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DEPT. OF HEALTH AND HUMAN SERVICES

Division of Medicaid & Long-Term Care

Nebraska Medicaid Annual Report for State Fiscal Year 2017-2018

December 3, 2018

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

Message from the Director

We are pleased to present the Medicaid Annual Report for state fiscal year 2017-2018. This report, organized into 10 sections, is part of the Division of Medicaid and Long-Term Care's (MLTC) effort to provide the legislature with a broad overview of the Nebraska Medicaid program and the state it serves.

As you will see in this report, MLTC takes seriously its ongoing commitment to delivering quality health care to Medicaid members across the state. As we enter the new state fiscal year and the beginning of Heritage Health's third year approaches, MLTC is seeking new ways to use the Division's strengths and capabilities to better serve Nebraska's Medicaid members. Our ongoing initiatives, like the Health Management Program and the Data Management & Analytics Solution, exemplify this commitment.

The Division would like to thank our partners in the legislature and community, as well as the thousands of Medicaid providers across Nebraska, who share the Department of Health and Human Services' mission to "Help People Live Better Lives." MLTC is looking forward to the road ahead as we continue to improve the lives of the state's Medicaid members.

Please contact me if you have any questions about this report.

Matthew A. Van Patton, DHA, Director
Division of Medicaid & Long-Term Care
Department of Health and Human Services

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I. EXECUTIVE SUMMARY

The Division of Medicaid and Long-Term Care (MLTC), part of the Nebraska Department of Health and Human Services (DHHS), is the administrator of the state's Medicaid program. With an appropriated budget of more than $2 billion, MLTC acts as a payor for health care services to 12 percent of Nebraska's residents, including low-income children and their parents, the aged, and individuals with disabilities.

Every state outlines the eligibility, benefits, provider payments, and service delivery systems of its specific Medicaid program within guidelines set by the federal government. Although there are numerous federal requirements, individual states have differences in eligibility requirements, the method of delivering services, and benefits.

The past state fiscal year saw the first full year of operations for Heritage Health, Nebraska's newest and most comprehensive Medicaid managed care program. At the beginning of Heritage Health in early 2017, nearly all Medicaid clients were enrolled in managed care, including populations excluded from previous managed care programs. Most Medicaid-covered services, including physical health, behavioral health, and pharmacy benefits are now delivered through managed care with the exception of long-term services and supports. In the past state fiscal year, MLTC has seen this new managed care program stabilize, which has allowed the division to plan for future improvements.

Medicaid is a significant payer of health services in Nebraska. With approximately 55,000 enrolled medical providers, MLTC has an important partnership with Nebraska's medical community for the delivery of care. The Heritage Health Managed Care Organizations (MCOs) are required by federal law and their contracts with the state to maintain robust provider networks. In state fiscal year 2018 (SFY18), over $2.1 billion was paid for services by Nebraska Medicaid.

MLTC takes seriously the trust the program's stakeholders place in it to provide quality health care in a cost-efficient manner. To achieve this goal, MLTC is undertaking many reforms to its information technology systems to transform how program data is gathered, service payments are made, and program eligibility (for clients and providers) is determined. Additional reforms are being made in modernizing processes and program regulations.

MLTC has made tremendous strides over the past year and looks forward to continuing its work in state fiscal year 2019.

II. MLTC STRUCTURE

MLTC includes Medicaid, the Children's Health Insurance Program (CHIP), and the State Unit on Aging. Medicaid pays for health care services to eligible aged, persons with disabilities, low-income pregnant women, and children and their parents, covering more than one in every 10 Nebraskans. The Division also administers non-institutional home and community-based waiver programs serving the aged, adults and children with disabilities, and infants and toddlers with special needs.

MLTC is divided into five sections with nearly 600 full-time employees, and also partners with a section of the Division of Children and Family Services (CFS). The Division is structured as follows:

- Delivery Systems: This section is responsible for oversight of the Heritage Health managed care program and its associated contracts, home and community-based services, and benefit design.
- Healthcare Infomatics and Business Integration: This section is responsible for business operations, technology initiatives to improve operational effectiveness, data analytics, and supporting functions.
- Policy and Communications: This section is responsible for external communications, regulatory compliance, and monitoring the federal authorities under which the Medicaid program operates, including the Medicaid state plan.
- Finance and Program Integrity: This section oversees the program integrity unit, provider relations, financial analysis and reimbursement, budget, and associated reporting.
- State Unit on Aging: This section collaborates with public and private service providers to promote a comprehensive and coordinated community-based services system to assist individuals with living in a setting of their choice and continuing to be contributing members of the community.
- Eligibility: In partnership with CFS, this section handles Medicaid eligibility field operations. This section is overseen by the CFS Deputy Director of Field Operations, who also reports to the Medicaid Director.

Chart 1: MLTC Leadership

III. ELIGIBILITY AND POPULATIONS SERVED

Originally enacted in 1965 under Title XIX of the Social Security Act, Medicaid is a public health insurance program which provides coverage for low-income individuals. Medicaid is an entitlement program, meaning it guarantees benefits to anyone who meets the qualifications.

Nebraska Medicaid, in general, provides coverage for individuals in the following eligibility categories:

- Children;
- Aged, blind, and disabled (ABD);
- Pregnant women; and
- Parent/caretaker relatives.

Eligibility factors vary by group and include income and resource guidelines. Medicaid enrollment and costs are closely related to the economy. With below-average poverty and unemployment rates, as reflected in charts 2 and 3, Nebraska's total Medicaid enrollment has remained stable at about 12 percent of the state's total population for the last few years (see Chart 4).

The major changes to enrollment as reflected in the chart show a modest growth in program enrollment during the Great Recession and an increase in enrollment since SFY 2016. Effective July 19, 2012, Nebraska implemented a separate CHIP program that added prenatal and delivery services for the unborn children of pregnant women who are not Medicaid eligible.

Chart 2: Nebraska Population by FPL Compared to National Figures

	Nebraska	United States	Percent of Nebraskans	Percent of Entire US
Under 100% FPL	184,700	41,077,500	10%	13%
100% to 199% FPL	298,700	54,621,300	16%	17%
100% to 399% FPL	627,300	94,275,300	33%	29%
Above 400% FPL	765,500	130,397,800	41%	41%

Chart 3: Average Unemployment Levels

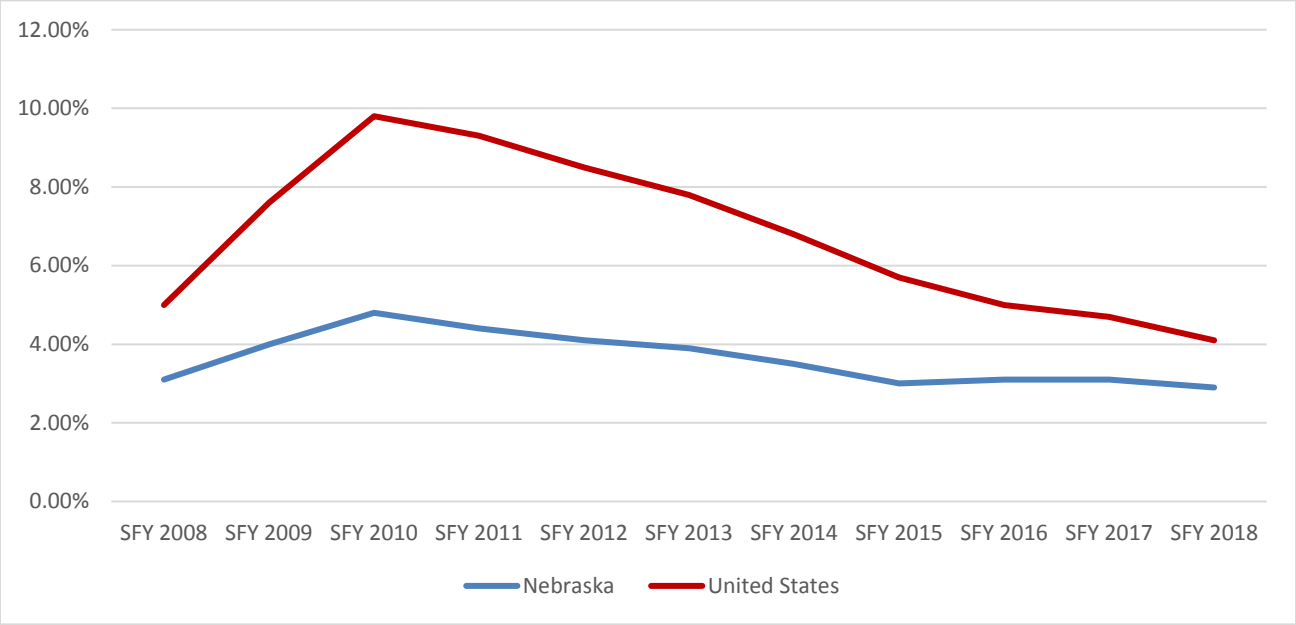
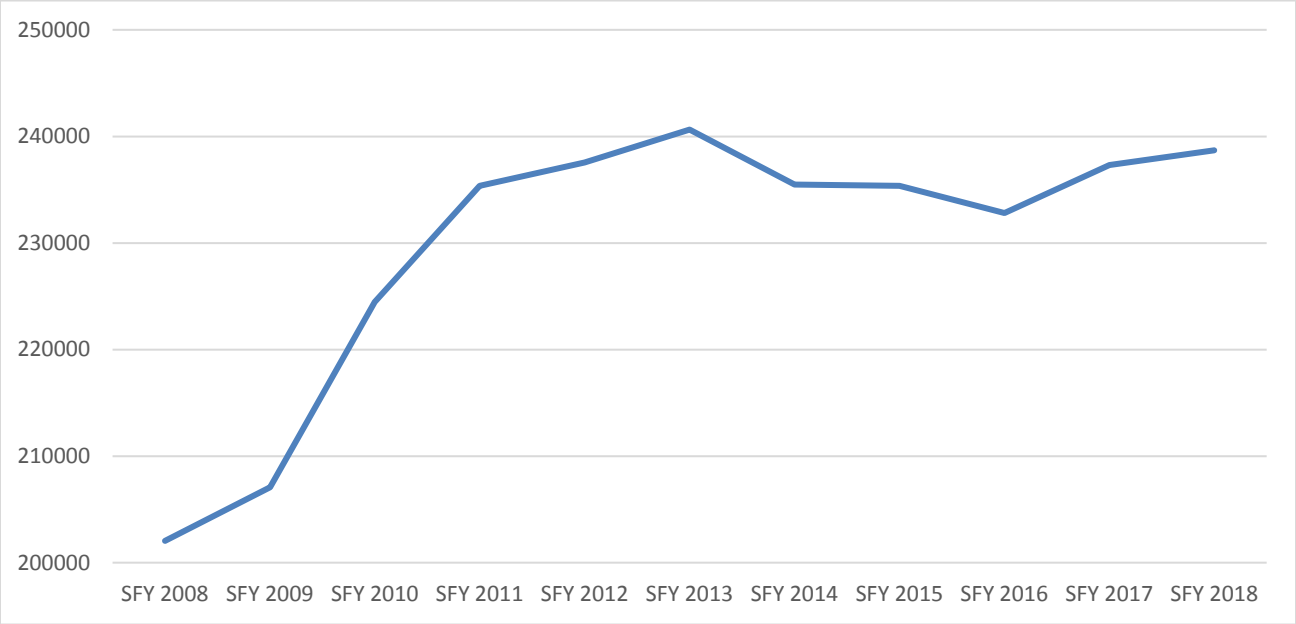


Chart 4: Average Monthly Medicaid Clients by SFY



The majority of Nebraska Medicaid clients (including CHIP children, pregnant women and parents/caretaker relatives) are subject to modified adjusted gross income (MAGI) budgeting methodology as required by the Affordable Care Act (ACA, 2010). It uses federal income tax

rules and tax filing status to determine an individual's Medicaid eligibility. This change was to simplify eligibility for certain groups and align it with eligibility for state insurance marketplaces. Other Medicaid eligibility groups in the state are still subject to other criteria, specifically groups that do not qualify based solely on income. These groups qualify for Medicaid based primarily on age or disability.

Chart 5 provides the 2018 federal poverty levels, and Chart 6 explains several of the Medicaid programs. MAGI groups are in blue.

Chart 5: 2018 Poverty Guidelines

Household Size	50% FPL	100% FPL	138% FPL	200% FPL
1	$6,070	$12,140	$16,754	$24,280
2	$8,230	$16,460	$22,715	$32,920
3	$10,390	$20,780	$28,677	$41,560
4	$12,550	$25,100	$34,638	$50,200

Chart 6: Nebraska Medicaid Coverage Groups and Income Eligibility Requirements

MAGI groups are in blue.

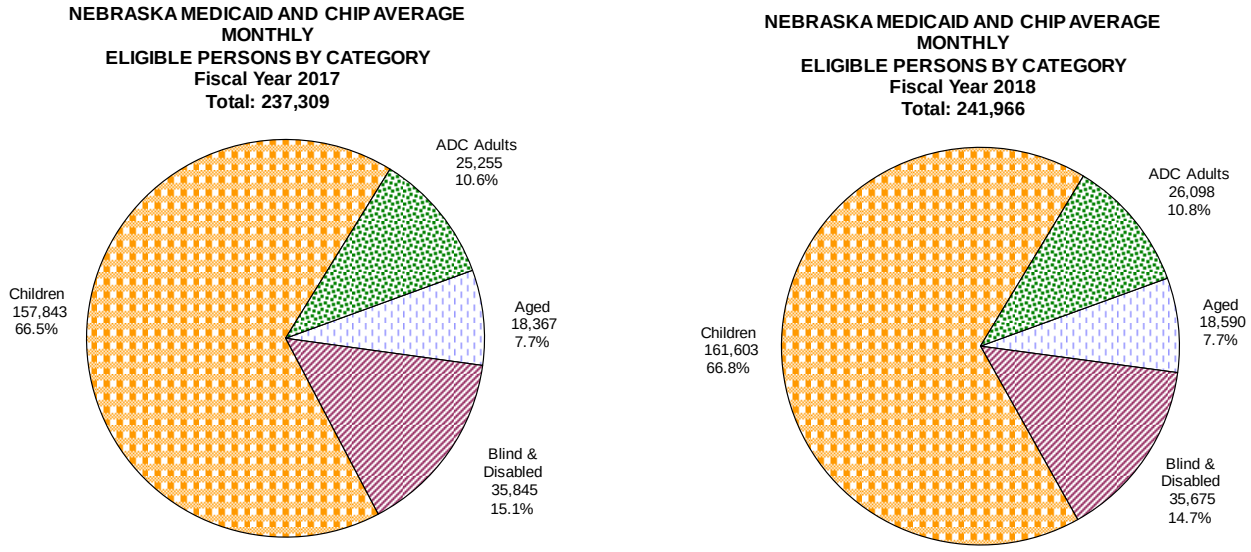
Program		Description	Income Limit
MAGI	**Subsidized Adoption and Guardianship Assistance (SAGA)**	Individuals ages 19-21, if subsidized guardianship or adoption agreement was entered into after the individual turned 16	Twenty-three percent (23%) of the federal poverty level (FPL)
	IMD	Individuals in an institution for mental disease ages 19-21.	Fifty-one percent (51%) of the FPL
	Parent/Caretaker Relatives	Parents or caretaker relatives of a dependent child under the age of 19.	Fifty-eight percent (58%) of the FPL
	Pregnant Women	An eligible pregnant woman remains Medicaid eligible through a sixty-day postpartum period. There is continuous eligibility for the newborn through his or her first birthday	194% of the FPL
	Newborn to Age One	Children from birth to age one.	162% of the FPL
	Children Ages One to Five	Children ages one to five.	145% of the FPL
	Children Ages Six to Eighteen	Children ages six through the month of their 19th birthday.	133% of the FPL
	CHIP	The Children's Health Insurance Program (CHIP) was created in 1997 under Title XXI of the Social Security Act. In Nebraska, CHIP is operated using the same delivery system, benefit package, and regulations as Medicaid. Eligible children must be uninsured.	213% of the FPL

Program		Description	Income Limit
MAGI	**599 CHIP**	A separate CHIP which covers prenatal and delivery services for the unborn children of pregnant women who are not Medicaid eligible.	197% of the FPL
Non-MAGI	**Former Foster Care**	An individual who is under twenty-six, was in foster care and receiving Medicaid at age eighteen or nineteen, and is not eligible for Medicaid under another program.	No income or resource guidelines, must meet general eligibility requirements (e.g. citizenship, residency, etc…)
	Transitional Medical Assistance (TMA)	12 months of transitional coverage for Parent/caretaker relatives who are no longer Medicaid eligible due to earned income. In the second 6 months, if the income is above 100% FPL, the family can pay a premium and be Medicaid eligible.	The first six months are without regard to income. The second 6 months, 185% of the FPL
	Aged, Blind, and Disabled	Individuals 65 or older or under 65, but are determined blind or disabled by SSA.	100% of the FPL with certain resource limits.
	Medicare Buy-In	Specified low-income Medicare beneficiaries (SLMB) and qualified individuals for whom the state pays a Medicare Part B Premium	SLMB = 120% QI = 135% Of the FPL with certain resource limits.
	Medically Needy	These are individuals who have a medical need and are over the income requirements for other Medicaid categories. This Medicaid category allows the individual to obligate their income above the standard on their own Medical bills and establish Medicaid eligibility	Income level is based on a standard of need. For a household size of 2 the income guideline is $392/month.
	Medicaid Insurance for Workers with Disabilities	These are individuals with disabilities who are eligible for Medicaid but for their earnings. They are disabled and trying to work but need to keep their Medicaid coverage to enable them to work.	200% of the FPL Between 200% FPL and 250% they must pay a premium.
	Katie Beckett	Children age 18 or younger with severe disabilities who live in their parent(s)'s household, but who otherwise would require hospitalization or institutionalization due to their high level of health care needs	Parent's income is waived under TEFRA.
	Breast and Cervical Cancer	These are women screened for breast or cervical cancer by the Every Women Matters Program and found to need treatment.	Women are below 225% FPL using EWM criteria.

Non-MAGI	**Emergency Medical Services for Aliens**	Individuals who are ineligible due to citizenship or immigration status. Must have an emergency medical condition (including emergency labor and delivery)	Income and resource vary depending on the category of eligibility.
	Subsidized Adoption	Children age 18 or younger for whom an adoption assistance agreement is in effect or foster care maintenance payments are made under Title IV-E of the Act. For non IV-E a medical review is required.	No income or resource guidelines.
	Subsidized Guardianship	Children age 18 or younger for whom kinship guardianship assistance maintenance payments are made under Title IV-E of the Act.	No income or resource guidelines.

Chart 7, below, compares enrollment in different eligibility categories for SFYs 2017 and 2018. Total Medicaid and CHIP enrollment increased from 237,309 to 241,966. The majority of this increase is attributed to the Children category.

Chart 7: Average Nebraska Monthly Enrollment for Medicaid and CHIP, SFY16 and SFY17



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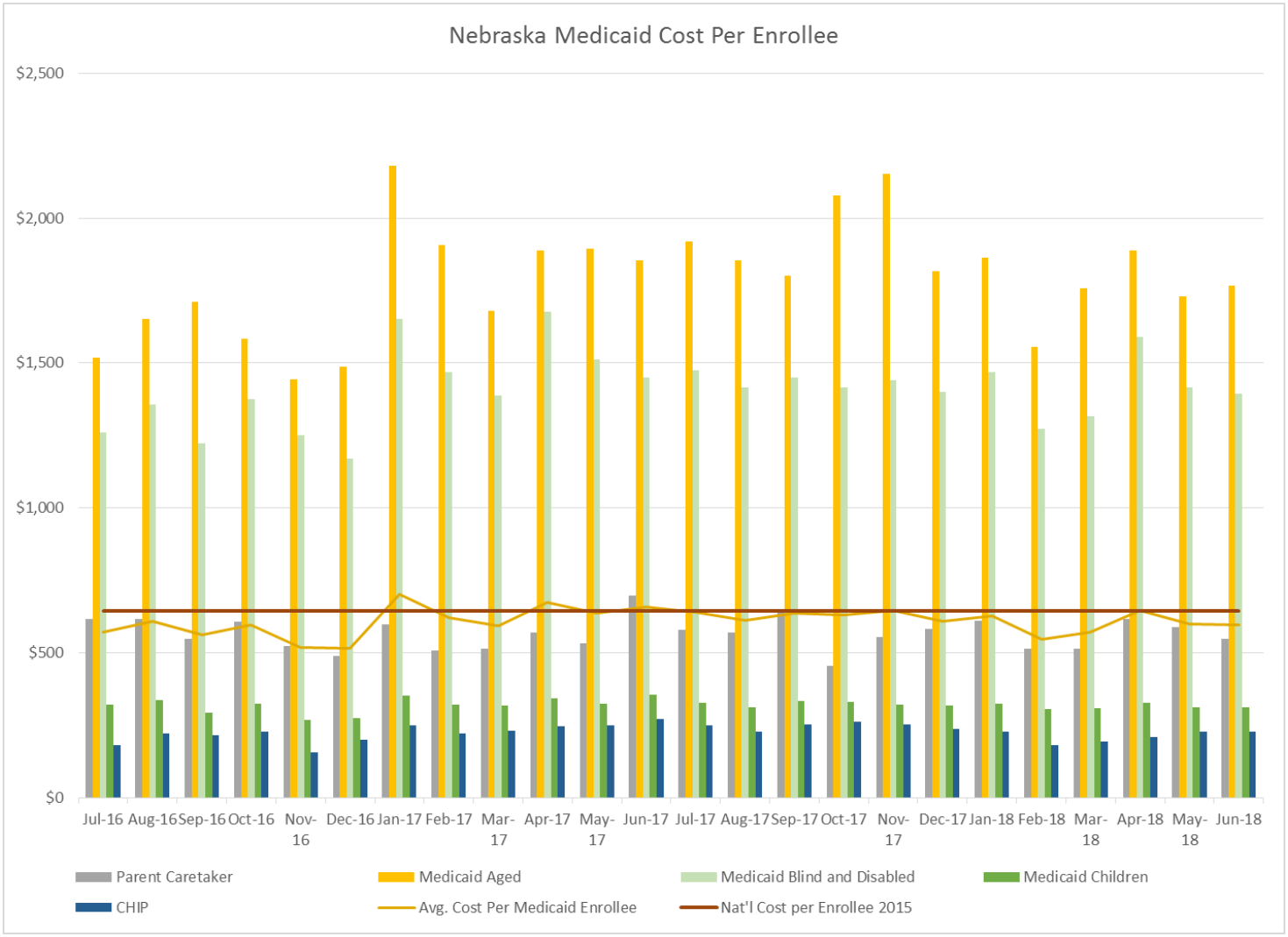
Charts 8 and 9 compare the cost of different eligibility categories. While the Aged and Blind & Disabled categories represent 22.4% of clients, they account for 64.9% of expenditures. Children account for 66.8% of clients, but only 26.8% of expenditures. As noted in Chart 8, the average

[1] ADC: Adults with Dependent Children

cost per Medicaid enrollee briefly increased at the launch of Heritage Health in January 2017, as fee-for-service claims still overlapped with managed care premium payments. Since then the average monthly cost per enrollee has remained constant at or below the national average in most months.

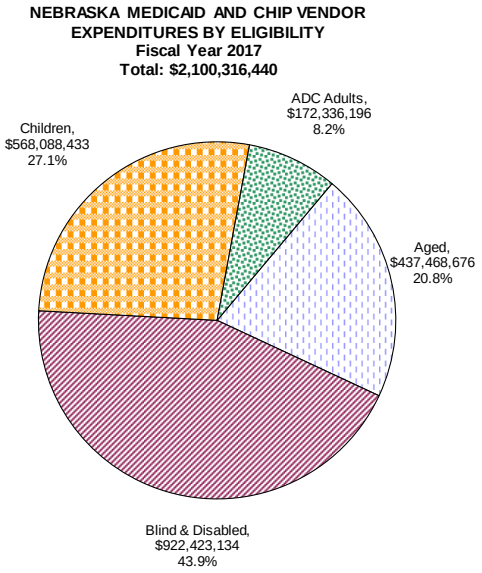
Chart 9 does not account for all Medicaid and CHIP expenditures, in part because some payments and refunds are not specific to a recipient or eligibility category. Examples of transactions not included are drug rebates, payments made outside the Medicaid Management Information System (MMIS)[2], and premium payments paid on behalf of persons eligible for Medicare. Client demographic data is not available for these expenditures. This means some expenditures, particularly in the Aged and Blind & Disabled categories, are understated.

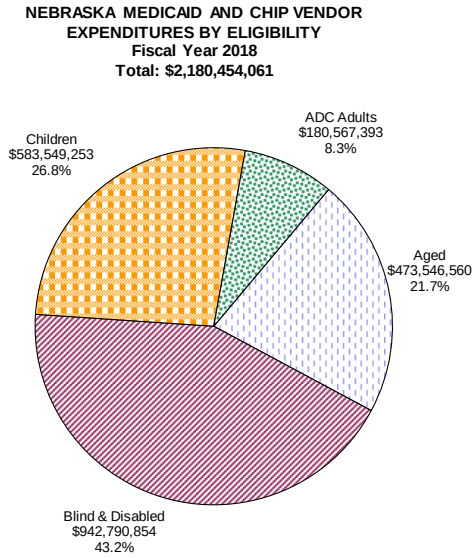
Chart 8: Nebraska Medicaid Cost per Enrollee



[2] These payments include Aged and Disabled Waiver Providers (paid in N-Focus), sub-award agencies (On-Base), and assistive technology partnership contractors (Nebraska Information System).

Chart 9: **Nebraska Medicaid and CHIP Annual Cost by Eligibility Category**





IV. BENEFIT PACKAGE

Federal Medicaid statutes mandate that states provide certain services and allow states the option of providing other services. The Nebraska Medical Assistance Act (68-901 to 68-975) and the Medicaid State Plan delineate the mandatory and optional services available to Medicaid and CHIP recipients in Nebraska. These mandatory and optional services are denoted in Chart 10.

Chart 10: Federal Medicaid Mandatory and Optional Services Covered in Nebraska

Mandatory Services	Optional Services
Inpatient and outpatient hospital services	Prescribed drugs
Laboratory and x-ray services	Intermediate care facilities for the developmentally disabled (ICF/DD)
Nursing facility services	Home and community based services (HCBS)
Home health services	Dental services
Nursing services	Rehabilitation services
Clinic services	Personal care services
Physician services	Durable medical equipment
Medical and surgical services of a dentist	Medical transportation services
Nurse practitioner services	Vision-related services
Nurse midwife services	Speech therapy services
Pregnancy-related services	Physical therapy services
Medical supplies	Chiropractic services
Early and periodic screening and diagnostic treatment (EPSDT) for children	Occupational therapy services
	Optometric services
	Podiatric services

	Hospice services
	Mental health and substance use disorder services
	Hearing screening services for newborn and infant children
	School-based administrative services

Recent and Upcoming Benefit Package Changes

MLTC continuously evaluates its benefits package to make changes based on new medical procedures and best practices. MLTC collaborates with the Heritage Health plans to identify any potential service gaps and policy implications.

Dental Benefits

Over this past state fiscal year, several changes were announced to the benefit package available to Medicaid members. One of the biggest changes to the Medicaid benefit package which occurred in SFY 2018 was the transition of the dental benefit into managed care. On October 1, 2017, Managed Care of North America (MCNA) began operations as Nebraska Medicaid's Dental Benefits Manager. Similar to Heritage Health, MCNA manages all aspects of Medicaid members' dental care, from scheduling appointments to paying dental providers.

Substance Use Disorder Treatment

Recent federal Medicaid regulations added new limits to MLTC's ability to allow residential substance use disorder (SUD) services in institutes for mental disease (IMDs) for Medicaid-enrolled adults ages 21-64. This change has the potential to disrupt treatments in less costly settings. In response, MLTC plans to submit a waiver application to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services to implement a Section 1115 demonstration waiver to continue Nebraska Medicaid's policy of allowing SUD residential services in IMDs for Medicaid-enrolled adults ages 21-64.

Non-emergency Medical Transportation

MLTC is currently working toward carving the non-emergency medical transportation (NEMT) service in to managed care. Including NEMT in the Heritage Health benefits package contributes to DHHS's division-wide goal of integrating services and partnerships and will help MLTC realize the advantages of managed care. After assessing options, MLTC decided the best way to administer the NEMT service was to carve it in to the Heritage Health benefit package. This carve-in is also a strategic component of MLTC's MMIS sunset plan.

Input from statewide providers, Medicaid recipients, and other stakeholders is valued in assessing specific benefits, as is coordination with other divisions within DHHS to ensure successful implementation of new benefits.

V. SERVICE DELIVERY

Nebraska delivers Medicaid and CHIP primarily through Heritage Health, a risk-based managed care program. Managed care is a health care payor system in which the state pays a monthly set amount per member as payment to the managed care organizations (MCOs). In a risk-based managed care system, MCOs are responsible for the management and provision of specific Medicaid-covered services. Nationally, 39 other states (including the District of Columbia) contract with risk-based MCOs to provide Medicaid services.

Heritage Health combines all physical health, behavioral health, and pharmacy benefits into one comprehensive plan available to Nebraska's Medicaid enrollees. In SFY 2018, there were three MCOs available to Heritage Health members. When a Medicaid member enrolls in Heritage Health, MLTC's enrollment broker (AHS) assigns them to one of the available plans. New members have the right to select one of the three health plans within 90 days of joining Heritage Health. In addition, the annual open enrollment period is available to all members from November 1 to December 15. During this time, all members may choose to change plans.

Heritage Health's person-centered approach integrates physical and behavioral health services. This approach focuses on the individual member's needs and promotes preventative health care. The State aims to continue decreasing reliance on emergency and inpatient levels of care by providing clients with evidence-based care options that emphasize early intervention and community-based treatment. The integrated physical and behavioral health managed care program has the potential to achieve:

- Improved health outcomes;
- Member choice;
- Enhanced integration of services and quality of care;
- Emphasis on person-centered care, including enhanced preventive and care management services and recovery-oriented care;
- Reduced rate of costly and avoidable care; and
- Improved financial sustainability of the system.

Heritage Health provides coordination of physical health, behavioral health, and pharmacy needs. In addition, Heritage Health has established oversight of its administrative and clinical programs' quality. This oversight includes local, regional, and state-wide committees with participants from the MCOs, providers, MLTC staff, and stakeholders.

Heritage Health was implemented with the goal of improving the health and wellness of Medicaid members by increasing their access to comprehensive health services in a cost-effective manner. With this goal in mind, Nebraska requires the MCOs to report certain performance measures. These measures have been adjusted throughout SFY 2018 in order to improve the quality of the data available to MLTC.

In the last quarter of SFY 2018, MLTC was able to complete its benchmark measures for Heritage Health's three performance improvement projects. These projects are tracking follow-ups to emergency department visits for mental illness and substance use, Tdap immunization percentage in pregnant women, and Hydroxyprogesterone Caproate injection percentage in pregnant women. With the baseline established with data from calendar year 2017, MLTC will now be able to monitor these health outcomes for improvement.

Heritage Health is an alternative to fee-for-service (FFS), in which a state Medicaid program pays each Medicaid provider for each service provided. The Nebraska Medicaid program still has certain populations covered in this manner. These groups include individuals with Medicare as their primary insurance, individuals who are enrolled in one of DHHS's home and community based waiver programs for those with physical or developmental disabilities, as well as individuals who live in long-term care institutional settings such as nursing homes or intermediate care facilities. While these individuals now have their physical, behavioral, and pharmacy health services coordinated by their Heritage Health plan, the administration of their long-term supports and services (such as their institutional or in-home care) remain administered through FFS.

VI. PROVIDERS

MLTC works with Nebraska's medical providers to deliver health care to Medicaid clients. As discussed previously, the vast majority of Medicaid services are paid through the MCOs. The state makes capitation payments to MCOs who coordinate provider networks and provider reimbursement. As noted, some programs continue to be paid on a fee-for-service basis.

As of July 2018, there were 47,939 in-state Medicaid providers. Of those in-state providers, 19,274 are billing providers and 28,665 are group members. Out-of-state providers totaled 7,168 for Nebraska Medicaid. Of those out-of-state providers, 1,283 are billing providers and 5,885 are group members.

Provider details including the type of practice and number of in-state and out-of-state providers are noted in Chart 11.

Chart 11: Nebraska Medicaid Providers by Type, July 2018

Provider Type	Provider Type of Practice	In-State	Out-of-State
Adult Substance Abuse Provider	Group Practice	40	
Ambulatory Surgical Centers		55	9
Anesthesiologist	Group Practice	191	14
	Group Practice Member	1,271	345
	Individual or Solo Practice	50	29
Assertive Community Treatment	Group Practice	9	
Clinic	Group Practice	358	13
Community Support	Group Practice	55	
	Group Practice Member	597	
Day Rehabilitation	Group Practice Member	21	
Day Treatment Provider		21	
Dispensing Physician	Group Practice Member	7	
Doctor Of Dental Surgery – Dentist	Group Practice	325	5
	Group Practice Member	761	65
	Individual or Solo Practice	435	23

Provider Type	**Provider Type of Practice**	**In-State**	**Out-of-State**
Doctors Of Chiropractic Medicine	Group Practice	248	7
	Group Practice Member	184	33
	Individual or Solo Practice	235	9
Doctors Of Podiatric Medicine	Group Practice	63	1
	Group Practice Member	80	16
	Individual or Solo Practice	39	4
Doctors of Osteopathy	Group Practice	2	
	Group Practice Member	756	281
	Individual or Solo Practice	20	13
Federally Qualified Health Center	Group Practice	48	1
Free Standing Birth Center		2	
Hearing Aid Dealer	Group Practice	49	1
	Group Practice Member	43	5
	Individual or Solo Practice	22	4
Home Health Agency		104	
Hospice		78	1
Hospitals	Children Facility (Hospital Only)	23	21
	Rehabilitation Facility (Hospital Only)	13	4
		493	263
Indian Health Hospital Clinic		3	
Laboratory		78	41
Licensed Dental Hygienist	Group Practice	11	
	Group Practice Member	23	
	Individual or Solo Practice	12	
Licensed Drug & Alcohol Counselor	Group Practice Member	255	6
Licensed Independent Mental Health Practitioner	Group Practice	110	
	Group Practice Member	1,202	1
	Individual or Solo Practice	408	13
Licensed Medical Nutrition Therapist	Group Practice	7	
	Group Practice Member	24	7
	Individual or Solo Practice	2	
Licensed Mental Health Practitioner	Group Practice	3	
	Group Practice Member	1,251	81
	Individual or Solo Practice	43	
Licensed Practical Nurse	Group Practice Member	3	
	Individual or Solo Practice	6	

Provider Type	Provider Type of Practice	In-State	Out-of-State
Licensed Psychologist	Group Practice	44	1
	Group Practice Member	597	69
Licensed Psychologist	Individual or Solo Practice	109	2
Community Treatment Aide I	Group Practice Member	246	
	Individual or Solo Practice	1	
Community Treatment Aide	Group Practice Member	21	
Mental Health Professional/Masters Level Equivalent	Group Practice Member	1,143	10
	Individual or Solo Practice	2	
Nurse Midwife	Group Practice Member	90	24
Nurse Practitioner	Group Practice	65	1
	Group Practice Member	2,296	676
	Individual or Solo Practice	96	23
Nursing Homes		1,334	17
Occupational Therapy Health Services	Group Practice	449	1
	Group Practice Member	897	9
	Individual or Solo Practice	1	
Optical Supplier		41	1
Optometrists	Group Practice	199	5
	Group Practice Member	279	36
	Individual or Solo Practice	88	4
Orthopedic Device Supplier		1	
Other Prepaid Health Plan		4	
Pharmacist	Group Practice Member	2	
Pharmacy	Independent Pharmacy	290	102
	Large Chain Pharmacy	230	54
	Other Pharmacy	65	29
	Professional Pharmacy	13	3
	Small Chain Pharmacy	124	30
	Unit Dose, Independent Pharmacy	9	3
	Unit Dose, Large Chain Pharmacy	3	1
Physician Assistant	Group Practice Member	1,729	504
Physicians	Group Practice	185	6
	Group Practice Member	10,922	3,646
	Individual or Solo Practice	414	218
Professional Clinic	Group Practice	3,213	135

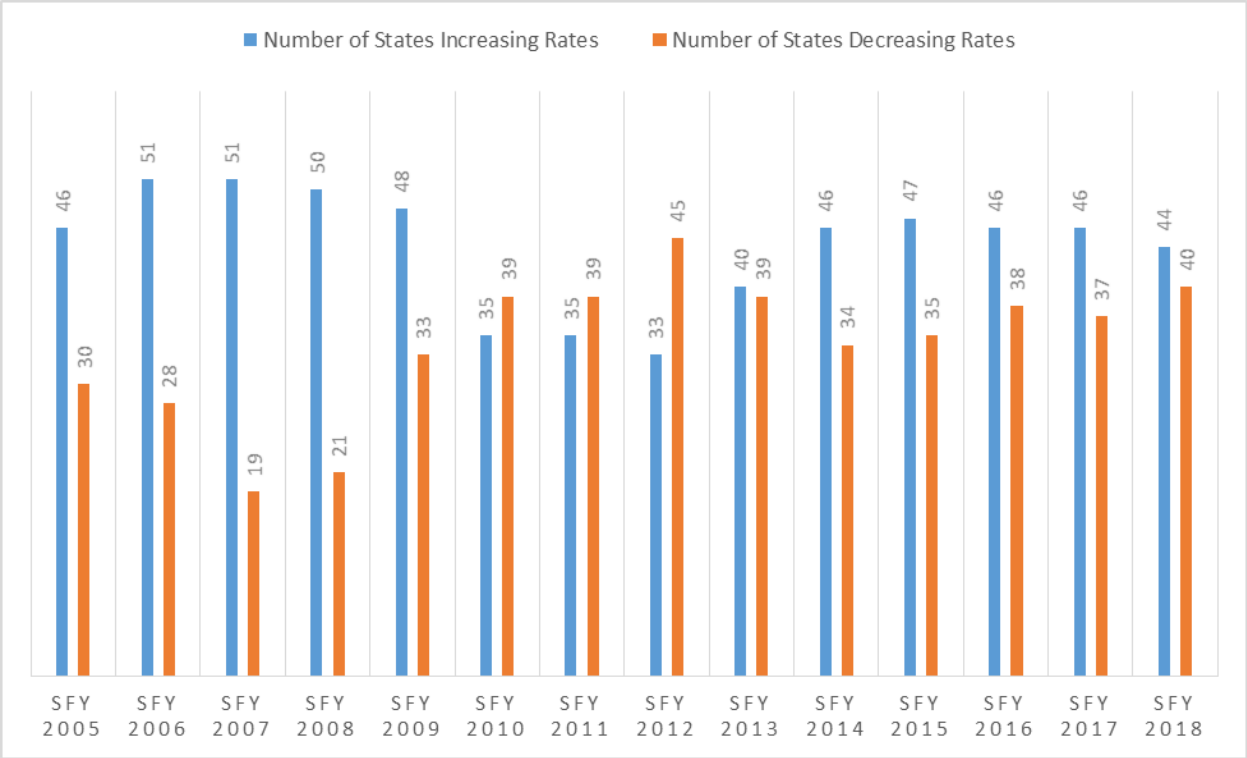
Provider Type	Provider Type of Practice	In-State	Out-of-State
Professional Resource Family Care	Group Practice	4	
Provisionally Licensed Drug & Alcohol Counselors	Group Practice Member	49	
Provisionally Licensed PHD-PPHD	Group Practice	1	
	Group Practice Member	109	
	Individual or Solo Practice	1	
Psychiatric Residential Treatment Facility		5	3
Qualified Health Maintenance Organization		6	
Registered Nurse	Group Practice	5	
	Group Practice Member	98	6
	Individual or Solo Practice	14	1
Registered Physical Therapist	Group Practice	655	7
	Group Practice Member	1,531	50
	Individual or Solo Practice	16	
Rental And Retail Supplier (RTLR)		230	36
NFOCUS (PAS and Waiver Services)		6,354	100
Residential Rehabilitation		21	
Rural Health Clinic-Independent	Individual or Solo Practice	37	
Rural Health Clinic-Provider Based (Less Than 50 Beds)	Individual or Solo Practice	128	3
Rural Health Clinic-Provider Based (Over 50 Beds)	Individual or Solo Practice	8	
Specially Licensed Phd/Psychology Resident	Group Practice Member	9	
Speech Therapy Health Service	Group Practice	443	3
	Group Practice Member	2,169	15
	Individual or Solo Practice	19	2
Substance Abuse Treatment Center	Group Practice	98	
Therapeutic Group Home		7	
Transportation		569	15
Treatment Crisis Intervention		2	
Tribal 638 Clinic	Group Practice	10	1
	TOTALS	**47,939**	**7,168**

The Nebraska Medicaid program uses different methodologies to reimburse different Medicaid FFS services. However, the vast majority of Medicaid claims are now paid by the MCOs in Heritage Health.

- 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 (DRG) or per diem rate.
- Critical access hospitals (CAH) are reimbursed on a per diem based on a reasonable cost of providing the services.
- Federally qualified health centers (FQHCs) are reimbursed via the alternative payment methodology.
- Rural health clinics (RHCs) are reimbursed their cost or on 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 persons with developmental disabilities (ICF/DDs) are reimbursed on a per diem rate based on a cost model.
- HCBSs, including assisted living costs, are reimbursed at reasonable fees as determined by Medicaid.

In order to control costs, many states cut provider rates during the Great Recession and its aftermath, as shown in Chart 12. However, as shown in Chart 13, Nebraska Medicaid providers have received rate increases every year from SFY 2012 to 2017. Primary care services increased nationally to Medicare rates in January 2013 as a result of the ACA. The federal government funded the difference between Medicaid and Medicare rates. This national rate bump expired in December 2014. However, Nebraska elected to continue this rate increase through SFY 2017.

Chart 12: Medicaid Provider Rate Changes



The measurement in Chart 12 contains multiple categories of rates. As such, a state could be counted as both increasing and decreasing rates in the same year.

Chart 13: Nebraska Medicaid Rate Changes

SFY	Rate Increase
2012	Rates increased 1.54%
2013	Rates increased up to 2.25% to a maximum of 100% of Medicare rates as of January 1, 2013
2014	Rates increased up to 2.25% to a maximum of 100% of Medicare rates as of January 1, 2014
2015	Rates increased up to 2.25% to a maximum of 100% of Medicare rates for behavioral health, nursing facilities, assisted living, and ICF-DD providers. Other Medicaid services rates increased up to 2% to a maximum of 100% of Medicare rates.
2016	Rates increased up to 2.25% to a maximum of 100% of Medicare rates for behavioral health, nursing facilities, assisted living, and ICF-DD providers. Other Medicaid services rates increased up to 2% to a maximum of 100% of Medicare rates.
2017	Rates increased up to 2.25% to a maximum of 100% of Medicare rates for behavioral health, nursing facilities, assisted living, and ICF/DD providers. Other Medicaid services rates increased up to 2% to a maximum of 100% of Medicare rates.

2018	No rate changes were implemented

No provider rate changes occurred in SFY 2018. Now, the vast majority of services provided by Nebraska Medicaid are paid for by MCOs, which are not bound by state fee schedules. Each MCO must have an adequate provider network and may negotiate reimbursement rates with providers in its network.

VII. VENDOR EXPENDITURES

Medicaid and CHIP are financed jointly by the federal and state governments, with the federal government matching state spending at a rate known as the Federal Medical Assistance Percentage (FMAP), which varies from state to state. FMAP is based on each state's per capita income relative to the national average and is highest in the poorest states, varying from 50% to 73%. Nebraska's FMAP in federal fiscal year (FFY) 2018[3] was 52.55% for Medicaid and 89.79% for CHIP. Due to the ACA, the CHIP FMAP increased beginning in FFY 2016. Chart 14 shows the FMAP for both Medicaid and CHIP for FFY14 through 19.

Chart 14: Nebraska FMAP Rates

Federal Fiscal Year	Medicaid FMAP	CHIP FMAP
FFY14	54.74%	68.32%
FFY15	53.27%	67.29%
FFY16	51.16%	88.81%
FFY17	51.85%	89.30%
FFY18	52.55%	89.79%
FFY19	52.58%	89.81%

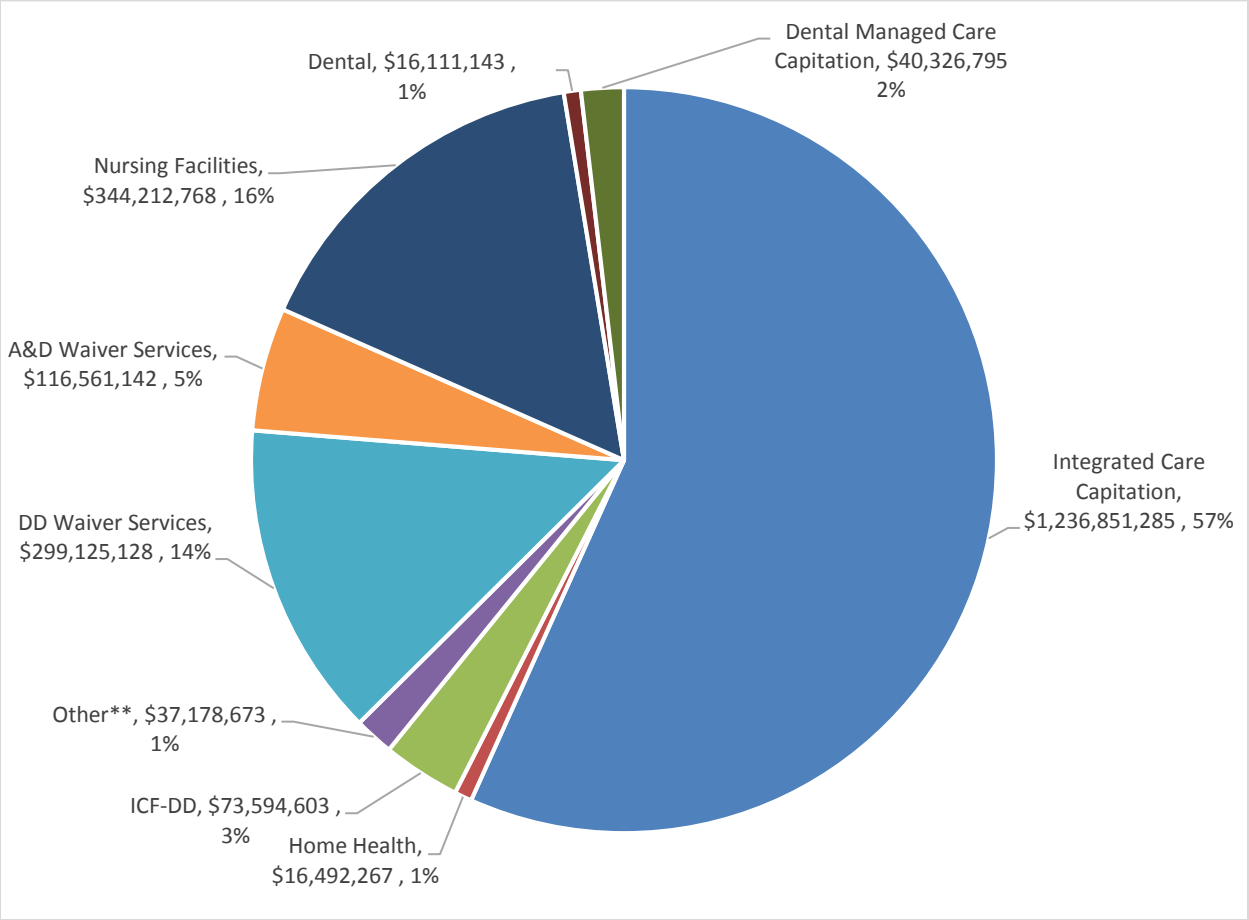
For SFY18 total vendor payments for Medicaid and CHIP expenditures were $2,180,454,061.

- This total includes drugs, inpatient and outpatient hospital, physicians, practitioners, and early and periodic screening, diagnostic and treatment.
- A&D Waiver includes $694,652 of expenditures under the Traumatic Brain Injury waiver.
- The expenditures include payments to vendors only; no adjustments, refunds or certain payments for premiums or services paid outside of the Medicaid Payment System (MMIS) or NFOCUS.

[3] October 1, 2017 to September 30, 2018

Chart 15 shows how the expenditures to vendors are distributed by service type.

Chart 15: SFY18 Medicaid and CHIP Expenditures by Service



Not all Medicaid and CHIP expenditures are captured in Chart 15. Several other transactions are highlighted below:

- Drug rebates are reimbursements made by pharmaceutical companies to Medicaid and CHIP that reduce individual drug costs to a more competitive or similar price that is being offered to other large drug payers, such as insurance companies. In SFY 2018, Medicaid received a total of $141.4 million in drug rebates.
- Disproportionate share hospital (DSH) payments are additional payments to hospitals that serve a high number of Medicaid and uninsured patients. In SFY 2018, Medicaid paid $44,184,440 through the DSH program, a 3.1% decrease compared to $46,587,545 paid in SFY 2017.
- Medicaid pays the Medicare Part B premium for clients that are dually eligible for Medicare and Medicaid. In SFY 2018, Medicaid paid $54,211,723 for Medicare

premiums, a 4.48% increase from the $51,885,724 for Medicare premiums paid in SFY 2017. Monthly premium amounts for calendar years 2017 and 2018 were $134.00.

- Part D clawback payments are made to CMS to cover the State's share of prescription drugs for persons dually eligible for both Medicare and Medicaid. In SFY 2018, clawback payments totaled $66,367,837, a 6.8% increase from the $62,138,338 paid in SFY 2017. The clawback payment amount per person is based on a complex formula that takes into account the cost of drugs and the federal matching rate.

A significant shift in the management and administration of Medicaid services has taken place over the past several years with the growth of managed care. As noted in Chart 15, a majority of MLTC's expenditures come in the form of capitation payments for managed care. Charts 16 and 17 note the relative cost of services covered via capitation payments.

Chart 16: Percentage of Capitated Health Spend by Service Category

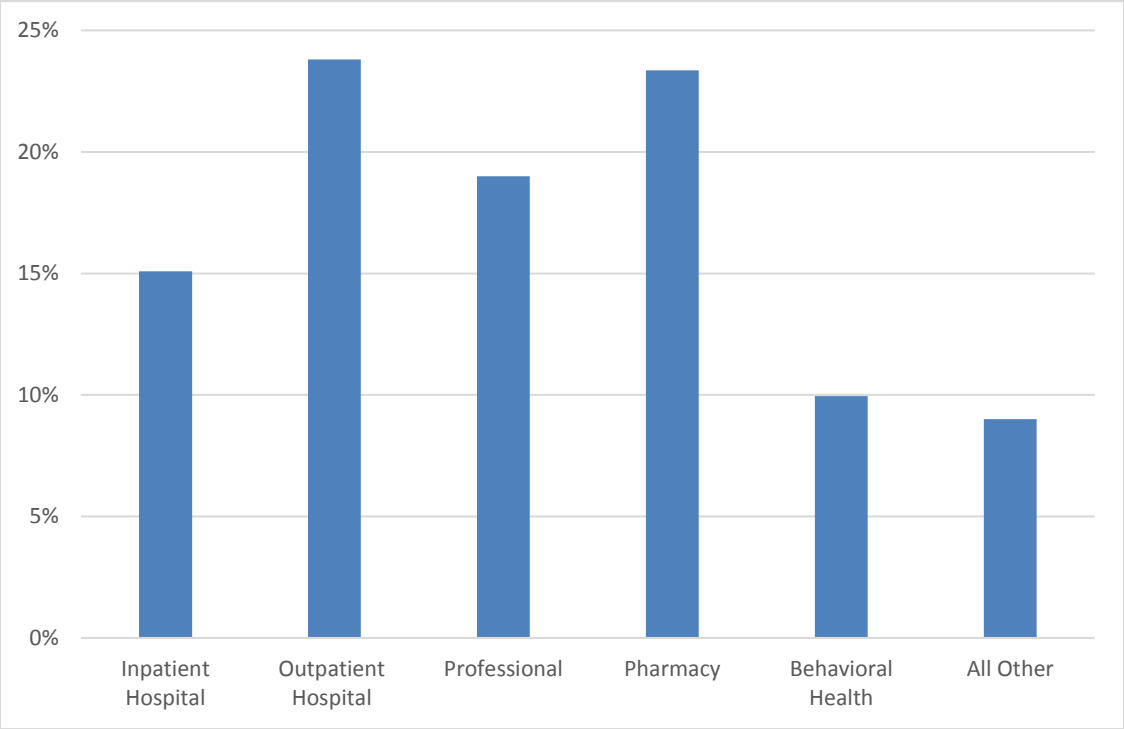
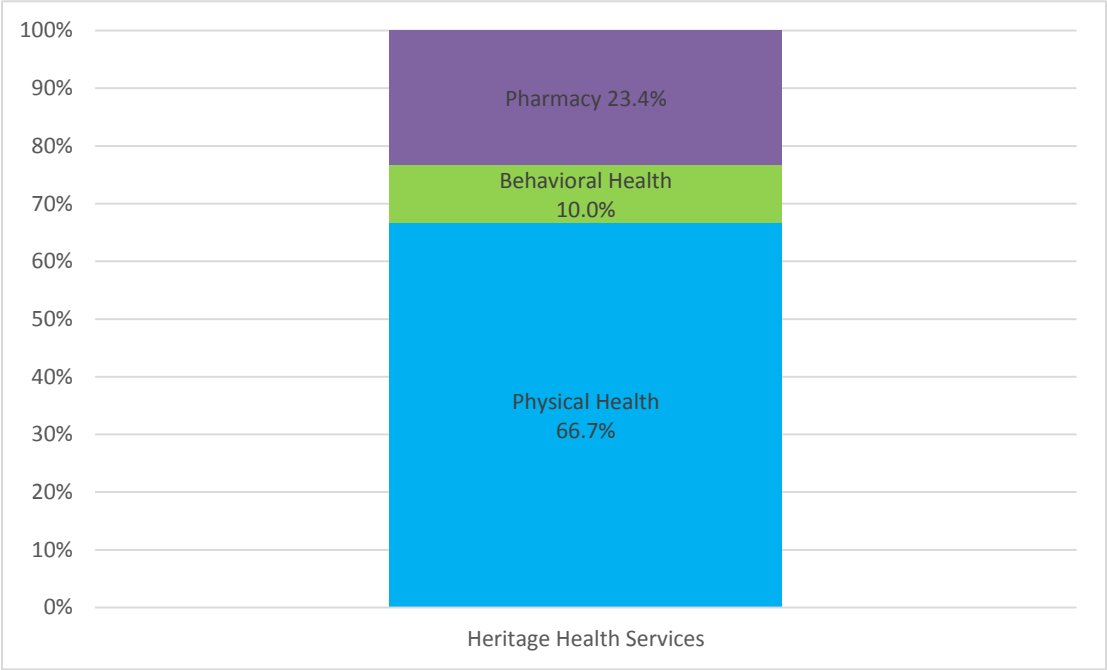


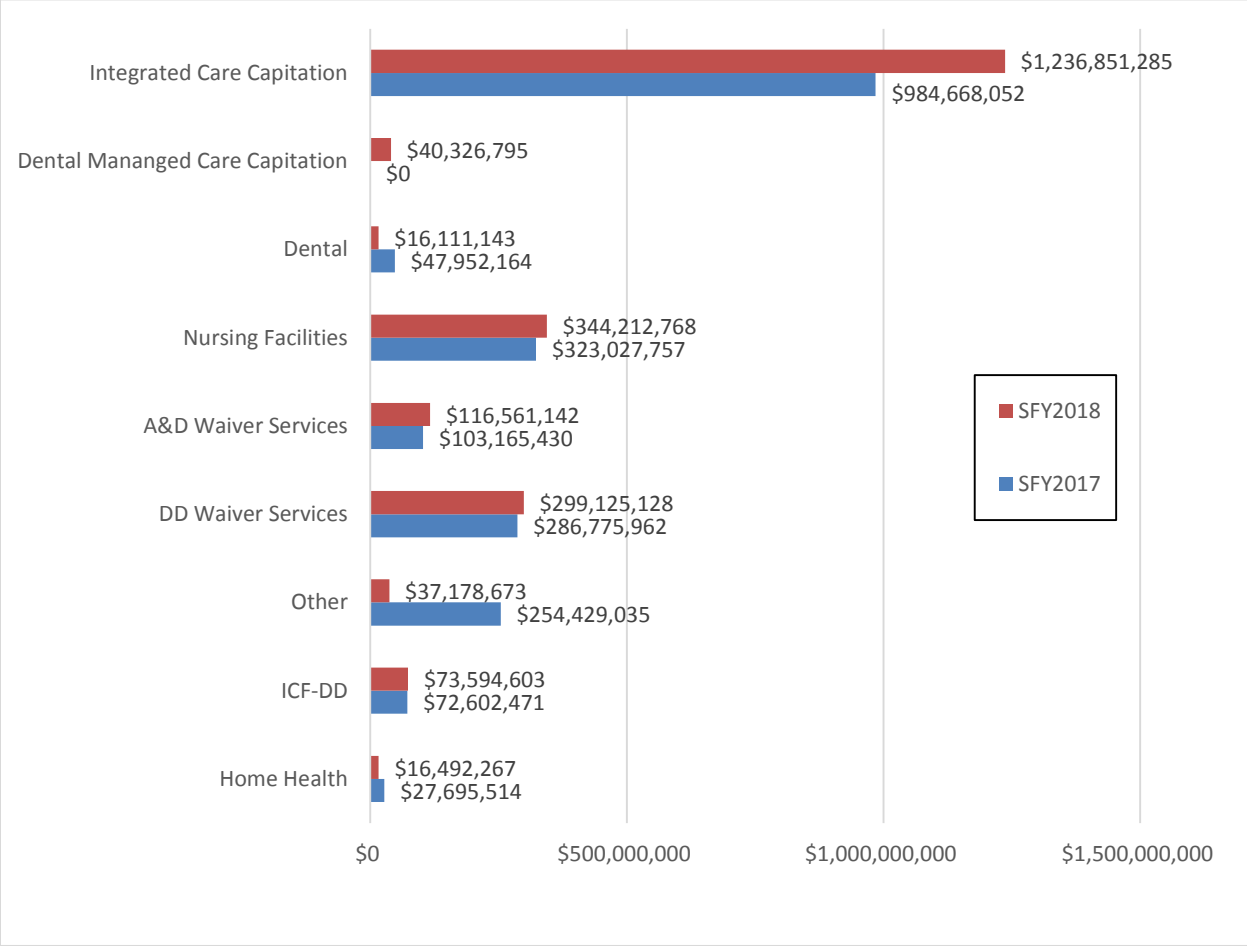
Chart 17: Heritage Health Medical Services by Relative Cost[4]



[4] There are additional behavioral health services that are provided alongside physical health services which are counted in the physical health total.

Chart 18 compares vendor expenditures from SFY 2017 and 2018 side by side and notes the growth of managed care.

Chart 18 Medicaid and CHIP Expenditures SFY17 and SFY18[5]



LONG-TERM CARE SERVICES

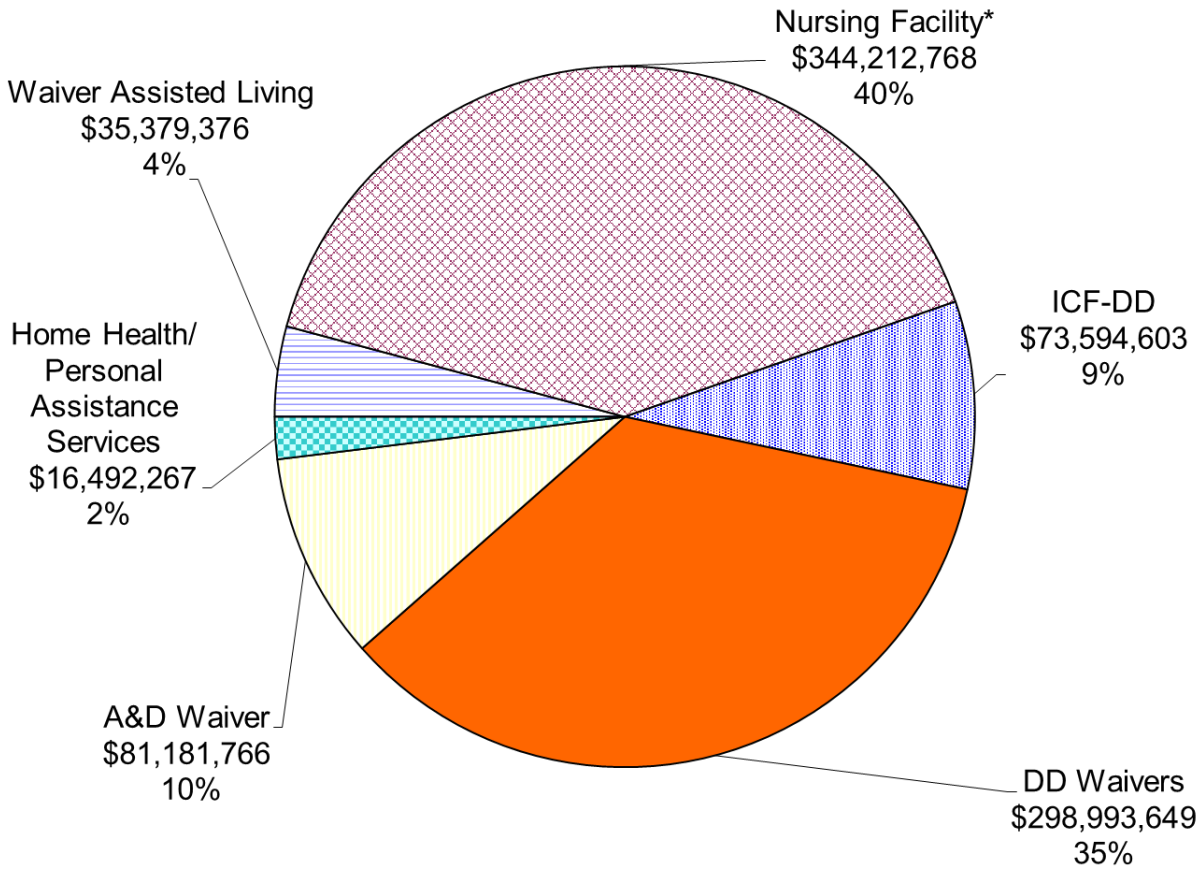
Long-term care (LTC) services support individuals with chronic or ongoing health needs related to age or disability. In SFY18, Medicaid expenditures for LTC services totaled $849,854,429. These services are geared to multiple levels of client need ranging from limited assistance with activities of daily living to complex nursing interventions. Assistance can be offered in a variety of settings from an individual's home to small group settings with community supports or nursing facilities. In general, home and community based care is less expensive and offers greater independence for the consumer than facility-based care.

[5] Dental services were carved into Dental Managed Care Capitation effective October 1, 2017.

For these reasons, state and federal initiatives encourage the development of care options in the community as an alternative to institutional care. Efforts to encourage home and community based alternatives to facility care are resulting in a gradual rebalancing of LTC expenditures.

The following charts (19 and 20) show the cost of Medicaid expenditures for LTC services, and the cost of LTC services delivered in institutions compared to the cost of care delivered in home and community settings for SFY 2018.

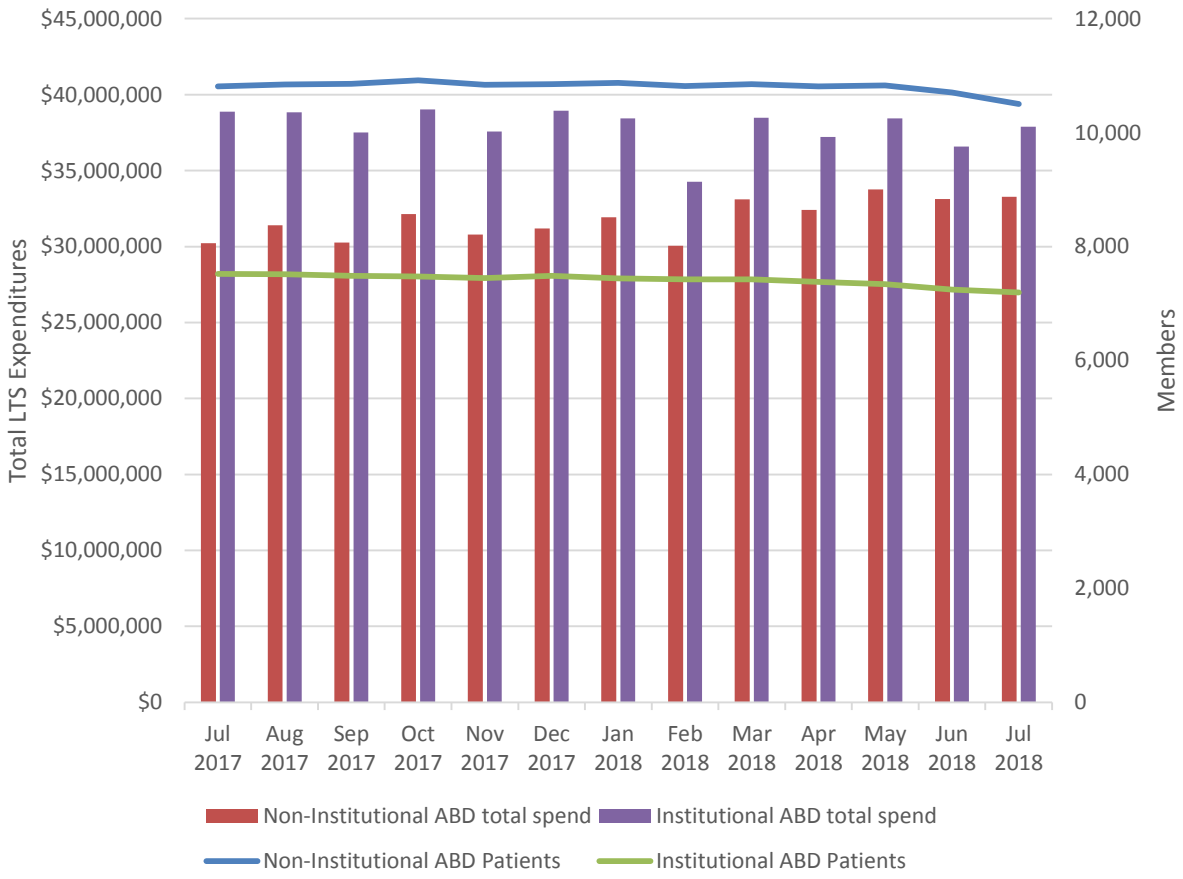
Chart 19: SFY18 Medicaid Expenditures for LTC Services



Category	Definitions
Nursing Facility	Payment made to nursing facility services for aged and disabled Medicaid eligible clients.
ICF-DD	Payment made to intermediate care facility services for intellectually and developmentally disabled Medicaid eligible clients.
DD Waivers	Payment made for an array of home and community based services for intellectually and developmentally disabled Medicaid

	eligible clients; Medicaid offers two waivers for this population.
A&D Waiver	Payment made for an array of home and community based services for aged and disabled Medicaid eligible clients, not to include the Assisted Living service shown below to support living independently in their own home.
Home Health/Personal Assistance Services	Payment made for community-based care covered under the Medicaid State Plan to support Medicaid eligible clients living independently in their own home.
Waiver Assisted Living	Payment made for the Assisted Living service within the Aged and Disabled waiver, this payment allows clients to continue living in the community rather than in a nursing facility.

Chart 20: Nebraska LTC Expenditures by Living Arrangement



VIII. SFY18 HIGHLIGHTS AND ACCOMPLISHMENTS

Dental Benefits Manager Launched

On October 1, 2017, the fee-for-service (FFS) Medicaid and CHIP dental benefit transitioned to managed care with Managed Care of North America, Inc. (MCNA) contracted to administer this benefit. This change in the delivery of dental services has resulted in increased member participation. This increase was due in part to member dental cards, member outreach from MLTC, and MCNA informing them of this change. Moving into the second year of MCNA's operations as Nebraska's dental benefit manager, MLTC is focusing on increasing the number of Medicaid-enrolled children who have accessed preventative dental services and increasing the size of the provider network. Like many forms of health care, preventative dental care is critical to the health and wellness of all Medicaid members, especially children.

Heritage Health Began Year Two

Heritage Health began its second year of operations as Nebraska's integrated Medicaid managed care program on January 1, 2018. The program's operations largely stabilized through its first year. By mid-2017, all three of the Heritage Health Managed Care Organizations were exceeding their contract standards and were adjudicating more than 97 percent of claims in less than 15 business days. The second year of Heritage Health began with a focus on quality services and saw the formation of the Quality Improvement Committee to effectively compare the quality of services delivered from each MCO. The Division is also focusing more closely on performance improvement projects for the three MCOs, which focus on vaccination rates and emergency department utilization.

Aging and Disabled Resource Centers Made Permanent

Aging and Disability Resource Centers (ADRCs), began in Nebraska in 2016 as a pilot program managed by the State Unit on Aging, which is overseen by MLTC. The documented success of this pilot assisted legislative efforts to migrate it from pilot to permanent.

Disabled Nebraskans of all ages and all Nebraskans age 60 and over are eligible to receive needed services through ADRCs, whose main mission is to provide Nebraskans with a single point of entry to navigate and access long-term care services. With convenient access by phone and in-person, those in need of assistance for themselves, or for those they care for, can receive information, referrals, and person-centered counseling. ADRC offices are located in Lincoln, Omaha, Beatrice, Norfolk, Hastings, Kearney, and Scottsbluff.

HIPP Program Changes Approved by CMS

In August 2017, the Health Insurance Premium Payment (HIPP) program received federal approval from the Centers for Medicare and Medicaid Services (CMS) on a State Plan Amendment (SPA) that revised the HIPP cost-effectiveness test for individuals. The HIPP

program reimburses health insurance premiums for Medicaid recipients who have other health insurance when it is determined to be cost-effective for the State. The SPA will allow HIPP to also review those who are self-insured in addition to those with employer-sponsored insurance. Implementing this SPA increased the number of participants who will benefit from the program as well provided the State more opportunities to recoup the costs of medical services provided to Medicaid recipients.

Electronic Data Interchange (EDI) Platform Migration Completed

In May 2018, the EDI Platform Migration project successfully completed ahead of schedule. The project implemented enhanced software for the translation and transport of EDI HIPAA transactions to and from the MMIS for various functions such as eligibility, claims status, referrals, claims, and remittances. This project was successfully implemented in phases to mitigate potential risks to business operations and will continue to be utilized in future data interfaces.

IX. LOOKING AHEAD

Health Management Program

The objective of the Health Management Program is to create a management and intelligence infrastructure for quantifying the value of managed care coordination activities within the patient populations identified and managed by the Heritage Health MCOs. By fulfilling this objective, MLTC is better able to deliver on its Quadruple Aim for Heritage Health members. The Quadruple Aim seeks to improve the patient's care experience, the provider's care experience (in quality and satisfaction), improve the health of the population, and reduce the per capita cost of health care.

This new infrastructure will fulfill several important functions, specifically, enhanced clinical, statistical, economic and ethical evaluation capabilities; mechanisms for improved collaboration and coordination to better fulfill The Quadruple Aim, foster market innovations, and drive performance improvement; and publication of information to share our knowledge and accomplishments with the marketplace.

MLTC's path toward realizing this goal began with engaging the MCOs in recurring meetings to evaluate and address the utilization of population health topics. In the upcoming year, MLTC will be defining the necessary infrastructure to deploy this program; the DMA solution will be a crucial component of the Health Management Program.

Non-Emergency Medical Transportation

MLTC is currently working toward carving the non-emergency medical transportation (NEMT) benefit, such as transportation to routine doctor's appointments, into the Heritage Health benefits

package. Including NEMT in the Heritage Health benefits package contributes to DHHS's division-wide goal of integrating services and partnerships and will help MLTC to better realize the advantages of managed care. With the goal of sunsetting the claims broker function of the MMIS, combined with a focused goal for our health plans to deliver cost-effective whole-person care, MLTC sought alternative ways to administer this service. After assessing options, MLTC decided the best way to administer the NEMT service was to carve it in to the Heritage Health benefit package.

Carving NEMT into Heritage Health bridges a gap in the continuum-of-care for all members and enhances Heritage Health's ability to provide person-centered care management. Additionally, DHHS will be able to set performance standards for NEMT, similar to other performance standards in Heritage Health. These standards can be tied to financial withholds to promote quality service for Heritage Health members. MLTC will engage stakeholders, including both members and NEMT providers. NEMT providers will be advised of MLTC's target launch date of July 1, 2019.

Data Management and Analytics (DMA) Solution

DHHS is currently replacing its data warehouse and decision support system with an updated data warehouse and business intelligence technology platform. DHHS contracted with Deloitte Consulting LLP to implement their HealthInteractive solution. The DMA project, which successfully began in February 2018, has been on schedule through 2018 and is still scheduled for go-live in June 2019. More information on this project is available in MLTC's MMIS Replacement Planning Report, which is submitted to the legislature quarterly.

Eligibility and Enrollment Solution (EES)

The ACA requires significant changes to state Medicaid eligibility and enrollment (E&E) systems. Nebraska's current Medicaid eligibility system cannot meet ACA requirements without significant modification and investment. As a result, Nebraska is implementing a new Medicaid Eligibility and Enrollment system. The project to move Medicaid eligibility and enrollment to the new solution is called EES. Medicaid eligibility will be the first to move to the new EES platform. After stabilization of Medicaid eligibility functions, Economic Assistance programs will also move to the EES platform, creating an integrated eligibility solution for many DHHS programs. A multi-year roadmap is being developed to phase in various eligibility categories.

<u>Eligibility and Enrollment Solution (EES) Phase 3 Long-Term Care Case Management:</u>
MLTC is partnering with the Division of Developmental Disabilities to consider case management options for all DHHS long-term care programs. Options are being considered from technical, programmatic, and operational perspectives, with the goals of promoting administrative simplification while improving custom service.

Electronic Visit Verification (EVV)

The Electronic Visit Verification (EVV) and Fiscal Agent (FA) projects were originally planned as a consolidated effort because they are both intended to support the same user base and many common services. With the passage of the 21st Century CURES Act, EVV became federally mandated for implementation prior to January 1, 2019, for personal assistance services and January 1, 2023, for home health services.

Bill S. 2897 was signed into law on July 30, 2018, which delayed the reduction in federal funds to states that have not implemented EVV from January 1, 2019, to January 1, 2020. This bill also delays penalties until 2021 for states that have shown a "good faith effort" in implementing EVV in Medicaid-funded personal care. Development of an EVV system is intended to improve oversight, ensure authorized services are delivered as planned, and reduce manual activities needed to process paper timesheets and claims payment.

The decision was made to separate the EVV and FA projects due the complexity of the projects, including cross-divisional coordination and the need to meet the federally mandated EVV compliance date. Below are the high-level planning dates for EVV.

EVV Project Milestone	Target Date
Release RFP	1/3/2019
Vendor Begins Implementation	7/1/2019
EVV Go-live	11/10/2019

Fiscal Agent (FA)

The FA project was separated from the Electronic Visit Verification (EVV) project due to the necessity of focusing on meeting a federally mandated compliance date for EVV. Simplifying the EVV go-live allows the FA project to be phased in after the EVV go-live. The FA project remains a high priority because it is necessary for the transition to participant-directed services, which promotes personal choice and control over the services and supports the participant is receiving.

The FA vendor will facilitate payment of services by providing administrative support to individual in-home caregivers through tax withholding, state and federal unemployment tax payment, and fiscal accounting.

FA Project Milestone	Target Date (Estimated)
Release RFP	September 2019
Vendor Implementation Starts	May 2020
Fiscal Agent Go-Live	November 2020

Long-Term Care Case Management

The Long-Term Care Case Management (LTC CM) solution project is replacing multiple, separate, siloed case management software applications (NFOCUS, CONNECT and Therap) with a single new software application. The new system will support the full lifecycle of participant care from initial inquiry for LTC services to case closure, including information and referral; intake; assessment and reassessment; service planning and service authorization; service delivery; and reporting. The LTC CM solution is intended to reduce paper-based documentation and tracking, streamline overall processes, and improve participant and provider communication.

The project goals and objectives include improved customer service to participants, authorized representatives, and providers; improved efficiency and effectiveness of program operations; consistent determinations for LTC programs; identifying efficiencies for information technology systems and resources; and monitoring and improving health care outcomes for Medicaid.

At this time, this project's timeline is being evaluated against other system needs and projects' progress.

Reimbursement Methodology Changes

Nebraska Medicaid continually assesses the value for all stakeholders in the Medicaid program. In the coming year, MLTC will be more closely looking at the outcomes achieved with the dollars spent and consequences of the current payment methodologies in use. In recent years, health care payers have been transitioning provider payments from cost-based to value and performance-based payment models. MLTC has already transitioned to using prospective and alternative payment methodologies in many cases, but there is still much opportunity to improve the value of the purchase for taxpayers, beneficiaries, and other stakeholders in the Nebraska Medicaid program.

Nebraska Medicaid is evaluating the current methodologies and planning reimbursement methodology changes for long term care nursing facilities per diem rates, provider-based rural health clinics under 50 beds payment, dental services rendered at federally qualified health centers, and payment for outpatient hospital services. MLTC will be working with all stakeholders around the transition of payments for the services listed above. MLTC may consider changes to additional payment methodologies or change plans on the items listed above as work progresses.

X. CONCLUSION

MLTC takes seriously its ongoing commitment to delivering quality health care to more than 230,000 of Nebraska's most vulnerable residents. To meet this commitment to all of Medicaid's stakeholders, including members, providers, and taxpayers, the Division continues to focus on improving all aspects of its operations. Through initiatives like the Health Management Program and long-term care case management, procurements like the DMA solution, and integrating services and partnerships with initiatives like the NEMT carve-in, MLTC is positioning itself to provide safety-net care and services in the years to come.

Additionally, MLTC is committed to transparency and providing information to the legislature and the general public as the Division continues its transformation. The Division looks forward to continuing to work with the governor, the legislature, and stakeholders to improve and sustain Medicaid for current and future generations.