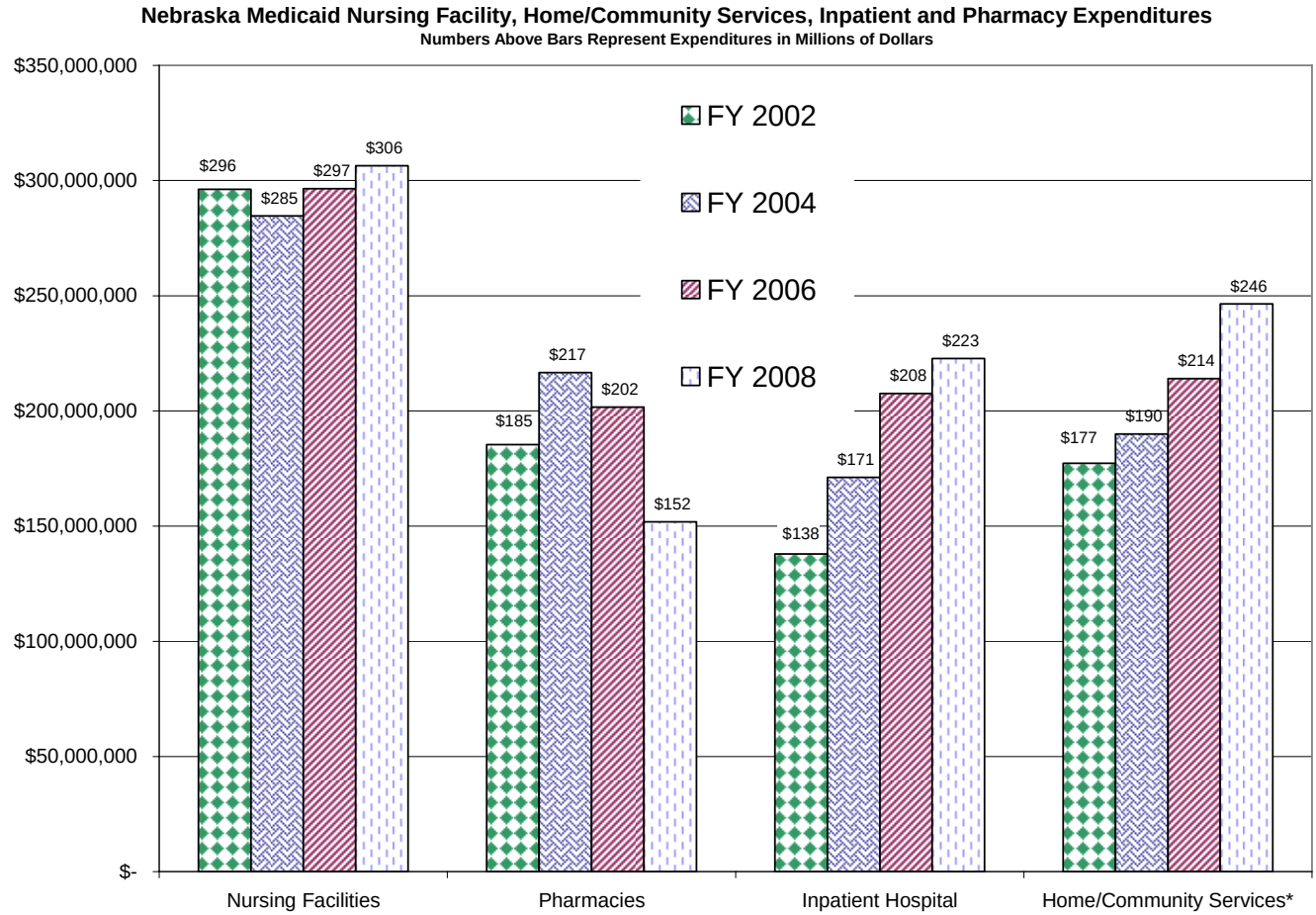
Figure 7



These trends are based on vendor payments. As such, they reflect the decrease in drug costs as a result of the Medicare Part D Prescription Drug Benefit. The two eligibility categories that would reflect that decrease in drug costs are the Aged and the Blind and Disabled. The majority of persons in the Aged and the Blind and Disabled categories now have their drug costs paid by Medicare. (Medicare Part D took effect in January 2006, thus Medicare Part D affected only the second half of SFY 2006). The ADC Adult and Children's categories are unaffected by Part D. They show increases in excess of 9% in average cost per eligible from SFY 2004 to SFY 2006 and SFY 2006 to SFY 2008.

The top four vendor expenditure categories in Medicaid are nursing facilities, pharmacies, home and community services, and inpatient hospitals. The home and community service category consists of home health, personal assistance services and waiver services, including assisted living. The trends are shown in Figure 8.

Figure 8



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

The impact of the Medicare Part D Prescription Drug Benefit is clearly shown, with pharmacy expenditures declining from $217 million in SFY 2004 to $152 million in SFY 2008. A slight four-year decline in nursing facility expenses was reversed in 2006, although nursing facilities as a percentage of the overall Medicaid program continued a slight decline. Home and community services continue to grow both in terms of dollar and as a percentage of the Medicaid program as more care and services are delivered outside of traditional institutional settings.

E. Program Budget and Expenditures

On September 15, 2008, DHHS submitted the biennial budget request to the Governor, including a request for Medicaid funding. The Medicaid request is $1,605,563,764 for SFY 2010 and $1,641,574,217 for SFY 2011. The SCHIP request is $48,278,086 for SFY 2010 and $48,905,866 for SFY 2011.

This request was based on projected spending for SFY 2010 and SFY 2011 and incorporated utilization projection increases of 1% for the Aged, 3% for the Blind and Disabled, 1.5% for Children and no change in ADC Adults. The projected increase in price is 1% each year for all services except drugs. The projected increase for drugs is 6% each year. The SFY 2010-2011 request includes an increase related to price and utilization projections consistent with state and federal requirements and the entitlement nature of the program.

The request also incorporates the following General Fund reductions for SFY 2011:

1. Nursing home rate decrease	$600,000
2. An increase of $15,000 in the outlier threshold for Medicaid Diagnosis Related Group (DRG) hospitals reimbursement	$598,573
3. Reduction in Indirect Medical Education factor reimbursement for hospitals from 72.64% to 70%	$50,775
4. Reduction in critical access hospital reimbursement from 100% of cost to 90% of cost	$687,903
5. Reduction in outpatient hospital reimbursement from 82.45% of cost to 75% of cost	$899,826
6. Coverage of disability childcare limited to the cost exceeding traditional childcare	$725,380
7. Premium payment for families whose income is over 185% of the Federal Poverty Level. This applies to children whose eligibility determination disregards parental income.	$426,430
8. Limit of 52 visits per year on outpatient mental health and substance abuse therapy for adults	$251,261
9. Implementation of two-tiered payment rates for office and facility-based care provided by physicians	$4,000,000

F. Status of Implementation of 2005 Medicaid Reform Plan

I. The Medicaid program in Nebraska, as it is currently structured, is not fiscally sustainable

1. **DHHS has contracted to evaluate health outcomes and cost-effectiveness through a defined contribution study**

A contract was awarded to Mercer Health and Benefits to evaluate the health outcomes and cost-effectiveness of the Medicaid Reform experience of other states and provide recommendations. Priority areas for examination include: Dental, Transportation, Long-Term Care, Behavioral Health, Cost Sharing including Premiums, Benchmark Plans and Tiered Benefit Programs and Managed Care. A draft report was provided to the Medicaid Reform Council and the Health and Human Services Committee of the Legislature on October 1, 2008. A final recommendations report will be provided on December 1, 2008.

2. **Federal citizenship and identification documentation is being collected from all Medicaid applicants**

DHHS implemented Section 6030 of the federal Deficit Reduction Act of 2005 on July 1, 2006. This federal legislation requires that agencies obtain specific documents establishing citizenship and identity for all clients claiming to be U.S. citizens. All documentation on current clients has been received. All applicants applying as U.S. citizens are required to provide citizenship and identity documentation before benefits begin.

3. **Analysis of the feasibility of partial month eligibility has been completed**

Federal regulations require that Medicaid coverage be effective three months prior to the date of application (i.e. retroactive coverage) and until the date an individual is no longer eligible. Nebraska elected to follow a federal option to provide eligibility for the full month if an individual is eligible at any time during the month. Federal regulations allow partial month coverage during the first and last months of eligibility. Feasibility analysis was conducted with a recommendation that this change should be implemented with the new Medicaid Management Information System (MMIS).

4. **Limits on covered services for adults have been implemented**

Effective July 1, 2008, the following limitations on benefits became effective for Medicaid eligible clients age 21 and older: $1,000 per year for dental services; one pair of eyeglass frames and lenses in a twenty-four month period; 12 chiropractic treatments per year; 60 outpatient medical rehabilitation visits for any combination of physical therapy, speech therapy and occupational therapy; and one hearing aid per ear every four years. The Nebraska State Employee's Benefit Plan was used as the comparison model for benefits. Additionally, the benefits provided by other state Medicaid programs were reviewed.

5. **DHHS has received recommendations regarding the Nebraska's State Children's Health Insurance Program**

DHHS contracted with Mercer Health and Benefits to study Nebraska's State Children's Health Insurance Program (CHIP), also known as Kids Connection. The study included a review of the organization and administration of the program; the establishment of premiums, copayments and deductibles; and the establishment of limits on the amount, scope and duration of services offered to recipients. A final recommendations report was provided to the Medicaid Reform Council on December 1, 2007. DHHS does not plan to convert the current CHIP to a stand alone SCHIP at this time.

6. **The feasibility of implementing a premium buy-in program for children with disabilities has been evaluated**

For children with special health care needs who access Medicaid through home and community-based waivers and through Katie Beckett provisions, parental income is disregarded when determining the child's eligibility for services. DHHS recommends the application of premium payments for families with incomes exceeding 185% FPL. Premium assessments would begin at one percent (1%) of family income for families with income at 185% FPL and range up to five percent (5%) of family income for higher income levels. Premiums will be due monthly. Prepayment of premiums will be required to ensure eligibility.

II. The fastest growing expenditure category in the Medicaid program is prescribed drugs

1. **DHHS partners are outreaching and educating prescribers of behavioral health drugs regarding best practices**

Three ongoing projects were developed. The three projects are: 1) analyses of patients taking three or more atypical antipsychotic medications in a 60-day time frame; 2) children under the age of 5 taking anti-depressant, stimulant or atypical antipsychotic drugs; and 3) any patient taking 5 or more behavioral health drugs concurrently. These projects have become a regular part of the business of the Medicaid behavioral health and pharmacy teams.

DHHS is currently partnering with Magellan Behavioral Health Services and the Nebraska Medical Association (NMA) to provide education and outreach to the prescribers of behavioral health drugs. Outreach includes educational resources, best practices information, feedback forms and opportunities for consultations with NMA clinicians.

2. **Prior authorization for all new brand name drugs where determined appropriate by Drug Utilization Review (DUR) Board is required**

More than 100 drug products have been placed on prior authorization status since the implementation of the review process for brand name drugs by DHHS. Products remain in prior authorization status for a minimum of 6 months before final review by the DUR Board. Recommendations from the Board may include open access, restrictions for quantity or age, or continued prior authorization.

The largest single class of drugs addressed by the DUR has been those used for treatment of cough or cold which have no clinical advantage over other covered products but are significantly more costly. The DUR Board developed a list of recommended covered generic cough and cold products and, effective November 1, 2007, coverage was restricted to listed products.

3. DHHS will establish a preferred drug list and purchasing pool for prescribed drugs

DHHS contracted with Mercer Health and Benefits to study the current Medicaid Pharmacy program and the potential use of a preferred drug list and purchasing pool. The study was completed in October 2007. The study recommended a variety of program improvements which will be reviewed once implementation of the new Point of Sale contractor has been completed.

The study further indicated a wide range of possible savings by developing and implementing a Preferred Drug List (PDL) and a pooled purchasing arrangement. Legislative Bill 830, passed during the 2008 legislative session, established broad parameters for the PDL and pooled purchasing. DHHS has posted a Request for Proposal (RFP) for a Pharmacy Benefits Manager. The bill requires program establishment by July 1, 2010.

III. Long-Term Care Services for the elderly and disabled are the largest expenditure categories in the Medicaid Program

1. Home and Community-Based Waiver Services have been expanded

Waiver slots are approved to expand incrementally to meet the projected growth in the segments of the population expected to need long-term care services. The 10% per year increase in slots takes into account the projected changes in aged and disabled populations.

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

2. DHHS has developed and will implement a Long-Term Care Needs Assessment Tool

DHHS is in the process of implementing the Nebraska Home Care Tool for assessing whether clients meet the functional criteria to be eligible for services of the Aged and Disabled Medicaid Waiver or a nursing facility. Programming of the electronic tool and validity is complete. In conjunction, the regulations which address level of care criteria have been revised and are in the promulgation process. Proposed implementation is January 1, 2009.

3. DHHS will conduct a study for rate setting methodology for Long-Term Care Services

A Request for Proposals was released for recommendations for improving Nebraska's Medicaid nursing facility reimbursement structure. The contractor, Myers & Stauffer, was selected in August 2008 and has begun work.

The contractor will determine the efficiencies and inefficiencies of the current rate setting system and provide suggestions for improvement. The final report by the contractor is due to DHHS on May 1, 2009.

4. **A Rural Long-Term Care Reform Advisory Committee has been appointed**

The Rural Long-Term Care Reform Advisory Committee began work in 2006. The goal was to recommend strategies to change Nebraska's rural long-term care system from one that relies on institutional care to one that serves consumers in non-institutional settings.

A final report was completed and distributed to the Medicaid Reform Council and other work groups to use as a resource. The report identified barriers and possible solutions to the provision of services in the following areas: Workforce, Housing, Community Integration, Consumer Awareness and Transportation.

5. **DHHS will evaluate emerging technologies and identify available, cost effective technology for distance care**

DHHS is pursuing a contract with the University of Nebraska to research and write a report that includes: 1) an assessment of current and emerging in-home monitoring services involving telehealth technologies nationally; 2) an assessment of in-home telehealth monitoring services coverage and reimbursement by other state Medicaid agencies, by Medicare, and by commercial insurers; and 3) a cost/benefit analysis of in-home telehealth monitoring service outcomes, along with policy recommendations for Medicaid coverage of appropriate and cost effective services.

IV. Consistent with the experience of commercial health insurance companies, a small percentage of Medicaid recipients account for the majority of Medicaid expenditures

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

DHHS has contracted with US Care Management to provide a voluntary Enhanced Care Coordination Program for high-cost Medicaid recipients who have multiple medical conditions. The contractor will use mail and telephone methods to outreach to potential enrollees statewide. The program will use educational and health management strategies to work with enrolled clients. A nurse case manager will be assigned to assess health risk and work as an adjunct to a primary care physician. If no primary physician is identified for the client, it will be a priority of the case manager to facilitate a relationship between the client and a primary care physician. The program began September 1, 2008.

2. **DHHS has evaluated the feasibility of implementing a teen pregnancy home visitation program**

Nurse home visitation services for high risk Medicaid eligible pregnant and parenting teens as risk-reduction treatment under the Early and Periodic Screening and Diagnostic Treatment (EPSDT) benefit were developed. The services focused on providing information on prenatal and infant care, training on parenting and developing interaction with infants, family planning assistance, providing linkage and coordination with community services, and offering support. The Centers for Medicare and Medicaid Services (CMS) reviewed the contracts and determined the services were not eligible for federal financial participation. The program was, therefore, discontinued.

V. Medicaid policy emphasizes personal responsibility and accountability for the payment of health care and related expenses and the appropriate utilization of health care and related services

1. DHHS has developed client specific information to assist clients in being good health care consumers

DHHS has reviewed and revised client benefit information available on the Division of Medicaid and Long-Term Care web site to provide clients with specific benefit information and promote appropriate choices when accessing Medicaid benefits. In addition, DHHS reviews all client benefit information provided by the Medicaid managed care plans to assure accuracy in benefit information and consistency in promoting this strategy.

2. DHHS will identify public health conditions prevalent in the Medicaid population and distribute education materials

A workgroup met to identify public health conditions particularly prevalent in the Medicaid population using Medicaid data. Three conditions were identified: dental caries, cardiovascular disease and prenatal care. Culturally competent public health education materials for consumers to address those issues were identified and are being distributed through a variety of community and DHHS sources.

3. DHHS "Own Your Future" Grant activities

Information from Nebraska's "Own Your Future" Long-Term Care Planning campaign continues to be available for consumers on the Answers-4-Families website, a partnership between DHHS and the University of Nebraska's Center for Children, Families and the Law. The Long-Term Care Planning portion of this website (http://www.answers4families.org/family/long-term-care) contains information on community resources, financial planning, home modification, legal planning, long-term care insurance, preventive health care, alternatives to nursing facility care, talking with family members about future plans and other relevant information. There is also a link from the DHHS website (http://www.dhhhs.ne.gov/ags/ltcPlanning.htm) to this information.

As the official Campaign has ended, there are no plans at this time for additional awareness, training or outreach activities.

4. DHHS has implemented a Long-Term Care Partnership Program

DHHS and the Nebraska Department of Insurance have completed establishment of a long-term care partnership program in which persons who use benefits from qualified insurance policies to cover their long-term care expenses are allowed to protect an equivalent amount of assets for Medicaid eligibility and estate recovery purposes. The program's intent is to create incentives for private financing of long-term care and to provide an appropriate mechanism for sheltering assets. The Nebraska Long-Term Care Partnership was authorized in LB 965 (2006). Federal authority was contained in the Deficit Reduction Act of 2005.

A Medicaid state plan amendment with federal approval of this program was effective July 1, 2006. The Department of Insurance (DOI) certifies long-term care policies offered in Nebraska that meet federal requirements necessary to qualify for partnership status. A listing of these policies and other information about the program for consumers, agents, and insurance companies is available through the DOI website at http://www.doi.ne.gov/ltcare . DHHS regulations have been adopted to provide for the disregard of protected assets during Medicaid eligibility determination and estate recovery. Partnership states continue to collaborate with each other to enhance consumer education, agent training, and interstate reciprocity.

5. **DHHS has studied the feasibility of a "cash and counseling" model**

The Community Supports program is a consumer-directed Medicaid waiver and allows eligible individuals to direct authorized funding for services and support, including personal emergency response systems, assistive technology, vehicle and home modifications, community living and day supports, and respite. The Community Supports program became available statewide as a choice to individuals who have funding authorized through the Division of Developmental Disabilities.

VI. Nebraska should encourage alternatives to Medicaid

1. **The Nebraska Health Insurance Policy Coalition developed recommendations to encourage more small employers to offer health insurance coverage to their employees**

The Policy Coalition reviewed the results of surveys that were sent to small employers and employees who work for small employers to identify what types of insurance policies would be attractive to them both in terms of price and benefit package. The Coalition provided a final recommendations report in March 2007.

2. **DHHS will provide technical assistance to promote the establishment of community health centers and satellite operations**

A technical assistance committee was created to promote the establishment of community health centers and satellite operations in the areas of Norfolk, Grand Island-Hastings, Crete, Cass County, Thurston County and Dixon County. The Norfolk Community Health Center Clinic is waiting for notification of requested competitive grant funds to become a federally-funded Community Health Center. The Grand Island-Hastings communities have applied for a Health Resources and Services Administration (HRSA) Planning Grant to evaluate the feasibility of a Community Health Center. The Ponca Tribe in Omaha is expected to apply for funding from HRSA to become a Community Health Center.

A secondary funding initiative from HRSA targeted Cass, Dixon and Thurston Counties. The One World Community Health Center in Omaha received funding to expand into Cass County and is establishing a new federally funded access site in Plattsmouth, Nebraska. Planning grant funding was received for expansion projects in Dixon and Thurston Counties and opportunities to establish new health care access points continue in these counties.

Ongoing assistance will continue from the DHHS Office of Rural Health and the Iowa-Nebraska Primary Care Association.

3. **DHHS has identified and provided information and technical assistance to entities potentially eligible for but not currently enrolled in the 340B program**

DHHS determined that key eligible organizations would include, but not be limited to, community health centers, family planning agencies, migrant health centers, AIDS clinics, urban Indian clinics, and STD clinics. Through contacts with the American Public Health Association and Office of Pharmacy Affairs in the Health Resources and Services Administration, a list of providers eligible to purchase drugs at 340B pricing was obtained. Letters were sent to the identified eligible organizations explaining the services and website for enrollment with the final result being all were taking advantage of the program.

VII. Nebraska should explore possible sources of additional federal funds

1. Federal funds will be leveraged as allowed by law and regulation

DHHS completed a comprehensive review of the cost allocation plan, resulting in a comprehensive identification of Medicaid-related staff functions. Information was exchanged with other state Medicaid programs and federal regulation changes were reviewed. A new time reporting process for the Division of Medicaid and Long-Term Care to document staff time by activity and support Medicaid federal fund claiming was implemented. DHHS established a continuous review process for the purposes of maximizing federal fund claims as allowed by law and regulation and will review opportunities to leverage federal funds as they arise.

G. Program Changes

1. DHHS will undertake a hospital methodology study

The current hospital inpatient rates paid by Medicaid are based on 1997 cost and claims data. The Medicaid hospital inpatient Diagnosis Related Grouping (DRG) system was designed to be rebased every three years. Through the RFP process a contract was awarded to on October 3, 2008, to Navigant Consulting, Inc. The contractor will: review the existing inpatient hospital reimbursement methodology; produce a policy paper that will identify the options available for modifying current hospital inpatient payment systems; and rebase inpatient hospital rates. A rebasing will necessitate a complete recalculation of prospective per discharge and per diem rates for all acute, psychiatric and rehabilitation hospital providers reimbursed under the Fee-For-Service (FFS) system. In addition, an evaluation of the Disproportionate Share Hospital (DSH) methodology will be conducted.

2. DHHS will evaluate the expansion of managed care

The full-risk physical health Managed Care Organization (MCO) has demonstrated substantial cost savings over the traditional fee-for-service healthcare delivery system. DHHS will evaluate the expansion of managed care statewide. Additionally, DHHS will evaluate moving to an MCO-only model. The Medicaid Reform Council endorsed continued study of expanded managed care statewide but advised the Legislature to proceed with caution to ensure access to care is not disrupted and that it is fiscally sound.

3. DHHS will implement policies to avoid payment of 'Never Events'

"Never Events" are errors in medical care that are of concern to both the public and healthcare professionals and providers, and are clearly identifiable and measurable. Never events cause serious injury or death to patients and result in unnecessary costs to Medicaid due to the need to treat the consequences of the errors. CMS has announced that Medicare will no longer pay the extra cost of treating certain categories of conditions that occur while the patient is in the hospital. DHHS will amend the Medicaid State Plan consistent with Medicare policy.

4. **DHHS will implement changes to the PCCM Program**

DHHS will remove requirements for paper and/or electronic referrals for physician-to-physician (or primary care-to-specialist) services. Similar referral processes have failed to demonstrate cost savings or utilization control in the private insurance market and have been largely discontinued. Allowing clients direct access to specialists will streamline the healthcare delivery process and lift a significant obligation from many participating providers' offices. The decrease in administrative burden may encourage additional provider participation in the PCCM program and create greater access for clients.

5. **DHHS will implement Electronic Fund Transfer (EFT) for payments to Medicaid providers**

Thirty-seven percent of the payments made by the MMIS are made via electronic fund transfer (EFT). This 37% of the payments equals 75% of the dollars paid by MMIS. Of the remaining 63% of MMIS payments, 25% of the Medicaid dollars are made via paper warrants. An implementation plan has been developed to enroll all Medicaid providers in EFT. Payment of Medicaid providers via EFT will be consistent with the State Treasurer's Office policies and will increase Medicaid efficiencies and reduce costs associated with distribution of paper warrants.

Proposed implementation is January 1, 2009 for providers paid by the MMIS and by July 1, 2009 for providers paid by N-FOCUS.

6. **DHHS will evaluate the use of technology**

Electronic billing by providers

Electronic claim submission assists DHHS to operate a more efficient payment system. DHHS currently receives 80% of claims electronically. DHHS' current MMIS is able to accept and process all incoming claim types for services provided to eligible clients. Providers benefit when they submit electronic claims with shorter turnaround time for payments resulting in improved cash flow, improved tracking and monitoring capabilities, and reduced postage and paper handling costs.

DHHS has begun an awareness campaign to remind providers of the benefits of electronic claim submission. With support from the Medicaid Electronic Data Interchange (EDI) Help Desk, the goal is to have 90% percent electronic claim submission prior to implementation of the new MMIS.

Electronic subscription to Medicaid information

DHHS implemented an electronic subscription service for the DHHS web pages in the spring of 2008. Through on-line subscription, providers receive notices when Provider Handbooks, Provider Bulletins, fee schedules, contact information, or other information is added to the Division of Medicaid and Long-Term Care web pages. The subscription notification provides a link to the updated page. All updates are linked to the Division's Recent Web Updates page. Implementation of this feature has increased Division efficiency and cost effectiveness by eliminating mailing and postage. Any interested users can subscribe to the web page notification through the links on each page.

7. **DHHS will implement a new Medicaid card**

DHHS plans to implement a new eligibility card for clients eligible for the Medicaid program. Clients currently receive a monthly eligibility document consisting of an 8 ½" by 11" paper containing eligibility information for all members of the eligibility case. The proposed eligibility Medicaid Card will be a reusable card similar to current health insurance cards distributed to each client on initial eligibility. Current monthly printing and mailing costs for Medicaid eligibility cards would be greatly reduced with distribution of longer lasting cards. Providers would continue to have access to verification of eligibility via DHHS web-based and Interact Voice Response (IVR) systems through HIPAA compliant eligibility transactions with Medicaid.

8. **DHHS will simplify and continue to evaluate fee schedules**

DHHS has updated and simplified Medicaid fee schedules by listing dollar amounts rather than unit values. The goal is for the revised fee schedules to be transparent and user-friendly while contributing to staff efficiency. DHHS will continue its efforts to make fee schedules easier for providers to use.

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

DHHS will explore the possibility of contracting with a Transportation Broker to provide non-emergency medical and non-medical transportation statewide. The Medicaid Reform Council concurred with this recommendation and highly encouraged the Department to interface with all potential transportation networks in the state.

10. **DHHS has entered into a revised Administrative Services Organization (ASO) contract to better manage behavioral health services**

The Division of Medicaid and Long-Term Care, together with the Division of Children and Family Services and the Division of Behavioral Health, has entered into a two year Behavioral Health ASO managed care contract with Magellan Behavioral Health beginning July 1, 2008. This contract eliminates duplication of services and cost shifting and insures access to quality mental health and substance abuse services throughout the State of Nebraska in the least restrictive most cost effective way possible. For the past six years, the ASO has concentrated on the management of inpatient and sub acute services. The current contract focuses on clinical review and management of mental health and substance abuse outpatient services. DHHS plans to explore the implementation of an at-risk mental health and substance abuse managed care model.

11. **DHHS will evaluate implementation of radiology management services**

Radiology management can improve quality while reducing costs. Effective management of radiology services assures patients get the tests that will help improve diagnosis, decreases costs by reducing the use of tests which do not improve diagnosis, and provides specialized expertise on radiology.

12. **DHHS will develop a Program of All-Inclusive Care for the Elderly (PACE)**

DHHS will develop a PACE program. This program provides comprehensive health care services within a defined geographic area for voluntarily-enrolled individuals age fifty-five and older. DHHS will make capitated, actuarially-determined payments to a PACE organization which will utilize Medicare, Medicaid, and private pay revenues to provide coordinated care. The organization will be at-risk for all covered services offered by Medicare and Medicaid. The intent of the program is to enhance the quality of life and independence for frail, older adults.

III. Conclusion

Although the Medicaid program continues to grow, the growth in the Medicaid program has begun to slow. In the three years since the publication of the Medicaid Reform Plan, DHHS has undertaken significant steps to implement the recommendations it contains. To slow the growth of the Medicaid Program and ensure fiscal sustainability, thoughtful and dynamic strategies that go beyond those proposed in the Medicaid Reform Report of 2005 are discussed in this report. These strategies have been developed to make Medicaid more efficient and cost effective through better management of services, better delivery of care, more appropriate services and improved administration of the program.

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