Division of Medicaid & Long-Term Care

Nebraska Medicaid Reform Annual Report

December 1, 2014

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

Division of Medicaid & Long-Term Care
Department of Health and Human Services

December 1, 2014

We are pleased to present the Medicaid Annual Report for State Fiscal Year 2014. The Children's Health Insurance Program (CHIP), which Nebraska administers as a Medicaid expansion and a separate stand-alone program, is included in this report.

As outlined in this report, the Division of Medicaid and Long-Term Care continues its commitment to increase efficiency and manage costs of the Medicaid program in Nebraska. Many of our initiatives in SFY 2014 resulted from new federal requirements and state legislation, most with the same target of better fiscal management and more efficient service provision. This report offers a review of the ongoing work of the Division, highlighting the year's major initiatives, describing the larger projects for the year ahead, and detailing the persons served and services provided through the program.

Division of Medicaid & Long-Term Care
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Nebraska Medicaid Annual Report
Neb. Rev. Stat. § 68-908(4)

I. INTRODUCTION

Medicaid is a public health insurance program that provides coverage for low-income individuals. Originally enacted in 1965 under Title XIX of the Social Security Act, Medicaid is an entitlement program (a program that guarantees benefits to anyone who meets the qualifications) covering a low-income population primarily including seniors, children and individuals with disabilities.

State Medicaid programs are administered by the states with oversight from the Centers for Medicare & Medicaid Services (CMS), part of the federal Department of Health and Human Services (HHS). Every state outlines the eligibility, benefits, provider payments, and service delivery systems of its specific Medicaid program within broad guidelines set by the federal government. Although there are numerous federal requirements, eligibility and benefit packages can vary widely from state to state.

The Children's Health Insurance Program (CHIP) was created in 1997 under Title XXI of the Social Security Act, and was designed to offer insurance coverage for low-income children with family income above Medicaid limits. States administer their CHIP programs in different ways. In Nebraska, CHIP is operated as a "Medicaid expansion" meaning that CHIP, with a few exceptions, operates using the same delivery system, benefit package and regulations as Medicaid. Effective July 19, 2012, Nebraska implemented a "separate" CHIP program; this change added prenatal and delivery services for the unborn children of certain women who do not meet Medicaid eligibility criteria. In 2014, another "separate" CHIP program was implemented to cover those children who would otherwise have lost eligibility due to new eligibility rules created through the Affordable Care Act (ACA). With both the CHIP expansion and stand-alone programs, Nebraska is now considered a CHIP "combination" state.

Medicaid and CHIP are financed jointly by the federal government 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 FFY 2014 was 54.74% for Medicaid and 68.32% for CHIP.

II. DISCUSSION

A. ELIGIBLE CLIENTS

Nebraska Medicaid provides coverage for individuals in the following eligibility categories: Children; Aged, Blind & Disabled; Pregnant Women and Aid to Dependent Children (ADC) Adults. Additional eligibility factors vary by group and include income, resources and employment status. Nebraska's CHIP has operated as a Medicaid expansion program since May 1998 and provides health coverage for eligible uninsured children if they have income at or below 213% of the federal poverty level (FPL) and are not eligible for Medicaid. As of July 2012, Nebraska implemented a separate CHIP program to provide coverage to the unborn children of women who are not otherwise eligible for Medicaid, have no creditable insurance and meet financial requirements.

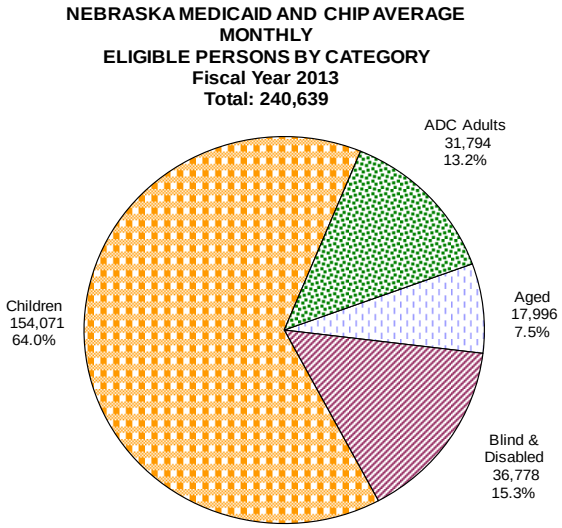
On January 1, 2014, Nebraska implemented mandatory changes in accordance with the ACA. A new eligibility category for Former Foster Care individuals was implemented. This mandatory group provides coverage, through age 26, for individuals who age out of foster care while under the State or a Tribe's responsibility.

The 2101(f) CHIP was implemented as a separate CHIP. Children who lose Medicaid or CHIP eligibility (with or without health insurance) due to the new methodology of considering income under the ACA are eligible for an additional year of Medicaid coverage if the child had Medicaid as of December 31, 2013, unless specific conditions or exceptions apply. This protected group expires on December 31, 2015.

The ACA requires the use of Modified Adjusted Gross Income (MAGI) as the income methodology for Medicaid and CHIP children, pregnant women and parents/caretaker relative groups. The Aged, Blind, and Disabled population are not subject to MAGI or other eligibility changes under the ACA. States were required to convert their current financial eligibility income standards from net standards that incorporate current income disregards to an equivalent MAGI income standard. Nebraska worked with an actuarial contractor and converted the States income standards to the equivalent MAGI income standards.

ELIGIBLE POPULATIONS

FIGURE 1



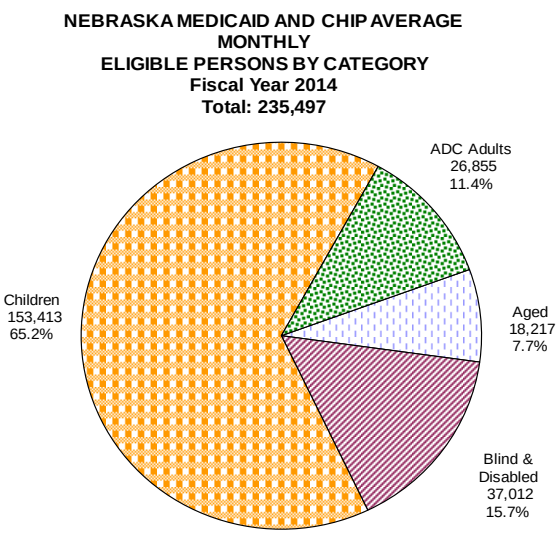
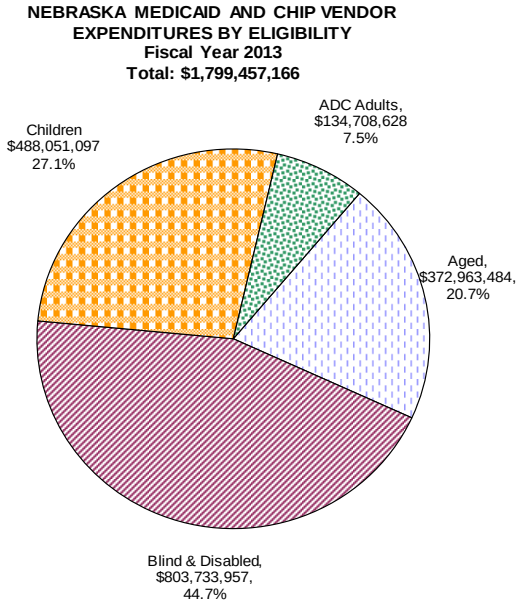


FIGURE 2



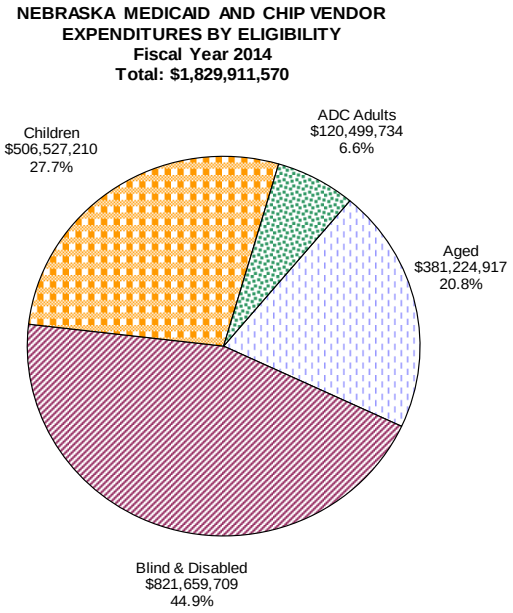


Figure 1 compares eligibility categories for State Fiscal Years (SFYs) 2013 and 2014. The total decrease in average monthly eligibles from SFY 2013 to SFY 2014 was 2.1%. The largest percentage decrease was in the ADC Adults category, which was reduced by 15.5%. Average monthly eligibles in the Children's category decreased by 0.4%. The Blind & Disabled category grew 0.6%, and the Aged category grew by 1.2%.

Figure 2 compares vendor expenditures by eligibility category for SFYs 2013 and 2014. Viewing Figures 1 and 2 together provides insight into the cost differences of different eligibility categories. While the Aged and Blind & Disabled category represents 23.5% of clients, they account for 65.7% of expenditures. This is almost the exact opposite with children who account for 65.1% of clients but only 27.7% of expenditures.

Figure 2 does not account for all Medicaid/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), and premium payments paid on behalf of persons eligible for Medicare. Client demographic data are not available for these expenditures. This means that some expenditures, particularly in the Aged and Blind & Disabled categories, are understated.

Categories expected to decrease as a result of the transition to Managed Care did show a decrease. These categories are outpatient health, physician services, and inpatient hospital. Even though pharmacy benefits are not in managed care, managed care assignment of primary care providers and care coordination can result in a decrease in pharmacy costs. The Disabled category also experienced a substantial increase in home and community-based services for persons with developmental disabilities.

The Aged category was the third largest growing eligibility category with expenditures increasing 2.2% from $372,963,484 in SFY 2013 to $381,224,917 in SFY 2014. The largest increase was in Children at 3.8% from $488,051,097 in SFY 2013 to $506,527,210 in SFY 2014. ADC Adults declined 10.5% in expenditures from $134,708,628 in SFY 2013 to $120,499,734 in SFY 2014.

B. COVERED SERVICES

Federal Medicaid statutes mandate states to provide certain services and allow states the option of providing other services. The Nebraska Medical Assistance Act delineates the mandatory and optional services available to Medicaid and CHIP recipients in Nebraska.

Figure 3

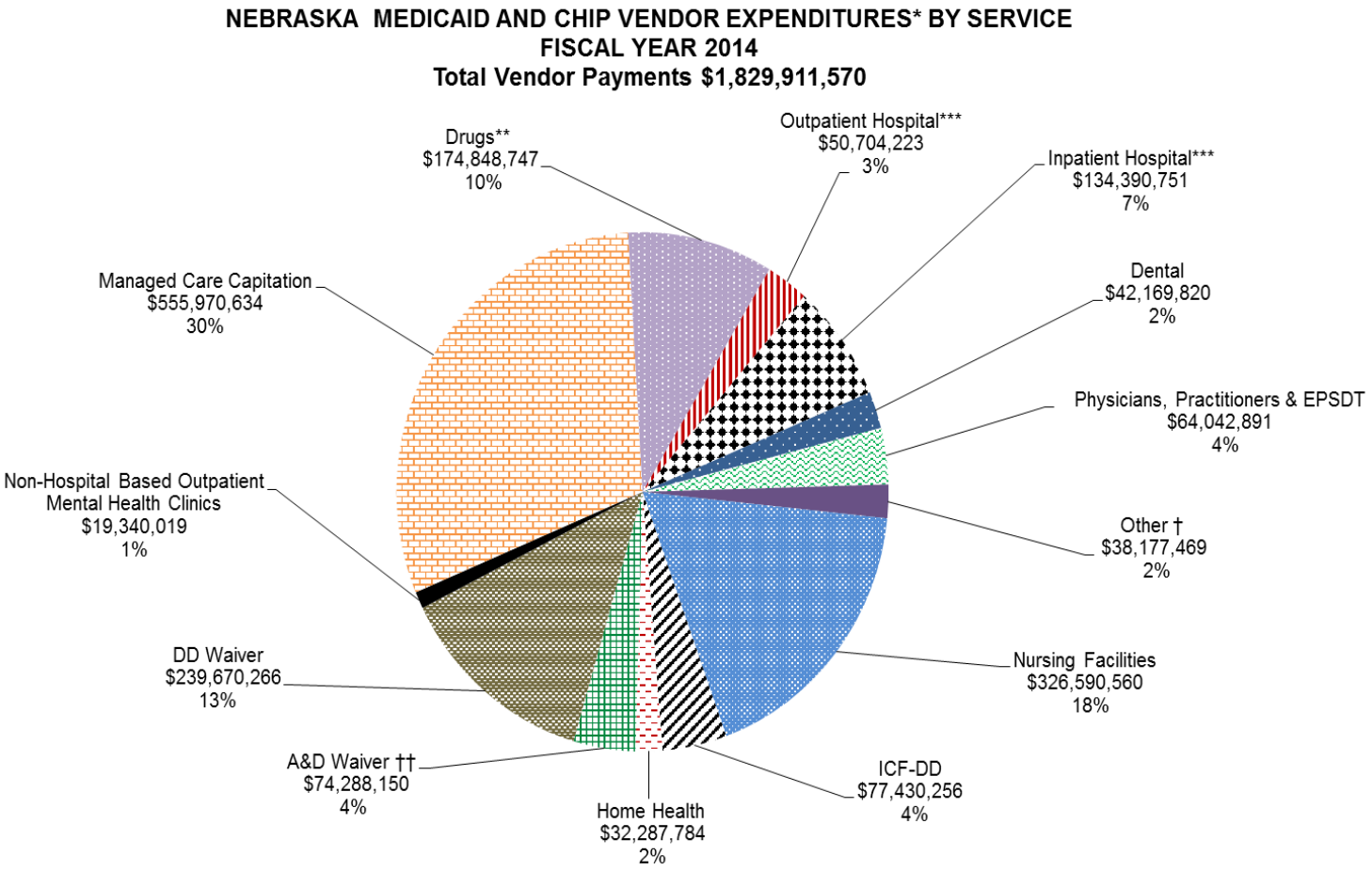
Federal Medicaid Mandatory and Optional Services Covered in Nebraska
Neb. Rev. Stat. 68-911

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 diagnostic treatment (EPSDT) services for children	• Prescribed drugs • Intermediate care facilities for the developmentally disabled (ICF/DD) • 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 use disorder services • Hearing screening services for newborn and infant children • School-based administrative services

VENDOR EXPENDITURES

Figure 4 shows how the $1.8 billion in Medicaid/CHIP expenditures to vendors are distributed by vendor type. Total vendor payments increased $30,454,404 or 1.7% from SFY 2013 to SFY 2014. With the move to statewide managed care, there were service payments in SFY 2013 that became capitation payments in SFY 2014.

Figure 4



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

** $96.5 million in offsetting drug rebates is not reflected in the drug expenditures of $174,848,747

*** DSH payments of $51.6 million are not reflected in Inpatient or Outpatient Hospital Expenditures

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

†† A&D Waiver includes $699,938 of expenditures under the Traumatic Brain Injury waiver

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. Full-risk managed care is a health care delivery system where managed care organizations (MCOs) are contracted to authorize, arrange, provide, and pay for the delivery of services to enrolled clients. Managed care facilitates access to a primary care provider, emphasizes preventive care and encourages the appropriate utilization of services in the most cost-effective setting. Nebraska Medicaid has utilized managed care in three urban counties since 1995, and added the seven surrounding counties in August 2010. As of July 1, 2012, Nebraska's managed care program was expanded statewide for physical health services. This move is projected to result in additional savings to Medicaid and CHIP over time. On September 1, 2013, Nebraska shifted its behavioral health program to an at-risk model.

Figure 5 shows vendor expenditures from SFY 2013 and 2014 side by side. The expansion of physical health managed care to cover the remaining 83 counties explains the decrease in these services and the corresponding increase in managed care capitation payments, and it appears that the Managed Care program is controlling the costs of Medicaid and CHIP.

Figure 5

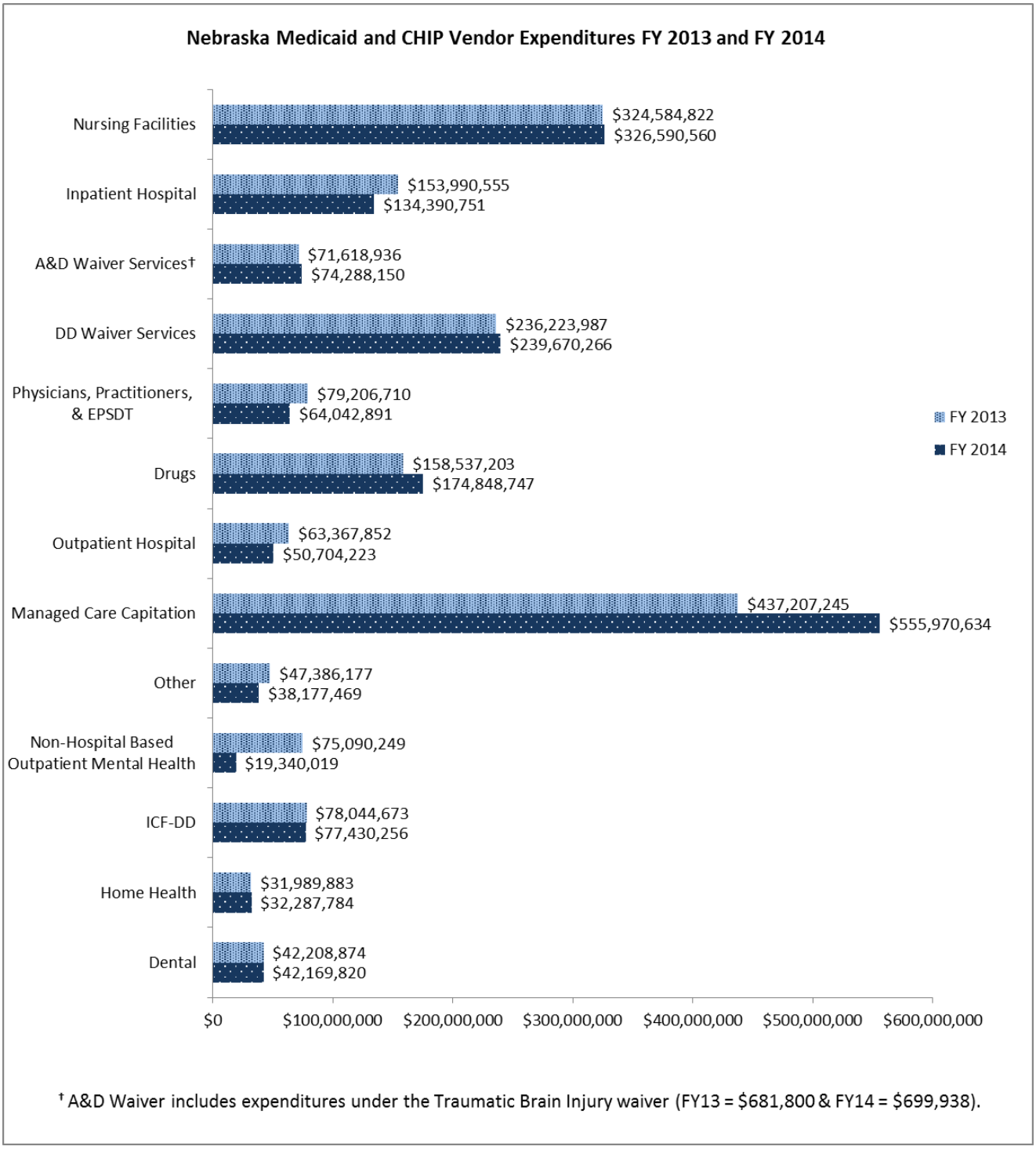

Nebraska Medicaid and CHIP Vendor Expenditures FY 2013 and FY 2014
Nursing Facilities
$324,584,822
$326,590,560
Inpatient Hospital
$153,990,555
$134,390,751
A&D Waiver Services†
$71,618,936
$74,288,150
DD Waiver Services
$236,223,987
$239,670,266
Physicians, Practitioners, & EPSDT
$79,206,710
$64,042,891
Drugs
$158,537,203
$174,848,747
Outpatient Hospital
$63,367,852
$50,704,223
Managed Care Capitation
$437,207,245
$555,970,634
Other
$47,386,177
$38,177,469
Non-Hospital Based Outpatient Mental Health
$75,090,249
$19,340,019
ICF-DD
$78,044,673
$77,430,256
Home Health
$31,989,883
$32,287,784
Dental
$42,208,874
$42,169,820
FY 2013
FY 2014
$0
$100,000,000
$200,000,000
$300,000,000
$400,000,000
$500,000,000
$600,000,000
† A&D Waiver includes expenditures under the Traumatic Brain Injury waiver (FY13 = $681,800 & FY14 = $699,938).

Figure 6

$1,829,911,570	**Vendor Payments**
$51,614,426	Disproportionate Share Hospital/Rate Adjustments
$44,076,259	Medicare Premiums
$4,182,764	Intergovernmental Transfer (IGT)
$55,378,773	Other Payments (Managed Care, Transportation, Federal Insurance Contributions Act taxes, AssistTech, Upper Limit Pmts)
($101,088,236)	Rebates/Refunds
($131,800,856)	General Funds Paid in Other Budget Programs
$51,740,416	Phased Down Contribution
$1,804,015,178	**Net Medicaid and CHIP Expenditures**

Not all Medicaid/CHIP expenditures are captured in Figure 4. Medicaid/CHIP vendor expenditures totaled $1,829,911,570 in SFY 2014. The net program expenditures for this same time period totaled $1,749,210,137. Several of these manual transactions are highlighted below.

Drug rebates are reimbursements made by pharmaceutical companies to Medicaid/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 2014, Medicaid received $96.5 million in drug rebates, an increase of 3.5% compared to the $93.2 million received in SFY 2013.

Disproportionate share hospital (DSH) payments are additional payments to hospitals that serve a high number of Medicaid and uninsured patients. In SFY 2014, Medicaid paid $51,614,426 through the DSH program, a 22.9% increase compared to $42,013,107 paid in SFY 2013.

Medicaid pays the Medicare Part B premium for clients that are dually eligible for Medicare and Medicaid. In SFY 2014, Medicaid paid $44,076,259 for Medicare premiums, a 2.4% increase from the $43,056,973 paid in SFY 2013. Part B premium amounts were $99.90 per month in calendar year (CY) 2012, $104.90 in CY 2013, and $104.90 in CY 2014. CY 2015 monthly premium amounts are estimated at $110.15.

Intergovernmental transfers (IGTs) are payments made to public providers that have 40% or higher Medicaid utilization and whose direct nursing or direct support costs have exceeded the Medicaid maximum allowable rate. In SFY 2014, Medicaid paid $4,182,764 for IGTs, a decrease of 17.2% from the $5,049,284 paid in SFY 2013.

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 2014, Clawback payments totaled $51,740,416, a 1.4% increase from the $51,031,590 paid in SFY 2013. The Clawback payment

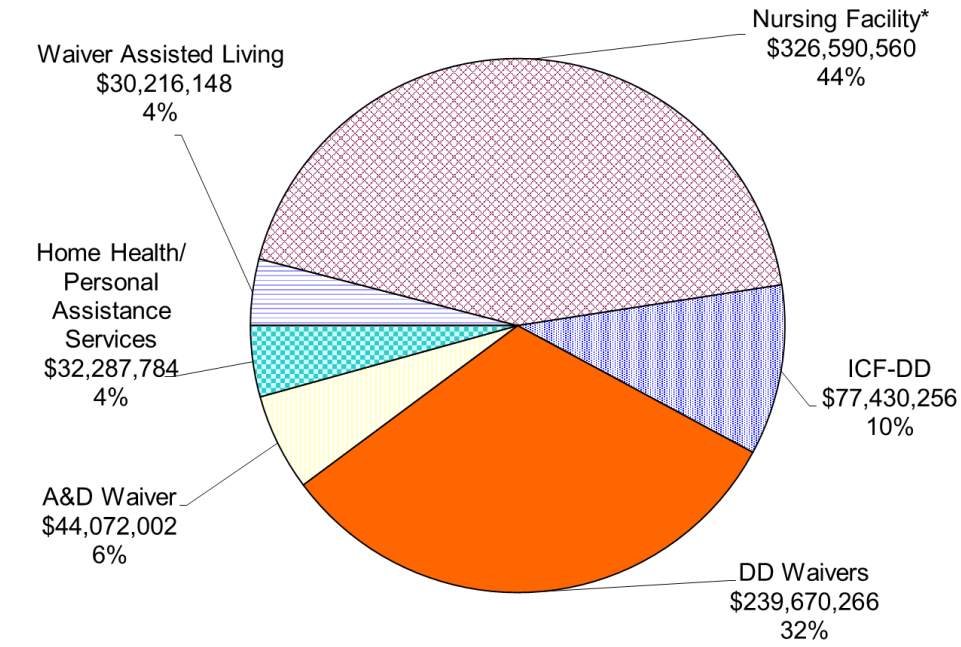
amount per person is based on a complex formula that takes into account the cost of drugs and the FMAP. Nebraska's FMAP has been steadily decreasing since FFY 2011.

LONG-TERM CARE SERVICES

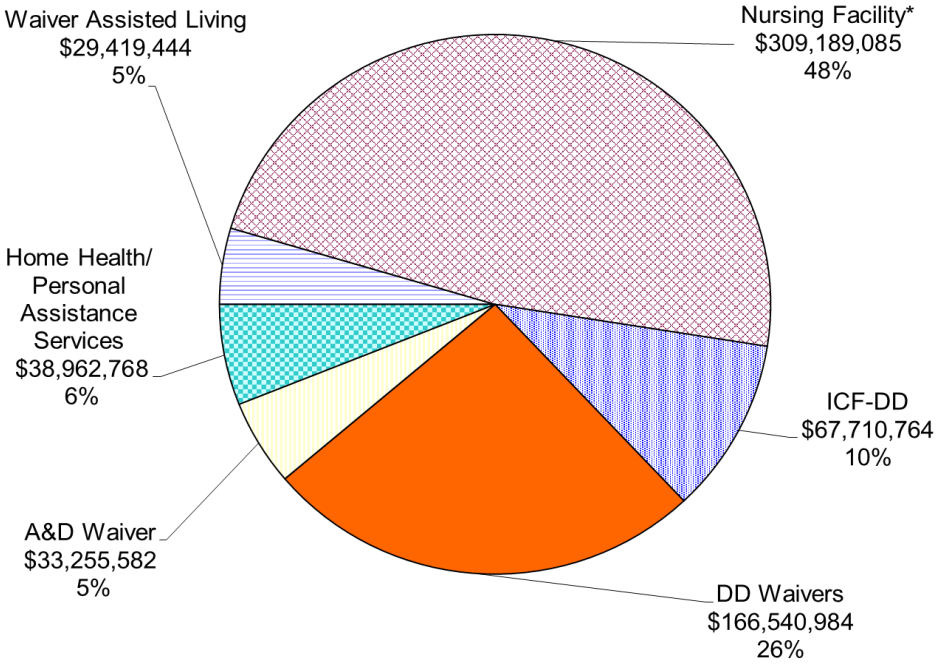
Long-term care (LTC) services support individuals with chronic or ongoing health needs related to age or disability. Services are geared to multiple levels of client need ranging from limited assistance with activities of daily living to complex nursing interventions. Assistance can be offered in a variety 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. Efforts to encourage home and community-based alternatives to facility based-care are resulting in a gradual rebalancing of LTC expenditures.

Figure 7

FY 2014 Medicaid Expenditures for Long-Term Care Services
Total: $750,267,016



FY 2009 Medicaid Expenditures for Long-Term Care Services
Total: $645,078,627



*Includes rate increase associated with LB600 implementation.
†A&D Waiver includes expenditures under the Traumatic Brain Injury waiver (FY09 = $681,376 & FY14 = $699,938).

C. PROVIDER REIMBURSEMENT

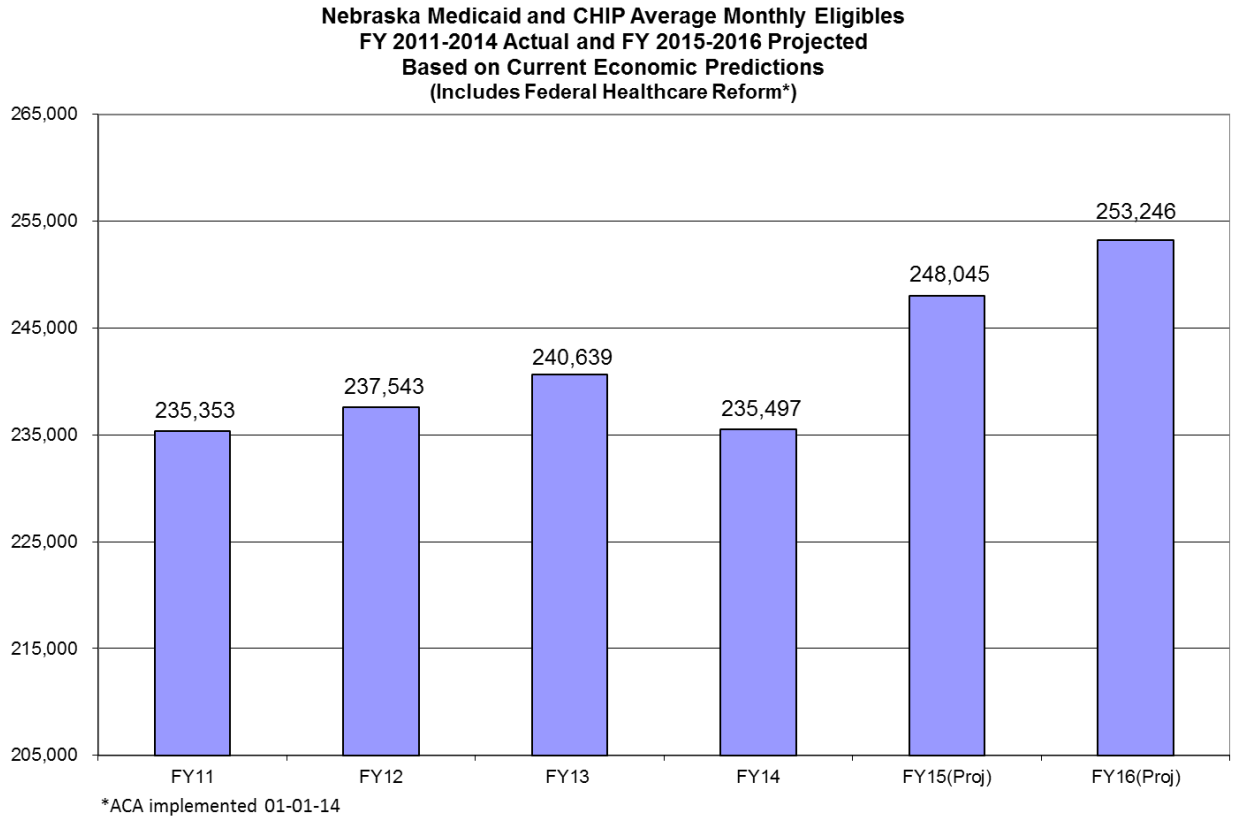
Medicaid purchases health services for clients on a fee-for-service (FFS) basis or, increasingly, by paying premiums to MCOs that coordinate provider networks and provider reimbursements.

The Nebraska Medicaid Program uses different methodologies to reimburse different 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 (DRG) or per diem rate. Critical Access Hospitals are reimbursed a per diem based on a reasonable cost of providing the services. Federally Qualified Health Centers (FQHCs) are reimbursed on a prospective payment system. Rural Health Clinics (RHCs) are reimbursed their 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. ICF/DDs are reimbursed on a per diem rate based on a cost model. Home and community-based waiver services, including assisted living costs, are reimbursed at reasonable fees as determined by Medicaid.

In many states, budget and enrollment pressures on Medicaid have led to cuts in provider rates. Nebraska Medicaid providers have received rate increases every year from 2005 through 2011. Effective July 1, 2011, rates for all provider types, excepting primary care services, were decreased by 2.5%. Effective July 1, 2012, the rates that were decreased were increased 1.54%. Effective July 1, 2013, Medicaid rates were increased up to 2.25% to a maximum of 100% of Medicare rates as of January 1, 2013. This did not include primary care services which were increased as a result of implementation of the ACA. Effective July 1, 2014, rates were again increased by up to 2.25% to a maximum of 100% of Medicare rates as of January 1, 2014.

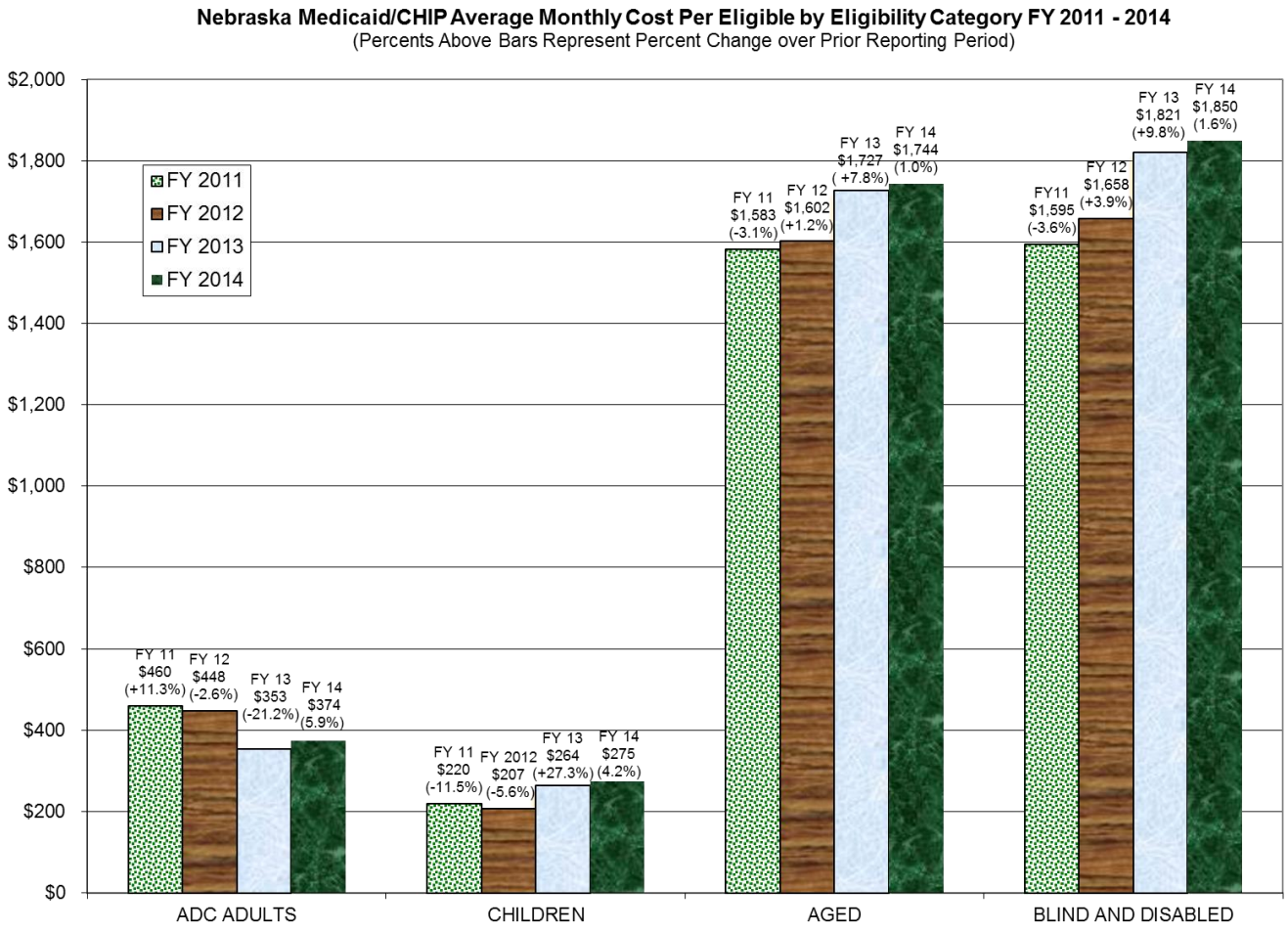
D. PROGRAM TRENDS AND PROJECTIONS

Figure 8



Nebraska Medicaid and CHIP experienced a significant increase in eligibles, starting in the latter half of SFY 2009 then continuing through SFY 2011, with an increase from SFY 2010 to 2011 of 4.9%. The increase from SFY 2011 to SFY 2012 was a modest 0.9%, attributed in part to the statutory expansion of CHIP eligibility to 200% FPL and to the national economy. The number of eligibles increased 1.3% from SFY 2012 to SFY 2013 and then decreased 2.1% from SFY 2013 to SFY 2014. Based on historical trends and on the findings of a Milliman report regarding implementation of the ACA, the average monthly eligibles in SFY 2015 are expected to increase by 5.3% as this year represents a full year of ACA implementation. Average monthly eligibles in SFY 2016 are expected to increase 2.1% over SFY 2015.

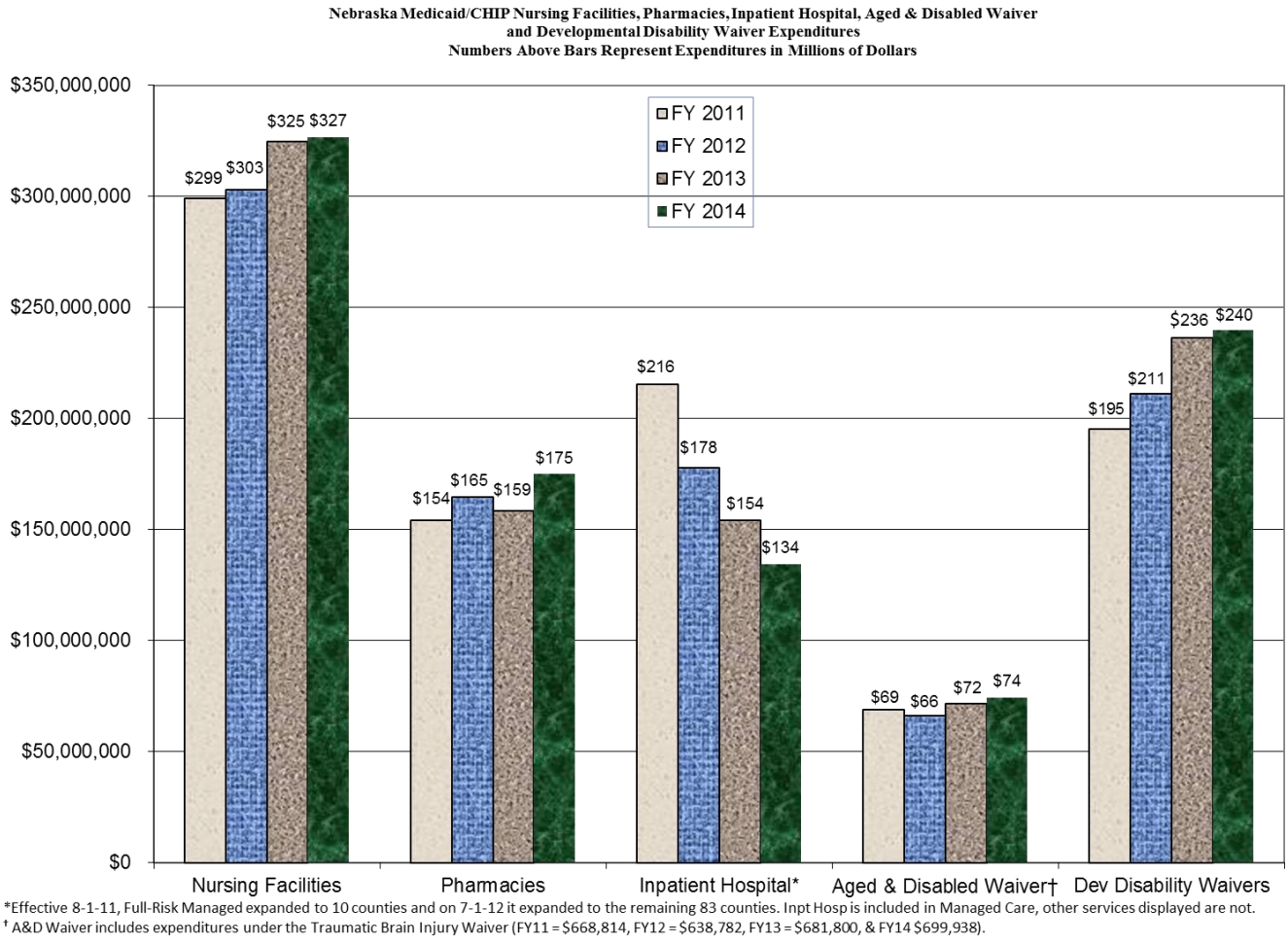
Figure 9



The average monthly cost per eligible (Figure 9) increased 3.2% overall from SFY 2013 to SFY 2014. The largest cost per eligible increase was in the ADC Adults category, which increased by 5.9%. The Aged category increased by 1.0%. The Children category increased by 4.2% and the Blind & Disabled category increased by 4.2%. As noted previously, decreases in expenditures in the Adult categories appear to be related, in large part, to the increasing inclusion of those clients in managed care.

The top four vendor expenditure categories in Medicaid/CHIP (excluding managed care capitation payments) are nursing facilities, pharmacies, inpatient hospital, and home and community services. The home and community service category consists of home health, personal assistance services and waiver services, including assisted living. Figure 10 reflects the trends in these categories from SFY 2011 through SFY 2014. The drop in inpatient hospital expenditures reflects inclusion in managed care.

Figure 10



*Effective 8-1-11, Full-Risk Managed expanded to 10 counties and on 7-1-12 it expanded to the remaining 83 counties. Inpt Hosp is included in Managed Care, other services displayed are not.
† A&D Waiver includes expenditures under the Traumatic Brain Injury Waiver (FY11 = $668,814, FY12 = $638,782, FY13 = $681,800, & FY14 $699,938).

E. SFY 2014 INITIATIVES

Highlighted below are some of the major projects during SFY 2014.

Enhanced Provider Enrollment and Screening Requirement

The ACA included enhanced provider screening and enrollment requirements for all Medicaid service-rendering providers in addition to those that order, refer, and prescribe services. Nebraska Medicaid implemented many of these requirements and is in the process of signing a contract with a vendor who will conduct provider screening and enrollment activities, including providing a web portal to simplify the application process, application and fee collection, database screening, and site visits. Currently the proposed contract is under review by CMS.

In May 2014, Nebraska Medicaid Provider Relations transitioned its provider enrollment processes and document retention to the OnBase enterprise content management system. This has resulted in process efficiencies and improvements in the turnaround times of the initial screening of provider submitted Service Provider Agreements. Additionally, it has improved records retention and retrieval, reduced costs by moving from a paper to secure-email process, and permitted closer oversight of the provider enrollment process.

Additional Program Integrity Initiatives

Medicaid also participates in a variety of new state and federal initiatives:

- ***The Medi-Medi Project:*** CMS contracts with vendors to aggregate Medicare and Medicaid claims data to identify fraud, waste or abuse by providers across both programs. Nebraska is participating in this project.

- ***Audits of New Initiatives:*** The Medicaid payment for primary care services at Medicare rates initiative has specific auditing requirements that are completed by Program Integrity staff.

- ***Payment Suspensions Due to Credible Allegations of Fraud:*** The ACA requires that Medicaid programs protect state and federal funds by suspending provider payments when there is a credible allegation of fraud against the provider. The protocols include specific tracking and notifications that must be followed.

National Correct Coding Initiative

Nebraska Medicaid continues to implement all of the National Correct Coding Initiative (NCCI) edits as mandated by the ACA. CMS updates and adds to the edits quarterly. CMS is planning an audit of state Medicaid agency compliance with the implementation of NCCI. An announcement of the audit is expected in September 2014.

ICD-10 – International Classification of Diseases Version 10

The federal DHHS mandated transition from the International Classification of Diseases version 9 (ICD-9) to ICD-10 for all Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entities (health care providers, clearinghouses and payers). Working in collaboration with the Division of Information & Technology (IS&T), MMIS requirements were developed; coding was completed and policies, forms and contracts were revised. External interface testing with trading partners started in April 2014, and significant systems changes were implemented on October 1, 2014. CMS delayed ICD-10 implementation until October 1, 2015. Because of this delay, providers will not be submitting claims with the ICD-10 codes until after that date. Additional testing and development along with communication and provider outreach activities continue.

MITA 3.0 -- Medicaid IT Architecture

The Medicaid IT Architecture (MITA) is a CMS initiative to establish national guidelines for technologies and processes that improve program administration for the State Medicaid Enterprise. CMS requires each state to complete a MITA 3.0 State Self-Assessment (SS-A) to

obtain enhanced federal funding for its Medicaid program. All technology-related funding requests from the state Medicaid agency to CMS must now reference MITA status and explain how MITA maturity will be enhanced through the funded work. The Division will complete and submit its SS-A in December 2014.

Administrative Simplification

All HIPAA covered entities, including providers, clearinghouses and payers, are required to comply with the ACA requirements to implement the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange® (CORE). The CORE Operating Rules are further standardization of the HIPAA Standard Electronic Transactions version 5010, implemented on January 1, 2012. Planning and implementation of the first two CORE phases began in 2013; these phases affect health plan eligibility (270/271) and health care claim status (276/277) transactions. This project is known as Medicaid AS-ECS (Administrative Simplification – Eligibility and Claim Status). An RFP was issued to procure a solution to the real-time requirements. Edifecs was awarded the contract in November 2013.

Transition of Medicaid Eligibility Function

In 2013, work began to move the eligibility determination for Medicaid and CHIP programs from the Division of Children and Family Services (CFS) to MLTC. The ACA required a joint application between Medicaid and insurance affordability products on the federally-facilitated marketplace and a break in the tie between Medicaid and public assistance. On July 1, 2103, supervision of Medicaid eligibility staff was transitioned from CFS to MLTC. This included all individuals in the Lincoln and Lexington Customer Service Centers (CSC), the Lincoln ACCESSNebraska Document Imaging (ANDI) Center and local office staff statewide. Effective October 1, 2013, Medicaid operations were transitioned to this Medicaid specific workforce and separate telephone numbers and processes to support Medicaid applicants and recipients were implemented.

Implementation of ACA Eligibility Changes

The implementation of the Medicaid eligibility requirements under the ACA were effective January 1, 2014. New regulations were adopted that consolidate Medicaid eligibility regulations from NAC titles 468, 469 and 477 into a consolidated title 477.

The use of MAGI as the income methodology for Medicaid and CHIP children, pregnant women and parents/caretaker relative groups became effective January 1, 2014. Nebraska's financial eligibility income standards were converted from net standards that incorporate income disregards to the equivalent MAGI income standard.

Significant system and process changes were required to support new policies and procedures as well as the separation of Medicaid from Economic Assistance operations. This required collaboration between divisions as well as significant effort from IS&T, Legal, the Department of Administrative Services and Human Resource and Development and Training.

MLTC Quality of Care and Analytics Team

In August 2012 MLTC started building a Quality team. During SFY 14, this team has evolved and now includes quality of care analysis as well as data analytics. The team's work has focused on conducting surveys, analyzing data, and developing and submitting reports to monitor and analyze quality of care. The team analyzes quality of care data, encounters, MCO reports, CMS Core Quality Measures for adults and children and eligibility and enrollment data. The team assists Managed Care contract managers monitor and evaluate the MCOs' quality performance improvement plans. In addition, the team is working on the implementation and submission of T-MSIS federal reporting and participates on the Health Information Exchange project.

External Quality Review Organization Contract

An RFP was issued to solicit a qualified contractor to provide external quality review services. This is a federal requirement for Medicaid management care programs. Island Peer Review Organization was awarded this contract effective October 1, 2013.

Medicaid Upper Payment Limit

Starting in 2013, CMS required states to submit upper payment limit (UPL) demonstrations on an annual basis. Previously, this information was collected or updated only when a state was proposing an amendment to a reimbursement methodology in its Medicaid State Plan. Starting in 2014, and annually thereafter, states are required to submit annual UPL demonstrations for inpatient hospital services, outpatient hospital services, clinics, physician services (for states that reimburse targeted physician supplemental payments), ICF/DD, private residential treatment facilities and institutes for mental diseases. This information must be submitted by the state prior to the start of each SFY. An RFP was issued to solicit proposals for qualified vendors to assist with these new requirements. The contract was awarded to Navigant.

Primary Care Services at Medicare Rates

Effective January 1, 2013, Medicaid payment rates for primary care services furnished by certain physicians in CYs 2013 and 2014 cannot be less than the Medicare rates. This minimum payment level applies to specified primary care services furnished by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. The methodology for FFS payments and for managed care capitation rates was approved by CMS. Although the federal rule to pay certain physicians no less than the Medicare rates ends December 2014, the Department will continue to reimburse these providers at the Medicare rates beginning in January 2015.

American Dental Association Claim Form 2012

Effective October 1, 2013, the Department no longer accepted the 1994, 1999, and 2002 versions of the American Dental Association (ADA) claim form. The 2006 ADA form was accepted only through December 31, 2013. Effective January 1, 2014, the 2012 ADA claim form became the only hardcopy dental claim form accepted by the Department for prior authorizations and reimbursement of services. On or after January 1, 2014, any claims received utilizing the older versions of the ADA Claim Form are returned to the provider.

Utilization Review Contract

Medicaid issued an RFP to solicit bids for a contractor, certified as a Quality Improvement Organization (QIO), to manage a statewide quality and utilization control program for services provided to Nebraska Medicaid clients in FFS programs. The contractor will review and make determinations regarding prior authorization, continued service (clinical) reviews, and continued service (non-clinical) reviews for hospital, ambulatory surgical centers and home health and private-duty nursing services. The contract was awarded to Telligen.

Non-Emergency Medical Transportation RFP

A Non-Emergency Medical Transportation RFP was released in September 2013. The purpose of this RFP was to enhance client transportation services and strengthen quality assurance activities. IntelliRide was awarded the contract effective May 2014.

Immediate Enrollment in Physical Health Managed Care

Effective February 1, 2014, the Department implemented immediate enrollment into managed care. Previously managed care enrollment was active the first of the next month following the choice of health plan either through voluntary enrollment or auto-assignment. This resulted in additional months of FFS enrollment and a delay in care coordination. With immediate enrollment, managed care coverage is active back to the beginning of the month in which the choice of health plan is made.

Health Information Exchange (HIE)

The Nebraska Health Information Initiative (NeHII) is the lead Health Information Exchange (HIE) in Nebraska and has the capability to serve any health care provider. Another HIE, Electronic Behavioral Health Information Network (eBHIN) focuses on the behavioral health care providers. Effective September 1, 2014, eBHIN transitioned network management functions to Heartland Community Health Network. This transition will help to sustain technology services into the future. The main purpose of an HIE is to exchange laboratory, radiology, medication history, clinical documentation, public health information and other medical data among Nebraska providers and hospitals. Nebraska Medicaid submitted a funding request to CMS on behalf of NeHII in July 2013. If approved, this funding will allow NeHII to assist Medicaid providers in achieving meaningful use of their electronic health record (EHR) technology, which is one of the qualifications for the EHR Incentive Program. Several of the meaningful use measures relate to the exchange of key medical information. The funding request is pending CMS approval at this time. The federal funding would be at 90% the total funds requested were just over $2.4 million.

Electronic Health Record (EHR) Incentive Payment Program

This program was established under the Federal Health Information Technology for Economic and Clinical Health (HITECH) Act, which is a part of the American Reinvestment and Recovery Act (ARRA) of 2009. The Medicare EHR Incentive Program is administered by CMS and the Medicaid EHR Incentive Program is administered by the states. HITECH funds this program through 2021. Nebraska launched the EHR Incentive Program on May 7, 2012. As of June 30, 2014, nearly $51 million has been paid to Nebraska providers. There are currently 596 eligible

professionals and 73 eligible hospitals participating in the program. A request for proposal (RFP) was issued to implement a new computer system that will allow for tracking of the providers as they move through the various program years and stages of the EHR incentive program. This will also allow better dashboard reporting. Maximus was awarded the contract in April 2014. Implementation of the new system is planned for October 6, 2014.

F. SFY2015 PROJECTS

Many of the SFY 2014 projects detailed above will continue in SFY 2015. In addition, new projects will be implemented.

Eligibility and Enrollment RFP and Independent Verification and Validation

The ACA requires significant changes to state Medicaid eligibility and enrollment (E&E) systems. Nebraska's current Medicaid eligibility system cannot meet the ACA requirements without significant modification and investment. As a result, Nebraska is implementing a new Medicaid E&E system. RFPs were issued for a new Medicaid eligibility solution and independent verification and validation (IV&V) activities associated with implementing a new Medicaid eligibility solution. WIPRO was awarded the contract for the E&E on March 19, 2014 and the project began on August 28, 2014. The new solution is expected to conclude in the latter half of SFY 16. Enhanced Federal funding is available for this project. First Data was awarded the contract for IV&V on November 13, 2013.

MMIS Replacement Project

Nebraska's MMIS was created in 1977 and can no longer meet the demands of a rapidly changing Medicaid environment. The need for expedient programmatic changes and the ability to readily produce data are just two of the many enhancements necessary to efficiently manage today's Medicaid program. Nebraska Medicaid began the replacement planning by building on a previous alternatives analysis to examine current options for upgrading/replacing the MMIS. Augmenting the alternatives analysis will be a procurement analysis and market analysis. The procurement analysis will look at contracting options, one RFP vs. multiple RFPs, a cost benefit study and how to handle particular Medicaid business functions. The market analysis will include a survey of other state MMIS projects, a vendor request for information (optional) and initial onsite vendor demonstrations. With technology improvements and increased federal requirements continuing, these efforts will leverage the work completed through the MITA 3.0 State Self-Assessment process. The culmination of the analysis effort will assist the Division in decision making and lead to the next steps in the procurement process.

Provider Screening and Enrollment

An RFP was issued in February 2014 for provider screening and enrollment services. On July 1, 2014, an intent to award to MAXIMUS Health Services, Inc. was posted. The proposed contract is currently under review by CMS. Once approved, implementation is expected in the final quarter of SFY 2015.

Administrative Simplification

Implementation of CORE (as described previously) Phase II and Phase III is planned for SFY 2015. Planning for CORE IV operating rules, compliance certification and health plan identifier will begin in SFY 2015.

Transformed-Medicaid Statistical Information System (T-MSIS)

The T-MSIS project, started in January 2013, is the expansion of federal reporting measures from the states' MMISs. The new report will be submitted monthly instead of quarterly. Report data has been expanded to include: eligibility information, health care quality measures, and managed care measures in addition to medical services claims and frequency reporting. Implementation and submission of T-MSIS reporting will begin in November 2014.

Radiology Management Services

An RFP has been issued to solicit bids for a qualified contractor to determine medical necessity and prior authorize advanced imaging studies for clients covered through FFS. A March 2015 implementation date is expected.

Nebraska Casemix System Web (NCSWeb)

Effective July 2014, Nebraska Medicaid implemented a live, secure web-based system for nursing home providers. This casemix system allows providers to generate level of care reports as well as weighted days reports. It also enables them to see the status of their resident assessments in terms of timeliness, errors, reimbursement, accurate billing, resident data, and not having their claims rejected. It will eliminate the monthly and yearly mailing of reports to facilities. Nebraska Medicaid has been collaborating with nursing facility associations in order to instruct providers on the use of the system. It is expected that the use of this system will be mandatory in early 2015.

Balancing Incentive Program (BIP)

As a result of LB 690, MLTC submitted a grant application for the Balancing Incentive Program (BIP) to CMS on July 31, 2014. The BIP supports states in providing care in the most appropriate, least restrictive setting. The BIP provides enhanced funding for states that commit to creating a No Wrong Door/Singe Entry system and a standardized assessment, and provide conflict-free case management for clients seeking community long-term services and supports. The enhanced funding must be used to strengthen home and community-based services. The grant application was approved by CMS on September 11, 2014.

Expanded Services in Physical Health Managed Care

Effective July 1, 2015 Nebraska Medicaid will be carving dental, hospice, non-emergency ambulance, and transplant services into the physical health managed care delivery system. In addition, clients eligible for Medicaid through the subsidized adoption and Women with Cancer programs will be mandatory for enrollment into managed care for July 2015.

Integration of Physical Health and Behavioral Health Managed Care

Effective July 1, 2017, Nebraska Medicaid will be integrating physical health and behavioral health managed care programs. In addition, the pharmacy benefit will be carved in to the managed care delivery system to further promote integration of care for clients. A request for proposal is anticipated to be released in late 2015 for three managed care vendors statewide.

Managed Long-Term Services and Supports

Work has begun on developing a statewide managed care program for the delivery of long-term care services and supports. Examples of long-term care services included in this initiative are nursing facility, personal assistance, home health, and those provided under home and community based services waivers, such as home care/chore, respite and assisted living. Goals of the program include the following:

- Improve client health status and quality of life by better coordination of medical care, behavioral health care and community-based services and supports.
- Promote client choice and use of the right services and supports at the right time in the right amount.
- Increase client access to responsive, quality services and supports.
- Use financial resources wisely to sustain Nebraska Medicaid.

An advisory council was formed to provide input into the design, planning, implementation and monitoring of the program. In October and November 2013, town hall meetings were conducted across the state to provide an opportunity for broader public input in the program design. The targeted implementation date is July 2018.

III. CONCLUSION

The Department of Health and Human Services, Division of Medicaid & Long-Term Care strives to operate a Medicaid program which addresses the health care needs of eligible low-income Nebraska residents in a cost-effective and deliberately planned manner. The number of Medicaid eligible recipients has increased in recent years due to economic conditions. The program and policies referenced in this Annual Report work to moderate the growth of Medicaid expenditures. These policies and initiatives slow the growth of the Medicaid program and further fiscal sustainability by making the program more efficient and cost-effective through careful management of services, better delivery of care, more appropriate services and improved program administration.

The Division looks forward to continuing to work with the Governor, the Legislature, the Medicaid Reform Council, and stakeholders to improve Medicaid for current and future generations.